

10 August 1971

C 27, AR 40-501  
App IV

★APPENDIX IV  
JOINT MOTION MEASUREMENT  
(TM 8-640)

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Rescinded.

APPENDIX V

TABLE OF MINIMUM VALUES OF VISUAL ACCOMMODATION FOR ARMY AVIATION

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

★APPENDIX VI

PULMONARY FUNCTION PREDICTION FORMULAS—ARMY AVIATION

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1. Predicted Vital Capacity (Baldwin)  
 $27.63 - (0.112 \times \text{age}) \times \text{height in cm.}$
2. Predicted Maximum Breathing Capacity (Motley)  
 $(97 - \frac{\text{age}}{2}) \times \text{body surface area (in M}^2\text{)}$

★ APPENDIX VII  
METHODS OF ASSESSING CARDIOVASCULAR DISABILITY

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al; Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
I.	Patient with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea, or anginal pain.	Ordinary physical activity as walking and climbing stairs, does not cause angina. Angina with strenuous or rapid or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalents; e.g., can carry 24 lbs up eight steps; carry objects that weigh 80 lbs.; do outdoor work (shovel snow, spade soil); do recreational activities (skiing, basketball, squash, handball, jog and walk 5 mph).	Cardiac status uncompromised.
II.	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	Slight limitations of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening. Walking more than two blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.	Patient can perform to completion any activity requiring $\geq 5$ metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents; e.g. have sexual intercourse without stopping, garden, rake, weed, roller skate, dance fox trot, walk at 4 mph on level ground.	Slightly compromised.
III.	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight in normal conditions.	Patient can perform to completion any activity requiring $\geq 2$ metabolic equivalents but cannot and does not perform to completion any activities requiring $\geq 5$ metabolic equivalents; e.g. shower without stopping, strip and make bed, clean windows, walk 2.5 mph, bowl, play golf, dress without stopping.	Moderately compromised.
IV.	Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Inability to carry on any physical activity without discomfort—anginal syndrome may be present at rest.	Patient cannot or does not perform to completion activities requiring $\geq 2$ metabolic equivalents. Cannot carry out activities listed above (specific activity scale, Class III).	Severely compromised.

New York Heart Association Therapeutic Classification

*Therapeutic classification*

**Class A**—Patients with cardiac disease whose physical activity need not be restricted.

**Class B**—Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against severe or competitive physical efforts.

**Class C**—Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.

**Class D**—Patients with cardiac disease whose ordinary physical activity should be markedly restricted.

**Class E**—Patients with cardiac disease who should be at complete rest, confined to bed or chair.

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*Revised classification (prognosis)*

**Class I**—Good.

**Class II**—Good with therapy.

**Class III**—Fair with therapy.

**Class IV**—Guarded despite therapy.

**APPENDIX VIII  
PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE**

9 February 1987

Profile serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing—ears	E Vision—eyes	S Psychiatric
1 . . . . .	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits, or limitation of motion; no demonstrable abnormality; able to do hand-to-hand fighting.	No loss of digits, or limitation of motion; no demonstrable abnormality; be capable of performing long marches, standing over long periods.	★ Audiometer average level for each ear not more than 25 dB at 500, 1000, 2000 Hz with no individual level greater than 30 dB. Not over 45 dB at 4000 Hz.	Uncorrected visual acuity 20/200 correctable to 20/20, in each eye. .	No psychiatric pathology. May have history of a transient personality disorder.
2 . . . . .	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which do not prevent hand-to-hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.	Audiometer average level of 6 readings (3 per ear) at 500, 1000, 2000 Hz or not more than 30 dB, with no individual level greater than 35 dB at these frequencies, and level not more than 55 dB at 4000 Hz; or audiometer level 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz, and 35 dB at 4000 Hz in better ear. (Poorer ear may be deaf.)	Distant visual acuity correctable to 20/40-20/70, 20/30-20/100, 20/20-20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcoholic or drug addiction. Individuals who have been evaluated by a physician (psychiatrist) and found to have a character and behavior disorder will be processed through appropriate administrative channels.
3 . . . . .	Unable to perform full effort except for brief or moderate periods.	Defects or impairments which interfere with full function requiring restriction of use.	Defects or impairments which interfere with full function requiring restriction of use.	★ Speech reception threshold in best ear not greater than 30 dB HL, measured with or without hearing aid; or, acute or chronic ear disease not falling below retention standard. Aided speech reception threshold measured at "comfort level"; i.e., volume control of hearing aid adjusted to 50 dB HL speech noise.	Uncorrected distant visual acuity of any degree which is correctable not less than 20/40 in the better eye or an acute or chronic eye disease not falling below retention standards.	Satisfactory remission from an acute psychotic or neurotic disorder which permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided.)

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**APPENDIX VIII**  
**PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE—Continued**

Profile serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing—ears	E Vision—eyes	S Psychiatric
4 . . . . .  Factors to be considered.	Below standards contained in chapter 3.  Organic defects, age, build, strength, stamina, weight, height, agility, energy, muscular coordination, function, and similar factors.	Below standards contained in chapter 3.  Strength, range of motion, and general efficiency of upper arm, shoulder girdle and back, including cervical, thoracic, and lumbar vertebrae.	Below standards contained in chapter 3.  Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back.	Below standards contained in chapter 3.  Auditory sensitivity and organic disease of the ears.	Below standards contained in chapter 3.  Visual acuity, and organic disease of the eyes and lids.	Below standards contained in chapter 3.  Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorder impairment of functional capacity.

### APPENDIX IX SCOPE AND RECORDING OF MEDICAL EXAMINATIONS

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
1	✓	✓	The entire last name, first name, and middle name are recorded. If the individual's first and/or middle name consists of initial(s) only, indicate by adding (IO). When Jr. or similar designation is used, it will appear after the middle name. If there is no middle name or initial, put a dash after the first name.	Jackson, Charles Guy Rush, Benjamin— Osler, William Z. (IO) Jenner, Edward Thomas Jr. Baird, J. T.
2	✓	✓	Enter examinee's grade and component. The entry USA is used for all personnel on active duty with the United States Army. Reserve components of the Army are indicated by USAR or ARNGUS. If examinee has no military status, enter the word "civilian," leaving space for later insertion of grade and component upon entry into the military service.	CPT, USA; MAJ, USAR; SGT, USA; SFC, ARNGUS; Civilian.
3	✓	✓	Examinee's social security number. If none, enter a dash.	396-38-0699/—
4	✓	✓	Examinee's current civilian mailing address. Do not confuse with military organization or present temporary mailing address.	
5	✓	✓	Enter purpose of examination. If for more than one purpose, enter each. If for aviation personnel, enter "Flight" plus Class 1, 1A, 2, 2A or 3; and enter "Initial," "Repeat" or "Periodic," as required.	Induction; RA Enlistment; Periodic; RA commission; Retirement; Flight Class I (Initial).
6	✓	✓	Enter date on which the medical examination is accomplished. Record in military style. This item is to be completed at the medical examining facility.	10 Feb 65 3 Mar 65
7	✓	✓	Do not use abbreviation.	Male
★ 8	✓	✓	Enter the corresponding number for the appropriate race/ethnicity: American Indian/Alaskan Native—1 Asian/Pacific Islander—2 Black, not of hispanic origin—3 Black, hispanic origin—4 White, not of hispanic origin—5 White, hispanic origin—6 Unknown—7	3
9	✓	✓	Enter total active duty time in the military and/or full time Civil Service or Federal employment only. Express as years plus twelfths. Reserve time may be entered in item 16.	
10	✓	✓	Enter branch of military service or civilian agency as appropriate. <i>Do not confuse with components of the services.</i>	DA DAF DN USMC FBI CIA State Dept.
11	✓	✓	The examinee's current military unit of assignment, active or reserve. If no current military affiliation, enter a dash.	
12	✓	✓	Record in military style; i.e., day, month and year, followed by age, in parenthesis, to the nearest birthday.	14 Jan 43(21) 26 Mar 20(45)

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
13	✓	✓	Name of city and State of examinee's birth. If not born in a city or town, enter county and State. If born in a foreign country, enter city or town and country.	Baltimore, MD Dinwiddie County, VA Marseilles, France
14	✓	✓	Name, followed by relationship in parentheses, and address of next of kin. This is the person to be notified in the event of death or emergency. If there is no next of kin, enter "none."	Mrs. Annie F. Harris (Wife) 1234 Fairfax Ave. Atlanta, GA 20527-1234
	✓	✓	Name of examining facility or examiner and address. If APO, include local national location.	Military Entrance Processing Station 310 Gaston Ave. Fairmont, WV 12441-3217 Dr. Raymond T. Fisher 311 Marcy Street Phoenix, AZ 39404-0311
16	✓	✓	List any prior service number(s) and service(s). In the case of service academy examinees, enter the title, full name, and address of sponsor (individual who requested the examination). For Selective Service registrants list the examinee's Selective Service number and identify as such. Identifying or administrative data for the convenience of the examining facility should be entered either in item 16, if space allows, or otherwise in the upper right hand corner of the SF 88. If the examination is for an aviation procurement program and the examination has prior military service, enter the branch of service.	
17	✓	✓	The individual's current military job or specialty by title and SSI/MOS, including total time in this capacity expressed in years and/or twelfths. For pilots, enter current aircraft flown and total flying time in hours. In the case of free fall parachuting and/or marine (SCUBA) diving, so state and report the time in months or years of qualification.	
18	✓	✓	Record all swollen glands, deformities, or imperfections of head or face. In the event of detection of a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If enlarged lymph nodes of the neck are detected they will be described in detail and a clinical opinion of the etiology will be recorded.	2 in. vertical scar right forehead, well healed, no symptoms. 3 discrete, freely movable, firm 2 cm nodes in the right anterior cervical chain, probably benign.
19	✓	✓	Record all abnormal findings. Record estimated percent of obstruction to air flow of septal deviation, enlarged turbinates, or spurs are present.	20 percent obstruction to air flow on right due to septal deviation.
20	✓	✓	Record all abnormal findings.	Marked tenderness over left maxillary sinus.
21	✓	✓	Record any abnormal findings. If tonsils are enucleated, this is considered abnormal, thus check this item abnormal.	Tonsils enucleated.
22	✓	✓	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered.	Bilateral severe swelling, injection and tenderness of both ear canals.
23	✓	✓	Record all abnormal findings. If tested, a definite statement will be made as to whether the ear drums move on valsalva maneuver or not. In the event of scarring of the tympanic membrane the percent of involvement of the membrane will be recorded as well as the nobility of the membrane. Valsalva required for all diving, free fall parachuting, and flying duty examinations.	Valsalva normal bilaterally. 2 mm oval perforation, left posterosuperior quadrant. No motion on valsalva maneuver, completely dry. No evidence of inflammation at present.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
24	✓	✓	Record abnormal findings. If ptosis of lids is detected, a statement will be made as to the cause of the interference with vision. When pterygium is found, the following should be noted: 1. Encroachment on the cornea, in millimeters, 2. Progression, and 3. Vascularity.	Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye. Does not encroach on cornea; nonprogressive, avascular.
25	✓	✓	Whenever opacities of the lens are detected, a statement is required regarding size, progression since last examination, and interference with vision.	Redistribution of pigment, macular, rt. eye, possibly due to solar burn. No loss of visual function. No evidence of active organic disease.
26	✓	✓	Record all abnormal findings.	
27	✓	✓	Record all abnormal findings.	
28	✓	✓	If rales are detected, state cause. The examinee will be evaluated on the basis of the cause of the pulmonary rales or other abnormal sounds and not simply on the presence of such sounds.	Sibilant and sonorous rales throughout chest. Prolonged expiration. See item 73 for cause.
29	✓	✓	Abnormal heart findings are to be described completely. Whenever a cardiac murmur is heard, the time in the cardiac cycle, the intensity, the location, transmission, effect of respiration, or change in the position, and a statement as to whether the murmur is organic or functional will be included. When murmurs are described by grade, indicate basis of grade (IV or VI).	Grade II/IV soft, systolic murmur heard only in pulmonary area and on recumbency, not transmitted. Disappears on exercise and deep inspirations (physiological murmur).
30	✓	✓	Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency.	Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency.
31	✓	✓	Include hernia. Note any abdominal scars and describe the length in inches, location, and direction. If a dilated inguinal ring is found, a statement will be included in item 31 as to the presence or absence of a hernia.	2½ in. linear diagonal scar, right lower quadrant.
★ 32	✓	✓	Digital rectal required for all 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.
33	✓	✓	Record all abnormal findings.	
34	✓	✓	Whenever a varicocele or hydrocele is detected, a statement will be included indicating the size and the presence of pain. If an undescended testicle is detected, a statement will be included regarding the location of the testicle, particularly in relation to the inguinal canal.	Varicocele, left, small.
35	✓	✓	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as, for example, a history of a broken arm with no significant finding at time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the "normal" column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is desired.	No weakness, deformity, or limitation of motion, left arm.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
36	✓	✓	Record any abnormality. When flat feet are detected, a statement will be made as to the stability of the foot, presence of symptoms, presence of eversion, bulging of the inner border, and rotation of the astragalus. Pes planus will not be expressed in degree, but should be recorded as mild, moderate, or severe.	Flat feet, moderate. Foot stable, asymptomatic, no eversion or bulging; no rotation.
37	✓	✓	Record as for item 35.	
38	✓	✓	Include pelvis, sacroiliac, and lumbrosacral joints. Check history. <i>If scoliosis is detected, the amount and location of deviation in inches from the midline will be stated.</i>	Scoliosis, right, 1/2 inch from midline at level of T-8.
39	✓	✓	Only scars or marks of purely identifying significance or which interfere with function are recorded here. Tattoos which are obscene or so extensive as to be unsightly will be described fully.	1-inch vertical linear scar, dorsum left forearm. 3-inch heart-shaped tattoo, nonobscene, lateral aspect middle 1/2 left arm.
40	✓	✓	Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment.	Small, discrete, angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping. Similar lesion on glans penis.
41	✓	✓	Record complete description of any abnormality.	
42	✓	✓	Record all abnormalities. This is not to be confused with ARMA (item 72).	
43	(*)	(*)	*See paragraph 10-23 for requirements for pelvic examination and Papanicolaou test. Check vaginal or rectal. Record any abnormal findings.	Normal.
44	✓	✓	Dental examination accomplished by a dentist is required for applicants for Service Academy, Uniformed Services University of the Health Sciences, the Four-Year ROTC Scholarship Program, and diving training and duty (see also AR 40-29 and chap. 7 of this regulation). Examinations accomplished for appointment as commissioned or warrant officers, enlistment or induction in the Army, Army National Guard, and Army Reserve, aviation training and duty, entrance on active duty or active duty for training, periodic (Active Army, Army National Guard and Army Reserve), discharge, relief from active duty, or retirement <i>do not</i> require dental examinations accomplished by a dentist. Examining physicians will apply the appropriate standards prescribed by chapters 2, 3, 4, or 6, and indicate "acceptable" or "nonacceptable."	Nonacceptable.
45A	✓	✓	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.	
B	✓	✓		
C	✓	✓		
D	✓	✓		
46	✓	✓	Required for initial examination for appointment, enlistment or induction into the Active or Reserve Component; for aviation, diver, HALO, and Special Forces training; and for discharge and relief from active duty or retirement (if a medical examination is accomplished). Not required for periodic examinations, including flying duty, unless clinically indicated. Note place and date taken, and findings.	Womack Army Community Hospital, Ft Bragg. NC 28307-5000, 11 July 1985, negative.
47	✓	✓	Kahn, Wasserman, VDRL or cardiolipin microfloculation tests recorded as nonreactive or reactive. On reactive reports note	Nonreactive. Reactive.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
48	(*)	✓	<p>date, place and titre. Serology not required for periodic examinations, unless clinically indicated.</p> <p>*Required for retirement or if age 40 or over; also if indicated; and on all flying, Special Forces and diving duty examinations regardless of age. Representative original samples of all leads (including precordial leads) properly mounted and identified on SF 520 (EKG report) will be attached to the original SF 88. SF 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 on all copies of SF 88.</p>	<p>Normal Abnormal—see attached SF 520.</p>
49 ★ 50	✓	✓	<p><b>(Rescinded)</b></p> <p>Mammography—Baseline age 35 and annually at and after age 40 for women on active duty or active duty for training tours in excess of 1 year.</p> <p>White Blood Cell Count—All marine divers.</p> <p>Hematocrit (or Hemoglobin) required for all periodic, all flying duty and all separation examinations. Not required for Reserve Component personnel, except flying duty.</p> <p>Stool Guaiac—Periodic and separation examinations for all Army members age 40 and over, and on all <i>initial</i> flying and diving duty examinations regardless of age.</p> <p>Cholesterol—Periodic and separation examinations commencing at age 20. All flying duty examinations.</p> <p>Fasting Blood Glucose—Active Army members age 40 and over.</p> <p>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.</p> <p>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, Advanced Course Army ROTC, and direct appointment of commissioned and warrant officers from civilian sources. HTLV-III testing must be accomplished prior to accession. If more than 6 months elapse between the test and accession, the test must be repeated.</p>	<p>Identify test(s) and record results.</p>
51	✓	✓	<p>Record in inches to the nearest quarter inch (without shoes). For Class 1 and 1A aviation personnel, record time of day if near height limits. For initial Classes 1, 1A; initial Class 2 (Aviator); and continuance Class 2 (Aviator) not previously measured: Leg length, sitting height, and functional arm reach will be measured, in accordance with guidance from HQDA(SGPS-CP-B), on all applicants less than 68 inches in height. Data will be recorded in item 73.</p>	<p>71½.</p>
52	✓	✓	<p>Record in pounds to the nearest whole pound (without clothing and shoes).</p>	<p>164.</p>

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
53	✓	✓	Record as black, blond, brown, gray or red.	Brown.
54	✓	✓	Record as blue, brown, gray or green.	Blue.
55	✓	✓	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For definition of obesity see appendix I.	
56	(*)	✓	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°.
57A	✓	✓	Record for all examinees.	110/76.
57B	(*)	✓	Required for initial flying and diving duty.	
C			*For type A examinations and for continuance on flying and diving duty (Type B), required only if indicated by abnormal history, examination or findings in 57A; e.g., sitting blood pressure exceeds limits prescribed by standards of medical fitness applicable to the purpose of the examination. Abnormal readings should be rechecked as prescribed by paragraph 11-10 or by Cdr, USAAMC, for flying duty examinations.	
58A	✓	✓	Record for all examinees.	
58B, C, D and E	(*)	✓	Required for initial flying and diving duty. *For Type A examinations and for continuance on flying and diving duty (Type B), required only if indicated by abnormal history, examination or findings in 58A; e.g., if A is 100 or more, or below 50. If either D or E is 100 or more, or less than 50, record pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73.	
59	✓	✓	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye.	20/100 corr. to 20/20. 20/50 corr. to 20/20.
60	(*)	✓	*Refraction required for induction, enlistment and appointment if corrected vision is less than the minimum visual standards stated in paragraph 2-13a or if deemed appropriate by the examiner regardless of visual acuity. Cycloplegic required for initial selection for Class 1 and 1A flying duty examinations (preferred agent is cyclopentolate 1%). The word "manifest" or "cycloplegic," whichever is applicable, will be entered after "refraction." An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value.	By - 150 S + 0.25 CX 05. By - 150 S + 0.25 CX 175.
61	✓	✓	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20) an entry will be made of the corrected vision for each eye and lens value after the word "by."	20/40 corr. to 20/20 by same. 20/40 corr. to 20/20 by +0.50.
62	-	✓	Identify test used; i.e., either Maddox Rod or Stereoscope, Vision Testing, and record results, Prism Div and PD not required. Not required for diving. All subjective tests will be at 20 feet or at a distance setting of SVT. For flying duty Classes 1, 1A and 2, the following are required: A Cover Test (CT) at near and distance, with an accommodative fixation target (visual acuity letter) in primary position. Distance CT will be performed in horizontal and vertical fields of gaze. A Near Point of Convergence (NPC) will be measured from the anterior corneal surface and reported under "PC" in millimeters. For NPC, accommodative target will be used. An accommodative (Prince) rule will not be used.	Stereoscope, Vision Testing (SVT). ES° 4 EX° 0 R.H. 0 L.H. 0 Prism Div . . . . . CT Ortho. PC 35 PD.
63	-	✓	Record values without using word "diopters" or symbols.	Right 10.0; Left 9.5

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
64	✓	✓	Required for all flying duty examinations. For others required only as initial test and subsequently only when indicated. Record results in terms of test used. Pass or Fail—number of plates missed over number of plates in test. The Farnsworth Lantern (FALANT)(USN) may be utilized. If the examinee fails either of these tests, he or she will be tested for red/green color vision and results recorded as "pass" or "fail" red/green (not applicable to flying duty, see paragraph 4-12).	Pseudoisochromatic plate; or PIP.  Pass 3/14. Fail 9/14.
65	—	✓	Identify test used. Record results in "Corrected" or "Uncorrected," as applicable. Enter score for Verhoeff or VTA as "pass" or "fail" plus number missed over maximum score for that test.	Verhoeff pass 0/8. VTA pass through D; fail 1/9.
66	—	✓	Identify test used and results. If a visual field defect is found or suspected in the confrontation test, a more exact perimetric test is made using the perimeter and tangent screen. Findings are recorded on visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.
67	—	(*)	*Only if indicated by history, record results. If not indicated, enter "Not Indicated by History (NIBH)."	NIBH.
68	—	✓	Record test results and describe all abnormalities.	Normal.
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.
70	—	—	Not required. Enter dash in each space.	
71	✓	✓	Test and record results at 500, 1000, 2000, 3000, 4000, and 6000 cycles.	
72	(*)	✓	*Only if indicated. Adaptability Rating for Military Aeronautics (ARMA) and Reading Aloud Test (RAT) (appendix X; also AR 40-29) required for initial entry of aviation personnel, Classes 1, 1A, 2 and 3, and air traffic controllers, Class 2A. Enter as "ARMA satisfactory" or "ARMA unsatisfactory." Unsatisfactory ARMA requires a summary of defects responsible for failure in item 73. ARMA, RAT and DA Form 3742 required for service academies and preparatory schools. Results of other psychological testing, when accomplished, will be attached to SF 88. Military Diving Adaptability Rating (MDAR) required for initial entry for diving duty. This rating will include consideration of requirements of paragraph 7-10. If the chamber required for paragraph 7-10d(3) is not available, that test will be conducted at the Naval Diving and Salvage Training School. Include a statement in item 73 in answer to paragraph 7-10g(3) whether he or she has fear of depths, inclosed places or of the dark.	ARMA sat. ARMA unsat.—see item 73.  RAT sat.  MDAR sat. MDAR unsat.
73	✓	✓	If SF 93 is not used, the examinee will enter a brief statement about the state of his or her health since his or her last examination. Examiner will enter notes on examination as necessary. Significant medical events in the individual's life, such as major illnesses or injuries, and any illness or injury since the last in-service medical examination, will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof, will be noted where appropriate. Comments from other items may also be continued in this space. If additional space is	No significant or interval history.  Traumatic cataract, left eye, removed 29 July 1964, no comp., see item 59-60 for vision correction.  Item 72 cont: History of

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
			<p>needed, use SF 507. History and related comments recorded on SF 93, when this form is used, will not be transferred or commented on except as necessary in connection with the examination. All aviation personnel will include and <i>sign</i> the following entry: "I understand I must be cleared by a flight surgeon after hospitalization or sick in quarters (AR 600-105); must inform him or her after treatment or activities which may require restriction (AR 40-8); I have read AR 40-8; I have informed the examining physician of any changes in health since last examination." (Rubber stamp may be used.)</p> <p>Other statements of medical history such as "no history of asthma, allergies, loss of consciousness, or convulsions," etc. may also be used.</p> <p>Results of cardiovascular screening will be entered as follows: Favorable or Unfavorable.</p>	multiple idiopathic syn-copal attacks.
74	✓	✓	Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect which may be of future significance, such as nonstatic defects which may become worse. Enter item number followed by short, concise diagnosis; do not repeat full description of defect which has already been described under the appropriate item. Do not summarize minor, nonsignificant findings.	
75	✓	✓	Notation will be made of any further specialized examinations or tests that are indicated. Item 75 will also include the statement "protective mask spectacles required (AR 40-3)" whenever indicated under the criteria set forth in AR 40-3.	
76	✓	✓	The physical profile as prescribed in chapter 9 will be recorded.	1 1 1 1 2 1
77	✓	(*)	* Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5. Though not required, this item may be completed as a recommendation of the examining physician in the case of applicants or nominees for the USMA or the USNA. No entry will be made for USAFA applicants or nominees.	
78	✓	✓	List all disqualifying defects by item number. This listing is required even though the defects are stated in item 74. If qualified, enter a dash.	
79-81	✓	✓	Enter typed or printed name of examiners. If examination is accomplished for entrance into service academies (USMA, USNA, USAFA, USCGA, USMMA) signatures of physician and dentist are required. If examination is accomplished for entrance into aviation duty, Classes 1, 1A, 2, 2A, and 3, signature of a military or civilian employee flight surgeon (Army, Navy or Air Force) is required. Examinations accomplished for enlistment or induction, entrance on active duty of Reserve Component members, and all periodic, discharge, relief from active duty and retirement examinations must be signed by a physician. Dentist, optometrists, podiatrists, audiologists, nurse practitioners, and physician assistants may also sign attesting to that portion of the examination actually accomplished by them.	
82	(*)	(*)	* See paragraph 10-14d.	

\*Notes: 1. When a "Repeat" Class 1 and 1A flying duty examination is required due to examinee not beginning flight training within 18 months from the date of the original Class 1 or 1A examination, the "Repeat" Class 1 and 1A will be identical to the initial examination except that:

a. If a normal chest X-ray has been reported within the past 3 years, a repeat chest X-ray is not required unless clinically indicated. Information regarding the original X-ray will be recorded in item 45, SF 88.

b. If a negative test for sickle cell trait is recorded in the health record, a repeat test need not be done. A notation that the test was negative will be recorded in item 50, SF 88.

c. Anthropometric measurements, if required, may be transcribed from the original SF 88 without being repeated.

*All other portions of the flying duty examination, including the cycloplegic refraction, must be repeated.*

d. A new Report of Medical History (SF 93) is required in all cases.

2. When flying duty medical examinations are performed on Army personnel at USAF and USN facilities, certain tests may not be available (e.g., RAT) or tests other than those used by the Army may be the only ones available (e.g., Farnsworth Lantern rather than PIP). In such cases, the Cdr. USAAMC, is authorized to waive the requirement or accept the substitute test.

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P I N : 0 1 5 5 6 2 - 0 3 5

**★ APPENDIX X  
READING ALOUD TEST**

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Reading Aloud Test (RAT):

a. The Reading Aloud Test will be administered to all applicants. The test will be conducted as follows:

(1) Have the examinee stand erect, face the examiner across the room and read aloud, as if he were confronting a class of students.

(2) If he pauses, even momentarily, on any phrase or word, the examiner immediately and sharply says, "What's that?" and requires the examinee to start again with the first sentence of the test. The true stammerer usually will halt again at the same word or phonetic combination and will often reveal serious stammering.

b. Reading Aloud Test. "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter when the ooze of snow or ice is present, he slowly takes a short walk each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana oil!' Grandfather likes to be modern in his language."

c. When administered to aviation personnel, to include air traffic control personnel, the RAT will be used to determine the individual's ability to clearly enunciate, in the English language, in a manner compatible with safe and effective aviation operations. The examining physician will consult with a local instructor pilot or air traffic control supervisor in questionable cases.

<p>PERIODIC MEDICAL EXAMINATION (Statement of Exemption) (For use of this form, see AR 40-501; the proponent is the Office of The Surgeon General)</p>	<p>DATE</p>
<p>LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE &amp; SSN (Type or Print)</p>	
<p>ORGANIZATION</p>	
<p>I underwent a medical examination in conjunction with _____ on or about _____ (Date) at _____ _____(Medical Treatment Facility) and to the best of my knowledge there has been no significant change in my medical condition since the accomplishment of that medical examination.</p> <p>_____ (Signature)</p>	



**INTERIM MEDICAL EXAMINATION – AVIATION, FREE FALL PARACHUTING & MARINE (SCUBA) DIVING PERSONNEL**  
 (For use of this form, see AR 40-501; the proponent agency is the Office of The Surgeon General)

1. NAME (Last, First, MI)		2. GRADE		3. BRANCH				
4. SSN		5. SEX	6. RACE		7. DATE OF BIRTH			
8. ORGANIZATION								
9. DATE OF EXAMINATION		10. EXAMINING FACILITY AND ADDRESS						
11. FLIGHT DUTY PERFORMED								
12. TOTAL FLIGHT HOURS			13. FLIGHT HOURS LAST SIX MONTHS					
14. VISUAL ACUITY								
EYE	DISTANT			NEAR				
RIGHT	20/	CORR TO 20/		CORR TO				
LEFT	20/	CORR TO 20/		CORR TO				
OTHER (As required)								
15. AUDITORY ACUITY								
CALIBRATION (Check appropriate block) <input type="checkbox"/> ISO <input type="checkbox"/> ASA <input type="checkbox"/> ANSI <input type="checkbox"/> OTHER								
EAR	250	500	1000	2000	3000	4000	6000	8000
RIGHT								
LEFT								
16. BLOOD PRESSURE (Sitting with arm at heart level)		SYSTOLIC			17. HEIGHT		18. WEIGHT	
		DIASTOLIC						
TYPED OR PRINTED NAME OF REVIEWING MEDICAL OFFICER					SIGNATURE			

EKG MOUNTING		
I	II	III
AVR	AVL	AVF
V <sub>1</sub>	V <sub>2</sub>	V <sub>3</sub>
V <sub>4</sub>	V <sub>5</sub>	V <sub>6</sub>
EKG READING		
NAME OF PATIENT		SSN
SIGNATURE OF PHYSICIAN		DATE

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

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*General, United States Army,*  
*Chief of Staff.*

Official:

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

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

\*These regulations supersede AR 40-504, 28 June 1955, including C 1, 6 February 1959; DA letter AGAC-C (M) 220.01 (31 Dec 52) MEDCA, 12 January 1953, subject: Physical Standards for Special Registrants under Public Law 779; OTSG letter MEDDP, 23 March 1953, subject: Physical Standards for Special Registrants under Public Law 779; OTSG letter, MEDDP, 1 May 1953, subject: Physical Standards for Special Registrants under Public Law 779; DA message 402203.9 April 1959; DA message 409220, 9 May 1959; and DA message 435843, 11 September 1959; AR 40-110, 12 November 1952, including C 6, 4 September 1959; medical fitness standards contained in paragraph 4b, AR 611-22, 10 April 1959; paragraph 15f(1), AR 612-35, 31 July 1958; and AR 40-503, 9 May 1956, including C 1, 3 August 1956, and C 3, 6 May 1959.

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**CHAPTER 2**  
**MEDICAL FITNESS STANDARDS FOR APPOINTMENT,**  
**ENLISTMENT, AND INDUCTION**  
**(Short Title: PROCUREMENT MEDICAL FITNESS STANDARDS)**

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**Section I. GENERAL**

**2-1. Scope**

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

**2-2. Applicability**

a. These standards apply to—

(1) *Applicants for appointment as commissioned or warrant officers* in the Active Army, Army National Guard, and Army Reserve. (Special categories of personnel, such as physicians, dentists, and other specialists, will be procured under standards prescribed by the Secretary of the Army in appropriate personnel procurement program directives.)

★(2) *Applicants for enlistment.*

(3) *Civilian applicants for enlistment in the Regular Army.* These standards are applicable until enlistees have completed 4 months of active duty for medical conditions or physical defects that existed prior to original enlistment. (See also AR 635-40 and AR 635-200.)

(4) *Members of units of the Army National Guard or Army Reserve who apply for enlistment in the Regular Army* or who reenter active duty for training under the "split training" option must meet the standards of medical fitness prescribed by chapter 3. (See also para 3-2a(2) of this regulation, and AR 601-210 for administrative procedures for separation for medically unfitting conditions that existed prior to enlistment.)

(5) *Civilian applicants for enlistment in the Army National Guard and Army Reserve.* These standards are applicable until the enlistees have completed an initial period of active duty for training and return to their Reserve Component unit for medical conditions or physical defects that existed prior to original en-

listment. (See also AR 635-40, AR 635-200, and AR 135-178.)

(6) *Applicants for reenlistment* in the Active Army, Army National Guard, and Army Reserve after a period of more than 6 months has elapsed since discharge.

(7) *Applicants for the Advanced Course Army ROTC*, and other personnel procurement programs, other than induction, for which these standards are prescribed.

(8) *Retention of cadets* of the United States Military Academy, students enrolled in the Uniformed Services University of Health Sciences, and the Army ROTC programs, except for such conditions that have been diagnosed since entrance into the Academy, University or the ROTC programs. With respect to such conditions, upon recommendation of the Surgeon, United States Military Academy (for USMA cadets), the President, Uniformed Services University of Health Sciences (for students enrolled in that institution), or the Surgeon, United States Army Training and Doctrine Command (for ROTC cadets), the medical fitness standards of chapter 3 are applicable for retention in the Academy, the University of Health Sciences, the ROTC programs, appointment or enlistment, and entrance on active duty or active duty for training in a commissioned or enlisted status.

(9) *Registrants who undergo preinduction or induction medical examination*, except physicians, dentists and allied medical specialists who are to be evaluated under chapter 8.

(10) *Male applicants for enlistment in the US Air Force.*

(11) *Male applicants for nonprior service enlistment in the US Navy or Naval Reserve.*

(12) *"Changeable accessions" for enlistment in the US Marine Corps or Marine Corps Reserve.*

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

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

### 2-3. Abdominal Organs and Gastrointestinal System

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

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

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

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

*d. Fistula in ano.*

*e. Gastritis*, chronic hypertrophic, severe.

*f. Hemorrhoids.*

(1) External hemorrhoids producing marked symptoms.

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

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

*h. Hernia.*

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

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

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

*j. Megacolon* of more than minimal degree, *diverticulitis*, *regional enteritis*, and *ulcerative*

*colitis. Irritable colon* of more than moderate degree.

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

*l. Rectum*, stricture of prolapse of.

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

*n. Scars.*

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

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

*o. Sinuses* of the abdominal wall.

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

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

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

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

*r. Ulcer.*

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

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

★*s. Other* congenital or acquired abnormalities such as gastrointestinal bypass or stomach stapling for control of obesity; and defects which preclude satisfactory performance of military duty or which require frequent and prolonged treatment.

## Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

### 2-4. Blood and Blood-Forming Tissue Diseases

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

*a. Anemia:*

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

(2) Deficiency anemia, not controlled by medication.

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

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

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

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

*b. Hemorrhagic states:*

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

(2) Due to platelet deficiency.

(3) Due to vascular instability.

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

*d. Myeloproliferative disease (other than leukemia):*

(1) Myelofibrosis.

(2) Megakaryocytic myelosis.

(3) Polycythemia vera.

*e. Splenomegaly* until the cause is remedied.

*f. Thromboembolic disease* except for acute, nonrecurrent conditions.

**Section IV. DENTAL****2-5. Dental**

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

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

*b. Malocclusion*, severe, which interferes with the mastication of a normal diet.

*c. Oral tissues*, extensive loss of, in an amount that would prevent replacement of missing teeth with a satisfactory prosthetic appliance.

*d. Orthodontic appliances.* See special administrative criteria in paragraph 7-16.

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

**Section V. EARS AND HEARING****2-6. Ears**

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

*a. Auditory canal.*

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

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

(3) Severe external otitis, acute or chronic.

*b. Auricle.* Agenesis, severe; or severe traumatic deformity, unilateral or bilateral.

*c. Mastoids.*

(1) Mastoiditis, acute or chronic.

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

(3) Mastoid fistula.

*d. Meniere's syndrome.**e. Middle ear.*

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

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

(3) Acute or chronic serous otitis media.

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

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

*f. Tympanic membrane.*

(1) Any perforation of the tympanic membrane.

(2) Severe scarring of the tympanic membrane associated with hearing level by

audiometric test of 20 dB or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

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

## Section VI. ENDOCRINE AND METABOLIC DISORDERS

### 2-8. Endocrine and Metabolic Disorders

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

*a. Adrenal gland*, malfunction of, of any degree.

*b. Cretinism.*

*c. Diabetes insipidus.*

*d. Diabetes mellitus.*

*e. Gigantism or acromegaly.*

*f. Glycosuria*, persistent, regardless of cause.

*g. Goiter.*

(1) Simple goiter with definite pressure symptoms or so large in size as to interfere with the wearing of a military uniform or military equipment.

(2) *Thyrotoxicosis.*

### 2-7. Hearing

(See also para 2-6.)

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

*Hearing threshold level* greater than that described in table I, appendix II.

*h. Gout.*

*i. Hyperinsulinism*, confirmed, symptomatic.

*j. Hyperparathyroidism and hypoparathyroidism.*

*k. Hypopituitarism*, severe.

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

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

*n. Other endocrine or metabolic disorders* which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

## Section VII. EXTREMITIES

### 2-9. Upper Extremities

(See para 2-11.)

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

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

(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.*

(a) Pronation to the first quarter of normal arc.

(b) 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 1/3 of the distal phalanx of either thumb.

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

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

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

(4) Hyperdactylia.

(5) Scars and deformities of the fingers and/or hand which impair circulation, are symp-

omatic, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

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

## 2-10. Lower Extremities

(See para 2-11.)

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

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

(1) *Hip.*

(a) Flexion to 90°.

(b) Extension to 10° (beyond 0).

(2) *Knee.*

(a) Full extension.

(b) Flexion to 90°.

(3) *Ankle.*

(a) Dorsiflexion to 10°.

(b) Plantar flexion to 10°.

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

*b. Foot and ankle.*

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

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

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

(4) Clubfoot.

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

(6) Flatfoot, spastic.

(7) *Hallux valgus*, if severe and associated with marked extostosis 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 satisfacto-

ry 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 paras 2-9 and 2-10.)

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

### a. Arthritis.

★(1) Active or subacute arthritis.

(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, including Strumpell-Marie type.

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

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

c. *Dislocation*, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint, symptomatic and more than mild; or if, subsequent to surgery, there is evidence of more than mild instability in

comparison with the normal joint, weakness or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

### d. Fractures.

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

(3) Any old or recent fracture in which a plate, pin, or screws were used for fixation and left in place and which may be subject to easy trauma; i.e., as a plate tibia, etc.

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

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

f.1. *Myotonia congenita*. Confirmed.

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

h. *Osteoporosis*.

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

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

## Section VIII. EYES AND VISION

### 2-12. Eyes

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

#### a. Lids.

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

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

(4) Destruction of the lids, complete or ex-

tensive, 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 eye-

lids sufficient to cause unsightly appearance or watering of eyes (entropion or ectropion).

- (8) Lagophthalmos.
- (9) Ptosis interfering with vision.
- (10) Trichiasis, severe.

*b. Conjunctiva.*

(1) Conjunctivitis, chronic, including vernal catarrh and trachoma. Individuals with acute conjunctivitis are unacceptable until the condition is cured.

(2) Pterygium:

(a) Pterygium recurring after three operative procedures.

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

*c. Cornea.*

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

(2) Keratitis, acute or chronic.

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

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

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

*e. Retina.*

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

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

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

(4) Inflammation of the retina (retinitis or other inflammatory conditions of the retina to include 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 documented history of attacks of retrobulbar neuritis.

(3) Optic atrophy (primary or secondary).

(4) Papilledema.

*g. Lens.*

(1) Aphakia (unilateral or bilateral).

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

(3) Opacities of the lens which interfere with vision or which are considered to be progressive.

*h. Ocular mobility and motility.*

(1) Diplopia, documented, constant or intermittent from any cause or of any degree interfering with visual function (i.e., may suppress).

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

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

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

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

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

*i. Miscellaneous defects and diseases.*

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

(2) Absence of an eye.

(3) Asthenopia severe.

(4) Exophthalmos, unilateral or bilateral.

(5) Glaucoma, primary or secondary.

(6) Hemianopsia of any type.

(7) Loss of normal pupillary reflex reactions to light or accommodation to distance or Adie's 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 of medical rejection for appointment, enlistment, and induction are listed below. The special administrative criteria for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Signal Corps, and Military Police Corps are listed in paragraph 7-19.

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

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

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

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

★*b. Near visual acuity.* Near visual acuity of any degree which does not correct to at least J-6 or 20/40 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.; if an ophthalmological consultation reveals a condition which is disqualifying; or if refractive error is corrected by orthokeratology or radial keratotomy.

*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 paras 2-40 and 2-41.)

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

*a. Bartholinitis,* Bartholin's cyst.

*b. Cervicitis,* acute or chronic manifested by leukorrhea.

*c. Dysmenorrhea,* incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine activities.

*d. Endometriosis,* or confirmed history thereof.

*e. Hermaphroditism.*

*f. Menopausal syndrome,* either physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.

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

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

rous, 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 paras 2-40 and 2-41.)

(1) Absence or nondescent of both testicles.

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

(3) Undescended testicle.

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

*o. Uterus.*

(1) Cervical polyps, cervical ulcer, or marked erosion.

(2) Endocervicitis, more than mild.

(3) Generalized enlargement of the uterus due to any cause.

(4) Malposition of the uterus if more than mildly symptomatic.

*p. Vagina.*

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

(2) Vaginitis, acute or chronic, manifested by 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 paras 2-8, 2-40, and 2-41.)

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

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

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

c. *Enuresis* determined to be a symptom of an organic defect not amenable to treatment. (See also para 2-34.1c.)

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

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

f. *Incontinence* of urine.

g. *Kidney*.

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

(2) Acute or chronic infections of the kidney.

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

(4) Hydronephrosis or pyonephrosis.

(5) Nephritis, acute or chronic.

(6) Pyelitis, pyelonephritis.

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

i. *Peyronie's disease*.

j. *Prostate gland*, hypertrophy of, with urinary retention.

k. *Renal calculus*.

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

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

l. *Skeneitis*.

m. *Urethra*.

(1) Stricture of the urethra.

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

n. *Urinary fistula*.

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

## Section X. HEAD AND NECK

### 2-16. Head

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

a. *Abnormalities* which are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. See paragraph 2-31.

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

c. *Deformities of the skull of any degree* asso-

ciated with evidence of disease of the brain, spinal cord, or peripheral nerves.

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

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

(1) All cases involving absence of the bony substance of the skull which have been corrected but in which the defect is in excess of 1 square inch or the size of a 25-cent piece, will be referred to the Commander, United States Army Health Services Command together with a report of consultation;

(2) The report of consultation will include an evaluation of any evidence of alteration of brain function in any of its several spheres; i.e., intelligence, judgment, perception, behavior, motor control and sensory function as well as any evidence of active bone disease or other related complications. Current X-rays and other pertinent laboratory data will accompany such a report of consultation.

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

## 2-17. Neck

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

*a. Cervical ribs* if symptomatic, or so obvious

## Section XI. HEART AND VASCULAR SYSTEM

### 2-18. Heart

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

*a. All organic valvular diseases of the heart*, including those improved by surgical procedures.

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

*c. Electrocardiographic evidence* of major arrhythmias such as—

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

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

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

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

*d. Hypertrophy or dilatation of the heart* as evidenced by clinical examination or roentgenographic examination and supported by

that they are found on routine physical examination. (Detection based primarily on X-ray is not considered to meet this criterion.)

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

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

*d.* (Deleted)

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

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

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

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 Commander, United States Army Health Services Command for evaluation.

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

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

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

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

### 2-19. Vascular System

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

a. *Congenital or acquired lesions of the aorta and major vessels*, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilatation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

b. *Hypertension* evidenced by preponderant diastolic blood pressure over 90-mm or preponderant systolic blood pressure over 159 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 phenomenon, 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 asso-

ciated 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 by 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*. Height below 60 inches or over 80 inches (see administrative criteria in para 7-13).

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

b. *For enlistments and induction*.

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

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

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

### 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 paras 2-9, 2-10, and 2-11.)

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

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

*d. Obesity.* Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's

weight, in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

### Section XIII. LUNGS AND CHEST WALL

#### 2-24. General

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

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

*b. Acute abscess* of the lung.

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

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

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

*f. Acute nontuberculous pneumonia.*

*g. Foreign body in trachea or bronchus.*

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

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

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

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

*l. Recent fracture* of ribs, sternum, clavicle, or scapula.

*m. Significant abnormal findings* on physical examination of the chest.

#### 2-25. Tuberculous Lesions

(See para 2-38.)

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

*a. Tuberculosis*, active at any time within the

past 2 years, in any form or location. A positive tuberculin skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy because of recent skin test conversion are not disqualified.

*b. Rescinded.*

*c. Substantiated history* of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.

#### 2-26. Nontuberculous Lesions

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

*a. Acute mastitis*, chronic cystic mastitis, if more than mild.

*b. Bronchial asthma*, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.

*c. Bronchitis*, chronic with evidence of pulmonary function disturbance.

*d. Bronchiectasis.*

*e. Bronchopleural fistula.*

*f. Bullous or generalized pulmonary emphysema.*

*g. Chronic abscess of lung.*

*h. Chronic fibrous pleuritis* of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

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

*j. Empyema*, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

*k. Extensive pulmonary fibrosis* from any cause, producing dyspnea or exertion.

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

*m. Multiple cystic disease* of the lung or solitary cyst which is large and incapacitating.

*n. New growth of breast; history of mastectomy.*

*o. Osteomyelitis* of rib, sternum, clavicle, scapula, or vertebra.

*p. Pleurisy with effusion* of unknown origin within the previous 2 years.

*q. Sarcoidosis.* See paragraph 2-38.

*r. Suppurative periostitis* of rib, sternum, clavicle, scapula, or vertebra.

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

##### 2-27. Mouth

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

*a. Hard palate*, perforation of.

*b. Harelip*, unless satisfactorily repaired by surgery.

*c. Leukoplakia*, if severe.

*d. Lips*, unsightly mutilations of, from wounds, burns, or disease.

*e. Ranula*, if extensive. For other tumors see paragraphs 2-40 and 2-41.

##### 2-28. Nose

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

*a. Allergic manifestations.*

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

*b. Choana, atresia, or stenosis* of, if symptomatic.

*c. Nasal septum*, perforation of:

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

(2) If progressive.

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

*d. Sinusitis*, acute.

*e. Sinusitis*, chronic, when more than mild:

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

sues, or symptoms requiring frequent medical attention.

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

##### 2-29. Pharynx, Trachea, Esophagus, and Larynx

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

*a. Esophagus*, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagoscopy examinations.

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

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

★*d. Dysphonia plicae 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* (para 2-42).

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

## Section XV. NEUROLOGICAL DISORDERS

### 2-31. Neurological Disorders

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

#### a. Degenerative disorders.

- (1) Cerebellar and Friedreich's ataxia.
- (2) Cerebral arteriosclerosis.
- (3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.
- (4) Huntington's chorea.
- (5) Multiple sclerosis.
- (6) Muscular atrophies and dystrophies of any type.

#### b. Miscellaneous.

- (1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.
- (2) Migraine when frequent and incapacitating.
- (3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.
- (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 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.

#### 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. MENTAL DISORDERS

Diagnostic concepts and terms utilized in this section are in consonance with the Diagnostic and Statistical Manual, Third Edition (DSM-III), American Psychiatric Association, 1980.

### 2-32. Disorders with Psychotic Features

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

*History of a mental disorder with gross impairment in reality testing.* This does not include transient disorders associated with intoxication, severe stress or secondary to a toxic, infectious or other organic process.

### 2-33. Affective Disorders (Mood Disorders)

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

Persistence or recurrence of symptoms sufficient to cause interference with social, educational or vocational functioning or necessitate maintenance treatment or hospitalization.

### 2-34. Anxiety, Somatoform or Dissociative Disorders (Alternatively may be addressed as Neurotic Disorders)

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

a. *History of such disorder(s)* resulting in any or all of the below:

- (1) Hospitalization.
- (2) Prolonged care by a physician or other professional.
- (3) *Loss of time from normal pursuits* for repeated periods even if of brief duration, or
- (4) Symptoms or behavior of a repeated nature which impaired social, school or work efficiency.

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

### 2-34.1. Personality, Behavior or Learning Disorders

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

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

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

c. *Other behavior problems* including but not limited to conditions such as authenticated evidence of functional enuresis, sleepwalking, which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) or stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

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

### ★2-34.2. Psychosexual Conditions

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

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

b. *Transsexualism and other gender identity disorders*:

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

### 2-34.3. Substance Misuse

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

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

b. *Drug addiction or dependence*.

c. *Drug abuse* characterized by—

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

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

(3) The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids, with such frequency that it appears that the examinee has accepted the use of or reliance on these substances as part of his pattern of behavior. See also TB MED 290.

d. *Alcohol abuse*. The cause of rejection for appointment, enlistment and induction is the repeated use of alcoholic beverages which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility or disrupted personal relationships within 1 year of examination. See also TB MED 290.

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## Section XVII. SKIN AND CELLULAR TISSUES

## 2-35. Skin and Cellular Tissues

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

*a. Acne.* Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment.

*b. Atopic dermatitis.* With active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, occasionally wrists and hands), or documented history thereof.

*c. Cysts.*

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

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

*d. Dermatitis factitia.*

*e. Dermatitis herpetiformis.*

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

*f.1. Elephantiasis or chronic lymphedema.*

*g. Epidermolysis bullosa; pemphigus.*

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

*i. Furunculosis.* Extensive, recurrent, or chronic.

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

*k. Ichthyosis.* Severe.

*l. Leprosy.* Any type.

*m. Leukemia cutis; mycosis fungoides; Hodgkin's disease.*

*n. Lichen planus.*

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

*p. Neurofibromatosis* (Von Recklinghausen's disease).

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

*r. Psoriasis* or a verified history thereof.

*s. Radiodermatitis.*

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

*u. Scleroderma.* Diffuse type.

*v. Tuberculosis.* See paragraph 2-38.

*w. Urticaria.* Chronic.

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

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

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

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

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

## 2-36. Spine and Sacroiliac Joints

(See also para 2-11.)

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

*a. Arthritis.* See paragraph 2-11a.

*b. Complaint of disease or injury of the spine or sacroiliac joints* either with or without objective signs which has prevented the individual from successfully following a physically active

vocation in civilian life. Substantiation or documentation of the complaint without objective signs is required.

*c. Deviation or curvature of spine* from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis) if—

(1) Mobility and weight-bearing power is poor.

(2) More than moderate restriction of normal physical activities is required.

(3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.

(4) Of a degree which will interfere with the wearing of a uniform or military equipment.

(5) Symptomatic associated with positive physical finding(s) and demonstrable by X-ray.

*d. Diseases of the lumbosacral or sacroiliac joints* of a chronic type and obviously associated with pain referred to the lower extremities, muscular spasm, postural deformities and limitation of motion in the lumbar region of the spine.

*e. Granulomatous diseases* either active or healed.

*f. Healed fracture of the spine or pelvic bones* with associated symptoms which have prevented the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

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

*h. Spondylolysis or spondylolisthesis* that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

## 2-37. Scapulae, Clavicles, and Ribs

(See para 2-11.)

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

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

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

*c. Osteomyelitis* of rib, sternum, clavicle, scapula, or vertebra.

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

## Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

### 2-38. Systemic Diseases

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

*a. Dermatomyositis.*

*b. Lupus erythematosus*, acute, subacute, or chronic.

*c. Progressive systemic sclerosis.*

*d. Reiter's disease.*

*e. Sarcoidosis.*

*f. Scleroderma*, diffuse type.

*g. Tuberculosis.*

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

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

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

### 2-39. General and Miscellaneous Conditions and Defects

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

*a. Allergic manifestations.*

(1) Allergic rhinitis (hay fever). See paragraph 2-28.

(2) Asthma. See paragraph 2-26*b*.

(3) Allergic dermatoses. See paragraph 2-35.

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

(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of severe generalized reaction to common foods; e.g., milk, eggs, beef, and pork.

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

*c. Any deformity which is markedly unsightly* or which impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

*d. Chronic metallic poisoning* especially beryllium, manganese, and mercury. Undesirable

residuals from lead, arsenic, or silver poisoning make the examinee medically unacceptable.

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

*f. Reactive tests for syphilis* such as the RPR or VDRL followed by a reactive, confirmatory Fluorescent Treponemal Antibody Absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of a reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified or if the test reverts to a nonreactive status during an appropriate followup period (3-6 months).

*g. Filariasis; trypanosomiasis; amebiasis; schistosomiasis; uncinariasis* (hookworm) asso-

ciated with anemia, malnutrition, etc., if more than mild, and other similar worm or animal parasitic infestations, including the carrier states thereof.

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

*i. Industrial solvent* and other chemical intoxication, chronic including carbon bisulfide, trichlorethylene, carbon tetrachloride, and methyl cellosolve.

*j. Mycotic infection* of internal organs.

*k. Myositis or fibrositis*; severe, chronic.

*l. Residual of tropical fevers* and various parasitic or protozoal infestations which in the opinion of the medical examiner preclude the satisfactory performance of military duty.

## Section XX. TUMORS AND MALIGNANT DISEASES

### 2-40. Benign Tumors

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

*a. Any tumor of the—*

- (1) Auditory canal, if obstructive.
- (2) Eye or orbit, (para 2-12a(6)).
- (3) Kidney, bladder, testicle, or penis.
- (4) Central nervous system and its membranous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or of original lesion.

*b. Benign tumors of the abdominal wall* if sufficiently large to interfere with military duty.

*c. Benign tumors of the bone* likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

*d. Benign tumors of the thyroid* or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to

interfere with the wearing of a uniform or military equipment.

*e. Tongue, benign tumor of*, if it interferes with function.

*f. Breast, thoracic contents, or chest wall*, tumors of, other than fibromata lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

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

### 2-41. Malignant Diseases and Tumors

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

*a. Leukemia*, acute or chronic.

*b. Malignant lymphomata.*

*c. Malignant tumor*, except for small early basal cell epitheliomas, at any time, even though surgically removed, confirmed by accepted laboratory procedures.

## Section XXI. VENEREAL DISEASES

### 2-42. Venereal Diseases

In general the finding of acute, uncomplicated venereal disease which can be expected to re-

spond 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 (para

2-39f).

b. *Complications and permanent residuals of venereal disease* if progressive, of such nature as to interfere with the satisfactory performance of duty, or if subject to aggravation by military service.

c. *Neurosyphilis*. See paragraph 2-31c.

are in effect) will be processed as prescribed in AR 140-120 for members of the Army Reserve, or NGR 635-200, NGR 40-501, or NGR 40-3 for members of the Army National Guard of the United States, for disability separation or continuance in their Reserve status as prescribed in the cited regulations. Members of the Army National Guard and Army Reserve who may be unfit because of a disability resulting from injury incurred during a period of active duty training of 30 days or less, or active duty for training for 45 days ordered because of unsatisfactory performance of training duty, or inactive duty training will be processed as prescribed in AR 40-3 and AR 635-40.

d. Members on extended active duty who meet retention medical fitness standards, but may be administratively unfit or unsuitable will be reported to the appropriate commander for processing as provided in other regulations, such as AR 635-200.

e. Members on active duty who meet retention medical fitness standards, but who failed to meet procurement medical fitness standards on initial entry into the service (erroneous appointment, enlistment, or induction), may be processed for separation as provided in AR 635-120, AR 635-200, or AR 135-178 if otherwise qualified.

FOR ACTIVE ARMY MEMBERS, THE FOLLOWING SECTIONS II THROUGH XX SET FORTH, BY BROAD GENERAL CATEGORY, THOSE MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH REQUIRE MEDICAL BOARD ACTION AND REFERRAL TO A PHYSICAL EVALUATION BOARD. (USAR AND ARNG MEMBERS NOT ON ACTIVE DUTY WILL BE PROCESSED IN ACCORDANCE WITH AR 135-175, AR 135-178, AR 140-10 and NGR 600-200, AS APPROPRIATE.)

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

### 3-5. Abdominal and Gastrointestinal Defects and Diseases

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

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

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

d. *Cirrhosis of the liver*. Recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom.

e. *Gastritis*. Severe, chronic hypertrophic gastritis and repeated symptomatology and hospitalization, and confirmed by gastroscopic examination.

f. *Hepatitis, chronic*. When, after a reasonable time (1 or 2 years) following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

g. *Hernia*.

(1) *Hiatus hernia*. Severe symptoms not relieved by dietary or medical therapy, or recur-

rent bleeding in spite of prescribed treatment.

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

h. *Ileitis, regional*.

i. *Pancreatitis, chronic*. Frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

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

k. *Proctitis, chronic*. Moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea, and repeated admissions to the hospital.

l. *Ulcer, peptic, duodenal, or gastric*. Repeated hospitalization or "sick in quarters" because of frequent recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory and X-ray evidence of activity.

m. *Ulcerative colitis*. Except when responding well to treatment.

*n. Rectum, stricture of.* Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, or difficult bowel movements, requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

### 3-6. Gastrointestinal and Abdominal Surgery.

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

*b. Colostomy.* Per se, when permanent.

*c. Enterostomy.* Per se, when permanent.

*d. Gastrectomy.*

(1) Total, per se.

(2) Subtotal, with or without vagotomy, or gastrojejunostomy with or without vagotomy, when, in spite of good medical management, the individual:

(a) Develops "dumping syndrome" which persists for 6 months postoperatively, or

(b) Develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively, or

(c) Continues to demonstrate appreciable weight loss 6 months postoperatively.

*e. Gastrostomy.* Per se, when permanent.

*f. Ileostomy.* Per se, when permanent.

*g. Pancreatectomy.* Per se.

*h. Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy.* Followed by more than mild symptoms of digestive disturbance, or requiring insulin.

*i. Proctectomy.* Per se.

*j. Proctopexy, proctoplasty, proctorrhaphy, or proctotomy.* If fecal incontinence remains after an appropriate treatment period.

## Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

### 3-7. Blood and Blood-Forming Tissue Diseases

When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision. See also paragraph 3-38.

*a. Anemia.*

*b. Hemolytic crisis, chronic and symptomatic.*

*c. Leukopenia, chronic.*

*d. Polycythemia.*

*e. Purpura and other bleeding diseases.*

*f. Thromboembolic disease.*

*g. Splenomegaly, chronic.*

## Section IV. DENTAL

### 3-8. Dental Diseases and Abnormalities of the Jaws

Diseases of the jaws or associated tissues when, following restorative surgery, there remain re-

siduals which are incapacitating, or interfere with the individual's satisfactory performance of military duty, or leave unsightly deformities which are disfiguring.

## Section V. EARS AND HEARING

### 3-9. Ears

*a. Infections of the external auditory canal.* Chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

*b. Malfunction of the acoustic nerve.* Evaluate functional impairment of hearing under paragraph 3-10.

*c. Mastoiditis, chronic.* Constant drainage

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from the mastoid cavity, requiring frequent and prolonged medical care.

*d. Mastoiditis, chronic, following mastoidectomy.* Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.

*e. Meniere's syndrome.* Recurring attacks of sufficient frequency and severity as to interfere with the satisfactory performance of duty, or requiring frequent or prolonged medical care or hospitalization.

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*f. Otitis media.* Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent and prolonged medical care or hospitalization.

### 3-10. Hearing

Trained and experienced personnel will not be categorically disqualified if they are capable of effective performance of duty with a hearing aid. Ordinarily a hearing defect will not be considered sufficient reason for initiating disability separation or retirement processing. Most individuals having a hearing defect can be returned to duty with appropriate assignment limitations. The following is a guide in referring individuals with hearing defects for physical disability separation or retirement processing:

*a.* When a member is being evaluated for disability separation or retirement because of other impairments, the hearing defect will be carefully evaluated and considered in computing the total disability.

*b.* A member may be considered for physical

disability separation or retirement if, at the time he is being considered for separation or retirement for some other administrative reason, the medical examination discloses a substantial hearing defect. This refers particularly to cases requiring hearing aids and those having hearing levels which may be rateable at 30 to 40 percent or more in accordance with the Veterans Administration Schedule for Rating Disabilities. It should be noted that the decibel levels used in the VASRD are without hearing aids, and are related to American Standards Association calibrated testing equipment. Tests performed on International Standards Organization calibrated equipment must be converted to the ASA standard before arriving at a decision regarding the referral of a member for physical disability evaluation under this paragraph. It should be further noted that past performance of duty does not, per se, preclude separation or retirement because of physical disability caused by a hearing defect.

*c.* Processing of such individuals will be in accordance with AR 40-3.

## Section VI. ENDOCRINE AND METABOLIC DISORDERS

### 3-11. Endocrine and Metabolic Disorders

*a. Acromegaly.* With severe function impairment.

*b. Adrenal hyperfunction.* Which does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.

*c. Diabetes insipidus.* Unless mild and patient shows good response to treatment.

*d. Diabetes mellitus.* When proven to require hypoglycemic drugs in addition to restrictive diet for control.

*e. Goiter.* With symptoms of obstruction to breathing with increased activity, unless correctable.

*f. Gout.* Advanced cases with frequent acute exacerbations and severe bone, joint, or kidney damage.

*g. Hyperinsulinism.* When caused by a malignant tumor or when the condition is not readily controlled.

*h. Hyperparathyroidism.* When residuals or complications of surgical correction, such as renal disease or bony deformities, preclude the reasonable performance of military duty.

*i. Hyperthyroidism.* Severe symptoms of hyperthyroidism, with or without evidence of goiter, which do not respond to treatment.

*j. Hypofunction, adrenal cortex.* Requiring medication for control.

*k. Hypoparathyroidism.* With objective evidence and severe symptoms not controlled by maintenance therapy.

*l. Hypothyroidism.* With objective evidence and severe symptoms not controlled by medication.

*m. Osteomalacia.* Residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

## Section VII. EXTREMITIES

**3-12. Upper Extremities**

(See also para 3-14.)

*a. Amputations.* Amputation of part or parts of an upper extremity equal to or greater than any of the following:

(1) Of a thumb proximal to the interphalangeal joints.

(2) Of two fingers of one hand, other than the little finger, at the proximal interphalangeal joints.

(3) Of one finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

★*b. Joint ranges of motion.* Motion which does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TM 8-640.

(1) *Shoulder.*

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) *Elbow.*

(a) Flexion to 100°.

(b) Extension to 60°.

(3) *Wrist.* A total range extension plus flexion of 15°.

(4) *Hand.* For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints (TM 8-640).

(a) An active flexor value of combined joint motions of 135° in each of two or more fingers of the same hand.

(b) An active extensor value of combined joint motions of 75° in each of the same two or more fingers.

(c) Limitation of motion of the thumb that precludes opposition to at least two finger tips.

★*c. Recurrent dislocations of the shoulder.* When not repairable or surgery is contraindicated.

**3-13. Lower Extremities**

(See para 3-14.)

*a. Amputations.*

(1) Loss of toes which precludes the ability to run or walk without a perceptible limp, and to engage in fairly strenuous jobs.

(2) Any loss greater than that specified above to include foot, leg, or thigh.

*b. Feet.*

(1) Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(2) Pes Planus: Symptomatic, more than moderate, with pronation on weight bearing which prevent the wearing of a military shoe, or when associated with vascular changes.

(3) Talipes cavus when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevent the wearing of a military shoe.

*c. Internal derangement of the knee.*

(1) Residual instability following remedial measures, if more than moderate in degree.

(2) If complicated by arthritis, see paragraph 3-14a.

★*d. Joint ranges of motion.* Motion which does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TM 8-640.

(1) *Hip.*

(a) Flexion to 90°.

(b) Extension to 0°.

(2) *Knee.*

(a) Flexion to 90°.

(b) Extension to 15°.

(3) *Ankle.*

(a) Dorsiflexion to 10°.

(b) Plantar Flexion to 10°.

*e. Shortening of an extremity which exceeds 2 inches.*

**3-14. Miscellaneous**

(See para 3-12 and 3-13.)

*a. Arthritis.*

(1) *Arthritis due to infection.* Arthritis due to infection associated with persistent pain and marked loss of function, with objective

X-ray evidence and document history of recurrent incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection, see paragraphs 3-35k(7) and 3-40b.

(2) *Arthritis due to trauma*. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.

(3) *Osteoarthritis*. Severe symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(4) *Rheumatoid arthritis or rheumatoid myositis*. Substantiated history of frequent incapacitating episodes and currently supported by objective and subjective findings.

b. *Chondromalacia or osteochondritis dissecans*. Severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

#### c. Fractures.

(1) *Malunion of fractures*. When after appropriate treatment, there is more than moderate malunion with marked deformity and more than moderate loss of function.

(2) *Nonunion of fracture*. When after an appropriate healing period the nonunion precludes satisfactory performance of duty.

(3) *Bone fusion defect*. When manifested by more than moderate pain and loss of function.

(4) *Callus, excessive, following fracture*. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

#### d. Joints.

(1) *Arthroplasty*. Severe pain, limitation of motion, and of function.

(2) *Bony or fibrous ankylosis*. With severe pain involving major joints or spinal segments in unfavorable position, and with marked loss of function.

(3) *Contracture of joint*. Marked loss of function and the condition is not remediable by surgery.

(4) *Loose bodies within a joint*. Marked functional impairment and complicated by arthritis to such a degree as to preclude favorable results of treatment or not remediable by surgery.

★(5) *Prosthetic replacement of major joints*.

#### e. Muscles.

(1) *Flacid paralysis of one or more muscles*. Loss of function which precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(2) *Spastic paralysis of one or more muscles*. Loss of function which precludes the satisfactory performance of military duty.

#### f. Myotonia congenita.

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

h. *Osteoarthropathy, hypertrophic, secondary*. Moderately severe to severe pain present, with joint effusion occurring intermittently in one or multiple joints, and with at least moderate loss of function.

i. *Osteomyelitis, chronic*. Recurrent episodes not responsive to treatment and involving the bone to a degree which interferes with stability and function.

j. *Tendon transplant*. Fair or poor restoration of function with weakness which seriously interferes with the function of the affected part.

## Section VIII. EYES AND VISION

### 3-15. Eyes

a. *Active eye disease*. Active eye disease, or any progressive organic disease, regardless of the stage of activity, which is resistant to treatment and affects the distant visual acuity or visual field so that—

(1) Distant visual acuity does not meet the standard stated in paragraph 3-16e, or

(2) The diameter of the field of vision in the better eye is less than 20°.

#### b. Aphakia, bilateral.

c. *Atrophy of optic nerve*. Due to disease.

*d. Glaucoma.* If resistant to treatment or affecting visual fields as in *a(2)* above, or if side effects of required medication are functionally incapacitating.

*e. Degenerations.* When vision does not meet the standards of paragraph 3-16e, or when vision is correctable only by the use of contact lenses or other special corrective devices (telescopic lenses, etc.).

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

*g. Ocular manifestations of endocrine or metabolic disorders.* Not unfitting, per se. However, residuals or complications, or the underlying disease may be unfitting.

*h. Residuals or complications of injury.* When progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3-16e.

*i. Retina, detachment of.*

(1) *Unilateral.*

(a) When visual acuity does not meet the standard stated in paragraph 3-16e.

(b) When the visual field in the better eye is constricted to less than 20°.

(c) When uncorrectable diplopia exists.

(d) When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(2) *Bilateral.* Regardless of etiology or results of corrective surgery.

### 3-16. Vision.

*a. Aniseikonia.* Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.

*b. Binocular diplopia.* Not correctable by surgery, and which is severe, constant, and in zone less than 20° from the primary position.

*c. Hemianopsia.* Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to render an individual unfit.

*d. Night blindness.* Of such a degree that the individual requires assistance in any travel at night.

*e. Visual acuity.*

(1) Vision which cannot be corrected with spectacle lenses to at least: 20/60 in one eye and 20/60 in the other eye, or 20/50 in one eye and 20/80 in the other eye, or 20/40 in one eye and 20/100 in the other eye, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/800 in the other eye, or

(2) An eye has been enucleated.

*f. Visual field.* Bilateral concentric constriction to less than 20°.

## Section IX. GENITOURINARY SYSTEM

### 3-17. Genitourinary System

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

*b. Dysmenorrhea.* Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day.

*c. Endometriosis.* Symptomatic and incapacitating to a degree which necessitates recurrent absences of more than 1 day.

*d. Hypospadias.* Accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings and the condition is not amenable to treatment.

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

*f. Kidney.*

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

(2) *Congenital anomaly*. Bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) *Cystic kidney (polycystic kidney)*. When symptomatic and renal function is impaired or is the focus of frequent infection.

(4) *Glomerulonephritis, chronic*.

(5) *Hydronephrosis*. More than mild, bilateral, and causing continuous or frequent symptoms.

(6) *Hypoplasia of the kidney*. Symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) *Nephritis, chronic*.

(8) *Nephrosis*.

(9) *Perirenal abscess*. Residuals of a degree which preclude the satisfactory performance of duty.

(10) *Pyelonephritis or pyelitis*. Chronic, which has not responded to medical or surgical treatment, with evidence of hypertension, eye-ground changes, or cardiac abnormalities.

(11) *Pyonephrosis*. Not responding to treatment.

*g. Menopausal syndrome, physiologic or artificial*. More than mild mental and constitutional symptoms.

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

*i. Urethritis, chronic*. Not responsive to treatment and necessitating frequent absences from duty.

### 3-18. Genitourinary and Gynecological Surgery

*a. Cystectomy*.

*b. Cystoplasty*. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.

*c. Hysterectomy*. When residual symptoms or complications preclude the satisfactory performance of duty.

*d. Nephrectomy*. When, after treatment, there is infection or pathology in the remaining kidney.

*e. Nephrostomy*. If drainage persists.

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

*g. Pyelostomy*. If drainage persists.

*h. Ureterocolostomy*.

*i. Ureterocystostomy*. When both ureters are markedly dilated with irreversible changes.

*j. Ureteroileostomy cutaneous*.

*k. Ureteroplasty*.

(1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

(2) When bilateral, evaluate residual obstruction or hydronephrosis and consider fitness on the basis of the residuals involved.

*l. Ureterosigmoidostomy*.

*m. Ureterostomy*. External or cutaneous.

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

*o. Kidney transplant*. Recipient of a kidney transplant.

## Section X. HEAD AND NECK

### 3-19. Head

(See also para 3-27.)

Loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms such as described in paragraph 3-28.

### 3-20. Neck

(See also para 3-11.)

*Torticollis (wry neck)*. Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

## Section XI. HEART AND VASCULAR SYSTEM

## 3-21. Heart

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

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

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

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

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

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

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

*h. Pericarditis.*

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

(2) Chronic serous pericarditis.

*i. Rheumatic valvulitis.* Cardiac insufficiency at functional capacity and therapeutic level of Class IIC or worse as defined by the American Heart Association (app VII). A diagnosis made during the initial period of service or enlistment which is determined to be a residual of a condition which existed prior to entry in the service should be considered unfitting regardless of the degree of severity.

*j. Ventricular premature contractions.* Frequent or continuous attacks, whether or not associated with organic heart disease, accompanied by discomfort or fear of such a degree as to interfere with the satisfactory performance of duty.

## 3-22. Vascular System

*a. Arteriosclerosis obliterans.* When any of the following pertain:

(1) Intermittent claudication of sufficient se-

verity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest or,

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain, or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity, or

(3) Involvement of more than one organ, system, or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.

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

★*c. Aneurysms.* Aneurysm of any vessel not correctable by surgery, aneurysm corrected by surgery after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. (Prior to commencing the trial of duty period a medical board will be accomplished in all cases.) At the completion of the trial of duty period a detailed report from the commander/supervisor will be incorporated with an addendum to the medical board in all cases.

*d. Periarteritis nodosa.* With definite evidence of functional impairment.

★*d.1. Surgery of the heart, pericardium or vascular system.*

(1) Permanent prosthetic valve implantation.

(2) Permanent pacemaker insertion.

(3) Vascular reconstruction, after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. (Prior to commencing the trial of duty period a medical board will be accomplished in all cases.) At the completion of the trial of duty period, a detailed report from the commander/supervisor will be incorporated with an addendum to the medical board in all cases.

(4) Coronary bypass surgery, after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. (Prior to commencing the trial of duty pe-

riod, a medical board will be accomplished in all cases.) At the completion of the trial of duty period, a detailed report from the commander/supervisor will be incorporated with an addendum to the medical board which will be accomplished in all cases.

*e. Chronic venous insufficiency (post-phlebotic syndrome).* When more than mild and symptomatic despite elastic support.

*f. Raynaud's phenomenon.* Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.

*g. Thromboangiitis obliterans.* Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other complications.

*h. Thrombophlebitis.* When repeated attacks requiring treatment are of such frequency as to interfere with the satisfactory performance of duty.

*i. Varicose veins.* Severe and symptomatic despite therapy.

### 3-23. Miscellaneous

*a. Erythromelalgia.* Persistent burning pain in the soles or palms not relieved by treatment.

*b. Hypertensive cardiovascular disease and hypertensive vascular disease.*

(1) Diastolic pressure consistently more than 110 millimeters of mercury following an adequate period of therapy in an ambulatory status, or

(2) Any documented history of hypertension, regardless of the pressure values, if associated with one or more of the following:

(a) More than minimal changes in the brain.

(b) Heart disease.

(c) Kidney involvement, with moderate impairment of renal function.

(d) Grade III (Keith-Wagner-Barker) changes in the fundi.

*c. Rheumatic fever, active, with or without heart damage.* Recurrent attacks.

*d. Residual of surgery of the heart, pericardium, or vascular system* resulting in inability of the individual to perform duties without discomfort or dyspnea. When the surgery involves insertion of a pacemaker, coronary artery revascularization, reconstructive vascular surgery employing exogenous grafting material, or similar newly developed techniques or prostheses, the individual will be required to undergo medical and physical evaluation board processing.

## Section XII. LUNGS AND CHEST WALL

**3-24. Tuberculous Lesions**

(See TB Med 236.)

*a. Pulmonary tuberculosis.*

★(1) When the disease of a member on active duty is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)

★(2) When a member of the U.S. Army Reserve not on active duty has disease that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before he will be capable of performing full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

(3) A member of the ARNG, not on active duty, will be separated from the ARNG in accordance with the provisions of NGR 20-4 (officers) or NGR 25-3 (enlisted). Such members will be permitted to reenlist or be reappointed in the ARNG if they meet the standards of this chapter following a 12- to 15-month period of treatment including an appropriate period of convalescence.

*b. Tuberculous emphysema.***3-25. Nontuberculous Lesions**

*a. Bronchial asthma.* Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks controlled only by continuing corticosteroid therapy, or with frequent attacks not controlled by other oral medication.

*b. Atelectasis, or massive collapse of the lung.* Moderately symptomatic with paroxys-

mal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications which require repeated hospitalization.

*c. Bronchiectasis or bronchiolectasis.* Cylindrical or saccular type which is moderately symptomatic, with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema with a moderate amount of bronchiectastic sputum, or with recurrent pneumonia, or with residuals or complications which require repeated hospitalization.

*d. Bronchitis.* Chronic, severe, persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications which require repeated hospitalization.

*e. Cystic disease of the lung, congenital.* Involving more than one lobe of a lung.

*f. Diaphragm, congenital defect.* Symptomatic.

*g. Hemopneumothorax, hemothorax, or pyopneumothorax.* More than moderate pleuritic residuals with persistent underweight, or marked restriction of respiratory excursions and chest deformity, or marked weakness and fatigability on slight exertion.

*h. Histoplasmosis.* Chronic and not responding to treatment.

*i. Pleurisy, chronic, or pleural adhesions.* Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

*j. Pneumothorax, spontaneous.* Repeated episodes of pneumothorax not correctable by surgery.

*k. Pneumoconiosis.* Severe, with dyspnea on mild exertion.

*l. Pulmonary calcification.* Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

*m. Pulmonary emphysema.* Marked emphy-

sema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

*n. Pulmonary fibrosis.* Linear fibrosis or fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

*o. Pulmonary sarcoidosis.* If not responding to therapy and complicated by demonstrable moderate reduction pulmonary function.

*p. Stenosis, bronchus.* Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring hospitalization of such frequency as to interfere with the satisfactory performance of duty.

### ★3-26. Surgery of the Lungs and Chest

*Lobectomy.* If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

## Section XIII. MOUTH, ESOPHAGUS, NOSE, PHARYNX, LARYNX, AND TRACHEA

### 3-27. Mouth, Esophagus, Nose, Pharynx, Larynx, and Trachea

#### *a. Esophagus.*

(1) Achalasia unless controlled by medical therapy.

(2) Esophagitis, persistent and severe.

(3) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction and weight loss, which does not respond to treatment.

(4) Stricture of the esophagus of such a degree as to almost restrict diet to liquids, require frequent dilatation and hospitalization, and cause difficulty in maintaining weight and nutrition.

#### *b. Larynx.*

(1) Paralysis of the larynx characterized by bilateral vocal cord paralysis seriously interfering with speech and adequate airway.

(2) Stenosis of the larynx of a degree causing respiratory embarrassment upon more than minimal exertion.

*c. Obstructive edema of glottis.* If chronic, not amenable to treatment and requiring tracheotomy.

*d. Rhinitis.* Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting, concomitant severe headaches, and foul, fetid odor.

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

*f. Trachea.* Stenosis of trachea.

## Section XIV. NEUROLOGICAL DISORDERS

### 3-28. Neurological Disorders

*a. Amyotrophic sclerosis, lateral.*

*b. Atrophy, muscular, myelopathic.* Includes severe residuals of poliomyelitis.

*c. Atrophy, muscular.* Progressive muscular atrophy.

*d. Chorea.* Chronic, progressive chorea.

*e. Convulsive disorders.* (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) When seizures are not adequately controlled (com-

plete freedom from seizure of any type) by standard drugs which are relatively nontoxic and which do not require frequent clinical and laboratory re-evaluation.

*f. Friedreich's ataxia.*

*g. Hepatolenticular degeneration.*

*h. Migraine.* When the cause is unknown, and manifested by frequent incapacitating attacks or attacks which last for several consecutive days, and unrelieved by treatment.

*i. Multiple sclerosis.*

*j. Myelopathy, transverse.*

*k. Narcolepsy.* When attacks are not controlled by medication.

*l. Paralysis agitans.*

*m. Peripheral nerve conditions.*

(1) *Neuralgia.* When symptoms are severe, persistent, and not responsive to treatment.

(2) *Neuritis.* When manifested by more than moderate, permanent functional impairment.

(3) *Paralysis due to peripheral nerve inju-*

*ry.* When manifested by more than moderate, permanent functional impairment.

*n. Syringomyelia.*

*o. General.* Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

### ★Section XV. MENTAL DISORDERS

Diagnostic concepts and terms utilized in this section are in consonance with the Diagnostic and Statistical Manual, Third Edition (DSM-III), American Psychiatric Association, 1980.

#### 3-29. Disorders with Psychotic Features

Mental disorders not secondary to stress, intoxication, infectious, toxic or other organic causes with gross impairment in reality testing resulting in interference with duty or social adjustment.

#### 3-30. Affective Disorders (Mood Disorders)

Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization, necessity for limitations of duty or duty in protected environment or resulting in interference with effective military performance.

#### 3-31. Anxiety, Somatoform, or Dissociative Disorders (Alternatively may be addressed as Neurotic Disorders)

Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization, necessity for limitations of duty or duty in protected environment or resulting in interference with effective military performance.

#### 3-32. Organic Mental Disorders

Persistence of symptoms or associated personal-

ity change sufficient to interfere definitively with the performance of duty or social adjustment.

#### 3-32.1. Personality, Psychosexual or Factitious Disorders; Disorders of Impulse Control Not Elsewhere Classified; Substance Use Disorders

These conditions may render an individual administratively unfit rather than unfit because of physical disability. Interference with performance of effective duty in association with these conditions will be dealt with through appropriate administrative channels.

#### 3-32.2. Adjustment Disorders

Transient, situational maladjustments due to acute or special stress do not render an individual unfit because of physical disability, but may be the basis for administrative separation if recurrent and cause interference with military duty.

#### 3-32.3. Disorders Usually First Evident in Infancy, Childhood or Adolescence

These disorders, to include primary mental deficiency or special learning defects, or developmental disorders do not render an individual unfit because of physical disability but may result in administrative unfitness if the individual does not show satisfactory performance of duty.

## Section XVI. SKIN AND CELLULAR TISSUES

## 3-33. Skin and Cellular Tissues

a. *Acne*. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

b. *Atopic dermatitis*. More than moderate or requiring periodic hospitalization.

c. *Amyloidosis*. Generalized.

d. *Cysts and tumors*. See section XIX.

e. *Dermatitis herpetiformis*. Which fails to respond to therapy.

f. *Dermatomyositis*.

g. *Dermographism*. Interfering with the satisfactory performance of duty.

h. *Eczema, chronic*. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

i. *Elephantiasis or chronic lymphedema*. Not responsive to treatment.

j. *Epidermolysis bullosa*.

k. *Erythema multiforme*. More than moderate, chronic or recurrent.

l. *Exfoliative dermatitis*. Chronic.

m. *Fungus infections, superficial or systemic types*. If not responsive to therapy and interfering with the satisfactory performance of duty.

n. *Hidradenitis suppurativa and folliculitis decalvans*.

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

p. *Leukemia cutis and mycosis fungoides*.

q. *Lichen planus*. Generalized and not responsive to treatment.

r. *Lupus erythematosus*. Chronic discoid variety with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

s. *Neurofibromatosis*. If repulsive in appearance or when interfering with the satisfactory performance of duty.

t. *Panniculitis*. Relapsing, febrile, nodular.

u. *Parapsoriasis*. Extensive and not controlled by treatment.

v. *Pemphigus*. Not responsive to treatment and with moderate constitutional or systemic symptoms, or interfering with the satisfactory performance of duty.

w. *Psoriasis*. Extensive and not controllable by treatment.

x. *Radiodermatitis*. If resulting in malignant degeneration at a site not amenable to treatment.

y. *Scars and keloids*. So extensive or adherent that they seriously interfere with the function of an extremity.

z. *Scleroderma*. Generalized, or of the linear type which seriously interferes with the function of an extremity.

aa. *Tuberculosis of the skin*. See paragraph 3-35k(7).

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

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

ad. *Xanthoma*. Regardless of type, but only when interfering with the satisfactory performance of duty.

ae. *Other skin disorders*. If chronic, or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

## Section XVII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

## 3-34. Spine, Scapulae, Ribs, and Sacroiliac Joints

(See also para 3-14.)

a. *Congenital anomalies*.

(1) *Dislocation, congenital, of hip*.

(2) *Spina bifida*. Demonstrable signs and moderate symptoms of root or cord involvement.

(3) *Spondylolysis or spondylolisthesis*. With more than mild symptoms resulting in re-

peated outpatient visits, or repeated hospitalization, or significant assignment limitations.

*b. Coxa vara.* More than moderate with pain, deformity, and arthritic changes.

*c. Herniation of nucleus pulposus.* More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective

findings to demonstrate interference with the satisfactory performance of duty.

*d. Kyphosis.* More than moderate, interfering with function, or causing unmilitary appearance.

*e. Scoliosis.* Severe deformity with over 2 inches deviation of tips of spinous process from the midline.

## Section XVIII. SYSTEMIC DISEASES, AND MISCELLANEOUS CONDITIONS AND DEFECTS

### 3-35. Systemic Diseases

*a. Amyloidosis.*

*b. Blastomycosis.*

*c. Brucellosis.* Chronic with substantiated, recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.

★*d. Leprosy.* Any type which seriously interferes with performance of duty or is not completely responsive to appropriate treatment.

*e. Lupus erythematosus disseminated, chronic.*

*f. Myasthenia gravis.*

*g. Mycosis*—active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals which themselves are unfitting.

*h. Panniculitis,* relapsing, febrile, nodular.

*i. Porphyria cutanea tarda.*

*j. Sarcoidosis.* Progressive with severe or multiple organ involvement and not responsive to therapy.

*k. Tuberculosis.*

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis, tuberculous empyema, and tuberculous pleurisy.

(3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(4) Tuberculosis of the female genitalia.

(5) Tuberculosis of kidney.

(6) Tuberculosis of the larynx.

(7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals and complications.

### 3-36. General and Miscellaneous Conditions and Defects

*a. Allergic manifestations.*

(1) *Allergic rhinitis.* See paragraphs 3-27*d* and *e*.

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

(3) *Allergic dermatoses.* See paragraph 3-33.

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

*b. Cold injury.* Evaluate on severity and extent of residuals, or loss of parts as outlined in paragraphs 3-12 and 3-13. See also TM MED 81.

*c. Miscellaneous conditions and defects.* Conditions and defects, individually or in combination, if—

★(1) The conditions result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor.

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

★(3) In view of the member's 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 3-3*b* of this regulation, questionable cases including those involving latent impairment and/or those when no single impairment but a combination of two or more impairments may be considered to render the individual unfit will be referred to physical evaluation boards.

*d.* Exceptionally, as regards members of the National Guard of the United States and the

Army Reserve, not on active duty, medical conditions and physical defects of a progressive nature approaching the levels of severity described

as unfitting in other parts of this chapter, when unfitness within a short time may be expected.

### Section XIX. TUMORS AND MALIGNANT DISEASES

#### 3-37. Malignant Neoplasms

*a. Malignant neoplasms* which are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

*b. Malignant neoplasms* in individuals on active duty when they are of such a nature as to preclude satisfactory performance of duty, and treatment is refused by the individual.

*c. Presence of malignant neoplasms* or reasonable suspicion thereof when an individual not on active duty is unwilling to undergo treatment or appropriate diagnostic procedures.

*d. Malignant neoplasms*, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

#### 3-38. Neoplastic Conditions of Lymphoid and Blood-Forming Tissues

Neoplastic conditions of the lymphoid and blood-forming tissues.

#### ★3-39. Benign Neoplasms

*a. Benign tumors*, except as noted in *b* below, are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment should be considered unfit only if their condition precludes their satisfactory performance of military duty.

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

(1) Ganglioneuroma.

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

### Section XX. VENEREAL DISEASES

#### 3-40. Venereal Diseases

*a. Symptomatic neurosyphilis* in any form.

*b. Complications or residuals of venereal dis-*

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

*tranquilizing, motion sickness, steroid, anti-hypertensive, or ataraxic drugs.*

Pilots with the above conditions, or other conditions which are disqualifying, but who have a statement of demonstrated ability (waiver) from the FAA may in some cases be granted local medical clearance to fly Army aircraft upon written approval by the Cdr, USAAMC. Such approval may contain limitations, such as clearance to fly Army aircraft only with another fully qualified pilot or with a student pilot of demonstrated ability for safe solo flight in that aircraft. (See also para 10-26k, Waivers.)

(3) In addition, the following provisions apply to all civilian pilots:

(a) *Maximum allowable body weight and size* will be that which does not exceed seat, restraint system, or aircraft gross weight design limits; and which does not prevent normal functions required for safe and effective aircraft flight, to include interference with aircraft instruments and controls. Minimum body size, weight and physical strength will be that which allows safe and effective flight in Army aircraft to include proper function of ejection seats and other safety equipment. Local flight surgeons will prepare written reports and recommendations as required. Questionable cases will be referred to Cdr, USAAMC, for final determination.

(b) *Near and distant visual acuity* must be not less than 20/20 or correctable to 20/20. If uncorrected acuity is less than 20/20, corrective spectacles are required to be worn while flying. If the assigned duties of the individual include flying with vision related equipment (such as night vision goggles): distant visual acuity must be 20/20 uncorrected, or correctable to the acceptable level by any vision correction capability inherent to the device, or the device must be compatible with corrective spectacles.

(c) *Illegal use of any drug at any time* by DA civilian pilots and contract civilian pilots is medically unfitting for flying duty.

(d) Any civilian pilot employed by the Department of the Army or by a firm under contract to the Department of the Army, even though he or she holds a valid FAA Second Class Medical Certificate, may be denied medical clearance to fly

Army aircraft if, in the opinion of the flight surgeon, *the individual poses an unacceptable risk* to him- or herself, to government property, or to other individuals. Questionable cases will be referred to Cdr, USAAMC for final determination of medical fitness for flying duty.

(e) Any civilian pilot employed by the Army as a test pilot may be required by the Cdr, USAAMC to meet *special medical criteria* shown to be specifically related to safe and effective performance of his or her flying duties; subject to concurrence by the Office of Personnel Management.

c. *Medical consultation service.* A central Army Aviation Medicine Consultation Service (AMCS) and an Aeromedical Data Repository (ADR) are established at the US Army Aeromedical Center, Fort Rucker, AL 36362. Consultation services are available to unit flight surgeons, command surgeons and the CG, US Army Health Service Command. Normally, requests for consultation by surgeons of higher headquarters will be initiated through unit flight surgeons to facilitate availability of essential medical records and related data. Medical consultation will not be requested by individual aviators nor by aviation unit commanders.

(1) Any individual on flying status may be referred for aviation medicine consultation by proper medical authority.

(2) An individual who is suspended from flying for medical reasons can only be referred to the AMCS by an authority equal to or higher than the one who suspended him.

(3) Army Reserve and Army National Guard personnel not on active duty may be referred through the Army area commander or Chief, National Guard Bureau, as appropriate.

(4) Non-US Army aviation personnel may be referred to the AMCS with prior approval of the CG, US Army Health Services Command.

(5) Requests for aviation medicine consultation will be forwarded direct to Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362.

(6) The Cdr, USAAMC, may utilize or authorize utilization of the Aeromedical consultation services of the US Navy and US Air Force, with the approval of appropriate medical authority of those agencies.

(7) The ADR will be used to assess the ade-

quacy of existing aeromedical fitness standards through an epidemiological study of medical qualifications of the population group and to form the basis of proposed changes to standards.

The ADR mission will be conducted in coordination with the US Army Aeromedical Research Laboratory.

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

### 4-4. Abdomen and Gastrointestinal System

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

*a. Enlargement of liver*, except when liver function tests are normal with no history of jaundice (other than during the neonatal period or associated with viral hepatitis), and the condition does not appear to be caused by active disease.

*★b. Functional bowel distress syndrome* (irritable colon), megacolon, diverticulitis, regional enteritis, ulcerative colitis or history thereof.

*★c. Hernia.*

(1) *Any variety*, other than small asymptomatic umbilical.

(2) *Classes 1 and 1A*, operation for hernia within the preceding 60 days. *Classes 2 and 3*, operation for hernia within the preceding 30 days.

*★d. History of bowel resection for any cause except—*

(1) *Appendectomy.*

(2) *Intussusception* in childhood or infancy.

*★e. Any other operations for relief of intestinal adhesions or intussusception.* Pylorotomy in

infancy, without complications at present will not, per se, be cause for rejection.

*f. Ulcer.*

(1) *Classes 1 and 1A.* See paragraph 2-3r.

*★(2) Classes 2 and 3.* Until reviewed and found fit by the Cdr, USAMMC, ATTN: HSXY-AER, Fort Rucker, AL 36362.

*★g. Cholecystectomy.*

(1) *Classes 1 and 1A.* Cholecystectomy within the preceding 90 days, or sequelae of cholecystectomy such as post-operative stricture of the common bile duct, reforming of stones in the hepatic or common bile ducts, incisional hernia, symptoms of post-cholecystectomy syndrome, or abnormal liver functions.

(2) *Classes 2 and 3.* Cholecystectomy within the preceding 60 days or sequelae of cholecystectomy such as those in paragraph 4-4g(1) above.

*h. Abdominal fistula or sinus.*

*i. Cholelithiasis.*

*j. Hemorrhage from the upper gastrointestinal tract* or history thereof, until reviewed and found fit by the Cdr, USAAMC.

## Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

### 4-5. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for flying duty

Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-4 plus sickle cell trait until evaluated and found fit by Cdr, USAAMC. Evaluation is not required for ATC Personnel, Class 2A.

## Section IV. DENTAL

### 4-6. Dental

The causes of medical unfitness for flying duty

Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-5.

## Section V. EARS AND HEARING

### ★4-7. Ears

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-6, plus the following:

a. *Abnormal labyrinthine function* when determined by appropriate tests.

b. *Any infectious process of the ear, except mild asymptomatic external otitis*, until completely healed.

c. *Deformities of the pinna* if associated with tenderness which may be distracting when constant pressure is extended as from wearing protective headgear.

d. *History of attacks of vertigo* with or without nausea, vomiting, deafness or tinnitus.

e. *Occlusion of either eustachian tube or limited motility of either tympanic membrane*.

f. *Post auricular fistula*.

g. *Unexplained recurrent or persistent tinnitus*.

h. *Radical mastoidectomy*.

i. *Simple mastoidectomy and modified radical mastoidectomy* until recovery is complete and the ear is functionally normal.

j. *Tympanoplasty*.

(1) *Classes 1 and 1A*. Tympanoplasty, until completely healed with acceptable hearing and good motility, as documented by current ENT evaluation and contingent upon review by Cdr, USAAMC.

(2) *Classes 2 and 3*. Tympanoplasty, until completely healed with acceptable hearing (app II) and good motility.

k. *Cholesteatoma or history thereof*.

l. *Classes 1 and 1A*. Otosclerosis.

m. *Any surgical procedure in the middle ear which includes fenestration of the oval window, stapedectomy, fenestration of the horizontal semicircular canal, the use of any prosthesis or graft, reconstruction of the stapes with any prosthesis, or any endolymphatic shunting procedure*.

### 4-8. Hearing

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are—Hearing loss in decibels greater than shown in table 2, appendix II.

## Section VI. ENDOCRINE AND METABOLIC DISEASES

### 4-9. Endocrine and Metabolic Diseases

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-8, plus the following:

a. *Hypothyroidism, hyperthyroidism, or history thereof*.

b. *Hyperuricemia*.

c. *Hypoglycemia or history thereof*.

## Section VII. EXTREMITIES

### 4-10. Extremities

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-9, 2-10, 2-11, and 4-23 plus dimensions, strength, endurance or limitation of motion which might compromise flying safety.

## Section VIII. EYES AND VISION

### 4-11. Eyes

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

★a. *Asthenopia* of any degree including convergence insufficiency.

★b. *Chorioretinitis* or substantiated history thereof including evidence of presumed ocular histoplasmosis syndrome.

c. *Coloboma* of the choroid or iris.

d. *Epiphora*.

★e. *Inflammation of the uveal tract*; acute,

chronic, or recurrent or history thereof, including anterior uveitis, peripheral uveitis or pars planitis, and posterior uveitis.

*f. Pterygium* which encroaches on the cornea more than 1 mm or is progressive as evidenced by marked vascularity or a thick elevated head.

*g. Trachoma* unless healed without cicatrices.

★*h. Optic or retrobulbar neuritis* or history thereof.

★*i. Central serous retinopathy* or history thereof.

★*j. Pseudophakia* (intraocular lens implant).

★*k. Congenital optic nerve pit.*

★*l. Retinal holes or tears* or history thereof.

★*m. Optic nerve drusen or hyaline bodies of the optic nerve.*

★*n. Herpetic corneal ulcer or keratitis*; acute, chronic, recurrent, or history thereof.

★*o. Xerophthalmia.*

★*p. Elevated intraocular pressure.*

(1) *Classes 1 and 1A.*

(a) *Glaucoma* as evidenced by applanation tension 30 mm Hg or higher, or secondary changes in the optic disc or visual field associated with glaucoma.

(b) *Preglaucoma or intraocular hypertension* as evidenced by two or more determinations of 22 mm Hg or higher or a persistent difference of 4 or more mm Hg tension between the two eyes, when confirmed by applanation tonometry.

(2) *Classes 2 and 3.*

(a) *Glaucoma.*

(b) *Preglaucoma* until reviewed by the Cdr, USAAMC.

★*q. History of extraocular muscle surgery* until reviewed by Cdr, USAAMC.

★*r. Full or part time use of contact lenses including orthokeratology* (to correct refractive error), or history thereof, until reviewed by Cdr, USAAMC.

*s. History of refractive keratoplasty* including anterior or radial keratotomy.

★*t. Visual or acephalic migraine*, or history thereof.

#### 4-12. Vision

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

*a. Class 1.*

(1) *Color vision.*

★(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set unless applicant passes the Farnsworth Lantern (FALANT) (USN) test, or

★(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set unless FALANT is passed.

★(c) When administered in lieu of (a) or (b) above, failure to pass the FALANT, with more than 2 errors in the reading of 18, or more than 3 in a reading of 27 test lights.

(2) *Depth perception.*

★(a) Any error in lines B, C, or D when using the Armed Forces Vision Tester.

(b) Any error with Verhoeff Stereometer when used in lieu of (a) above or when examinee fails (a).

(3) *Distant visual acuity*, uncorrected, less than 20/20 in each eye.

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

(5) *Field of vision.*

(a) Any demonstrable scotoma, other than physiologic or anatomic.

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

★(6) *History of night blindness*, confirmed by failure to pass night vision test.

(7) *Ocular motility.*

(a) Any diplopia or suppression in the Red Lens Test which develops within 20 inches from the center of the screen in any of the 6 cardinal directions.

★(b) Esophoria greater than 8 prism diopters.

★(c) Exophoria greater than 8 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(e) Heterotropia, any degree.

(f) Near point of convergence (NPC) greater than 70 mm.

★(8) *Power of accommodation* or less than minimum for age as shown in appendix V.

(9) *Refractive error.*

★(a) Astigmatism is excess of  $\pm 0.75$  diopter.

(b) Hyperopia in excess of 1.75 diopter in any meridian.

(c) Myopia in excess of 0.25 diopter in any meridian.

★(d) Refractive error corrected by orthokeratology or radial keratotomy.

b. *Class 1A*. Same as Class 1 except as listed below:

(1) *Distant visual acuity*. Uncorrected less than 20/50 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(2) *Near visual acuity*.

(a) *Individuals under age 35*. Uncorrected, less than 20/20 (J-1) in each eye.

(b) *Individuals age 35 or over*. Uncorrected, less than 20/50 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(3) *Refractive error*.

(a) Astigmatism greater than  $\pm 0.75$  diopter.

(b) *Hyperopia*.

1. *Individuals under age 35*. Greater than 1.75 diopter in any meridian.

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

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

★(d) Refractive error corrected by orthokeratology or radial keratotomy.

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

★(1) *Distant visual acuity*. Uncorrected less than 20/100 in each eye (flight surgeons: 20/200) or not correctable with spectacle lenses to 20/20 in each eye.

★(2) *Near visual acuity*. Uncorrected less than 20/100 in each eye (flight surgeons: 20/200) correctable with spectacle lenses to at least 20/20 in each eye.

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

(4) *Ocular motility*.

★(a) Hyperphoria greater than 1.5 prism diopters.

★(b) Failure of the Red Lens Test (suppression or diplopia within 20 inches from the center of the screen in any of the 6 cardinal directions) until a complete evaluation performed by a qualified ophthalmologist has been forwarded to the Cdr, USAAMC, who will determine fitness for flying duty.

★(5) *Refractive error* of such magnitude that the individual cannot be fitted with aviation spectacles.

d. *Class 3*.

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

(2) *Distant visual acuity*. Uncorrected less than 20/200 in each eye, not correctable to 20/20 in each eye with spectacle lenses.

★(3) *Near visual acuity, field of vision, depth perception, refractive error*: same as Class 2.

## ★Section IX. GENITOURINARY SYSTEM

### 4-13. Genitourinary System

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-14 and 2-15, plus the following:

a. *Classes 1, 1A, 2 and 3*. A history of urinary tract stone formation until reviewed and found fit by Cdr, USAAMC, Fort Rucker, AL. Evaluation will follow guidance provided by Cdr, USAAMC, to include:

(1) Excretory urography.

(2) Renal function testing.

(3) Specified metabolic studies.

b. *Pregnancy and postpartum*.

(1) *Classes 1, 1A, 2 and 3 for entry into training*. For aviation duty, all classes; and for 6 weeks after termination of pregnancy by any means or until all complications and sequelae have resolved, whichever is longer.

(2) *Class 2A, ATC* if accompanied by signs or symptoms which, in the opinion of the flight surgeon and/or obstetrician, pose any significant risk to the health and well-being of the member or the fetus; or which, through performance degradation or potential degradation, results or may result in any compromise of aviation safety.

*c. Menstrual cycle changes, classes 2, 2A and 3, while signs or symptoms are present which result in increased risk in the aviation environment.*

*d. Significant hematuria or history thereof, from any cause, unless remedial and corrective procedures have been successfully accomplished.*  
*e. Hyposthenuria.*

## Section X. HEAD AND NECK

★(See also para 4-23)

### 4-14. Head and Neck

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-16, 2-17 and 4-23 plus the following:

*a. A history of subarachnoid hemorrhage.*  
*b. Cervical lymph node involvement of malignant origin.*  
*c. Loss of bony substance of skull.*  
*d. Persistent neuralgia, tic douloureux; or facial paralysis.*

## Section XI. HEART AND VASCULAR SYSTEM

### 4-15. Heart and Vascular System

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-18, 2-19 and 2-20 plus the following:

*a. Abnormal slowing of the pulse, fall in blood pressure, or alteration in cerebral circulation resulting in fainting or syncope because of digital pressure on either carotid sinus (abnormal carotid sinus reflex).*

★*b. A substantiated history of paroxysmal supraventricular arrhythmias, such as paroxysmal atrioventricular nodal reentry tachycardia, nonparoxysmal junctional tachycardia, atrial flutter, or atrial fibrillation unless for Class 2 or 3 and complete evaluation, including intracardiac electrophysiologic study, fails to demonstrate a pathophysiologic substrate for recurrent arrhythmias.*

★*c. A history of ventricular tachycardia.*

★*d. A history of rheumatic fever or documented manifestations diagnostic of rheumatic fever within the preceding 5 years. Strict historical documentation of the Jones criteria is required, including two major criteria (carditis, chorea, erythema marginatum, migratory polyarthritis, and subcutaneous nodules) and bacteriologic or immunologic evidence of Group A beta hemolytic streptococcal pharyngitis within 3 weeks of the clinical syndrome. Evidence of rheumatic valvulitis at any time in the clinical course is disqualifying under chapter 2-18a.*

★*e. Cardiac enlargement or dilated cardiomyopathy as determined by complete cardiac evaluation, including M-mode or two-dimensional echocardiography.*

*f. Blood pressure.* (Certain aviation personnel who exceed these standards may be temporarily allowed to continue flying duties in accordance with policy letters issued by the Cdr, USAAMC.)

★(1) *Preponderant systolic* less than 90 mm Hg or greater than 140 mm Hg, regardless of age.

★(2) *Preponderant diastolic* less than 60 mm Hg or greater than 90 mm Hg, regardless of age.

*g. Unsatisfactory orthostatic tolerance test.*

*h. Electrocardiographic.*

★(1) *Borderline ECG findings* (Classes 1, 1A and 2) until reviewed by the Cdr, USAAMC. Review and final determination is made locally on Class 3; assistance will be provided by the Cdr, USAAMC, upon request. (Cdr, USAAMC, ATTN: HSNY-AER, Fort Rucker, AL 36362).

(2) *Left bundle branch block.*

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

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

Table 4-1. Neurology

Complaint	Class 1, 1A			Class 2, 3			
	Permanent disqual.	2-yr wait	6-mo wait	Permanent disqual.	2-yr disqual.	3-mo disqual.	4-wk disqual.
Syncope	Unexplained	.....	.....	Until Rev	.....	.....	.....
Seizure	Any	.....	.....	Same	.....	.....	.....
Vascular Headache	Any	.....	.....	Same	.....	.....	.....
New Growth	Any	.....	.....	Same	.....	.....	.....
Craniotomy	Any	.....	.....	Same	.....	.....	.....
Bony Defect	Any	.....	.....	Same	.....	.....	.....
Encephalitis	6 yrs	.....	.....	Until Rev	.....	.....	.....
Meningitis	1 yr	.....	.....	Until Rev	.....	.....	.....
Metabolic Disorder	Until Rev	.....	.....	Same	.....	.....	.....
CNS Bends	Until Rev	.....	.....	Same	.....	.....	.....
EEG Abnormality	Until Rev	.....	.....	Specified	.....	.....	.....
Narcolepsy	Any	.....	.....	Same	.....	.....	.....
Peripheral							
Nerve Injury	Any	.....	.....	Same	.....	.....	.....
Vascular Problems	Any	.....	.....	Same	.....	.....	.....
Familial Disease	Any	.....	.....	Same	.....	.....	.....
Degenerative Disease	Any	.....	.....	Same	.....	.....	.....
Head Injury							
Bleeding	Any	.....	.....	Same	.....	.....	.....
Penetrated Dura	Any	.....	.....	Same	.....	.....	.....
Fragments	Any	.....	.....	Same	.....	.....	.....
CNS Defect	Any	.....	.....	Same	.....	.....	.....
EEG Abnormality	Due to Injury	.....	.....	Same	.....	.....	.....
Depressed Fracture	Any	.....	.....	Any	.....	.....	.....
Basilar Fracture	Any	.....	.....	LOC>2h	LOC 15m-2h	LOC<15m	.....
Linear Fracture	Any	.....	.....	LOC>2h	LOC 15m-2h	LOC<15m	.....
Post Trauma							
Syndrome	>48h	12-48h	<12h	>1 mo	2 wk-1 mo	48h-14d	<48h
Headaches only	>14d	7-14d	<7d	>1 mo	.....	>14d	<14d
Amnesia	>48h	12-48h	<12h	.....	>48h	12-48h	<12h
Confusion	>48h	12-48h	<12h	.....	.....	>48h	<48h
Loss of Consciousness	>2h	15m-2h	<15m	>24h	2-24h	15m-2h	<15m
CSF Leak	Any	.....	.....	>7d	.....	<7d	.....
Cranial N Palsy	Func Sig	.....	.....	Until Rev	.....	.....	.....

★Section XVI. MENTAL DISORDERS

4-24. Mental Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-32, 2-33, 2-34, 2-34.1, 2-34.2 and 2-34.3, except as modified below.

a. Any psychotic episode evidenced by impairment in reality testing, to include transient disorders, from any cause except transient delirium secondary to toxic or infectious processes before age 12.

b. Any history of an affective disorder fitting the diagnostic criteria outlined in DSM III to include major affective disorders, cyclothymic disorder, dysthymic disorder, and atypical affective disorders.

c. Any history of anxiety disorder, somatoform disorder, or dissociative disorder (including but not limited to those disorders previously described as neurotic) fitting the diagnostic criteria outlined in DSM III. Additional-

ly, the presence or history of any phobias or severe or prolonged anxiety episodes, after age 12, even if they do not meet the fully diagnostic criteria of DSM III.

d. Any history of an *episode* that fits the criteria for any of the diagnoses listed in *DSM III chapters on factitious disorders and disorders of impulse control* not listed elsewhere.

e. Any history of *pervasive or specific developmental disorders* usually first seen in childhood as outlined in *DSM III*. Stuttering, sleepwalking and sleep terror disorders are not disqualifying if not occurring after age 12.

f. Any suspected *personality or behavior disorder*. Personality traits insufficient to meet full DSM III criteria for personality disorder diagnosis that potentially affect flying duty may be cause for an unsatisfactory ARMA.

g. A history of any *adjustment disorder* that meets the diagnostic criteria of DSM III.

h. *Excessive use of alcohol* or history thereof which has interfered with the performance of duty, physical health, social relationship or family relationship.

(1) Such individuals, as well as those medically unfit under paragraph 2-37, can be returned to flying duties only in accordance with paragraph 10-26i (i.e., with waiver).

(2) Individuals under Class 2 or 3 continuance standards with mild or minimal alcohol-related problems which have not interfered with the performance of duty and who recognize that alcohol is or may become a problem for them and voluntarily enter and successfully complete a rehabilitation program in accordance with AR 600-85 (i.e., a military program) may be returned to flying duty by their commander, without a waiver, if rehabilitation is completed before the time prescribed in AR 600-105 for temporary suspension and a favorable recommendation is received from the alcohol rehabilitation program clinical director and the local flight surgeon. The flight surgeon may recommend to the commander the limitation of dual status for an initial period of time, if deemed appropriate. The individual must meet all other medical fitness standards for flying duty, to include provisions of AR 40-8, pertaining to systemic medication (must not be on antabuse therapy). He or she must also be free of significant

underlying psychologic or psychiatric disorder(s), have no evidence of lasting or residual health impairment (hepatic, gastroenteric or other sequelae), and be experiencing no significant social or family conflict.

(a) The flight surgeon will evaluate the individual not less than every 2 months for at least 1 year after return to flying duty to determine his continued medical fitness for such duty. One year after return to flying duty, the flight surgeon will submit an Aeromedical Summary to the Cdr, USAAMC. The Aeromedical Summary will be used by the Cdr, USAAMC, to determine overall adequacy and success of rehabilitation and locally approved return to flying duty. The flight surgeon will also evaluate the individual at least once approximately 18 months and 24 months after return to flying duty and then annually in conjunction with the annual medical examination for flying duty. The annual and interim reports of medical examination on aviation personnel returned to flying status in accordance with this paragraph (i.e., without waiver) will contain an entry (item 73, SF 88 (Report of Medical Examination), or item 14, DA Form 4497-R (Interim Medical Examination—Aviation, Free Fall Parachuting & Marine (SCUBA) Diving Personnel)) reflecting dates of the rehabilitation program and date of return to flying duties. A return to flying status without a waiver can be accomplished only one time; a waiver is required if the individual needs an additional subsequent rehabilitation program. The 18- and 24-month evaluation(s) will be recorded as an Aeromedical Summary and forwarded to the Cdr, USAAMC.

(b) All Aeromedical Summaries pertaining to the rehabilitated individual will include, in the narrative or attached thereto, narrative reports with recommendations from the Aviation Unit Commander and the ADAPCP Clinical Director.

(c) Active duty personnel and Reserve Component personnel on extended active duty must meet the above requirements to be returned to flying duty without a waiver. Reserve Component personnel not on active duty, who otherwise meet the above requirements, may be returned to flying duty following rehabilitation in a nonmilitary rehabilitation program if they otherwise meet the criteria of AR 600-85.

*i. Drug abuse or misuse.* Paragraph 2-37 will apply. A history of illicit use of any psychoactive substance not disqualifying under paragraph 2-37 must be reviewed by the Cdr, USAAMC. A history of experimental or infrequent use of marijuana is not medically unfitting for acceptance for aviation training. Illegal use of any drug or psychoactive substance of abuse, other than alcohol, at any time after acceptance for or during aviation training or duty is medically unfitting for further flying duty.

*j. History of suicide attempt or gesture at any time.*

*k. Insomnia, severe or prolonged.*

*l. Fear of flying* manifested as a psychiatric or somatic symptom (refusal to fly or conscious fear of flying; i.e., conscious choice not to fly, is an administrative problem).

*m. Vasomotor instability.*

*n. Abnormal emotional responses to situations of stress* (either combat or noncombat) when, in the opinion of the examiner, such reaction will interfere with the efficient and safe performance of an individual's flying duties.

### ★Section XVII. SKIN AND CELLULAR TISSUES

#### 4-25. Skin and Cellular Tissues

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

paragraph 2-35, plus any condition which interferes with the use of aviation clothing and equipment.

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

#### 4-26. Spine, Scapulae, Ribs, and Sacroiliac Joints

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-36 and 2-37 plus the following:

*a. Classes 1 and 1A.*

(1) A history of *disabling episode of back pains*, especially when associated with significant objective findings.

★(2) *Fracture or dislocation of the vertebrae* or history thereof.

★(3) *Lateral deviation of the spine from the*

*normal midline* of more than 1 inch (scoliosis), even if asymptomatic.

★(4) *Cervical arthritis or cervical disc disease.*

*b. Classes 2 and 3.* Any of the conditions listed in *a* above of such a nature or degree as to compromise health or flying safety, plus the following:

(1) *Fracture or dislocation of the cervical spine* or history thereof.

(2) *History of laminectomy or spinal fusion.*

### Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

#### 4-27. Systemic Diseases and Miscellaneous Conditions and Defects

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-38 and 2-39, except as modified below.

*a. Sarcoidosis.*

(1) *Classes 1, 1A and 3.* A history of sarcoidosis, even if in remission.

(2) *Class 2.* Sarcoidosis, even if in remission, until evaluated and found fit by Cdr, USAAMC.

*b. Tuberculosis.* See paragraphs 4-19d and *e.*

*c. Allergic manifestations.* See paragraphs 2-28, 2-39, 4-19 and 4-21.

*d. Malaria.*

(1) *Classes 1 and 1A.* A history of malaria unless—

(a) There have been no symptoms for at least 6 months during which time no antimalarial drugs have been taken.

(b) The red blood cells are normal in number and structure, and the blood hemoglobin is at least 12 grams percent.

(c) A thick smear (which must be done if the disease occurred within 1 year of the examination) is negative for parasites.

(2) *Classes 2, 2A, and 3.* A history of malaria unless adequate therapy in accordance with existing directives has been completed. The duration of removal from flying or air traffic control duties is an individual problem and will vary with the type of malaria, the severity of the infection and the response to treatment. However, personnel may not fly or control air traffic unless they have been afebrile for 7 days, their blood cells are normal in number and structure, their blood hemoglobin is at least 12 grams percent and a thick smear (which must be done if the disease occurred within 1 year of the examination) is negative for parasites. A thick smear and a medical evaluation will be performed every 2 weeks for at least 3 months after all antimalarial therapy has been stopped.

*e. Motion sickness. Classes 1 and 1A.*

(1) History of *motion sickness*, other than isolated instances without emotional involvement.

(2) History of previous elimination from flight training at any time due to *airsickness*.

*f. Drugs, beverage alcohol, immunizations, blood donations, diving, and other exogenous factors. Classes 2 and 3.* In accordance with AR 40-8. Oral contraceptives and low dose tetracyclines (other than minocycline) are not unfitting for Class 1, Class 1A, initial Class 2 or initial Class 3; provided however, that in the case of oral contraceptives the medication must

not have been prescribed for an underlying pathologic condition which is disqualifying; the applicant must have been on the specific drug for at least three cycles; and must be free of side effects at the time of examination for both oral contraceptives and low dose tetracycline; SF 93 (Report of Medical History) must show the type and dosage of drug, duration of treatment, and presence or absence of side effects.

*g. Exposure to riot control agents. Classes 2 and 3.* Following unprotected exposure, for 2 hours or until all symptoms of eye and/or respiratory tract irritation disappear, whichever is longer, and until all risk of secondary exposure from contaminated skin, clothing, equipment or aircraft structures has been eliminated through cleansing, decontamination, change of clothing and equipment, or other measures. In no case will both the pilot and copilot be deliberately exposed at the same time unless one is wearing adequate protective equipment.

*h. Other diseases and conditions. Classes 1, 1A, 2, 2A, and 3.* Other diseases and conditions which, based upon sound aeromedical principles, may, in any way, interfere with the individual's health and well-being or compromise flying safety; or which may progress to a degree which may compromise health, well-being or flying safety. This determination will be made initially, and recommendations made to the individual's commander, by the local flight surgeon. Final determination of fitness for flying duty in questionable cases will be made by Cdr, USAAMC.

## Section XX. TUMORS AND MALIGNANT DISEASES

### 4-28. Malignant Diseases and Tumors

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

*a. Classes 1 and 1A.* Same as paragraphs 2-40 and 2-41.

★*b. Classes 2 and 3.* Individuals having a malignant disease or tumor will be considered as medically unfit pending review and evaluation by Cdr, USAAMC.

## Section XXI. VENEREAL DISEASES

### 4-29. Venereal Diseases

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

*a. Classes 1, 1A, and 2.* A history of syphilis, unless—

(1) Careful examination shows *no lesions of cardiovascular, neurologic, visceral, mucocutaneous, or osseous syphilis.*

(2) Documentary proof is available that *all provisions of treatment* as contained in direc-

## CHAPTER 5

**MEDICAL FITNESS STANDARDS FOR ADMISSION TO US MILITARY  
ACADEMY, UNIFORMED SERVICES UNIVERSITY OF HEALTH SCIENCES,  
AND ARMY ROTC SCHOLARSHIP**

(Short Title: USMA, HEALTH SCIENCES UNIVERSITY, AND ROTC  
SCHOLARSHIP MEDICAL FITNESS STANDARDS)

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## Section I. GENERAL

## 5-1. Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for admission to the US Military Academy, Uniformed Services University of Health Sciences, and ROTC Scholarship.

## 5-2. Applicability

The causes for rejection 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 cadets of the US Military Academy.
- c. Applicants for entrance into the Uniformed Services University of Health Sciences.
- d. Applicants for entrance into the Army ROTC Scholarship Program.

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

## 5-3. Abdomen and Gastrointestinal System

The causes of medical unfitness 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 are the causes listed in paragraph 2-4.

## Section IV. DENTAL

## 5-5. Dental

The causes of medical unfitness are—

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

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

c. *Prosthodontic appliances*.

(1) Appliances below generally accepted

standards of design, construction, and tissue adaptation.

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

d. *Teeth*.

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

(2) Grossly disfiguring spacing of existing anterior teeth.

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

### Section V. EARS AND HEARING

#### 5-6. Ears

The causes of medical unfitness 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.

★d. *History of middle ear surgery* excluding myringotomy; i.e., tympanoplasty with or without insertion of prosthesis.

#### ★5-7. Hearing

The causes of medical unfitness are hearing sensitivity levels by audiometric testing greater than those prescribed in table III, appendix II.

### Section VI. ENDOCRINE AND METABOLIC DISORDERS

#### 5-8. Endocrine and Metabolic Disorders

The causes of medical unfitness are the causes

listed in paragraph 2-8.

### Section VII. EXTREMITIES

#### 5-9. Upper Extremities

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

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

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

#### 5-10. Lower Extremities

The causes of medical unfitness 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 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) Esotropia of over 15 prism diopters.

(2) Exotropia of over 10 prism diopters.

(3) Hypertropia of over 2 prism diopters.

#### 5-12. Vision

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

a. *Color blindness.* Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or vivid green.

b. *Visual acuity.* Distance visual acuity which does not correct to at least 20/20 in each eye with spectacle lenses.

*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.

★(5) *Refractive error* corrected by orthokeratology or radial keratotomy.

**Section IX. GENITOURINARY SYSTEM****5-13. Genitourinary System**

Causes of medical unfitness are the causes listed in paragraphs 2-14 and 2-15, plus the following:

- a. Atrophy, deformity, or maldevelopment of both testicles.*
- b. Epispadias.*
- c. Hypospadias, pronounced.*

*d. Penis*. Amputation or gross deformity.

*e. Phimosis*. Redundant prepuce is not cause for rejection.

*f. Urine.*

(1) *Albuminuria*. Persistent or recurrent of any type, regardless of etiology.

(2) *Casts*. Persistent or recurrent, regardless of cause.

**Section X. HEAD AND NECK****5-14. Head and Neck**

The causes of medical unfitness are the causes listed in paragraphs 2-16 and 2-17, plus the following:

*a. Deformities of the skull* in the nature of depressions, exostoses, etc., which affect the military appearance of the candidate.

*b. Loss or congenital absence of the bony substance of the skull* of any amount.

**Section XI. HEART AND VASCULAR SYSTEM****5-15. Heart and Vascular System**

The causes of medical unfitness are the causes listed in paragraphs 2-18, 2-19, and 2-20, plus the following:

*a. Any evidence of organic heart disease.*

*b. Hypertension* evidenced by preponderant readings of 140 mm or more systolic or preponderant diastolic pressure of over 90 mm.

**Section XII. HEIGHT, WEIGHT, AND BODY BUILD****5-16. Height**

Entrance to USMA, ROTC, and Uniformed Services University of Health Services:

*a. Male applicants*. Height below 60 inches or over 80 inches (see administrative criteria in para 7-18, chap 7).

*b. Female applicants*. Height below 58 inches or over 72 inches (see administrative criteria in para 7-18, chap 7).

**5-17. Weight**

Entrance to USMA, ROTC, and Uniformed Services University of Health Sciences:

*a. Male applicants*. Weight related to age and height which is below the minimum or in excess of the maximum shown in table I, appendix III.

*b. Female applicants*. Weight related to age

and height which is below the minimum or in excess of the maximum shown in table II, appendix III.

**5-18. Body Build**

The causes of medical unfitness are the causes listed in paragraph 2-23, plus the following:

*Obesity*. Even though an examinee's weight is within the maximum shown in table I, appendix III or table II, appendix III, as appropriate, he or she will be reported as nonacceptable when the medical examiner considers that the excess weight, in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion or immediate participation in the required physical activities.

**Section XIII. LUNGS AND CHEST WALL****5-19. Lungs and Chest Wall**

listed in paragraphs 2-24, 2-25, and 2-26.

The causes of medical unfitness are the causes

**Section XIV. MOUTH, NOSE, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX****5-20. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx**

more obstruction of either airway, or which interfere with drainage of a sinus on either side.

The causes of medical unfitness are the causes listed in paragraphs 2-27, 2-28, 2-29, and 2-30, plus the following:

*a. Septal deviation, hypertrophic rhinitis, or other conditions which result in 50 percent or*

*b. Speech abnormalities.* Defects and conditions which interfere with the candidate's ability to pronounce and enunciate words correctly and clearly considering the requirements of class recitation and the issuing of commands to groups.

**Section XV. NEUROLOGICAL DISORDERS****5-21. Neurological Disorders**

listed in paragraph 2-31.

The causes of medical unfitness are the causes

**★Section XVI. MENTAL DISORDERS****5-22. Mental Disorders**

The causes of medical unfitness are the causes listed in paragraphs 2-32, 2-33, 2-34, 2-34.1, 2-34.2 and 2-34.3 plus the following:

*a. Prominent antisocial tendencies, personality defects, neurotic traits, emotional instabili-*

*ty, schizoid tendencies, and other disorders of a similar nature.*

*b. Stammering or stuttering* which interferes with the candidate's ability to pronounce and enunciate words correctly and clearly, considering the requirements of class recitation and the issuing of commands to groups.

**Section XVII. SKIN AND CELLULAR TISSUES****5-23. Skin and Cellular Tissues**

The causes of medical unfitness are the causes listed in paragraph 2-35, plus the following:

*a. Acne, moderately severe, or interfering with the wearing of military equipment.*

*b. Acne scarring.* Severe.

*c. Bromidrosis.* More than mild.

*d. Vitiligo* or other skin disorders which are disfiguring or unsightly.

**Section XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS****5-24. Joints, Spine, Scapulae, Ribs, and Sacroiliac**

The causes of medical unfitness are the causes listed in paragraphs 2-11, 2-36, and 2-37, plus the following:

*Defects and diseases of the spine, scapulae, ribs, or sacroiliac joints* which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

**Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS**

**5-25. Systemic Diseases and Miscellaneous Conditions and Defects**

The causes for rejection are the same as those listed in paragraphs 2-38 and 2-39 plus the following:

*Systemic diseases and miscellaneous medical conditions and physical defects* which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

**Section XX. TUMORS AND MAGLIGNANT DISEASES**

**5-26. Tumors and Malignant Diseases**

The causes of medical unfitness are the causes

listed in paragraphs 2-40 and 2-41.

**Section XXI. VENEREAL DISEASES**

**5-27. Venereal Diseases**

The causes of medical unfitness are the causes listed in paragraph 2-42 plus the following:

*a. Confirmed positive serologic test for syphilis.*

*b. Positive spinal fluid test for syphilis at any time.*

(3) Contracture of joint: More than moderate, and if loss of function is severe.

(4) Loose foreign bodies within a joint: Complicated by arthritis, not remediable and seriously interfering with function.

*e. Muscles.*

(1) Paralysis secondary to poliomyelitis if the use of a cane or crutches is required.

(2) Progressive muscular dystrophy: Confirmed.

*f. Myotonia congenital.* Confirmed.

*g. Osteitis deformans* (Paget's Disease). Involvement in single or multiple bones with re-

sultant deformities or symptoms severely interfering with function.

*h. Osteoarthropathy, hypertrophic, secondary.* Moderately severe to severe pain present, with joint effusion occurring intermittently in one or multiple joints and with at least moderate loss of function.

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

*j. Tendon transplantation.* Fair or poor restoration of function with weakness which seriously interferes with the function of the affected part.

## Section VIII. EYES AND VISION

### 6-13. Eyes

The causes of medical unfitness for military service are—

*a. Active eye disease or any progressive organic eye disease* regardless of the stage of activity, resistant to treatment which affects the distant visual acuity or visual fields of an eye to any degree when—

(1) The distant visual acuity cannot be corrected to 20/70 in the better eye.

(2) The diameter of the visual field in the unaffected eye is less than 20 degrees.

*b. Aphakia, bilateral.*

*c. Atrophy of optic nerve* due to disease.

*d. Chronic congestive (closed angle) glaucoma or chronic noncongestive (open angle) glaucoma* if well established, with demonstrable changes in the optic discs or visual fields.

*e. Degenerations.* When visual loss exceeds the limits shown below or when vision is correctable only by the use of contact lenses, or other special corrective devices (telescopic lenses, etc.).

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

*g. Residuals or complications of injury to*

*the eye* which are progressive or which bring vision below the criteria in paragraph 6-14.

*h. Retina, detachment of.*

(1) *Unilateral.*

(a) When vision in the better eye cannot be corrected to at least 20/70;

(b) When the visual field in the better eye is constricted to less than 20° in diameter;

(c) When uncorrectable diplopia exists;

or

(d) When the detachment is the result of documented organic progressive disease or new growth, regardless of the condition of the better eye.

(2) *Bilateral.* Regardless of etiology or results of corrective surgery.

### 6-14. Vision

The causes of medical unfitness for military service are—

*a. Aniseikonia.* Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances, and difficulties in form sense, and not corrected by iseikonic lenses.

*b. Binocular diplopia.* Not correctable by surgery, and which is severe, constant, and in zone less than 20° from the primary position.

*c. Hemianopsia.* Of any type, if bilateral,

permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to render an individual unfit.

*d. Loss of an eye.* An individual with the loss of an eye if suitable prosthesis cannot be tolerated.

*e. Night blindness.* Of such a degree that the individual requires assistance in any travel at night.

★*f. Visual acuity* which cannot be corrected to at least 20/70 in the better eye with spectacle lenses.

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

## Section IX. GENITOURINARY SYSTEM

### 6-15. Genitourinary System

(See also para 1-16.)

The causes of medical unfitness for military service are—

*a. Dysmenorrhea.* Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than one day from civilian occupation.

*b. Endometriosis.* Symptomatic and incapacitating to a degree which necessitates recurrent absences of more than a day from civilian occupation.

*c. Enuresis* determined to be a symptom of an organic defect not amenable to treatment.

*d. Hypospadias.* Accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings and the condition is not amenable to treatment.

*e. Incontinence of urine.* Due to disease or defect not amenable to treatment and of such severity as to necessitate repeated absence from civilian occupation.

#### *f. Kidney.*

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

(2) Bilateral congenital anomaly of the kidney resulting in frequent or recurrent infections, or when there is evidence of obstructive uropathy not responding to medical and/or surgical treatment.

(3) Cystic kidney (polycystic kidney):

(a) Symptomatic. Impaired renal function, or if the focus of frequent infections.

(b) Asymptomatic, history of, confirmed.

(4) Hydronephrosis: More than mild, bilateral, and causing continuous or frequent symptoms.

(5) Hypoplasia of the kidney: Symptomatic, and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(6) Perirenal abscess residual(s) of a degree which interfere(s) with performance of duty.

(7) Pyelonephritis: Chronic, confirmed.

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

(9) Nephrosis.

(10) Chronic glomerulonephritis.

(11) Chronic nephritis.

*g. Menopausal syndrome,* either physiologic or artificial. More than mild mental and constitutional symptoms.

*h. Menstrual cycle irregularities* including amenorrhea, menorrhagia, leukorrhea, metrorrhagia, etc., per se, do not render the individual medically unfit.

*i. Pregnancy.*

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

*k. Urethritis,* chronic, not responsive to treatment.

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

### 6-16. Genitourinary and Gynecological Surgery

The causes of medical unfitness for military

with function, or causing unmilitary appearance.  
*f. Scoliosis.* Severe deformity with over 2

inches deviation of tips of spinous processes from the midline.

### Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

#### 6-35. Systemic Diseases

The causes of medical unfitness for military service are—

- a. Blastomycosis.*
- b. Brucellosis.* Documented history of chronicity with substantiated recurring febrile episodes, more than mild fatigability, lassitude, depression, or general malaise.
- c. Leprosy of any type.*
- d. Myasthenia gravis.* Confirmed.
- e. Porphyria cutanea tarda.* Confirmed.
- f. Sarcoidosis.* Not responding to therapy or complicated by residual pulmonary fibrosis.
- g. Tuberculosis.*

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

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

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

(4) Tuberculosis of the male genitalia: Involvement of prostate or seminal vesicles and other instances not corrected by surgical excision or when residuals are more than minimal or are symptomatic.

(5) Tuberculosis of the larynx, female genitalia, and kidney.

(6) Tuberculosis of the lymph nodes, skin, bone, joints, intestines, eyes, and peritoneum or mesenteric glands will be evaluated on an individual basis considering the associated involvement, residuals and complications.

#### 6-36. General and Miscellaneous Conditions and Defects

★The causes of medical unfitness for military service are—

##### *a. Allergic manifestations:*

(1) Allergic rhinitis (hay fever) (para 6-28d).

(2) Asthma (para 6-26a).

(3) Allergic dermatoses (para 6-34).

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

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

*c. Any deformity which is markedly unsightly or which impairs general functional ability to such an extent as would prevent satisfactory performance of military duty.*

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

*e. Cold injury, residuals of (example: frostbite, chilblain, immersion foot, or trench foot), such as a combination of deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.*

*f. Positive tests for syphilis with negative TPI test unless there is a documented history of adequately treated lues or any of the several conditions which are known to give a false positive S.T.S. (vaccinia, infectious hepatitis, immunizations, atypical pneumonia, etc.) or unless there has been a reversal to a negative S.T.S. during an appropriate followup period (3 to 6 months).*

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

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

*i. Industrial solvent and other chemical intoxication, chronic including carbon bisulfide,*

trichloroethylene, carbon tetrachloride, and methyl cellosolve.

*j. Mycotic infection of internal organs.*

*k. Myositis or fibrositis; severe, chronic.*

*l. Residuals of tropical fevers and various parasitic or protozoal infestations which in the opinion of the medical examiner would preclude the satisfactory performance of military duty.*

## Section XX. TUMORS AND MALIGNANT DISEASES

### 6-37. Benign Tumors.

★The causes of medical unfitness for military service are—

*a. Any tumor of the—*

(1) Auditory canal, if obstructive.

(2) Eye or orbit. See also paragraph 6-13.

(3) Kidney, bladder, testicle, or penis.

(4) Central nervous system and its membranous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or original lesion.

*b. Benign tumors of the abdominal wall if sufficiently large to interfere with military duty.*

*c. Benign tumors of the thyroid or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to interfere with the wearing of a uniform or military equipment.*

*d. Tongue, benign tumor of, if it interferes with function.*

*e. Breast, thoracic contents, or chest wall, tumors of, other than fibromata lipomata, and inclusion or sebaceous cysts which are of such size*

as to interfere with wearing of a uniform or military equipment.

*f. For tumors of the internal or external female genitalia, see paragraph 6-16.*

*g. Ganglioneuroma.*

*h. Meningeal fibroblastoma, when the brain is involved.*

### 6-38. Malignant Neoplasms

The causes of medical unfitness for military service are—

*Malignant growths* when inoperable, metastasized beyond regional nodes, have recurred subsequent to treatment, or the residuals of the remedial treatment are in themselves incapacitating.

### 6-39. Neoplastic Condition of Lymphoid and Blood-Forming Tissues

Neoplastic conditions of the lymphoid and blood-forming tissues are generally considered as rendering an individual medically unfit for military duty.

## Section XXI. VENEREAL DISEASES

### 6-40. Venereal Disease

The causes of medical unfitness for military service are—

*a. Aneurysm of the aorta due to syphilis.*

*b. Atrophy of the optic nerve due to syphilis.*

*c. Symptomatic neurosyphilis in any form.*

*d. Complications or residuals of venereal disease of such chronicity or degree that the individual would not be expected to perform useful duty.*

(2) For Airborne and Ranger training and duty. Distant visual acuity of any degree that does not correct to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.

(3) For Special Forces training and duty. Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye. Vision which does not correct to 20/20 in at least one eye with spectacle lenses.

(4) Color vision. Failure to identify red and/or green as projected by the Ophthalmological Projector or the Stereoscope, Vision Testing. (No requirement for Ranger training.)

*h. Genitourinary system.* Paragraphs 2-14 and 2-15.

*i. Head and neck.*

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull.

(3) Persistent neuralgia; tic douloureux; facial paralysis.

(4) A history of subarachnoid hemorrhage.

*j. Heart and vascular system.* Paragraphs 2-18, 2-19, and 2-20.

*k. Height.* No special requirement.

*l. Weight.* No special requirement.

*m. Body build.* Paragraph 2-23.

*n. Lungs and chest wall.*

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

(2) Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying if discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

*o. Mouth, nose, pharynx, larynx, trachea and esophagus.* Paragraphs 2-27, 2-28, 2-29 and 2-30.

*p. Neurological disorders.*

(1) Paragraph 2-31.

(2) Active disease of the nervous system of any type.

(3) Craniocerebral injury (para 4-23a(6)).

★*q. Mental disorders.*

(1) Paragraphs 2-32 through 2-34.3.

(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 and 2-37.

(2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than inch.

(3) Spondylolysis, spondylolisthesis.

(4) Healed fractures or dislocations of the vertebrae.

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

*t. Systemic disease and miscellaneous conditions and defects.*

(1) Paragraphs 2-38 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.

### 7-5. Medical Fitness Standards for Initial Selection for Free Fall Parachute Training

★The causes of medical unfitness for initial selection for free fall parachute training are the causes listed in chapter 2 plus the causes listed in this section. Disposition of medical reports will be as described in chapter 10, paragraph 10-29c.

a. *Abdomen and gastrointestinal system.* Paragraph 2-3.

b. *Blood and blood-forming disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

★(3) Sickle cell disease.

★(4) Sickle cell trait until evaluated by the Commander, US Army Aeromedical Center, ATTN: HSXY-AER, Fort Rucker AL 36362, and found to have no increased susceptibility to the free fall environment.

c. *Dental.*

(1) Paragraph 2-5.

(2) Any unserviceable teeth until corrected.

d. *Ears and hearing.*

(1) Paragraphs 2-6 and 2-7.

(2) Abnormal labyrinthine function.

(3) Any infectious process of the ear, including external otitis, until completely healed.

(4) History of attacks of vertigo with or without nausea, emesis, deafness or tinnitus.

(5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of eustachian tube.

(6) Perforation, marked scarring or thickening of the ear drum.

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

f. *Extremities.*

(1) Paragraphs 2-9, 2-10 and 2-11.

(2) Any limitation of motion of any joint which might compromise safety.

(3) Any loss of strength which might compromise safety.

(4) Instability of any degree or pain in a weight bearing joint.

g. *Eyes and vision.*

(1) Paragraphs 2-12 and 2-13.

(2) Uncorrected distant visual acuity of

worse than 20/70 in the better eye or worse than 20/200 in the poorer eye.

(3) Distant visual acuity of any degree that does not correct to at least 20/30 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.

(4) Color vision. Failure to identify red and green.

h. *Genitourinary system.* Paragraphs 2-14 and 2-15.

i. *Head and neck.*

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected.

(3) A history of subarachnoid hemorrhage.

j. *Heart and vascular system.* Paragraphs 2-18, 2-19 and 2-20.

k. *Height.* Paragraph 2-21.

l. *Weight.* Paragraph 2-22.

m. *Body Build.* Paragraph 2-23.

n. *Lungs and chest wall.*

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

(2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation/perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the examination and clinical evaluation shows complete recovery with normal pulmonary function.

o. *Mouth, nose, pharynx, larynx, trachea and esophagus.* Paragraphs 2-27, 2-28, 2-29 and 2-30.

p. *Neurological disorders.*

(1) Paragraph 2-31.

(2) The criteria outlined in paragraph 4-23 for Classes 2 and 3 flying duty apply.

★q. *Mental disorders.*

★(1) Paragraphs 2-32 through 2-34.3.

(2) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress. When in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

*r. Skin and cellular tissues.* Paragraph 2-35.

*s. Spine, scapulae, ribs and sacroiliac joints.*

(1) Paragraphs 2-36 and 2-37.

(2) Spondylolysis, spondylolisthesis.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

*t. Systemic diseases and miscellaneous conditions and defects.*

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

(2) Blood donations. Personnel will not per-

form free fall parachute duties for a period of 72 hours following the donation of blood.

(3) Chronic motion sickness.

(4) Any severe illness, operation, injury or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

*u. Tumors and malignant disease.* Paragraphs 2-40 and 2-41.

*v. Venereal diseases.* Paragraph 2-42.

### 7-6. Medical Fitness Standards for Retention for Free Fall Parachute Duty

Retention of an individual in free fall parachute duty will be based on—

*a.* The servicemember's demonstrated ability to perform satisfactorily free fall parachute duty.

*b.* The effect upon the individual's health and well-being by remaining on free fall parachute duty.

## Section III. MEDICAL FITNESS STANDARDS FOR ARMY SERVICE SCHOOLS

### 7-7. Medical Fitness Standards for Army Service Schools

The medical fitness standards for Army service

schools, except as provided elsewhere herein, are covered in DA Pam 351-4.

## Section IV. MEDICAL FITNESS STANDARDS FOR DIVING TRAINING AND DUTY

### 7-8. Medical Fitness Standards for Initial Selection for Marine (SCUBA) Diving Training (Special Forces and Ranger Combat Diving)

★The causes of medical unfitness for initial selection for marine self-contained underwater breathing apparatus (SCUBA) diving training are the causes listed in chapter 2 plus the causes listed in this section. Disposition of medical reports will be as described in chapter 10, paragraph 10-29c.

*a. Abdomen and gastrointestinal system.* Paragraph 2-3.

*b. Blood and blood-forming disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

★(3) Sickle cell disease; sickle cell trait until evaluated by Cdr, USAAMC, and found to have

no increased susceptibility to the hazards and potential risks of the diving environment.

*c. Dental.*

(1) Paragraph 2-5.

★(2) Any infectious process and any conditions which contribute to recurrence until eradicated.

★(3) Edentia; any unserviceable teeth until corrected.

★(4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures which interfere with the use of SCUBA. Residual teeth and *fixed* appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.

*d. Ears and hearing.*

(1) Paragraphs 2-6 and 2-7.

★(2) Persistent or recurrent abnormal labyrinthine function as determined by appropriate tests.

(3) Any infectious process of the ear, including external otitis, until completely healed.

(4) History of attacks of vertigo with or without nausea, emesis, deafness or tinnitus.

★(5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of eustachian tube. See pressure test requirement, paragraph 7-8w.

(6) Perforation, marked scarring or thickening of the eardrum.

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

*f. Extremities.*

(1) Paragraphs 2-9, 2-10 and 2-11.

(2) Any limitation of motion of any joint which might compromise safety.

(3) Any loss of strength which might compromise safety.

(4) Instability of any degree or pain in a weight-bearing joint.

★(5) History of osteonecrosis (aseptic necrosis of the bone) of any type.

*g. Eyes and vision.*

(1) Paragraphs 2-12 and 2-13.

★(2) Vision which does not correct to 20/20 in at least one eye.

★(3) Color vision. Failure to identify red and/or green as projected by the Ophthalmological Projector or the Stereoscope Vision Testing.

*h. Genitourinary system.* Paragraphs 2-14 and 2-15.

*i. Head and neck.*

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected.

(3) History of subarachnoid hemorrhage.

*j. Heart and vascular system.* Paragraphs 2-18, 2-19 and 2-20.

*k. Height.* Paragraph 2-21.

*l. Weight.*

(1) Paragraph 2-22.

(2) The individual must meet the weight standards prescribed by AR 600-9. The medical examiner may impose body fat measurements not otherwise requested by the commander.

*m. Body build.*

(1) Paragraph 2-23.

(2) Obesity of any degree.

*n. Lungs and chest wall.*

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

(2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation/perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the examination and clinical evaluation shows complete recovery with normal pulmonary function.

*o. Mouth, nose, pharynx, larynx, trachea and esophagus.* Paragraphs 2-27, 2-28, 2-29 and 2-30.

*p. Neurological disorders.*

(1) Paragraph 2-31.

(2) The criteria outlined in paragraph 4-23 for Classes 2 and 3 flying duty apply.

★*q. Disorders with psychotic features, affective disorders (mood disorders), anxiety, somatoform or dissociative disorders (neurotic disorders).*

(1) Paragraphs 2-32 through 2-34.3.

(2) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress. When in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

(9) Fear of depths, inclosed places or of the dark.

*r. Skin and cellular tissues.* Paragraph 2-35.

★*s. Spine, scapulae, ribs and sacroiliac joints.* (Consultation with an orthopedist and, if

available, diving medical officer will be obtained in questionable cases.)

(1) Paragraphs 2-36 and 2-37.

★(2) Spondylolisthesis; spondylolysis which is symptomatic or likely to interfere with diving duty.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

*t. Systemic diseases and miscellaneous conditions and defects.*

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

(2) Chronic motion sickness.

(3) Any severe illness, operation, injury or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

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

*v. Venereal diseases.* Paragraph 2-42.

★*w. If a hyperbaric chamber is available, examinees will be tested for the following disqualifying conditions:*

(1) *Failure to equalize pressure.* All candidates shall be subjected in a compression chamber to a pressure of 50 pounds (22.5 kg) per square inch to determine their ability to withstand the effects of pressure, to include ability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver. This test should not be performed in the presence of a respiratory infection that may temporarily impair the ability to equalize or ventilate.

(2) *Oxygen intolerance.* Individual susceptibility to oxygen shall be tested by determining the candidate's ability to breathe oxygen without deleterious effects at a pressure to 27 pounds (12.15 kg)(60 feet)(18 meters) for a period of 30 minutes.

#### 7-9. Medical Fitness Standards for Retention for Marine (SCUBA) Diving Duty (Special Forces and Ranger Combat Diving)

Retention of an individual in marine (SCUBA) diving duty will be based on—

*a.* The servicemember's demonstrated ability to perform satisfactorily marine (SCUBA) diving duty.

*b.* The effect upon the individual's health and well-being by remaining on marine (SCUBA) diving duty.

#### 7-10. Medical Fitness Standards for Initial Selection for Other Marine Diving Training (MOS 00B)

★SF 88 (Report of Medical Examination), SF 93 (Report of Medical History), and allied documents will be sent to HQDA (DASG-PSP-O), Washington, DC 20310 for review and approval. The causes of medical unfitness for initial selection for diving training are all of the causes listed in chapter 2, plus all of the causes listed in this section.

★*a. Abdomen and gastrointestinal system.*

(1) Paragraph 2-3.

(2) Hernia of any variety.

(3) Operation for relief of intestinal adhesions at any time.

(4) Chronic or recurrent gastrointestinal disorder which may interfere with or be aggravated by diving duty. Severe colitis, peptic ulcer disease, pancreatitis, and chronic diarrhea are disqualifying unless asymptomatic on an unrestricted diet for 24 months and no radiographic or endoscopic evidence of active disease or severe scarring or deformity.

(5) Laparotomy or celiotomy within the preceding 6 months.

*b. Blood and blood-forming tissue diseases.*

(1) Paragraph 2-4.

★(2) Sickle cell disease; sickle cell trait until evaluated by Cdr, USAAMC, and found to have no increased susceptibility to the hazards and potential risks of the diving environment.

(3) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

*c. Dental.*

(1) Paragraph 2-5.

★(2) Any infectious process and any conditions which contribute to recurrence until eradicated.

★(3) Edentia; any unserviceable teeth until corrected.

★(4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures, which interfere with use of SCUBA. Residual teeth and *fixed* appliances must be sufficient to

allow the individual to easily retain a SCUBA mouthpiece.

*d. Ears and hearing.*

★(1) Paragraphs 2-6 and 2-7.

(2) Perforation, marked scarring or thickening of the eardrum.

★(3) Inability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver while under 50 pounds of pressure in a compression chamber. See paragraph 7-8*w*.

(4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.

★(5) Hearing sensitivity level in either ear by reliable audiometric testing (regardless of conversational or whispered voice hearing sensitivity) which exceeds 20 decibels at any of the frequencies 250, 500, 1000, 2000 or which exceeds 45 decibels at frequency 4000.

★(6) History of otitis media or otitis externa with any residual effects which might interfere with or be aggravated by diving duty.

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

*f. Extremities.*

(1) Paragraphs 2-9, 2-10 and 2-11.

★(2) History of any chronic or recurrent orthopedic pathology which would interfere with diving duty.

★(3) Loss of any digit or portion thereof of either hand which significantly interferes with normal diving duties.

★(4) Fracture or history of disease or operation involving any major joint until reviewed by a diving medical officer.

★(5) Any limitation of the strength or range of motion of any of the extremities which would interfere with diving duty.

*g. Eyes and vision.*

(1) Paragraph 2-12.

★(2) Distant visual acuity, uncorrected, of less than 20/70 (better eye) and 20/200 (poorer eye); not correctable to 20/20.

★(3) Near visual acuity, uncorrected, of less than 20/50 or not correctable to 20/20.

(4) Color vision:

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set, or

(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set.

(c) When administered in lieu of (a) or (b) above, failure to pass the Farnsworth Lantern Test (FALANT) (USN Test).

★(d) Waivers may be granted by the reviewing authority if the examinee can correctly identify the red, green and brown colors used in diving operations. Such testing will include sufficient repetitions to insure against examinee passing by chance.

★(5) Abnormalities of any kind noted during ophthalmoscopic examination which significantly affect visual function or indicate serious systemic disease.

*h. Genitourinary system.*

(1) Paragraphs 2-14 and 2-15.

★(2) Chronic or recurrent genitourinary disease or complaints, including glomerulonephritis and pyelonephritis.

★(3) Abnormal findings by urinalysis, including significant proteinuria and hematuria.

★(4) Varicocele, unless small and asymptomatic.

*i. Head and neck.* Paragraphs 2-16, 2-17 and 4-14.

*j. Heart and vascular system.*

(1) Paragraphs 2-18, 2-19 and 2-20.

★(2) Varicose veins which are symptomatic or may become symptomatic as a result of diving duty; deep vein thrombophlebitis; gross venous insufficiency.

(3) Marked or symptomatic hemorrhoids.

★(4) Any circulatory defect (shunts, stasis and others) resulting in increased risk of decompression sickness.

★(5) Persistent tachycardia or arrhythmia except for sinus type.

★*k. Height.* Less than 66 or more than 76 inches.

*l. Weight.* Weight related to height which is outside the limits prescribed by AR 600-9.

*m. Body build.*

(1) Paragraph 2-23.

★(2) Obesity. Even though the individual's weight or body composition is within the limits prescribed by AR 600-9, he will be found medically unfit if the examiner considers that his weight and/or associated conditions in relation-

ship to the bony structure, musculature and/or total body fat content would adversely affect diving safety or endanger the individual's well-being if permitted to continue in diving status.

*n. Lungs and chest wall.*

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

(2) Congenital or acquired defects which restrict pulmonary function, cause air trapping or affect ventilation-perfusion ratio.

★(3) Any chronic obstructive or restrictive pulmonary disease at the time of examination.

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

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

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

(3) Any nasal or pharyngeal respiratory obstruction.

(4) Chronically diseased tonsils until removed.

★(5) Speech impediments of any origin; any condition which interferes with the ability to communicate clearly in the English language.

*p. Neurological disorders.*

(1) Paragraph 2-31.

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

★*q. Mental disorders.*

(1) Paragraphs 2-32 through 2-34.3.

(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 until reviewed by a diving medical officer.

(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 defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe driving.

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

★*v. Venereal disease.*

(1) Active venereal disease until adequately treated.

(2) History of clinical or serological evidence of active or latent syphilis, unless adequately treated, or of cardiovascular or central nervous system involvement at any time. Serological test for syphilis required.

★*w. Oxygen intolerance.* See paragraph 7-8w.

**★7-11. Medical Fitness Standards for Retention for Other Marine Diving Duty (MOS 00B)**

The medical fitness standards contained in paragraph 7-10 apply to all personnel performing diving duty except that divers of long experience and a high degrees of efficiency—

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

*b.* Must maintain their ability to equalize air pressure.

*c.* Uncorrected visual acuity, near and far, of not less than 20/100 in the better eye, correctable to not less than 20/30.

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

**7-12. Medical Fitness Standards for Enlisted Military Occupational Specialties**

*a.* The medical fitness standards to be utilized in the initial selection of individuals to enter a

specific enlisted military occupational specialty (MOS) are contained in AR 611-201. Visual acuity requirements for this purpose will be based upon the individuals' vision corrected by spectacle lenses.

b. Individuals who fail to meet the minimum medical fitness standards established for a particular enlisted MOS, but who perform the duties of the MOS to the satisfaction of the commander concerned are medically fit to be

retained in that specialty except when there is medical evidence to the effect that continued performance therein will adversely affect their health and well-being.

## Section VI. MEDICAL FITNESS STANDARDS FOR CERTAIN GEOGRAPHICAL AREAS

### 7-13. Medical Fitness Standards for Certain Geographical Areas

a. All individuals considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States are medically qualified to serve in similar or corresponding areas outside the continental United States.

b. Certain individuals, by reason of certain medical conditions or certain physical defects, may require administrative consideration when assignment to certain geographical areas is contemplated to insure that they are utilized within their medical capabilities without undue hazard to their health and well-being. In many instances, such individuals can serve effectively in a specific assignment when the assignment is made on an individual basis considering all of the administrative and medical factors. Guidance as to assignment limitations indicated for various medical conditions and physical defects is contained in chapter 9 and *c* below.

c. MAAG's, military attachés, military missions and duty in isolated areas (see AR 55-46, AR 600-200, and AR 612-2).

(1) The following medical conditions and defects will preclude assignments or attachment to duty with MAAG's, military attachés, military missions, or any type duty in isolated overseas stations requiring residence in areas where US military medical treatment facilities are limited or nonexistent:

(a) A history of peptic ulcer which has required medical or surgical management within the preceding 3 years.

(b) A history of colitis.

(c) A history of emotional or mental disorders, including character disorders, of such a degree as to have interfered significantly with past adjustment or to be likely to require treatment during this tour.

d. Any medical condition where maintenance

medication is of such toxicity as to require frequent clinical and laboratory followup.

e. Inherent, latent, or incipient medical or dental conditions which are likely to be aggravated by climate or general living environment prevailing in the area where the individual is expected to reside, to such a degree as to preclude acceptable performance of duty.

(2) Of special consideration is a thorough evaluation of a history of chronic cardiovascular, respiratory, or nervous system disorders. This is especially important in the case of individuals with these disorders who are scheduled for assignment and/or residence in an area 6,000 feet or more above sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Colombia; and Addis Ababa, Ethiopia.

(3) Remediable medical, dental, or physical conditions or defects which might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure from CONUS.

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

d. The medical fitness standards set forth in *c* above are prescribed for the purpose of meeting selection criteria for military personnel under consideration for assignment or attachment to duty with MAAG's, military attachés, military missions or any type duty in isolated overseas stations. These fitness standards also pertain to dependents of personnel being considered.

## Section VII. MEDICAL FITNESS STANDARDS FOR ADMISSION TO SERVICE ACADEMIES OTHER THAN US MILITARY ACADEMY

### ★7-14. Medical Fitness Standards for Admission to US Naval Academy

The medical fitness standards for admission to the United States Naval Academy are set forth in chapter 15 of the Manual of the Medical Department, US Navy, as well as NAVPERS 15010 Regulations Governing the Admission of Candidates into the United States Naval Academy as Midshipmen. The Manual of the Medical Department may be obtained from the Naval Medical Command, Code 09B21, Room 3009, 2300 E Street NW, Washington, DC 20372. The NAVPERS 15010 Regulations are available at

the Naval Publications and Forms Center, 5801 Tabor Avenue, Philadelphia, PA 19120.

### ★7-15. Medical Fitness Standards for Admission to US Air Force Academy

The medical fitness standards for admission to the United States Air Force Academy are set forth in section VI of AFM 160-1, Medical Examination. The special administrative criteria in paragraphs 7-16 through 7-19 are listed for the information and guidance of all concerned. AFM 160-1 may be obtained from HQ US Air Force, PDO 4008A, Bolling Air Force Base, Washington, DC 20372.

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

### 7-16. Dental—Induction, Enlistment or Appointment (See para 2-5.)

★*a.* Except for physicians, dentists and allied medical specialists, individuals who have orthodontic appliances and who are under active treatment are administratively unacceptable for enlistment or induction into the Active or Reserve Components of the Army, Air Force, Navy and Marine Corps for an initial period not to exceed 12 months from the date that treatment was initiated. Selective service registrants will be reexamined after the 12-month period. After the 12-month period, wherein a longer period of treatment is allegedly required, the registrant will be scheduled by the examining MEPS for consultation by a civilian or military orthodontist, and the report of this consultation will be forwarded through the Chief, Medical Section, Headquarters, United States Army Recruiting Command, Fort Sheridan, IL 60037 to the Commander, United States Army Health Services Command, Fort Sam Houston, TX 78234 for final determination of acceptability. The Commanding General, United States Army Health Services Command will coordinate, as appropriate with the Surgeon General, US Air Force, or the Surgeon General of the Navy on individuals whose induction into the Air Force, Navy, or Marine Corps is being considered. Phy-

sicians, dentists, and allied medical specialists liable for induction will be evaluated in accordance with the standards prescribed by chapter 8 of this regulation.

*c.* Officers and enlisted personnel of the Active Army, Army National Guard, and the Army Reserve are acceptable for active duty, or active duty for training if the orthodontic appliances were affixed subsequent to the date of original appointment or enlistment.

*d.* Cadets at the USMA or in the ROTC are also acceptable for appointment and active duty if the orthodontic appliances were affixed prior to or since entrance into these programs.

*e.* Individuals with retainer orthodontic appliances who are not required to undergo active treatment are administratively acceptable for appointment, enlistment, or induction.

### 7-17. Height—Regular Army Commission (See para 2-21*a*(1).)

Individuals being considered for appointment in the Regular Army who are over the maximum or under the minimum height standards will automatically be considered on an individual basis for an administrative waiver by Headquarters, Department of the Army, during the processing of their applications.

**★7-18. Height—USMA, ROTC and Uniformed Services University of Health Sciences**  
(See para 5-16.)

★The following applies to all candidates to the USMA, ROTC and the Uniformed Services University of Health Sciences:

Candidates for admission to the USMA, ROTC and the Uniformed Services University of Health Sciences, who are over the maximum height or below the minimum height, will automatically be recommended by the Department of Defense Medical Review Board for consideration for an administrative waiver by Headquarters, Department of the Army, during the processing of their cases, which may be granted provided they have exceptional educational qualifications, have an outstanding military record or have demonstrated outstanding abilities.

**7-19. Vision—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps**

★*a.* Individuals being initially appointed or assigned as officers in Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps may possess uncorrected distance visual acuity of any degree that corrects with spectacle lenses to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, and be able to identify without confusion the colors vivid red and vivid green. Refractive error corrected by orthokeratology or radial keratotomy is disqualifying.

**Section IX. MEDICAL FITNESS STANDARDS FOR TRAINING AND DUTY AS NUCLEAR POWERPLANT OPERATORS AND/OR OFFICER-IN-CHARGE (OIC) NUCLEAR POWERPLANT**  
(Ref. TB MED 267)

**★7-20. Medical Fitness Standards for Training and Duty at Nuclear Powerplants**

The causes for medical unfitness for initial selection, training, and duty as nuclear powerplant operators and/or officer-in-charge (OIC) nuclear powerplants are all the causes listed in chapter 2, plus the following:

★*a.* Paragraph 7-13*c.*

*b.* Retention of an officer in any of the branches listed in *a* above will be based on:

(1) The officer's demonstrated ability to perform appropriate duties commensurate with his age and grade.

(2) The officer's medical fitness for retention in Army service shall be determined pursuant to chapter 3, including paragraphs 3-15 and 3-16.

(3) If the officer is determined to be medically unfit for retention in Army service, but is continued on active duty or in Reserve Component service not on active duty under appropriate regulations, such continuance may also constitute a basis for retention of the officer in any of the branches listed in *a* above.

**★7-19.1. Hearing—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps and Signal Corps**

*a.* Individuals being initially appointed or assigned as officers in these branches may not possess hearing levels greater than those levels cited as Profile serial H-1, appendix VIII, this regulation.

*b.* Retention of an officer in any of the branches listed in (*a*) above will be based on:

(1) The officer's demonstrated ability to perform appropriate duties commensurate with his age and grade, and

(2) The officer's medical fitness for retention in Army service under chapter 3, paragraph 3-10.

*b.* Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or a vivid green.

*c.* Familial history of any of the following (refer to TB MED 267):

(1) Congenital malformations.

(2) Leukemia.

- (3) Blood clotting disorders.
- (4) Mental retardation.
- (5) Cancer.
- (6) Cataracts (early).

d. Abnormal results from the following studies which will be accomplished (see TB MED 267):

- (1) White cell count (with differential).
- (2) Hematocrit.
- (3) Hemoglobin.
- (4) Red cell morphology.

(5) Sickle cell preparation (regardless of race).

- (6) Platelet count.
- (7) Fasting blood sugar.

e. Presence or history of psychiatric illness requiring hospitalization or extensive treatment, or personality disorders, including alcoholism, where either, in the opinion of the examining officer, would make assignment at this specialty inadvisable.

## Section X. SPECIAL MEDICAL FITNESS STANDARDS FOR AVIATION TRAINING

### ★7-21. Federal Aviation Administration-Rated Personnel

When so directed in special procurement programs prescribed by the Department of the Army or the National Guard Bureau, personnel possessing current valid FAA private pilot certificates or higher certificates may be medically qualified for initial Army aviation flight training under Army Class 2 medical fitness standards.

### 7-22. Senior Career Officers

Selected senior career officers of the Army in the grades of lieutenant colonel, promotable, and colonel may be medically qualified for initial flight training under the following medical fitness standards:

a. Class 2, medical fitness standards for flying as prescribed in chapter 4, except—

(1) *Vision*. Uncorrected distant visual acuity of less than 20/100 in each eye or not correctable with spectacle lenses to 20/20 in each eye. Near visual acuity not correctable to 20/20 in each eye with spectacle lenses.

(2) *Refractive error*.

(a) *Astigmatism*. Greater than 1.00 diopter.

(b) *Hyperopia*. Greater than 1.75 diopters for individuals under the age of 35 years and greater than 2.00 diopters for individuals age 35 and over, in any meridian.

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

★(d) *Refractive error corrected* by orthokeratology or radial keratotomy.

b. Unsatisfactory ARMA.

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

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**Section I. General**

**8-1. Scope**

This chapter sets forth the minimum level of medical fitness standards for physicians, dentists, and allied medical specialists, including applicants for The Armed Forces Health Professions Scholarship Program.

**8-2. Applicability**

a. These standards apply only in evaluating physicians, dentists, or allied medical specialists, including applicants for The Armed Forces Health Professions Scholarship Program for—

(1) Induction.

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

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

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

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

c. As used further in this chapter, all references to "physicians, dentists, and allied medical specialists" are meant to include applicants for and participants in The Armed Forces Health

Professions Scholarship Program, and Postgraduate Medical and Dental Education Programs.

★d. In the event of mobilization, when the Service Secretaries determine that the services of retired Medical Department officers of the Army, Navy and Air Force are required, these standards will also apply to those retired officers being considered for voluntary or involuntary recall to active duty.

**8-3. Department of Defense Policy**

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

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

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

**8-4. Questionable Cases**

Questionable cases involving the diagnoses listed below will be referred in accordance with current procedures to the Commander, United States Army Health Services Command, 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*.

f. *Nephrolithiasis*.

## Section II. MEDICAL FITNESS STANDARDS

### 8-5. Basic Medical Fitness Standards

a. The nature of the duties expected of physicians, dentists, and allied medical specialists is such, in general, that although they may have physical defects or medical conditions which would ordinarily be cause for rejection for original entry into the military service, they may be expected to perform appropriate military duties in their specialties.

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

### 8-6. Abdomen and Gastrointestinal System

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

a. *Paragraphs 3-5 and 3-6.*

b. *Amebiasis.* A history of amebiasis when active hepatic involvement is present.

c. *Anal fistula* with extensive multiple sinus tracts.

d. *Chronic cholecystitis or cholelithiasis* if disabling for civilian practice.

e. *Liver disease.* A history of liver disease when presence of liver disease is manifested by hepatomegaly or abnormal liver function studies. If the disease is considered temporary, deferment for reexamination at a later date.

f. *Peptic ulcer.* A history of peptic ulcer complicated by obstruction, verified history of perforation, or recurrent hemorrhage is disqualifying. An individual with X-ray evidence of an active ulcer will be deferred for reexamination at a later date. A history of peptic ulcer or a healed ulcer, with scarring, but without a niche or crater as demonstrated by X-ray, is acceptable.

g. *Splenectomy.* A history of splenectomy except when the surgery was for trauma, surgery unrelated to disease of the spleen, hereditary spherocytosis, or disease involving the spleen where splenectomy was followed by correction of the condition for a period of at least 2 years.

h. *Ulcerative colitis.* Confirmed by proctosigmoidoscopic or X-ray findings.

### 8-7. Blood and Blood-Forming Tissue Diseases

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

### 8-8. Dental

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

### 8-9. Ears and Hearing

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

a. *Paragraph 3-9.*

b. *Auditory acuity.* Hearing which cannot be improved in one ear with a hearing aid to an average hearing level of 20 decibels or less in the speech reception range. Unilateral deafness is not disqualifying.

c. *Meniere's syndrome.* An individual who suffers Meniere's syndrome is disqualified when he or she has severe recurring attacks which cannot be controlled by treatment or requires hospitalization of sufficient frequency to interfere materially with civilian practice.

d. *Otitis media,* if chronic, suppurative, resistant to treatment, and necessitating hospitalization of sufficient frequency to interfere materially with civilian practice.

### 8-10. Endocrine and Metabolic Diseases

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

### 8-11. Extremities

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

a. *Paragraphs 3-12, 3-13, 3-14, and 8-22.*

b. *Amputation of leg or thigh* if suitable prosthesis is not available or if the use of a cane or crutch is required.

c. *Weight bearing joints.* Inability to bear

weight. Instability of a weight bearing joint or any disease processes of weight bearing joints requiring use of a cane or crutch.

*d. Congenital or acquired deformities* of the feet when shoes cannot be worn or if the individual is required to use a cane or crutches.

*e. Dislocated semilunar cartilage* when disabling for civilian practice.

*f. Loss of fingers or toes.* Qualification will be based upon the individual's ability to perform civilian practice in his or her speciality.

*g. Osteomyelitis.* Where there has been X-ray or other evidence of bone infection, drainage, or disturbance of weight bearing function in the preceding 12 months.

*h. Paralysis secondary to poliomyelitis* when a suitable brace cannot be worn or if cane or crutches are required for the lower extremities. Mobility of the extremities should be adequate to assure useful function thereof and a military appearance.

*i. Old ununited or malunited fractures,* involving weight-bearing bones when there is sufficient shortening or deformity to prevent the performance of military duty.

### 8-12. Eyes and Vision

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

*a. The causes listed in paragraphs 3-15 and 3-16,* except as modified below.

*b. Absence of an eye or when visual acuity has been reduced to light perception only* when there is active eye disease in the other eye or the vision in the other eye does not correct to at least 20/30.

### 8-13. Genitourinary System

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

*a. The causes listed in paragraphs 3-17 and 3-18.*

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

*c. Kidney.*

(1) Absence of one kidney where there is progressive disease or impairment of function in the remaining kidney.

(2) Cystic (polycystic kidney). Asymptomatic, history of.

*d. Nephritis.* A history of nephritis, with residuals such as hypertension or abnormal uri-

nary or blood findings.

*e. Nephrolithiasis. (Rescinded.)*

### 8-14. Head and Neck

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

*a. Paragraphs 3-19 and 3-20.*

*b. Skull defects are acceptable* unless residual signs and symptoms are incapacitating in civilian practice.

### 8-15. Heart and Vascular System

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

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

*b. Auricular fibrillation.* Paroxysmal auricular fibrillation with evidence of organic heart disease, or persistent auricular fibrillation from any cause.

*c. Auriculoventricular block,* when due to organic heart disease.

*d. Coarctation of the aorta and other significant congenital anomalies of the vascular system* unless satisfactorily treated by surgical correction.

*e. Hypertension.* Blood pressure frequently elevated to 200/120 or more (which returns to normal limits with rest and sedatives) or a persistent diastolic pressure over 100 mm mercury even though cerebral, renal, cardiac, and retinal findings are normal.

*f. Phlebitis.* Recurrent phlebitis, other than mild. Residuals of phlebitis, such as persistent edema, dermatitis, ulceration, or claudication, which interfere materially with civilian practice, also make the individual medically unfit.

*g. Valvular heart disease.* Cardiac insufficiency at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

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

*i. Rheumatic fever.*

(1) Residuals involving the heart at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

(2) Verified history of recurrent attacks, cardiac involvement, or subacute bacterial endocarditis within the past 2 years.

### 8-16. Height, Weight, and Body Build (Rescinded.)

**8-17. Lungs and Chest Wall**

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

a. *Paragraphs 3-24 and 3-25.*

b. *Bronchial asthma.* Associated with emphysema of sufficient degree to interfere with performance of duty, or with frequent attacks controlled only by continuous systemic corticosteroid therapy, or with frequent attacks which are not controlled by oral medication.

c. *Bronchiectasis and emphysema.* When outpatient treatment or hospitalization is of such frequency as to interfere materially with civilian practice. Bronchiectasis confined to one lobe is usually acceptable; however, the saccular, systic, and dry types, involving more than one lobe, make the individual medically unfit.

d. *Chronic bronchitis* complicated by disabling emphysema or requiring outpatient treatment or hospitalization of such frequency as to interfere materially with civilian practice.

e. *Pleurisy with effusion* of unknown etiology within the previous year.

f. *Sarcoidosis.* Symptomatic pulmonary sarcoidosis which has not responded promptly to therapy or which is complicated by residual pulmonary fibrosis.

g. *Spontaneous pneumothorax* with recovery is acceptable.

h. *Tuberculosis.*

(1) Tuberculosis, active in any form or location. A positive skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy because of recent skin test conversion are not disqualified.

(2) A history of active tuberculosis within the past 2 years which has not been treated with adequate drug therapy.

(3) A history of active tuberculosis within 1 year which has been or continues to be treated with drug therapy. A person in whom tuberculosis has been inactive for more than 1 year and who may reasonably be expected to be physically capable of performing satisfactory professional and associated military duties is acceptable even though on active drug therapy.

(4) Tuberculosis which has caused pulmonary or other organ function impairment which would preclude satisfactory performance of duty.

**8-18. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx**

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

a. *Paragraph 3-27.*

b. *Polyyps or mucocoeles,* when moderate to severe, suppurative, and unresponsive to treatment.

c. *Chronic sinusitis,* when moderate to severe, suppurative, and unresponsive to treatment.

**8-19. Neurological Disorders**

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the causes listed in paragraph 3-28.

**★8-20. Mental Disorders**

The causes of medical unfitness for physicians, dentists and allied medical specialists are listed in paragraphs 2-34.2, 2-34.3, 3-29, 3-30, 3-31, 3-32, 3-32.1, and 3-32.3.

**8-21. Skin and Cellular Tissues**

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

a. *Paragraph 3-33.*

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

c. *Pilonidal cysts* are acceptable.

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

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

a. *The causes listed in paragraph 3-34.*

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

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

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

e. *Spondylolysis, spondylolisthesis, or other congenital anomalies of the spine* with signifi-

cant recurrent symptoms on moderate or normal activity.

**8-23. Systemic Diseases and Miscellaneous Conditions and Defects**

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

*a. The causes listed in paragraphs 3-35 and 3-36.*

*b. Tuberculosis.*

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

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

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

**8-24. Tumors and Malignant Diseases**

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

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

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

**8-25. Venereal Diseases**

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

## CHAPTER 9

### PHYSICAL PROFILING

#### 9-1. Scope

This chapter sets forth a system of classifying individuals according to functional abilities.

#### 9-2. Applicability

The physical profile system is applicable to the following categories of personnel:

*a.* Registrants who undergo an induction or preinduction medical examination related to Selective Service processing.

*b.* Applicants for enlistment or appointment in the United States Army (Active and Reserve Components).

*c.* Applicants for enlistment or appointment in the United States Marine Corps.

*d.* Applicants for enlistment in the United States Air Force.

★*e.* Applicants for enlistment in the United States Navy when examined at military enlistment processing stations.

*f.* Members of any component of the United States Army throughout their military service, whether or not on active duty.

#### 9-3. General

*a.* The physical profile serial system described herein is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential. The limitations must be fully described for the various codes in paragraph 9-5. This information will assist the unit commander and personnel officer in their determination of individual assignment or reclassification action. In developing the system, the functions have been considered under six factors. For ease in accomplishing and applying the profile system, these factors have been des-

ignated "P-U-L-H-E-S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, rather than the defect per se, will be evaluated carefully in determining the numerical designation 1, 2, 3 or 4.

*b.* Aids such as X-ray films, electrocardiograms, and other specific tests which give objective findings will also be given due consideration. The factor to be considered, the parts affected, and the bodily function involved in each of these factors are as follows:

(1) *P—Physical capacity or stamina.* This factor concerns general physical capacity. It normally includes conditions of the heart; respiratory system; gastrointestinal system; genitourinary system; nervous system; allergic, endocrine, metabolic, and nutritional diseases; diseases of the blood and bloodforming tissues; dental conditions; diseases of the breast; and other organic defects and diseases which do not fall under other specific factors of the system. In arriving at a profile under this factor, it may be appropriate to consider build, strength, endurance, height-weight-body build relationship, agility, energy, and muscular coordination.

(2) *U—Upper extremities.* This factor concerns the hands, arms, shoulder girdle, and spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) *L—Lower extremities.* This factor concerns the feet, legs, pelvic girdle, lower back musculature, and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) *H—Hearing and ear.* This factor concerns auditory acuity and diseases and defects of the ear.

(5) *E—Eyes.* This factor concerns visual acuity and diseases and defects of the eye.

(6) *S—Psychiatric.* This factor concerns

personality, emotional stability, and psychiatric diseases.

c. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness and, consequently, is medically fit for any military assignment.

★(2) A physical profile "2" under any or all factors indicates that an individual possesses some medical condition or physical defect which may impose some limitations on classification and assignment. Individuals with numerical designator "2" under one or more factors, who are determined by a medical board to require an assignment limitation, may be awarded specific assignment limitations.

★(3) A profile containing one or more numerical designators "3" signifies that the individual has medical condition(s) or physical defect(s) which require certain restrictions in assignment within which the individual is physically capable of performing military duty. They should receive assignments commensurate with their functional capability.

★(4) A profile serial containing one or more numerical designators "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited. The numerical designator "4" does *not* necessarily mean that the member is unfit because of physical disability as defined in AR 635-40. When a numerical designator "4" is used, there are significant assignment limitations which must be fully described if such an individual is returned to duty. Code "V," "W" or "Y" is required (para 9-5).

★d. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. IN THIS RESPECT, PROFILING OFFICERS MUST CONSIDER THE EFFECT OF THEIR RECOMMENDATIONS UPON THE SOL-

DIER'S ABILITY TO PERFORM DUTY. PROFILES INCLUDING ASSIGNMENT LIMITATIONS, TEMPORARY OR PERMANENT, WHICH ARE RECORDED ON DA FORM 3349, PHYSICAL PROFILE BOARD PROCEEDINGS, PRESCRIBED BY THIS CHAPTER OR ON DD FORM 689, INDIVIDUAL SICK SLIP (FOR TEMPORARY PROFILES NOT TO EXCEED 30 DAYS AS PRESCRIBED BY AR 600-6), MUST BE REALISTIC. ALL PROFILES AND ASSIGNMENT LIMITATIONS MUST BE LEGIBLE, SPECIFIC AND WRITTEN IN LAY TERMS. SINCE PERFORMANCE OF ARMY DUTY AND ARMY UNIT EFFECTIVENESS ARE MAJOR CONSIDERATIONS, A CLOSE PERSONAL RELATIONSHIP MUST EXIST BETWEEN PHYSICIANS AND UNIT COMMANDERS/PERSONNEL MANAGEMENT OFFICERS. THIS RELATIONSHIP IS ESPECIALLY IMPORTANT WHEN RESERVE COMPONENT PERSONNEL ARE PROFILED.

(1) DETERMINATION OF INDIVIDUAL ASSIGNMENT OR DUTIES TO BE PERFORMED ARE COMMAND/ADMINISTRATIVE MATTERS. LIMITATIONS SUCH AS "NO FIELD DUTY," "NO OVERSEA DUTY," "MUST HAVE SEPARATE RATIONS," ARE NOT PROPER MEDICAL RECOMMENDATIONS.

(2) IT IS THE RESPONSIBILITY OF THE COMMANDER/PERSONNEL MANAGEMENT OFFICER TO DETERMINE PROPER ASSIGNMENT AND DUTY, BASED UPON KNOWLEDGE OF THE SOLDIER'S PROFILE, ASSIGNMENT LIMITATIONS, AND THE DUTIES OF HIS GRADE AND MILITARY OCCUPATIONAL SPECIALTY (MOS).

(3) APPENDIX VIII CONTAINS THE PHYSICAL PROFILE CAPACITY GUIDE.

#### 9-4. Modifier to Serial

To make a profile serial more informative, the modifier will be used as indicated below. These modifiers to the profile serial are not to be confused with code designation, indicating permanent limitation, as described in paragraph 9-5.

a. "P"—*Permanent*. This modifier indicates

that the profile is permanent and change may only be made by authority designated in paragraph 9-6.

★b. "T"—*Temporary*. This modifier indicates that the condition necessitating numerical designation "3" or "4" is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Individuals on active duty and Reserve Component members not on active duty with a "T" modifier will be medically evaluated at least once every 3 months with a view to revising the profile. In no case will individuals in military status carry a "T" modifier for more than 12 months without positive action being taken either to correct the defect or to effect other appropriate disposition. For Reserve Component members a determination involving entitlements to pay and allowances while disabled is an adjunct consideration. As a general rule, the physician initiating the "T" modifier will initiate appropriate arrange-

ments for the necessary correction or treatment of the temporary condition.

c. *Records*. Whenever a temporary medical condition is recorded on the DA Form 3349 or SF 88 (Report of Medical Examination) or is referred to in a routine personnel action, the modifier "T" will be entered immediately following each PULHES numerical designator when a temporary condition exists.

**9-5. Representative Profile Serial and Codes**

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, the following code designations have been adopted to represent certain combinations of numerical designators in the various factors and most significant assignment limitations. The alphabetical coding system will be recorded on personnel qualification records. This coding system will not be used on medical records to identify limitations. The numerical designations under each profile factor, PULHES, are set forth in appendix VIII.

	<i>Description/assignment limitation</i>	<i>Medical criteria</i>
(1) Profile Serial 111111. CODE A .....	No assignment limitation. Is considered medically fit for initial assignment under all PULHES factors for Ranger, Airborne, Special Forces training, and training in any MOS.	No demonstrable anatomical or physiological impairment within standards established in appendix VIII.
(2) Profile serial within a "2" as the lowest numerical designator. CODE B .....	May have assignment limitations which are intended to protect against further physical damage/injury. Combat fit. May have minor impairment under one or more PULHES factors which disqualify for certain MOS training or assignment.	Minor loss of digits, minimal loss of joint motion, visual and hearing loss below those prescribed for Code A in appendix VIII.
★(3) Profile serial with a "3" or "4" as the lowest numerical designator in any factor or as specified by a PPBD. CODE C .....	Possesses impairments which limit functions or assignments but within which the individual is capable of performing military duty.	Vascular insufficiency; symptomatic flat feet; low back pathology; arthritis of low back or lower extremities.
CODE D .....	No crawling, stooping, running, jumping, marching, or standing for long periods. (State time permitted in item 8.)	Organic cardiac disease; pulmonary insufficiency; hypertension, more than mild.
CODE E .....	No assignment to units requiring continued consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.

	<i>Description/assignment limitation</i>	<i>Medical criteria</i>
★CODE F .....	No assignment to isolated areas where definitive medical care (US Armed Forces hospital) is not available within 1-hour travel time.	Individuals who require continued medical supervision or periodic followup; Cases of established pathology likely to require frequent outpatient care or hospitalization.
CODE G .....	No assignment requiring handling of heavy materials including weapons (except individual weapon; e.g., rifle, pistol, carbine, etc.). No overhead work; no pullups or pushups. (State time permitted in item 8.)	Arthritis of the neck or joints of the upper extremities with restricted motion. Cervical disk disease; recurrent shoulder dislocation.
CODE H .....	No assignment where sudden loss of consciousness would be dangerous to self or others such as work on scaffolding, handling ammunition, vehicle driving, work near moving machinery.	Epileptic disorders (cerebral dysrhythmia) of any type; other disorders producing syncopal attacks or severe vertigo, such as Meniere's syndrome.
★CODE J .....	<ol style="list-style-type: none"> <li>1. No exposure to noise in excess of 85dBA or weapon firing without use of properly fitted hearing protection (not to include firing for POR qualification or annual weapons qualification). Annual hearing test required.</li> <li>2. Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85dBA or weapon firing (not to include firing for POR qualification or annual weapons qualification with proper ear protection). Annual hearing test required.</li> <li>3. No exposure to noise in excess of 85dBA or weapon firing without use of properly fitted hearing protection. This individual is "deaf" in one ear. Any permanent hearing loss in good ear will cause serious handicap. Annual hearing test required.</li> <li>4. Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85dBA or weapon firing (not to include firing for POR qualification or annual weapons qualification with proper ear protection). No duty requiring acute hearing. A hearing aid must be worn to meet medical fitness standards.</li> </ol>	Susceptibility to acoustic trauma.
CODE L .....	No assignment which requires daily exposure to extreme cold. (List specific time or areas in item 8.)	Documented history of cold injury; vascular insufficiency; collagen disease, with vascular or skin manifestations.
CODE M .....	No assignment requiring exposure to high environmental temperature. (List specific time or areas in item 8.)	History of heat stroke, history of skin malignancy or other chronic skin diseases which are aggravated by sunlight or high environmental temperatures.

the individual's functional ability to perform duty.

(3) When an individual with a permanent numerical designator "2" under one or more PULHES factors requires significant assignment limitations. PPBD action is required in these cases because the profile serial "2" normally denotes a minor impairment requiring no significant limitation(s).

(4) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(5) Upon request of the unit commander.

*c. Temporary profiles.* A temporary revision of profile will be accomplished when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it temporarily alters the individual's ability to perform duty. A profiling officer is authorized to issue a temporary profile without referring the case to the physical profile board or to the PPBD approving authority. Temporary profiles written on DA Form 3349 will not exceed 3 months. Temporary profiles written on DD Form 689 will not exceed 30 days.

*d. Individuals being returned to a duty status,* pursuant to the approved finding of physically fit by a physical evaluation board, the Army Physical Disability Agency or the Army Physical Disability Appeal Board under AR 635-40, will be given a physical profile commensurate with their physical condition under the appropriate factors by The Surgeon General. Assignment limitations will be established concurrently. Records will be forwarded by the Commanding General, MILPERCEN to HQDA (DASG-PSP-O); WASH, DC 20310, before notification of final action is returned to the medical facility having custody of the patient. After an appropriate period of time, such profile and limitations may be reviewed by a PPBD if the individual's functional capacity warrants such action. Changing of a designator "4" with a code V may be accomplished by a PPBD only with approval of MILPERCEN.

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

a fixed installation and will be provided the required medical supervision for a period of 1 year.

*f. The physical profile in controversial or equivocal cases* may be verified or revised by a PPBD, hospital commander or command surgeon. Unusual cases may be referred to the Commanding General, United States Army Health Services Command, for final determination of an appropriate profile.

*★g. Revision of the physical profile for reservists not on active duty* will be accomplished by the ARCOM/GOCOM Staff Surgeons, Medical Corps Commander (O5 and higher) of USAR hospitals, or the Surgeon, RCPAC, without medical board procedure. For members of the Army National Guard not on active duty, such profile revision will be accomplished by the Surgeon, National Guard Bureau, the State Surgeon or his designated medical officer. (See NGR 40-501) Direct communication is authorized between units and the profiling authority, and in questionable cases with the Commanding General, United States Army Health Services Command. Revision of physical profile for Reserve Component members will be based on relationship to military duties. Secondary evidence concerning the civilian milieu may be considered by medical personnel in determining the effect of their recommendation upon Reserve Component soldiers. The profiling authority will use DA Form 3349.

*h. Individuals whose period of service expires and whose physical profile code is "V," "W" or "Y"* will appear before a medical board to determine if processing, as provided in AR 635-40, is indicated.

### 9-9. Profiling Pregnant Members

*★a. Intent.* The intent of these provisions is to protect the fetus while insuring productive utilization of the servicewoman. Common sense, good judgment and cooperation must prevail between policy, patient and patient's commander to insure a viable program. (See TB MED 295.)

#### *b. Responsibility.*

(1) *Servicewoman.* Will seek medical confirmation of pregnancy. If pregnancy is confirmed, will comply with the instructions issued by medical personnel and her unit commander.

(2) *Medical personnel.* A physician will confirm pregnancy. If confirmed, will initiate prenatal care of the patient and issue a physical profile. Will insure that the unit commander is provided a copy of the profile. Will advise the unit commander as required.

(3) *Unit commander.* Will counsel all women as required by AR 635-100 or AR 635-200. Will consult with medical personnel as required.

*c. Physical profiles.*

(1) Profiles will be issued for the duration of the pregnancy. Profiles for members experiencing difficulty with the pregnancy will include additional limitations. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information.

(2) Physical profile will be issued as follows:

(a) Under physical stamina indicate "T-3."

(b) List diagnosis as "pregnancy, estimated delivery date \_\_\_\_\_."

(c) Profile will indicate the following limitations:

1. Except under unusual circumstances, the member should not be reassigned (within CONUS, to or from oversea commands) until pregnancy is terminated. (See AR 614-30 for waiver provisions.)

2. Exempt from the regular PT program of the unit; physical fitness testing; exposure to chemical agents in NBC training; standing at parade rest or attention for longer than 15 minutes; all immunizations except influenza and tetanus-diphtheria; participating in weapons training, swimming qualifications, drown proofing and field training exercises when excused from wearing of the uniform by the unit commander.

★3. No assignment to duties where nausea, easy fatigability or sudden lightheadedness would be hazardous to the woman or others, to include all aviation duty, Classes 1, 1A, 2, and 3. Class 2A, Air Traffic Control personnel, may continue ATC duties with approval of the flight surgeon, obstetrician and ATC supervisor.

4. May work shifts.

5. During the last 3 months of pregnancy, the woman must rest 20 minutes every 4 hours (sitting in a chair with feet up is acceptable). Her workweek should not exceed 40 hours; however, it does not preclude assignment as CQ

and other like duties performed in a unit, to include normal housekeeping duties. (CQ is part of the 40-hour workweek.)

*d. Performance of duty.* A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems (e.g., pregnancy induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel will assist unit commanders in determining duties.

*e. Sick in quarters.* A pregnant woman will not be placed sick in quarters solely on the basis of her pregnancy unless there are complications present which would preclude any type of duty performance.

*Convalescent leave.* (As prescribed by AR 630-5.)

★(1) Convalescent leave after delivery will be for a period determined by the attending physician.

(2) Convalescent leave after abortion will be determined on an individual case basis by the attending physician.

## 9-10. Preparation, Approval and Disposition of DA Form 3349 (Physical Profile Board Proceedings)

*a. Preparation of DA Form 3349.* (See fig 9-1.)

(1) DA Form 3349 will be used to record both temporary and permanent profiles.

(2) DA Form 3349 will be prepared as follows:

(a) *Items 1 through 5.* Self-explanatory. Obtain information from the member's medical and/or personnel record.

(b) *Item 6.* Enter under each PULHES factor, the appropriate profile serial code (1, 2, 3 or 4, as prescribed) and T (temporary) or P (permanent) prefix modifier. (Double profiling is not authorized. Double profiling is the placement of the numerical designator 2, 3 or 4 under a U, L, H, E or S factor and then placing the same designator under the "P" factor solely because it was awarded under the other factor.)

(c) *Item 7.* Record medical condition(s) and/or physical defect(s) in common usage, nontechnical language which a layman can understand. For example, "compound comminuted

fracture, left tibia," might simply be described as "broken shin bone."

(d) *Item 8.* Record assignment limitation code(s) and describe assignment limitation(s) as set forth in this chapter

(e) *Item 9.* Check appropriate box. If profile is temporary, enter expiration date.

(f) *Items 10 and 11.*

1. *Permanent profiles.* Permanent 3 profiles and permanent 2 profiles requiring major assignment limitation(s) require signatures of a minimum of two profile officers. In exceptional cases, as required by paragraph 9-8a a third member will also sign in item 11.

2. *Temporary profiles* not requiring major assignment limitations require only the signature of the profiling officer in item 10.

(g) *Items 12 and 13.* Will be completed by the approving authority when required by subparagraph b(1) below. Items 12 and 13 are not required for temporary profiles and permanent 2 profiles not involving major assignment limitations.

(h) *Items 14 and 15.* Will be completed by the unit commander upon receipt of the permanent profile.

(i) *Remarks.* Use for continuation of any item. Identify by item number.

b. *Approval of DA Form 3349.*

(1) The appointing authority is the approving authority for all permanent profiles requiring a "3" numerical designation and all permanent profiles requiring a "2" numerical designator and a major assignment limitation.

(2) If the approving authority does not concur with the PPBD recommendation, the board will be returned to the PPBD for reconsideration. If the approving authority does not concur in the reconsidered PPBD findings, the case will be referred to a medical evaluation board convened under the provisions of section II, chapter 7, AR 40-3.

c. *Disposition of DA Form 3349 (Permanent Profiles).*

(1) *By MTF.*

(a) Original and one copy to unit commander.

★(b) Copy to MILPO.

★(c) Copy to health record.

★(d) Copy to clinic file.

★(e) Only in cases involving *pseudofolliculitis of the beard* will the soldier be furnished a copy. (See TB MED 287.)

(2) *By unit commander.* Upon completion of item 15, the unit commander will forward the original to the unit's military personnel office for inclusion in the member's Military Personnel Records Jacket (MPRJ).

d. *Disposition of DA Form 3349 (Temporary Profiles).*

(1) Original and one copy to unit commander.

(2) Record temporary profile in health record.

★(3) Only in cases involving *pseudofolliculitis of the beard* will the soldier be furnished a copy.

### 9-11. Assignment Restrictions, or Geographical or Climatic Area Limitations

Paragraph 7-13 establishes that personnel fit for continued military status are medically fit for duty *on a worldwide basis*. Assignment restrictions or geographical or climatic area limitations are contained in paragraph 9-5 and on the reverse of DA Form 3349. Policies applying to assignment restrictions or geographical or climatic limitations with physical profiles are as follows:

a. There are no assignment restrictions or geographical or climatic area limitations associated with a numerical designator "1." An individual with "1" under all factors is medically fit for any assignment, including training in Ranger or assignment in Airborne or Special Forces.

b. There are normally no geographic assignment limitations associated with a numerical designator "2." The numerical designator "2" in one or more factors of the physical profile serial indicates that the individual possesses some medical condition or physical defect which may impose some limitation on MOS classification and duty assignment.

c. There are usually significant assignment restrictions or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designators "3."

d. There are always major assignment restrictions or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designators "4."

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

f. Assignment restrictions or geographical or climatic area limitations must be realistic and in accordance with accepted medical principles rather than based upon the personal beliefs or feelings of the profiling officer or the desires of the individual or the individual's family. Permanent limitations should be confirmed periodically, particularly in conjunction with inpatient or outpatient medical care and periodic medical examinations. (Every 4 years for Reserve Component personnel not on active duty, in conjunction with their periodic medical examination.)

#### ★9-12. Responsibility for Personnel Actions

Unit commanders/personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations. The unit commander's and MILPO copies of the DA Form 3349 will be delivered by means other than the individual on whom the report is made. Only in cases involving *pseudofolliculitis of the beard* will the soldier be furnished a copy.

PHYSICAL PROFILE BOARD PROCEEDINGS <small>For use of this form, see AR 40-501; the proponent agency is the Office of The Surgeon General</small>		MEDICAL TREATMENT FACILITY WRAMC	DATE 1 May 1983												
1. NAME (Last, First, MI) SMITH, HAROLD F.		2. SSN 111-11-1111	3. GRADE SSG												
4. ORGANIZATION Co B, 55th Engr Bn, Ft Belvoir, VA		5. COMPONENT RA													
PHYSICAL PROFILE															
6. FACTORS		7. PHYSICAL DEFECTS (Non-technical language)													
<table border="1" style="width:100%; text-align: center;"> <tr> <td>P</td><td>U</td><td>L</td><td>H</td><td>E</td><td>S</td> </tr> <tr> <td>3</td><td>1</td><td>1</td><td>1</td><td>1</td><td>1</td> </tr> </table> <p style="text-align: center; font-size: small;">(Enter T when applicable)</p>		P	U	L	H	E	S	3	1	1	1	1	1	Stomach Ulcer	
P	U	L	H	E	S										
3	1	1	1	1	1										
8. ASSIGNMENT LIMITATIONS ARE AS FOLLOWS:  No assignment to units requiring continued consumption of combat rations. No assignment to isolated areas where definitive medical care (US Armed Forces hospital) is not available within 1-hour travel time.															
9. This profile <input checked="" type="checkbox"/> is permanent <input type="checkbox"/> is temporary and expires on _____ (Enter date).															
10. TYPED NAME AND GRADE OF PROFILING OFFICER James A. Smith, MD (DAC)		SIGNATURE <i>James A. Smith</i>													
11. TYPED NAME AND GRADE OF PROFILING OFFICER Louis L. Jones, Major, MC		SIGNATURE <i>Louis L. Jones</i>													
ACTION BY APPROVING AUTHORITY															
12. Permanent change of profile is <input checked="" type="checkbox"/> approved <input type="checkbox"/> is not approved.															
13. TYPED NAME, GRADE AND TITLE OF APPROVING AUTHORITY Robert E. Grant, Colonel, MC, Chief, Prof Svcs		SIGNATURE <i>Robert E. Grant</i>	DATE 2 May 1983												
ACTION BY UNIT COMMANDER															
14. The permanent change in the physical profile serial <input type="checkbox"/> does <input type="checkbox"/> does not require a change in the member's <input type="checkbox"/> military occupational specialty <input type="checkbox"/> duty assignment because: (State the specific details concerning the physical functions required of the member and why the member can or cannot continue satisfactory performance of duty).															
15. TYPED NAME AND GRADE OF UNIT COMMANDER		SIGNATURE	DATE												
REMARKS															
DISTRIBUTION: Unit Commander - Original and 1 copy (to be delivered by means other than the individual on whom report is made); MILPO - 1 copy; Health Record Jacket - 1 copy; Clinic File - 1 copy.															

SAMPLE

## ASSIGNMENT RESTRICTIONS, GEOGRAPHICAL OR CLIMATIC AREA LIMITATIONS

- CODE: A - None.
- B - None.
- C - No crawling, stooping, running, jumping, marching, or standing for long periods. *(State time permitted in item 8)*
- D - No mandatory strenuous physical activity. *(State time permitted in item 8)*
- 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 handling of heavy materials including weapons *(except individual weapon, e.g., rifle, pistol, carbine, etc.)*. No overhead work, no pullups or pushups. *(State time permitted in item 8)*
- H - No assignment to unit where sudden loss of consciousness would be dangerous to self or others such as work on scaffolding, handling ammunition, vehicle driving, work near moving machinery.
- J - No assignment or duty in an area where safety of individual or others requires acute hearing. Hearing protection is required when exposed to hazardous noise for protection of individual's health.
- L - No assignment requiring daily exposure to extreme cold. *(List specific time or areas in item 8)*
- M - No assignment requiring exposure to high environmental temperature. *(List specific time or areas in item 8)*
- N - No continuous wearing of combat boots. *(State length of time in item 8)*
- P - No continuous wearing of woolen clothes. *(State length of time in item 8)*
- U - Limitation not otherwise described to be considered individual. *(Briefly define limitation in item 8)*

(19) ROTC. Enrollment in ROTC, all levels except for enrollment in the Four-year Scholarship Program which requires a Type B examination.

(20) Separation, resignation, retirement and relief from active duty, if accomplished. (SF 93 is not required in connection with separation examination for immediate reenlistment.)

(21) Free fall parachuting. (SF 93 required for initial selection only.)

(22) Marine (SCUBA) diving (Special forces and ranger combat diving). (SF 93 required for initial selection only.)

*c. Type B medical examination.* A Type B medical examination is required to determine the medical fitness of personnel under the circumstances enumerated below. SF 93 will be prepared except as noted.

★(1) Army aviation including selection, continuance, or periodic annual medical examination: Pilot, aircraft mechanic, air traffic controller, flight simulator specialist, or participant in frequent or regular flights as nondesignated or nonrated personnel not engaged in the actual control of aircraft, such as gunners, observers, etc. (SF 93 required for all Classes 1 and 1A examinations.)

(2) Marine diving (MOS 00B), including selection, continuance or periodic annual medical examination. (SF 93 required for initial selection only.) (For periodic examinations, individual health record and DA Form 3475-R (Diving Duty Summary Sheet) must be available to the examiner.)

(3) US Air Force Academy.

(4) US Air Force Academy Preparatory School.

(5) US Military Academy.

(6) US Military Academy Preparatory School.

(7) US Naval Academy.

(8) US Naval Academy Preparatory School.

(9) Four-year ROTC Scholarship.

(10) Entrance into the Uniformed Services University of Health Sciences.

## 10-17. Validity—Reports of Medical Examination

*a.* Medical examinations will be valid for the purpose and within the periods set forth below,

provided there has been no significant change in the individual's medical condition.

(1) Two years from date of medical examination for entrance into the United States Military Academy, the Uniformed Services University of Health Sciences, and the ROTC Scholarship Program. (This period may be modified to any period less than 2 years, and reexamination required as determined by the Director, Department of Defense Medical Examination Review Board (DODMERB).)

★(2) One year from date of medical examination to qualify for induction, enlistment, reenlistment, appointment as a commissioned officer or warrant officer, active duty, active duty for training, advanced ROTC, OCS, admission to USMA Preparatory School, entry into training for aviation Classes 1, 1A, 2, and 3, diving and free fall parachuting (except for medical examinations administered to ROTC cadets at Advance Camp (June, July and August). For purposes of continuance in ROTC, appointment as a commissioned officer, and entrance on active duty or active duty for training, those examinations are valid until 1 September of the following calendar year; e.g., an examination accomplished on 25 June 1982 will be valid to 1 September 1983.)

★(3) Approximately 1 year from date of examination (FAA Second Class) to qualify for entry into training for Air Traffic Control duties. These examinations are valid for the remainder of the month in which the examination was taken plus the next 12 calendar months, as specified in Federal Air Regulations.

★(4) When accomplished incident to retirement, discharge or release from active duty, medical examinations are valid for a period of 1 year from date of examination. If the examination is accomplished more than 4 months prior to retirement, discharge or release from active duty, DA Form 3081-R (Periodic Medical Examination (State of Exemption)) will be attached to the original SF 88. (See also para 10-25.) DA Form 3081-R (fig 10-1) will be reproduced locally on 8- by 10½-inch paper. The form number, title, and date should appear on each reproduced copy.

(Locate fig 10-1, a fold-in page, at the end of the regular size pages.)

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

★*b.* Except for flying duty, discharge or release from active duty, a medical examination conducted for one purpose is valid for any other purpose within the prescribed validity periods, provided the examination is of the proper scope specified in this chapter. If the examination is deficient in scope, only those tests and procedures needed to meet additional requirements need be accomplished and results recorded.

★*c.* The periodic examination obtained from members of the Army National Guard and Army Reserve (para 10-23) within the past 4 years will be valid for the purpose of qualifying for immediate reenlistment in the Army National Guard and Army Reserve of personnel not on active duty, provided there has been no change in the

individual's medical condition since his or her last complete medical examination.

★*d.* Army National Guard and Army Reserve members enlisted in the Alternate (Split) Training enlistment option. The validity period for medical examinations accomplished for enlistment, entry and reentry on active duty for training may be extended to 18 months as follows:

Prior to departure for the training installation for Phase II, members must undergo a physical inspection of the scope prescribed by AR 601-270. For ARNG members who do not process through a MEPS, the physical inspection must be accomplished by ARNG Medical Corps officers or civilian physicians. All ARNG and USAR members arriving at the training installations must have in their possession their military health record containing the initial Report of Medical Examination (SF 88) properly annotated by the physician who accomplished the physical inspection.

## Section II. PROCUREMENT MEDICAL EXAMINATIONS

### 10-18. Procurement Medical Examinations

For administrative procedures pertaining to procurement medical examinations (para 2-1) conducted at military enlistment processing stations (MEPSs) see AR 601-270. For procedures per-

taining to appointment and enlistment in the Army National Guard and Army Reserve, see AR 140-120 and NGR 40-501. For procedures pertaining to enrollment in the Army ROTC, see AR 145-1.

## Section III. ★RETENTION AND SEPARATION MEDICAL EXAMINATIONS

### 10-19. General

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

### 10-20. Active Duty For Training and Inactive Duty Training

*a.* Individuals on active duty for 30 days or less and those ordered to active duty for training without their consent under the provisions of AR 135-91 are not routinely required to undergo medical examination prior to separation. A medical examination will be given when—

(1) The individual has been hospitalized for an illness or an injury which may result in disability, or

(2) Sound medical judgment indicates the desirability of a separation medical examination, or

(3) The individual alleges medical unfitness or disability at the time of completion of active duty for training, or

(4) The individual requests a separation examination.

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

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

(2) He or she alleges medical unfitness or disability.

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

## 10-21. Health Records

★*a.* Medical examiners will review the health record (AR 40-66) of each examinee whenever an examination is conducted for the purpose of relief from active duty, relief from active duty for training, resignation, retirement, separation from the service, or when accomplished in connection with a periodic medical examination. The examinee's medical history as recorded in the health record is an important part of the physician's total evaluation. Health records include a medical evaluation and summary of each medical condition treated which is of clinical importance and materially affects the health of the individual. If the health record is not available (e.g., lost records, civilian examinees, Reserve Component personnel), an SF 93 will be accomplished.

*b.* In the accomplishment of medical examinations conducted under the provisions of this regulation for purposes other than those noted above, the health records of examinees should be reviewed by the examiner whenever such records are available.

## 10-22. Mobilization of Units and Members of the Reserve Components of the Army

Members of ARNGUS and USAR will be given medical examinations every 4 years as prescribed in AR 140-120 and NGR 40-501 (10 U.S.C. 1004). Medical examinations incident to mobilization are not required.

## 10-23. Periodic Medical Examinations

### *a. Application and scope.*

★(1) The periodic medical examination is required for all officers, warrant officers and enlisted personnel of the Army regardless of component. Individuals undergoing this examination should assist the physician by a frank and complete discussion of their past and present health, which, combined with appropriate medical examinations and clinical tests, will usually be adequate to determine any indicated measures or remedies. The purpose of the periodic medical examination is to assist in the maintenance of health. (In the event of mobilization, except for Class 2, aviators, and Class 2A, air traffic controllers, all periodic medical examinations prescribed by this paragraph for Active Army members are suspended.)

(2) Retired personnel are authorized, but not required, to undergo a periodic medical examination. They will make advance arrangements with the medical examining station before reporting for such examination (DA Pam 600-5).

★(3) Other than required medical surveillance, the periodic medical examination is not required for an individual who has undergone or is scheduled to undergo, within 1 year, a medical examination, the scope of which is equal to or greater than that of the required periodic medical examination. The member will be furnished DA Form 3081-R (Periodic Medical Examination (Statement of Exemption)) who will prepare it and submit it to the unit commander or personnel officer for appropriate action. DA Form 3081-R (fig 10-1) will be reproduced locally on 8- × 10½-inch paper.

(4) The examining physician will thoroughly investigate the examinee's current medical status. When medical history, the examinee's complaints, or review of any available past medical records indicate significant findings, these findings will be described in detail, using SF 507 (Clinical Record—Report on or Continuation of SF), if necessary. If, as a result of the personal discussion of health between the medical officer and the examinee, it appears that there has been a change in the functional capacity of any component of the physical profile serial, the medical officer will recommend a change in the serial in accordance with chapter 9.

(5) Members will be found qualified for retention on active duty if they meet the requirements of chapters 1 and 3 (chaps 1, 3, and 8 in the case of medico-dental registrants). Special attention is directed to paragraphs 1-4 and 3-3 in this regard.

(6) Members who appear to be medically unfit will be referred to a medical board (AR 40-3).

(7) All reports of periodic medical examinations will be reviewed by a physician designated by the medical treatment facility commander. (Those administered by a MEPS will be reviewed by the chief medical officer.) The review will be accomplished in the following manner:

(*a*) The individual health record and the SF 88 will be reviewed in the presence of the examinee during which the reviewing physician will counsel the examinee regarding—

1. Remedial conditions found upon examination (appointments will be made for the purpose of instituting care).

2. Continuing care for conditions already under treatment.

3. General health education matters including, but not limited to, smoking, alcohol and drug abuse, sexual behavior, overweight or underweight and methods for correction.

(b) When the review is completed, and there is a need to change the member's physical profile and/or assignment limitations, DA Form 3349 (Medical Condition—Physical Profile Record) will be prepared and distributed as prescribed in chapter 9 of this regulation. SF 88 or extracts of the individual health record will not be released to the unit commander or personnel officer.

(8) The medical examination for general officers and full colonels should be performed on an individual appointment basis. The duplicate report (SF 88) in the case of each general officer will be forwarded by the examining facility direct to HQDA(DAPE-GO), WASH, DC 20310. In the case of each full colonel, the duplicate SF 88 will be forwarded by the examining facility direct to HQDA(DAPC-MSR), Alexandria, VA 22332 for file in the individual's official military personnel file (OMPF).

(9) In addition to the periodic medical examination prescribed by paragraph c(2) below, all women in the Army, regardless of age, on active duty or active duty for training tours in excess of 1 year will undergo two annual breast and pelvic examinations, to include a Papanicolaou cancer detection test, following initial entry on active duty. At age 25, and annually thereafter, this special examination is mandatory and will be accomplished during the anniversary month of the individual's birthday, and should be conducted by a qualified specialist whenever possible. A record of the examination and test results will be maintained in the health record.

(10) All personnel with potential hazardous exposures in their work environment, for which medical surveillance examinations are required to insure that there is no harmful effect to their health, will receive appropriate medical surveillance examinations. Such examinations will be specific to job exposure.

b. *Followup.* A member of the ARNGUS or USAR who is not on active duty will be scheduled for followup appointment and consultations at Government expense when necessary to complete the examination. Treatment or correction of conditions or remediable defects as a result of examination will be scheduled if authorized. If the individual is not authorized treatment, he will be advised to consult a private physician of his own choice at his own expense.

★c. *Frequency.*

(1) *General officers.*

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

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

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

(2) *Rated aviators and flight surgeons.*

(a) Rated aviators and flight surgeons, Active and Reserve Components who meet and continue to work under Class 2 medical fitness standards for flying (including rated aviators qualified for aviation service but not assigned to operational flying duty positions) must undergo a periodic Type B medical examination at ages 19, 21, 23, 25, 27, 29, 31, 33, 35 and annually thereafter.

(b) During the years when a Type B examination is not required because of age, each rated aviator and flight surgeon will undergo an eye examination; blood pressure, height, weight and hematocrit measurement; audiometric test

and electrocardiogram. The results of these will be recorded on DA Form 4497-R (*Interim Medical Examination—Aviation, Free Fall Parachuting and Marine (SCUBA) Diving Personnel*). DA Form 4497-R (fig 10-3) will be reproduced locally on 8½- by 11-inch paper.

(Locate fig 10-3, a fold-in page, at the end of the regular size pages.)

(c) Each Active Component aviator or flight surgeon must take the examinations cited in (a) and (b) above within the 3-month period preceding the end of the birth month. All examinations taken within this period will be considered to have been taken during the birth month. Reserve Component personnel must take the required examination during the designated fiscal quarter.

(d) Personnel examined in accordance with paragraph 10-23c(3) (student aviators and

medical personnel) or 10-26g (FEB, post-accident, illness or injury, preparation for PCS, etc.) within the 6 months preceding the end of their birth month or designated quarter will be considered to have met their periodic examination requirement for the year. In some cases, this may result in a validity period of an examination of up to 18 months, in accordance with table 10-1.

(e) When DA Form 4186 (*Medical Recommendation for Flying Duty*) is completed after a Type B or interim examination, the last day of the birth month or designated quarter will normally be entered as the date the medical clearance expires. When an examination is given in the early part of the 3-month period preceding the end of the birth month, the DA Form 4186 will expire up to 15 months later. When an examination is given under the provisions of (d)

★Table 10-1. Number of Months for Which a Flying Duty Medical Examination Is Valid (Active Component)

Birth month	Month in which last FDME was given											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	12	11	10	9	8	7	18	17	16	15	14	13
Feb	13	12	11	10	9	8	7	18	17	16	15	14
Mar	14	13	12	11	10	9	8	7	18	17	16	15
Apr	15	14	13	12	11	10	9	8	7	18	17	16
May	16	15	14	13	12	11	10	9	8	7	18	17
Jun	17	16	15	14	13	12	11	10	9	8	7	18
Jul	18	17	16	15	14	13	12	11	10	9	8	7
Aug	7	18	17	16	15	14	13	12	11	10	9	8
Sep	8	7	18	17	16	15	14	13	12	11	10	9
Oct	9	8	7	18	17	16	15	14	13	12	11	10
Nov	10	9	8	7	18	17	16	15	14	13	12	11
Dec	11	10	9	8	7	18	17	16	15	14	13	12

Read down left column to examinee's birth month; read across to month of last FDME; intersection number is maximum validity period. When last FDME was within the 3-month period preceding the end of the birth month, validity period will normally not exceed 15 months. When last FDME was for entry into aviation training, for FEB, post-accident, post-hospitalization, pre-appointment (WOC), etc., validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with paragraph 10-26j, by 1 month only for the purpose of completing an examination begun before the end of the birth month.

above, the clearance may not expire for 18 months. See table 10-1 and paragraph 10-26j.

(3) *Student aviators and medical personnel.*

(a) Individuals reporting for initial entry flight training or for the basic course in aviation medicine must have in their possession a copy of the appropriate FDME which has been reviewed and approved by the Cdr, USAAMC. The class of examination required for student aviators will be in accordance with AR 611-85 or 611-110. These examinations are valid for 1 year from the date of examination for this purpose as specified in paragraph 10-17a(2).

(b) Student aviators or aviation medicine students who undergo an initial or repeat Class 1, 1A, or 2 examination or a Warrant Officer Candidate Pre-Appointment examination (done as a flight physical) within the 6 months preceding the end of their birth month or designated quarter will be considered to have met their periodic examination requirement as specified in paragraph 10-23c(2) for the year. The examination may, therefore, be valid for up to 18 months, in accordance with table 10-1.

(4) *Air traffic controllers.* (See para 10-26l below, Air traffic control personnel.)

(5) *Class 3 aviation personnel.*

(a) Active and Reserve Component members who must meet Class 3 medical fitness standards for flying duty will undergo an initial Type B examination. The results will be recorded on SF 88 and allied documents. Thereafter, Active Duty personnel will undergo a Type B examination within 3 months before the end of their birth month at ages 20, 25, 30, 35, 40 and annually thereafter. Reserve Component personnel must take the required examination during the designated fiscal quarter.

(b) In those years in which a Type B examination is not required because of age, they will undergo an eye examination; blood pressure, height, weight and hematocrit measurement; audiometric test and electrocardiogram. The results of these tests will be recorded on DA Form 4497-R (fig 10-3) which will be locally reproduced on 8½ by 11-inch white paper.

(c) The provisions of paragraph 10-23c(2)(c), (d) and (e) regarding validity periods apply to Class 3 examinations.

(6) *Diving personnel.*

(a) Marine (SCUBA) divers must have a Type B examination at ages 19, 21, 23, 25, 27, 29, 31, 33, 35 and annually thereafter. In addition, they will take annually an eye examination, blood pressure, height, weight, and audiometric and electrocardiographic tests. (This annual examination will be recorded on DA Form 4497-R; see fig 10-3.) After age 35, they will take a Type B examination annually.

(b) Marine divers (MOS 00B, other than SCUBA) must have an annual Type B examination, regardless of age. (This is an Occupational Safety and Health Act requirement.) This examination must be taken within 3 months before the end of the diver's birthday month. The results of the above tests will be reviewed by a flight surgeon or other physician trained in diving or hyperbaric medicine.

(7) *All other personnel on active duty* will undergo a periodic examination within 3 calendar months before the end of the birthday month, at ages 20, 25, 30, 35, 40, 45, 50, 55, 60 and annually thereafter. Periodic examinations of active duty members prior to age 20 are not required. An examination accomplished within the 3 calendar months before the end of the anniversary month will be considered as having been accomplished during the anniversary month.

(8) *The frequency of medical surveillance examinations* varies according to job exposure. Annual or less frequent examinations will be performed during the birthday month. More frequent examinations will be scheduled during the birthday month and at appropriate intervals thereafter.

(9) *All members of the Ready Reserve not on active duty—*

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

(b) Members of the Ready Reserve not on active duty will accomplish a statement of medical fitness annually.

(10) *Under exceptional circumstances*, where conditions of the service preclude the accomplishment of the periodic examination, it

may be deferred by direction of the commander having custody of field personnel files until such time as its accomplishment becomes feasible. An appropriate entry explaining the deferment will be made in the health record and on Health Record—Chronological Record of Medical Care (SF 600) when such a situation exists.

(11) *Individuals on duty at stations or locations having inadequate military medical facilities* to accomplish the complete medical examination will be given as much of this examination as local military medical facilities permit, and will undergo a complete medical examination when official duties take them to a station having adequate facilities.

**★d. Reporting of medical conditions.**

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

(2) Any change in physical profile or limitations found on periodic medical examinations will be reported to the unit commander on DA Form 3349 (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.

**10-24. Promotion**

*a.* Officers, warrant officers, and enlisted personnel on active duty, regardless of component, are considered medically qualified for promotion on the basis of the periodic medical examination outlined in paragraph 10-23.

*b.* Army Reserve officers and warrant officers not on active duty who have been selected for promotion will be considered medically qualified for promotion on the basis of a Type A medical examination accomplished within 1 year of the effective date of promotion. Army National Guard officers and warrant officers will be governed by NGR 40-501.

**10-25. Separation**

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

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

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

	Required	Not required	Can be requested by member (in writing)
Retirement after 20 or more years of active duty.	X*		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X*		
Expiration of term of active service (separation or discharge, less than 20 years of service).		X	X
Upon review of health record, evaluating physician or physician assistant (PA)** at servicing MTF determines that, because of medical care received during active service, medical examination will serve best interests of member and Government; e.g., hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		
Individual is member of the Army National Guard on active duty or active duty for training in excess of 30 days.		X	X
Individual is member of the Army National Guard and has been called into Federal service (10 USC 3502).	X*		
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X*		
Officers, WOs and enlisted members previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (chap 6, AR 635-40, and predecessor regulations).	X (Plus MEB and PEB)		
Officers, WOs and enlisted members previously processed for physical disability (AR 635-40) and found fit for duty with one or more numerical designators "4" in their physical profile serial.	X*		
All officers, WOs and enlisted members with one or more temporary numerical designators "4" in their physical profile serial.	X*		
Officers and WOs being processed for separation under provisions of specific sections of AR 635-100 that specify medical examination/mental status evaluation.	X*		
Officers and WOs being processed for separation under provisions of AR 635-100, when medical examination/mental status evaluation is not a requirement.		X	X
Enlisted members being processed for separation under provisions of paragraphs 5-3 and 16-4 of chapter 5, chapter 8, and chapter 9, AR 635-200.	X		
Enlisted members being processed for separation under provisions of chapter 13, AR 635-200 (both mental evaluation and medical examination required).	X		
Enlisted members being processed for separation under provisions of section III of chapter 14 and chapter 15, AR 635-200. (Mental status evaluation only is required. Medical examination may be requested by member in writing and, if so requested, should be accomplished expeditiously without regard to time constraints otherwise applicable in this paragraph to voluntary examination.)			X
Enlisted members being processed for separation under provisions of chapter 10, AR 635-200. (If medical examination is requested by member, then mental status evaluation is required.)			X

\*See footnotes at end of table.

for flying (originals of SF 88, SF 93, SF 520 (Clinical Record—Electrocardiographic Record), and SF 513 (Medical Record—Consultation Sheet), if applicable), accomplished in conjunction with application for flight training pursuant to AR 611-85 and AR 611-110, will be forwarded direct to the commander having personnel jurisdiction over the applicant for medical review as outlined below. In no case will original reports of medical examination be given to the applicant. Entrance into flight training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362. Reports of medical examination (originals of SF 88, SF 93, SF 520, and SF 513, if applicable) accomplished for continuance on flight duty for Active Army and USAR personnel, to include any supplemental examinations, will be forwarded direct to the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362 for review. Reports of medical examination (SF 88, SF 93, SF 520, and SF 513, if applicable) accomplished for Army National Guard personnel, to include the periodic examination prescribed in paragraph 10-23, will be processed in accordance with NGR 611-110 and forwarded to the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362, for final review. They will then be returned to their point of origin, if found qualified. If medically disqualified, they will be sent to the Chief, National Guard Bureau, ATTN: NGB-AVN-OC, Building E6810, Aberdeen Proving Ground, MD 21010, for further administrative action. The State Adjutant General may utilize current reports of medical examination that have previously been reviewed by the Commander, USAAMC for attachment to the Report of Proceedings of the Flying Evaluation Board submitted to the Chief, National Guard Bureau. Direct communication between the State Adjutant General and Commander, USAAMC, for this purpose is authorized.

(2) Clinical medical summaries, including indicated consultations, will accompany all unusual flying evaluation board cases forwarded to higher headquarters. Reports of hospital, medical, and physical evaluation boards will be used as a source of valuable medical documentation

although their recommendations have no direct bearing on qualification for flying duty.

(3) Concurrent use of the annual medical examination for flying for Federal Aviation Administration certification is no longer authorized by the FAA. Both sides of the FAA Report of Medical Examination (FAA Form 8500-8) must be completed.

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

*g. Type B medical examinations.* In addition to the personnel noted in paragraph 4-2, a Type B medical examination, unless otherwise specified below, will be given to—

(1) Military personnel on flying status who have been absent from, or who have been suspended from flying status by reason of a serious illness or injury, or who have been suspended or absent from flying status in excess of 6 months for any other reason.

(2) All designated or rated military personnel ordered to appear before a flying evaluation board (AR 600-105) when a medical question is involved.

(3) All personnel of the operating aircraft crew involved in an aircraft mishap, if it appears that there is any possibility whatsoever that human factors or medical considerations may have been instrumental in causing, or should be investigated as a result of, such accident. A flight surgeon or other qualified medical officer will screen the crewmembers at the earliest practicable time to determine if a Type B medical examination is necessary. All personnel injured as a result of an aircraft mishap will also undergo a Type B medical examination.

*h. Waivers.*

(1) *General.* A separate request for waiver need not accompany a Report of Medical Examination (SF 88). Recommendation concerning waivers will be made on the Report of Medical Examination by the examiner or reviewing medical official, if space permits. In any case requiring waiver or special consideration, full use will be made of consultations. These will be identified and attached to the Report of Medical Examination on an appropriate clinical form or a plain sheet of lettersize paper. Waiver of minor defects must in no way compromise flying safety

or affect the efficient performance of flying duty or the individual's well-being.

(2) *Initial applicants, Classes 1 and 1A.* Waivers will not be requested by the examiner or the examinee. If the examinee has a minor physical defect, a complete medical examination for flying duty will nevertheless be accomplished and details of the defect recorded. The report of examination will be forwarded to Cdr, USAAMC for review. If the review confirms that the applicant is disqualified, the report will be returned to the examining facility. The report will then be attached to the application for aviation training and forwarded as prescribed in the regulations applicable to the procurement program under which the application is submitted. If one or more major disqualifying defects exist, the examination need not be completed but will nevertheless be forwarded to the Cdr, USAAMC for reference in the event of subsequent reexamination of the applicant. Failure to meet prescribed standards for vision and refractive error will be considered a major disqualifying defect.

(3) *Initial applicants, and continuance, Class 2; and aeromedical PAs, Class 3.* A waiver may be requested by the examinee and/or recommended by the examining physician in item 75, SF 88. In each case of request or recommendation for initial waiver an Aeromedical Summary is required when specified by the Cdr, USAAMC. If a waiver is not recommended by the examining physician, the Cdr, USAAMC is authorized to require an Aeromedical Summary in specific cases when required for full evaluation. Waivers for minor physical defects, which will in no way affect the scope and the safe and efficient performance of flying duty, normally will be recommended by the examining physician, in which case the examinee need not make a separate request for waiver. If the waiver for such a condition is not recommended, the examinee may request a waiver from the appropriate authority as identified in paragraph 10-26i(2).

(4) *Nondesignated or nonrated personnel (crew chief, observers, flight medics, door gunners, and other Class 3 personnel).* In nondesignated or nonrated personnel, minor physical defects which will in no way affect the scope and safe, efficient performance of flying duties and which will not be aggravated by aviation duties

may be waived by the commander of the unit or station upon favorable recommendation of a flight surgeon. Notification of medical disqualification will be forwarded, in all instances in writing (DA Form 4186), by the flight surgeon concerned to the disqualified individual's commander along with appropriate recommendations for waiver of defects or suspension from flying status in accordance with existing directives. See ARs 600-105 and 600-106.

*i. Review and waiver action.*

(1) *Review action.* The Commander, USAAMC, ATTN: HSYX-AER, Fort Rucker, AL 36362 will review and make final determination (utilizing the procedures outlined in para 10-26e(1) for ARNG personnel) concerning medical fitness for—

(a) *Class 1*—Entrance into flight training.

(b) *Class 1A*—Entrance into flight training.

(c) *Class 2*—Individuals in flight training or on flight status as an aviator (military members) or pilot (civilian employees).

(d) *Class 2*—Entrance into training and continuance on flight status as a flight surgeon; entrance into training for aeromedical physician assistant.

(e) *Class 2A*—Entrance into and continuance in training and on duty as an air traffic controller. (See para 10-26l.)

(f) *Class 3*—Continuance on duty as an aeromedical physician assistant. (Class 3, other personnel, in accordance with para 10-26h(4) above.)

(2) *Waiver action.* The only agencies authorized to grant administrative waivers for medically unfitting conditions for aviation personnel are:

(a) Entrance into flight training, *Classes 1 and 1A*, and continuance in aviation service, *Class 2* aviators (*except MSC*): US Army MILPERCEN, HQDA (DAPC-OPA-V), Alexandria, VA 22332, and Chief, National Guard Bureau (NGB-AVN-OC), Building E6810, Aberdeen Proving Ground, MD 21010. *Class 2, Medical Service Corps* aviators: HQDA (SGPE-MS), Washington, DC 20324 (through HQDA (DASG-HCO-A)), Washington, DC 20310.

(b) *Class 2, Flight surgeons*; all persons being considered for or while in aeromedical training: HQDA (SGPE-MC), Washington, DC 20324 (through HQDA (DASG-PSP) Washington, DC 20310), and Chief, National Guard Bureau (NGB-ARS), Washington, DC 20310.

(c) *Class 2, DAC pilots*: Local Civilian Personnel Offices. Class 2, Contract civilian pilots (Fort Rucker): CG, US Army Aviation Center.

(d) *Class 2A, Entrance into and continuance in training and on duty as a military air traffic controller*: HQDA (DAPC-OPE-L-T), Alexandria, VA 22332, and Chief, National Guard Bureau (NGB-AVN-OC), Building E6810, Aberdeen Proving Ground, MD 21010, for conditions disqualifying for military duty even though a valid FAA medical certificate has been issued. (See para 10-26l.)

(e) *Class 2A, Civilian air traffic controllers*: Local Civilian Personnel Offices.

(f) *Class 3, Aeromedical physician assistants*: HQDA (SGPE-MC), Washington, DC 20324 (through HQDA (DASG-PSP), Washington, DC 20310).

(g) *Class 3, Other personnel*: See paragraph 10-26h(4).

(3) *In each of the above*, administrative waivers may be granted only upon written favorable recommendation from the Cdr, USAAMC, and concurrence of intermediate authority, where specified above. This recommendation may include limited flying status (e.g., co-pilot only) and may include requirements for further evaluation. The Cdr, USAAMC, is fulfilling his review and waiver responsibilities, is authorized to issue such policy letters as may be required to provide guidance to examiners in regard to examinations and procedures necessary to determine fitness for flying duty. He may also issue policy letters governing interim disposition of persons with certain remedial and/or minor defects, such as obesity, hypertension, use of systemic medication, and high frequency hearing loss in excess of standards. When annual reevaluation of waivers is required, the examining flight surgeon will insure that all information required by the Cdr, USAAMC, and/or by good medical judgment, is forwarded with the SF 88

and SF 93. To assist in determining medical fitness for flying duty, the Cdr, USAAMC, is authorized to establish an Aeromedical Consultant Advisory Panel (ACAP) consisting of experienced flight surgeons selected by him- or herself and of experienced aviators selected by the CG, USAAVNC, to help determine fitness for flying duty and to help make recommendations for aeromedical disposition to the appropriate waiver or suspension authority.

j. *Use of DA Form 4186 (Medical Recommendation for Flying Duty)*. (See also para 10-23c.) (Applies to all aviation personnel, including civilian employee pilots, civilian contractor pilots, and military and civilian air traffic controllers.)

(1) DA Form 4186 is a required official means of certifying that military and civilian personnel are medically fit to perform Army aviation duties. It is required for all personnel who must meet Army Class 1, 1A, 2, 2A, or 3 medical fitness standards (except rated aviators not performing operational flying duty, see below). (FAA medical certificates are also required for certain personnel, see para 10-26k.). The DA Form 4186 is to be completed at the time of: (a) Periodic examination; (b) after an aircraft mishap; (c) reporting to a new duty station or upon being assigned to operational flying duty; (d) when admitted to a medical treatment facility, sick in quarters or entered into a drug or alcohol rehabilitation program (AR 600-85); (e) when returned to flight status following (d) above; (f) when treated as an outpatient for conditions or with drugs which are disqualifying for aviation duty; (g) when being returned to flight status following restriction imposed under (f) above; and (h) other occasions, as required.

(2) Three copies of the DA Form 4186 will be completed. One copy will be given to the individual; one will be filed in the examinee's health record; and one copy will be sent to the examinee's unit commander who forwards it to the flight records office for inclusion in the flight records, in accordance with AR 95-1. The individual will, upon return to his or her unit following issuance of DA Form 4186, inform his or her commander or supervisor of his or her status and will utilize his or her copy of DA Form 4186 to verify his or her status. Health record copies will be filed as follows:

Most recent DA Form 4186 ..... File on top left

If above grants clearance to fly, then most recent DA Form 4186, if any, which shows a medical restriction from flying ..... File next under

If a waiver has been granted for any cause of medical unfitness for flying, the most recent DA Form(s) 4186 showing such waiver(s) ..... File next under

Any additional DA Form(s) 4186 which the flight surgeon determines to be required as a permanent record (Enter "Permanent Record" in "Remarks" section) ..... File next under

Other DA Form(s) 4186 ..... Destroy

(3) Issuance of this form, following a periodic medical examination (plus an FAA medical certificate when required), will constitute medical clearance for flying duty pending return of final review from the reviewing authority (Cdr, USAAMC, Fort Rucker, AL) if the examinee is found qualified for flying duty in accordance with chapter 4. If a newly discovered medically unfitting condition requiring waiver exists, such waiver must be granted by appropriate authority (para 10-26i(2)) before further flying duties may be performed. However, in the case of minor defects which will in no way affect the safe and efficient performance of flying duty and which will not be aggravated by such duty, the local commander may, upon favorable recommendation of the flight surgeon (DA Form 4186), allow the individual to continue to perform aviation duties, pending completion of the formal waiver process. Consultation on questionable cases will be obtained direct from the Cdr, USAAMC or his or her designated representative. When used for this purpose, the Remarks section of DA Form 4186 will be completed to reflect a limited length of time for which the clearance is being given.

(4) In determining when the next examination is due (item 8), any examination conducted within 3 calendar months before the end of the birth month will be considered to have been accomplished during the birth month. The medical clearance expiration date in item 8 will then normally be the end of the birth month approximately 1 year later. (See also para 10-23c(2)(d) and table 10-1 in regard to clearance up to 18

months.) DA Form 4186 may be signed by a flight surgeon, other physician or physician assistant when used to medically restrict aircrewmembers from flying duty. It may be signed only by a flight surgeon when used to return aircrewmembers to flying duty, except that return to flying duty by health care providers other than flight surgeons may be accomplished with telephonic approval of a flight surgeon if a flight surgeon is not locally available at a given installation. This clearance, to include the name of the consulting flight surgeon, will be recorded in the health record and on DA Form 4186. The term "Flight Surgeon" will be blocked out on DA Form 4186 if the signing official is not a commissioned Medical Corps flight surgeon. If a previously waived condition has changed significantly (i.e., condition worsens), a new waiver must be obtained before further flying duty is authorized. Item 9 of DA Form 4186 will show the date when waiver was first granted for each waived condition as well as date and nature of any significant changes in condition(s) which have been waived. DA Form 4186 may be used by a flight surgeon to extend a currently valid medical examination for a period not to exceed 1 calendar month beyond the end of the birth month or of the designated fiscal quarter for the purpose of completing an examination begun before the end of the birth month or designated fiscal quarter (however, FAA medical certificates cannot be extended).

(5) DA Form 4186 is not required for aviators in nonaviation duty positions but they must undergo periodic Class 2 examinations to determine continued medical fitness for flying duty and must promptly report to the flight surgeon any condition which might be cause for medical disqualification from aviation service. At the time of the periodic examination, and at any other time the aviator's fitness for flying duty is evaluated, entries will be made on SF 600 (Health Record—Chronological Record of Medical Care) indicating the status or outcome of such evaluation. (See also para 2-11, AR 40-3.)

(6) USAF and USN forms may be substituted when aeromedical support is provided by those Services.

*k. FAA medical certificates.* (See also para 10-7c.)

(1) In accordance with AR 40-3 and current agreements between the FAA and DOD, Army flight surgeons (Active and Reserve Components) and qualified civilian physicians employed by or under contract with the Army ("qualified" is defined as a physician who is a graduate of a military primary course in aviation or aerospace medicine) are authorized to issue FAA Medical Certificates, Second and Third Class; provided, however, that the facility to which the flight surgeon or civilian physician is assigned or attached must be designated (assigned an FAA number) by the FAA. All FAA-designated facilities are automatically provided copies of all necessary documents, forms, and resupply request forms by the FAA Mike Monroney Aeromedical Center (Code AAC-141), P.O. Box 25082, Oklahoma City, OK 73125 (phone: (Area Code 405) 686-4831). Applications for designation should be forwarded to HQDA (DASG-PSP-0), Washington, DC 20310. Non-flight surgeons are not authorized to issue FAA medical certificates. Physicians who hold civilian AME designations but who are performing duty with the Army will use the FAA number of the facility which is their place of duty.

(2) In no case are military flight surgeons authorized to issue FAA First Class Medical Certificates. However, when specifically authorized by an FAA regional flight surgeon, an Army flight surgeon (or qualified civilian employee physician) may prepare an FAA Medical Certificate, First Class, and forward it to the regional flight surgeon for signature (CONUS only). This will be done only with the prior approval of the regional flight surgeon and this service is available only at the discretion of a regional flight surgeon.

(3) Requirements for FAA medical certificates.

(a) FAA First Class—Applicants for positions as DAC pilots. When these are not already in the possession of the individual at the time of application and are available through (2) above, the applicant must obtain them on the basis of examination by an Army flight surgeon or qualified civilian employee physician. If not available in this manner, the certificate must be obtained from a civilian aviation medical examin-

er designated by the FAA to administer FAA First Class examinations (Senior AME).

(b) FAA Second Class—DAC pilots, pilots who are employees of firms under contract with the Army (other than aircraft manufacturers); military and civilian air traffic controllers. These individuals are required to undergo complete annual examination by military flight surgeons or qualified civilian employee physicians (or civilian AMEs, in accordance with para 10-7c) to determine their fitness to fly Army aircraft, in accordance with paragraph 4-3. (The provisions for interim (abbreviated) flying duty medical examinations, described elsewhere in this regulation, do not apply to military or civilian personnel required to possess valid FAA medical certificates.) If the individual should refuse to undergo such examination he or she will be denied medical clearance to fly or control Army aircraft. Following examination by a military flight surgeon or qualified civilian employee physician, however, civilian pilot examinees may elect to obtain their FAA Second Class Certificate from a civilian aviation medical examiner, at their own expense. If a flight surgeon or qualified civilian employee physician is not available within 60-minute travel time, those individuals required to possess FAA Second Class Certificates will normally obtain their FAA certificate from a local civilian aviation medical examiner (funding: see para 10-7g), and fitness for duty will be determined on the basis of this certificate. However, such an individual may be required to undergo further examination by a military or civilian employee physician if any doubt exists as to his or her fitness to fly or control Army aircraft. Questionable cases may be referred to the Cdr, USAAMC for assistance. Failure to undergo examination by a military or civilian employee physician, if so ordered by competent authority, is basis for denying medical clearance to fly or control Army aircraft.

(c) Military and civilian personnel not required to possess FAA medical certificates for their official duties but who request them for personal use may be issued such certificates in accordance with (1) and (2) above, at the discretion of the flight surgeon and workload permitting. FAA medical certificates will not be pre-

pared for individuals who do not request them. In no case will non-flight surgeons issue FAA medical certificates.

(d) Conduct of examination, processing of FAA Form 8500-8, and issuance of FAA Medical Certificates, Second and Third Class, will be in accordance with official policy of the FAA (Guide for AMEs and any other policy issued by FAA). Normally, certificates are issued at the time of examination if the individual is found to be fully qualified. No limitations or restrictions will be imposed except as specifically authorized by FAA. For example, a limitation of "For air traffic control duties only" on a certificate for an ATC may be made by FAA but is not authorized for use by Army flight surgeons.

(e) Use of the SF 88 in lieu of completing the entire FAA Form 8500-8 is not authorized. Both sides of FAA Form 8500-8 must be completed and must be signed by the flight surgeon except in (2) above or when FAA policy indicates otherwise such as when the individual is not qualified; or as otherwise directed by the FAA. (See FAA Guide for Aviation Medical Examiners.)

(f) In no case are flight surgeons or other Army physicians authorized to extend the validity of FAA medical certificates. Personnel required to possess valid FAA certificates while performing their official duties will be given priority, if required, to insure that their certificate does not expire before reexamination.

(g) Army flight surgeons administering examinations for FAA medical certificates will insure that examinations are complete and accurate; that all administrative requirements are met; that processing of all documents is accomplished on a timely basis; and that FAA policy is otherwise followed.

*l. Air traffic control personnel.* Military and civilian ATC personnel will undergo examination annually or as otherwise directed by the FAA. This examination may be performed during the birth month to facilitate scheduling but in no case will extensions be used to align the examination with the birth month. They will also undergo examination when directed by the flight surgeon under such conditions as post-hospitalization, when illness occurs or is suspected, or after an aviation mishap in which air traffic con-

trol may have been a factor. Use of DA Form 4186 applies to all ATC personnel (para 10-26k); as does AR 40-8. In addition, all ATC personnel who receive any communication whatsoever from FAA regarding their medical status with FAA will immediately report to the flight surgeon for a determination regarding fitness for ATC duty at Army facilities. (See also para 4-2, 10-7, 10-7a(3), 10-26i and 10-26k.)

(1) *Civilian ATC personnel employed by the Army* are medically qualified for employment on the basis of Qualification Standards GS-2152, Civil Service Handbook X-118 (available at local civilian personnel offices). They are also required by Part 65 and Part 67, Federal Aviation Regulations, to possess an FAA Airman Medical Certificate (FAA Form 8500-9) or combination Airman Medical and Student Pilot Certificate (FAA Form 8420-2), Second Class (or higher). Civilian ATC personnel will obtain their FAA Airman Medical Certificate from a military flight surgeon, if available. A photocopy of FAA Form 8500-B will be maintained in the flight surgeon's office. All FAA-designated facilities are automatically provided copies of all necessary documents, forms, and resupply request forms by the FAA Mike Monroney Aeromedical Center (Code AAC-141), P.O. Box 25082, Oklahoma City, OK 73125 (phone: (Area Code 405) 686-4831). If a military flight surgeon is not available, civilian ATC personnel may obtain their medical certificate from a civilian aviation medical examiner (see para 10-7c).

(2) *Military air traffic control personnel.*

(a) Military ATC personnel must meet FAA standards, must possess an FAA Airman Medical or combination Medical and Student Pilot Certificate, Second Class (or higher), and must also meet Army-unique standards specified in chapter 2 (for enlistment), chapter 3 (for retention), and chapter 4 (for ATC duty). When a military flight surgeon is available (and is performing duty at an FAA-designated military facility) ATCs will be examined by the flight surgeon to determine fitness under FAA and chapter 2 or 3 and 4 standards. FAA Form 8500-8 and associated FAA forms will be completed as specified by the FAA. In addition, the following entries will be made in the "NOTES"

section on the reverse side of the FAA Form 8500-8:

1. "Examinee also meets the Army-unique standards of AR 40-501" or "Examinee does not meet the Army-unique standards of AR 40-501."

2. The entry specified in quotes in item 72, appendix IX, will also be made in the "NOTES" section and will be signed by the examinee. One photocopy of the FAA Form 8500-8 will then be filed in the health record (AR 40-66); another photocopy will be sent to the Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362.

(b) If examinee meets FAA and Army-unique criteria, his FAA medical certificate and a local medical clearance for flying (DA Form 4186) will normally be issued at the time of examination. If the flight surgeon issues an FAA medical certificate that is subsequently altered, revoked or changed in any way by FAA, the ATC (who will normally be the recipient of any notice of change made by FAA) will immediately report to the nearest military flight surgeon for further determination of his or her fitness for ATC duty.

(c) If an ATC is examined for an FAA medical certificate but is not issued the certificate by the flight surgeon (due to questionable qualification, outright disqualification or other reason), the flight surgeon follows the instructions in the AME Guide; in most cases, he or she sends the FAA Form 8500-8 and allied forms to FAA where a decision is made and the examinee is subsequently notified. The examinee will then report to the flight surgeon when he or she receives any communication from FAA regarding his or her status such as special issue, waiver, exemption or letter of denial.

(d) When ATC personnel do not meet FAA and/or Army-unique standards, it may be possible to enter or continue ATC duties if all the following conditions are met:

1. The FAA issues an Airman Medical Certificate, with or without a statement of demonstrated ability or other form of "waiver," and

2. The local flight surgeon and the Cdr, USAAMC recommend a waiver, and

3. Waiver is granted by the authority indicated in paragraph 10-26*i* (MILPERCEN).

To recommend a waiver, the local flight surgeon will prepare and forward an SF 88, SF 93, allied documents, and an Aeromedical Summary to the Cdr, USAAMC, ATTN: HSXY-AER, Ft Rucker, AL 36362.

(e) When ATC personnel obtain their FAA medical certificate from a civilian examiner (see para 10-7*c*), the examinee will report the outcome of examination to his or her supporting MTF; and a health care provider will ascertain that he or she meets Army unique standards. If FAA and Army standards are met, this will be noted on SF 600 in the health record jacket, and the signed entry required in item 73, appendix IX, will be made on SF 600. A copy of SF 600 will be sent to the Cdr, USAAMC, ATTN: HSXY-AER, Ft Rucker, AL 36362. If the examinee fails to meet FAA or Army standards, local medical officials will consult the Cdr, USAAMC, ATTN: HSXY-AER, Ft Rucker, AL 36362 for further guidance.

(3) *Air traffic control trainees (military)*. Individuals reporting for initial ATC training must have in their possession a valid, current FAA Airman Medical Certificate, Second Class (FAA Form 8420-2). This may be issued by an appropriate civilian aviation medical examiner or a military flight surgeon in accordance with paragraph 10-7*c*.

#### ★Section V. USMA MEDICAL EXAMINATIONS (RESCINDED)

10-27. US Military Academy (Rescinded)  
Medical examinations for entrance into the

United States Military Academy are governed by AR 40-29.

#### Section VI. MOBILIZATION MEDICAL EXAMINATIONS

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

bilization medical examinations (para 6-1), see paragraph 10-22.

## Section VII. MISCELLANEOUS MEDICAL EXAMINATIONS

### 10-29. Miscellaneous Medical Examinations

*a. Specialized duties.* Medical examination of individuals for initial selection or retention in certain specialized duties requires verification of the absence of disease or anomalies which may affect performance of those duties. As examples, most military occupational specialties in the electronics field require good color vision; marine divers must be free of diseases of the ear; airborne personnel must have full strength and range of motion of extremities. In evaluating such personnel, the examiner will be guided by the requirements for special physical qualifications set forth in pertinent publications, such as chapters 4 and 7 of this regulation, AR 40-5, AR 611-201, TB MED 523, TB MED 279, and TB MED 501.

*b. Certain geographical areas.*

★(1) When an individual is alerted for movement or is placed on orders for assignment to duty with the system of Army attachés, military missions, military assistance advisory groups, or in isolated areas, the commander of the station to which he or she is assigned will refer the individual and his or her dependents, if any, to the medical facility of the command. The physician of the facility will carefully review the health records and other available medical records of these individuals. Medical fitness standards for certain geographical areas are contained in paragraph 7-9 and will be used in the evaluation and examination processes. In assessing the individual's potentiality for assignment in certain geographical areas, the examiner is urged to make use of other materials such as the *Medical Capabilities Study* (country-by-country), published by the Armed Forces Medical Intelligence Center, Fort Detrick, MD 21701 (AV 343-7214), which provide valuable information on environmental conditions in foreign countries. Particular attention will be given to ascertaining the presence of any disease or anomaly which may make residence of one or more members of the family inadvisable in the country of assignment. Review of the medical records will be supplemented by personal interviews with the individuals to obtain pertinent information concerning their state of health. The physician

will consider such other factors as length of time since the last medical examination, age, and the physical adaptability of the individual to the new area. Additional considerations of importance which bear on the advisability of residence in a given country are the scarcity or nonavailability of certain care and hospital facilities, and dependence on the host government for care. If, after review of records and discussion, it appears that a complete medical examination is indicated, a type A examination will be accomplished. Sponsors and dependents who are particularly anxious for assignments to certain areas are often inclined to minimize their medical deficiencies or hesitate to offer complete information to medical examiners regarding their medical condition or physical defect. The examiner must be especially alert to recognize such situations and fully investigate the clinical aspects of all suspected or questionable areas of medical deficiency. The commander having processing responsibility will insure that this medical action is completed prior to the individual's departure from his or her home station.

(2) The importance of this medical processing cannot be overemphasized. It is imperative that a thorough screening be accomplished as noted in (1) above for the best interests of both the individual and the Government. Individuals in these assignments function in a critical area. Their duties do not permit unscheduled absences. The peculiarities of the environment in which they and their dependents must live are often deleterious to health and present problems of adaptability for many individuals. In view of the unfavorable environments incident to many of these assignments, it is of prime importance that only those individuals will be qualified whose medical status is such as to provide reasonable assurance of continued effective performance and a minimum likelihood of becoming medical liabilities.

★(3) If as a result of his or her review of available medical records, discussion with the individual and his or her dependents, and findings of the medical examination, if accomplished, the physician finds the individual medically qualified in every respect under paragraph 7-9d, and to meet

the conditions which will be encountered in the area of contemplated assignment, he or she will complete and sign DA Form 3083-R (Medical Examination for Certain Geographical Areas). This form will be reproduced locally on 8½- by 11-inch paper in accordance with figure 10-2.

**(Locate fig 10-2, a fold-in page, at the end of the regular size pages.)**

The top margin of the form will be approximately ¼-inch for filing in the health record and outpatient record. A copy of this statement will be filed in the health record or outpatient record (AR 40-66) and a copy forwarded to the commander who referred the individual to the medical facility. If the physician finds a dependent member of the family disqualified for the proposed assignment, he or she will notify the commander of the disqualification. The examiner will not disclose the cause of the disqualification of a dependent to the commander without the consent of the dependent, if an adult, or a parent if the disqualification relates to a minor. If the military member or dependent is considered disqualified temporarily, the commander will be so informed and a re-examination scheduled following resolution of the condition. If the disqualification is permanent or if it is determined that the disqualifying condition will be present for an extended period of time, the physician will refer the military member to a medical board for documentation of the condition and recommendations concerning limitation of activities or areas of as-

signment. Either DA Form 3947 (Medical Board Proceedings) or DA Form 3349 (Physical Profile Board Proceedings Medical Condition—Physical Profile Record) may be used, the selection depending on the eventual use of the report.

★(4) Periodic medical examinations may be waived by the commander concerned for those individuals stationed in isolated areas; i.e., Army attachés; military missions and military assistance advisory groups, where medical facilities of the US Armed Forces are not available. Medical examinations so waived will be accomplished at the earliest opportunity when the individuals concerned are assigned or attached to a military installation having a medical facility. Medical examination of such individuals for re-employment purposes may not be waived.

★*c. Special Forces Initial Qualification, Military Free Fall (HALO) and Special Forces SCUBA Medical Examination Reports.* Entrance into Special Forces Qualification Course, Military Free Fall (HALO), and Special Forces SCUBA training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, US Army John F. Kennedy Special Warfare Center, ATTN: Surgeon, Fort Bragg, NC 28307. The SF 88, SF 93 and allied documents will be forwarded direct to the above ATTN line for review. The reviewed medical examination forms and allied documents will be returned direct to the sender to be incorporated in the member's application for training.

## Section VIII. MEDICO-DENTAL REGISTRANTS MEDICAL EXAMINATIONS

### 10-30. Medico-Dental Registrants Medical Examinations

Administrative procedures applicable to medical

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

## ★Section IX. ARMY PHYSICAL FITNESS AND WEIGHT CONTROL PROGRAM FOR ACTIVE MEMBERS AGE 40 AND OVER

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

*a. Criteria.* Routine medical examinations will be utilized as a vehicle for accomplishing the ini-

tial 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 required a special schedule for medical examination. All such members received a complete medical examination during the month of birth at age 40, 42, 44, etc. This allowed such

members to be screened within a period of approximately 2 years from the date of inception of this program, 30 June 1981. Personnel are identified for the periodic medical examination and screening for this Program and notified through procedures prescribed in DA Pamphlet 600-8. The cardiovascular screen is administered to all members age 40 or over at the time of each periodic medical examination at 5-year intervals (see para 10-23c) and during the retirement medical examination except when a prior over-40 screen has not been done. The retirement medical examination is mandatory (see para 10-25a). Members currently under age 40 will have a medical examination including cardiovascular screening upon attaining age 40 even if involved in a training program at the time. The cardiovascular screen will be a regular part of every medical examination after age 40.

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

(2) Commanders at medical centers and MEDDACs are responsible for implementing procedures established in this Program. This requires involvement of the chiefs of ambulatory care and department of medicine in scheduling and processing examinations in a timely manner. Local commanders will be briefed on the capabilities of the medical facility and the timeframe necessary for completion of the screening for all personnel. A continued review will be necessary to 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 a sample form.) Data

(1) *Asthma*. In evaluation of asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluatee's physician, this should result in rejection even though physical examination is normal.

(2) *Bronchiectasis*. Individuals who report a history of frequent respiratory infections (colds) accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported or suspected by a finding of posttussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings, or chest film abnormalities, confirmatory opinions should be sought from the examinee's personal physician, or the examinee should be referred to the appropriate chest consultant for evaluation and recommendations.

(3) *Tuberculosis*. Active tuberculosis is often asymptomatic and often not accompanied by ab-

normal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of tuberculosis will be missed. The most sensitive tool for detection of early pulmonary tuberculosis is the chest film. Any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe should be suspected strongly of being tuberculosis. It is thus imperative that all routine chest films be completely scrutinized by an experienced radiologist. Many tuberculous lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical-lordotic view must be obtained for clarification. It is neither practical nor possible in most instances to determine whether or not a tuberculous lesion is inactive on the basis of single radiologic examination. For all these reasons, any patient suspected of tuberculosis should be referred to a qualified chest consultant or to an appropriate public health clinic for evaluation. It is not feasible to carry out diagnostic skin tests and sputum studies in a medical examination station.

## Section VIII. CARDIOVASCULAR

### 11-10. Cardiovascular

*a. Blood pressure*. Blood pressure will be determined with the individual relaxed and in a sitting position with the arm at heart level. Current experience is that "low blood pressure" has been very much overrated in the past and, short of symptomatic postural hypotension, a normal individual may have a systolic blood pressure as low as 85-90 mm. Concern with blood pressure, thus, is to detect significant hypertension. It is mandatory that personnel entrusted to record blood pressure on examinees be familiar with situations that result in spurious elevation. It is only reasonable that a physician repeat the determination in doubtful or abnormal cases and insure that the proper recording technique was used. Artificially high blood pressure may be observed—

(1) If the compressive cuff is loosely applied.

(2) If the compressive cuff is too small for the arm size. (Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual this may require an "oversize" cuff.)

(3) If the blood pressure is repetitively taken before complete cuff deflation occurs (trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure).

(4) Prolonged bed rest will not precede the blood pressure recording; however, due regards must be given to physiologic effects such as excitement and recent exercise. Limits of normal for military applicants are defined in appropriate sections of AR 40-501. No examinee will be rejected as the result of a single recording. When found, disqualifying blood pressure will be rechecked for a preponderance based on at least three readings. For the purpose of general military procurement, the preponderant blood pressure will be determined by at least three readings at successive hour intervals during a day period. While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

(5) Blood pressure determination will be made in accordance with the recommendation of the

American Heart Association. The systolic reading will be taken as either the palpatory or auscultatory reading depending on which is the higher. (In most normal subjects, the auscultatory reading is slightly higher.) (Diastolic pressure will be recorded as the level at which the cardiac tones disappear by auscultation.) In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. If the technique can be ascertained to be correct, and there is no underlying valvular defect, a diastolic reading will be taken in these instances at the change in tone. Variations of blood pressures with the position change should be noted if there is a history of syncope or symptoms to suggest postural hypertension. Blood pressure in the legs should be obtained when simultaneous palpation of the pulses in upper and lower extremities reveal a discrepancy in pulse volume or amplitude.

*b. Cardiac auscultation.* Careful auscultation of the heart is essential so that significant cardiac murmur or abnormal heart sound will not be missed. Experience has shown that significant auscultatory findings may not be appreciated unless both the bell and diaphragm portions of the stethoscope are used in examination. As a minimum, attention should be directed to the second right interspace, second left interspace, lower left sternal border, and cardiac apex. Patients should be ex-

amined in the supine position, while lying on the left side, and in the sitting position leaning slightly forward. In the latter position, auscultation should be performed at the end of a full expiration remaining attuned for a high-pitched diastolic murmur of aortic valve insufficiency.

*c. Cardiac murmurs.* There are no absolute rules which will allow the physician to easily distinguish significant and innocent heart murmurs. For practical purposes, all systolic murmurs which occupy all or nearly all of systole are due to organic cardiac problems. Similarly, any diastolic murmur should be regarded as evidence of organic heart disease. Experience has taught that the diastolic murmur of aortic valve insufficiency and mitral valve stenosis are those most frequently missed. Innocent murmurs are frequently heard in perfectly normal individuals. In an otherwise normal heart, a slight to moderate ejection type pulmonary systolic murmur is the most common of all murmurs. When accompanied by normal splitting and normal intensity of the components of the second heart sound, such a murmur should be considered innocent. A particularly pernicious trap for the attentive physician is the thin chested young individual in whom such a pulmonary ejection murmur is heard and who, in recumbency, demonstrates persistent splitting of the sec-

### Section XV. ANUS AND RECTUM

#### 11-17. Anus and Rectum

a. When a suspicion of anorectal disease exists, a complete examination of this area should be done, including proctoscopy.

b. Digital rectal will be accomplished for all periodic examinations of active duty male personnel regardless of age and for all examinations of individuals 40 years of age or over.

### Section XVI. ENDOCRINE SYSTEM

#### 11-18. Endocrine System

a. Endocrine abnormalities will be evaluated during the general clinical evaluation. The thyroid will be palpated for abnormality and the individual observed for signs of hyper or hypothyroidism. General body habitus will be observed

for evidence of endocrine dysfunctions.

b. If sugar is found in the urine, repeated urinalyses, a 2-hour postprandial blood sugar and, when indicated, a glucose tolerance test will be accomplished preceded by 3 days of adequate (300 grams daily) carbohydrate intake.

### Section XVII. GENITOURINARY SYSTEM

#### 11-17. Genitourinary System

a. *Veneral disease and malformations.* A search will be made for evidence of venereal disease and malformations. The glans penis and corona will be exposed and urethra stripped. The testes and scrotal contents will be palpated, and the inguinal lymph nodes will be examined for abnormalities. When indicated, X-ray, other laboratory examinations, and instrumentation will be conducted.

b. *Female examination.* A pelvic examination will be performed on all female examinees. The presence of a female attendant is required and the examinee will be properly draped. The examination will include bimanual palpation, visual inspection of the cervix and vaginal canal by speculum and, when possible, a Papanicolaou smear. When there is an imperforate hymen or other contraindication to vaginal examination, a rectal ex-

amination will be performed and the method of examination will be noted on SF 88.

#### c. *Urinalysis.*

(1) Routine urinalysis, to include determination of specific gravity, protein and sugar, and microscopic study will be performed for all examinees. Examining physicians may require examinees to void the urine in their presence. Prior to voiding the examinee must be examined for the presence of venereal disease. When either albumin, casts, white blood cells, or red blood cells are found in the urine, urinalysis should be repeated not less than twice a day on 3 consecutive days. If cellular elements persist in the urine, the two-glass test should be performed to rule out lower urinary tract disease.

(2) If sugar is found in the urine the examinee will be subject to further observation of diabetes. See paragraph 11-18.

### Section XVIII. SPINE AND OTHER MUSCULOSKELETAL

#### 11-20. Spine and Other Musculoskeletal

a. *Orothopedic evaluation.* The examinee will perform a series of movements designed to bring into action the various joints and muscles of the body. This purpose is best accomplished by requiring the examinee to follow movements made by the examiner. Gait and posture will be specifically noted.

b. *Examination of range of motion.* Extend the arms and forearms fully to the front and rotate them at the shoulders. Extend the arms at right angles with the body; place the thumbs on the points of the shoulder; raise and lower the arms, bringing them sharply to the sides at each motion. Extend the arms fully to the front, keeping the palms of the hands together and the thumbs up;

carry the arms quickly back as far as possible, keeping the thumbs up, and at the same time raise the body on the toes. (Question the examinee regarding any previous dislocations of the shoulder.) Extend the arms above the head, locking the thumbs, and bend over to touch the ground with the hands, keeping the knees straight. (Question the examinee as to wrist injury for possible scaphoid fracture.) Extend one leg lifting the heel from the floor, and move all the toes freely; move the foot up and down and from side to side, bending the ankle joint, the knee being kept rigid; bend the knee freely; kick forcibly backward and forward; stand upon the toes of both feet; squat sharply several times; kneel upon both knees at the same time. (If the individual comes down on one knee after the other there is reason to suspect infirmity, such as injury to menisci.) (Question the examinee as to previous injury.) Lack of ability to perform any of these exercises indicates some defect or deformity that should be investigated further.

*c. Examination of major joints.*

- (1) *The shoulder.* With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry or abnormal configuration or muscle atrophy. From the back, with the examinee standing, observe the scapulo-humeral rhythm as examinee elevates the arms from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particular careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction and rotation. Compare each shoulder in this respect.
- (2) *The back.* With the examinee standing stripped, note the general configuration of the back, the symmetry of the shoulders and hips and any abnormal curvature including scoliosis, abnormal dorsal kyphosis, or excessive lumbar lordosis. Have examinee flex and extend spine and bend to each side, noting ease with which

this is done and the presence or absence of pain on motion.

- (3) *The knee.* With trousers, shoes, and socks removed observe general muscular development of legs, particularly the thigh musculature. Have examinee squat, and observe hesitancy, weakness, and presence or absence of pain or crepitus. In the presence of any history of "locking", recurrent effusion, or instability, or when limitation of motion or ligamentous weakness is detected, suitable X-rays should be obtained to include an anteroposterior, lateral, and intercondylar view.
- (4) *The elbow.* Have the examinee flex the elbows to a right angle and keeping the elbows against the body note ability to fully supinate and pronate the forearms. If indicated, X-rays should include an anteroposterior and lateral views.
- (5) *The wrist and hand.* Observe and compare range of motion of the wrists in flexion, extension, radial deviation, and ulnar deviation. Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor indicating possible underlying organic disease. Have the examinee flex and extend the fingers making sure the distal interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palms.
- (6) *The hip.* Have the examinee stand first on one foot and then the other, flexing the non-weight-bearing hip and knee and observing for ability to balance as well as for possible weakness of hip muscles or instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (i.e., the non-weight-bearing) hip.
- (7) *The feet.* The feet will be carefully examined for any deformity, the strength of the foot will be ascertained by having the examinee hop on toes.

**Section XIX. PSYCHIATRIC**

**11-21. Psychiatric**

a. During the psychiatric interview the examining physician must evaluate each individual sufficiently to eliminate those with symptoms of a degree that would impair their effective performance of duty.

b. The psychiatric interview will be conducted subsequent to the completion of all items on SF 88 and 89. During the interview, the examinee's behavior will be observed and an estimate made of his current mental status. Any evidence of disorganized or unclear thinking, of unusual

thought control, of undue suspiciousness or of apathy or "strangeness" will be noted. Any unusual emotional expression such as depression, expansiveness, withdrawal or marked anxiety, which is out of keeping with the content of the interview will be carefully evaluated.

c. The results of the psychiatric examination will be recorded on SF 88, item 42, as normal or abnormal in the space provided. If the individual is disqualified, the defect will also be recorded in item 74, SF 88.

**★APPENDIX II**  
**TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL**

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

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

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

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

**OR**

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

<i>Frequency</i>	<i>Better ear</i>
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 Level for Admission to US Military Academy, Uniformed Services University of Health Sciences, and Army ROTC Scholarship Program  
ISO 1964—ANSI 1969 (Unaided Sensitivity)**

Frequency	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
Each ear	25dB	25dB	25dB	45dB	45dB	45dB

**APPENDIX VII**  
**THE AMERICAN HEART ASSOCIATION FUNCTIONAL CAPACITY AND**  
**THERAPEUTIC CLASSIFICATION**

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**1. Function Capacity Classification**

*Class I.* Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.

*Class II.* Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.

*Class III.* Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.

★ *Class IV.* Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken,

discomfort is increased.

**2. Therapeutic Classification**

*Class A.* Patients with cardiac disease whose physical activity need not be restricted.

*Class B.* Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against severe or competitive physical efforts.

*Class C.* Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.

*Class D.* Patients with cardiac disease whose ordinary physical activity should be markedly restricted.

*Class E.* Patients with cardiac disease who should be at complete rest, confined to bed or chair.

## APPENDIX VIII

### PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE

1 December 1983

Profile serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing—ears	E Vision—eyes	S Psychiatric
1 . . . . .	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits, or limitation of motion; no demonstrable abnormality; able to do hand-to-hand fighting.	No loss of digits, or limitation of motion; no demonstrable abnormality; be capable of performing long marches, standing over long periods.	★Audiometer level, each ear not more than 25dB at 500, 1000, 2000Hz with no level greater than 30dB. Not over 45dB at 4000Hz.	Uncorrected visual acuity 20/200 correctible to 20/20, in each eye.	No psychiatric pathology. May have history of a transient personality disorder.
2 . . . . .	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which do not prevent hand-to-hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.	★Audiometer average level of 6 readings (3 per ear) at 500, 1000, 2000Hz not more than 30 dB, with no individual level greater than 35dB at these frequencies, and level not more than 55 dB at 4000Hz; or audiometer level 30dB at 500Hz, 25dB at 1000 and 2000Hz, and 35dB at 4000 Hz in better ear. (Poorer ear may be deaf.)	Distant visual acuity correctible to 20/40–20/70, 20/30–20/100, 20/20–20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcoholic or drug addiction. Individuals who have been evaluated by a physician (psychiatrist) and found to have a character and behavior disorder will be processed through appropriate administrative channels.
3 . . . . .	Unable to perform full effort except for brief or moderate periods.	Defects or impairments which interfere with full function requiring restriction of use.	Defects or impairments which interfere with full function requiring restriction of use.	★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 30dB with hearing aid set at "comfort	Uncorrected distant visual acuity of any degree which is correctible not less than 20/40 in the better eye or an acute or chronic eye disease not falling below retention standards.	Satisfactory remission from an acute psychotic or neurotic disorder which permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided).

## APPENDIX VIII

### PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE—Continued

Profile serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing—ears	E Vision—eyes	S Psychiatric
4 .....	★Below standards contained in chapter 3.	★Below standards contained in chapter 3.	★Below standards contained in chapter 3.	level"; i.e., adjusted to 50 dB HL speech noise, or acute or chronic ear disease not falling below retention standards.	★Below standards contained in chapter 3.	★Below standards contained in chapter 3.
Factors to be considered.	Organic defects, age, build, strength, stamina, weight, height, agility, energy, muscular coordination, function, and similar factors.	Strength, range of motion, and general efficiency of upper arm, shoulder girdle and back, including cervical, thoracic, and lumbar vertebrae.	Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back.	Auditory sensitivity and organic disease of the ears.	Visual acuity, and organic disease of the eyes and lids.	Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress, Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorder impairment of functional capacity.

## APPENDIX IX

### SCOPE AND RECORDING OF MEDICAL EXAMINATIONS

Item SF 88	Types of examinations		Explanatory notes	Model entries	
	A	B			
1	✓	✓	The entire last name, first name, and middle name are recorded. If the individual's first and/or middle name consists of initial(s) only, indicate by adding (IO). When Jr. or similar designation is used, it will appear after the middle name. If there is no middle name or initial, put a dash after the first name.	Jackson, Charles Guy Rush, Benjamin— Osler, William Z.(IO) Jenner, Edward Thomas Jr. Baird, J. T.	
2	✓	✓	Enter examinee's grade and component. The entry USA is used for all personnel on active duty with the United States Army. Reserve components of the Army are indicated by USAR or ARNGUS. If examinee has no military status, enter the word "civilian," leaving space for later insertion of grade and component upon entry into the military service.	CPT, USA; MAJ, USAR; SGT, USA; SFC, ARNGUS; Civilian.	
3	✓	✓	Examinee's social security number. If none, enter a dash.	396-38-0699	
4	✓	✓	Examinee's current civilian mailing address. Do not confuse with military organization or present temporary mailing address.	—	
★5	✓	✓	Enter purpose of examination. If for more than one purpose, enter each. If for aviation personnel, enter "Flight" plus Class 1, 1A, 2, 2A or 3; and enter "Initial," "Repeat" or "Periodic," as required.	Induction; RA Enlistment; Periodic; RA commission; Retirement; Flight Class 1 (Initial).	
6	✓	✓	Enter date on which the medical examination is accomplished. Record in military style. This item is to be completed at the medical examining facility.	10 Feb 65 3 Mar 65	
7	✓	✓	Do not use abbreviation.	Male Female	
8	✓	✓	As appropriate, enter the first three letters of one of the following: Caucasian, Negroid, Mongolian, Indian (American) or Malayan. Do not confuse with nationality or religion.	Cau Neg Mon Ind (American) Mal	
9	✓	✓	Enter total active duty time in the military and/or full time Civil Service or Federal employment only. Express as years plus twelfths. Reserve time may be entered in item 16.	7 6/12; 4 3/12	
10	✓	✓	Enter branch of military service or civilian agency as appropriate. Do not confuse with components of the services.	DA DAF DN USMC	FBI CIA State Dept
11	✓	✓	The examinee's current military unit of assignment, active or reserve. If no current military affiliation, enter a dash.		
12	✓	✓	Record in military style; i.e., day, month and year, followed by age, in parentheses, to the nearest birthday.	14 Jan 43(21) 26 Mar 20(45)	
13	✓	✓	Name of city and State of examinee's birth. If not born in a city or town, enter county and State. If born in a foreign country, enter city or town and country.	Baltimore, MD Dinwiddie County, VA Marseilles, France	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
14	✓	✓	Name, followed by relationship in parentheses, and address of next of kin. This is the person to be notified in the event of death or emergency. If there is no next of kin, enter "none."	Mrs. Annie F. Harris (Wife) 1234 Fairfax Ave. Atlanta, GA 20527
★15	✓	✓	Name of examining facility or examiner and address. If APO, include local national location.	Military Entrance Processing Station 310 Gaston Ave. Fairmont, WV 12441 Dr. Raymond T. Fisher 311 Marcy Street Phoenix, AZ 39404
16	✓	✓	List any prior service number(s) and service(s). In the case of service academy examinees, enter the title, full name, and address of sponsor (individual who requested the examination). For Selective Service registrants list the examinee's Selective Service number and identify as such. Identifying or administrative data for the convenience of the examining facility should be entered either in item 16, if space allows, or otherwise in the upper right hand corner of the SF 88. If the examination is for an aviation procurement program and the examinee has prior military service, enter the branch of service.	
★17	✓	✓	The individual's current military job or specialty by title and SSI/MOS, including total time in this capacity expressed in years and/or twelfths. For pilots, enter current aircraft flown and total flying time in hours. In the case of free fall parachuting and/or marine (SCUBA) diving, so state and report the time in months or years of qualification.	
18	✓	✓	Record all swollen glands, deformities, or imperfections of head or face. In the event of detection of a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If enlarged lymph nodes of the neck are detected they will be described in detail and a clinical opinion of the etiology will be recorded.	2 in. vertical scar right forehead, well healed, no symptoms. 3 discrete, freely movable, firm 2 cm nodes in the right anterior cervical chain, probably benign.
19	✓	✓	Record all abnormal findings. Record estimated percent of obstruction to air flow if septal deviation, enlarged turbinates, or spurs are present.	20 percent obstruction to air flow on right due to septal deviation.
20	✓	✓	Record all abnormal findings.	Marked tenderness over left maxillary sinus.
21	✓	✓	Record any abnormal findings. If tonsils are enucleated, this is considered abnormal, thus check this item abnormal.	Tonsils enucleated.
22	✓	✓	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered.	Bilateral severe swelling, injection and tenderness of both ear canals.
23	✓	✓	Record all abnormal findings. If tested, a definite statement will be made as to whether the ear drums move on valsalva maneuver or not. In the event of scarring of the tympanic	Valsalva normal bilaterally. 2 mm oval perforation, left posterosupe-

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
			membrane the percent of involvement of the membrane will be recorded as well as the mobility of the membrane. Valsalva required for all diving, free fall parachuting, and flying duty examinations.	rior quadrant. No motion on valsalva maneuver, completely dry. No evidence of inflammation at present.
24	✓	✓	Record abnormal findings. If ptosis of lids is detected, a statement will be made as to the cause of the interference with vision. When pterygium is found, the following should be noted: 1. Encroachment on the cornea, in millimeters, 2. Progression, and 3. Vascularity.	Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye. Does not encroach on cornea; nonprogressive, avascular.
25	✓	✓	Whenever opacities of the lens are detected; a statement is required regarding size, progression since last examination, and interference with vision.	Redistribution of pigment, macular, rt. eye, possibly due to solar burn. No loss of visual function. No evidence of active organic disease.
26	✓	✓	Record all abnormal findings.	
27	✓	✓	Record all abnormal findings.	
★28	✓	✓	If rales are detected, state cause. The examinee will be evaluated on the basis of the cause of the pulmonary rales or other abnormal sounds and not simply on the presence of such sounds.	Sibilant and sonorous rales throughout chest. Prolonged expiration. See item 73 for cause.
29	✓	✓	Abnormal heart findings are to be described completely. Whenever a cardiac murmur is heard, the time in the cardiac cycle, the intensity, the location, transmission, effect of respiration, or change in the position, and a statement as to whether the murmur is organic or functional will be included. When murmurs are described by grade, indicate basis of grade (IV or VI).	Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. Disappears on exercise and deep inspirations (physiological murmur).
30	✓	✓	Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency.	Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency.
31	✓	✓	Include hernia. Note any abdominal scars and describe the length in inches, location, and direction. If a dilated inguinal ring is found, a statement will be included in item 31 as to the presence or absence of a hernia.	2½ in. linear diagonal scar, right lower quadrant.
★32	✓	✓	Digital rectal required for all periodic 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.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
33	✓	✓	Record all abnormal findings.	
34	✓	✓	Whenever a varicocele or hydrocele is detected, a statement will be included indicating the size and the presence of pain. If an undescended testicle is detected, a statement will be included regarding the location of the testicle, particularly in relation to the inguinal canal.	Varicocele, left, small.
35	✓	✓	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as, for example, a history of a broken arm with no significant finding at time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the "normal" column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is desired.	No weakness, deformity, or limitation of motion, left arm.
36	✓	✓	Record any abnormality. When flat feet are detected, a statement will be made as to the stability of the foot, presence of symptoms, presence of eversion, bulging of the inner border, and rotation of the astragalus. Pes planus will not be expressed in degrees, but should be recorded as mild, moderate, or severe.	Flat feet, moderate. Foot stable, asymptomatic, no eversion or bulging; no rotation.
37	✓	✓	Record as for item 35.	
38	✓	✓	Include pelvis, sacroiliac, and lumbrosacral joints. Check history. <i>If scoliosis is detected, the amount and location of deviation in inches from the midline will be stated.</i>	Scoliosis, right, ½ inch from midline at level of T-8.
39	✓	✓	Only scars or marks of purely identifying significance or which interfere with function are recorded here. Tattoos which are obscene or so extensive as to be unsightly will be described fully.	1-inch vertical linear scar, dorsum left forearm. 3-inch heart-shaped tattoo, nonobscene, lateral aspect middle 1/3 left arm.
40	✓	✓	Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment.	Small, discrete, angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping. Similar lesion on glans penis.
41	✓	✓	Record complete description of any abnormality.	
42	✓	✓	Record all abnormalities. This is not to be confused with ARMA (Item 72).	
★43	(*)	(*)	*See paragraph 10-23 for requirements for pelvic examination and Papanicolaou test. Check vaginal or rectal. Record any abnormal findings.	Normal.
44	✓	✓	Dental examination accomplished by a dentist is required for applicants for Service Academy, Uniformed Services University of Health Sciences, the Four-Year ROTC Scholarship Program, and diving training and duty (see also AR 40-29 and chapter 7 of this regulation). Examinations accomplished for	Nonacceptable.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A			
			appointment as commissioned or warrant officers, enlistment or induction in the Army, Army National Guard, and Army Reserve, aviation training and duty, entrance on active duty or active duty for training, periodic (Active Army, Army National Guard and Army Reserve), discharge, relief from active duty, or retirement <i>do not</i> require dental examinations accomplished by a dentist. Examining physicians will apply the appropriate standards prescribed by chapters 2, 3, 4, 6, or 8, and indicate "acceptable" or "nonacceptable."	
★45A	✓	✓	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.	
B	✓	✓		
C	✓	✓		
D	✓	✓		
★46	✓	✓	Required for initial examination for appointment, enlistment or induction into the Active or Reserve Component; for aviation, diver, HALO, and Special Forces training; and for discharge and relief from active duty or retirement (if a medical examination is accomplished). <i>Not required for periodic examinations, including flying duty, unless clinically indicated. Note place and date taken, and findings.</i>	Womack Army Community Hospital, Ft Bragg, NC, 11 July 1979, negative.
★47	✓	✓	Kahn, Wasserman, VDRL or cardiolipin microflocculation tests recorded as nonreactive or reactive. On reactive reports note date, place and titre. Serology not required for periodic examinations, unless clinically indicated.	Nonreactive. Reactive.
★48	(*)	✓	*Required for retirement or if age 40 or over; also if indicated; and on all flying, Special Forces and diving duty examinations regardless of age. Representative original samples of all leads (including precordial leads) properly mounted and identified on SF 520 (EKG report) will be attached to the original SF 88. SF 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 on all copies of SF 88.	Normal Abnormal—see attached SF 520.
49			(Rescinded)	
★50	✓	✓	Mammography—After age 50 during periodic examination of Active Army women. White Blood Cell Count—All marine divers. 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 Active Army members age 40 and over, and on all <i>initial</i> flying and diving duty examinations regardless of age. Cholesterol } and } Periodic and separation examinations for all Fasting Blood } Active Army members age 40 and over. Glucose } 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.	Identify test(s) and record results.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
★51	✓	✓	Record in inches to the nearest quarter inch (without shoes). For Class 1 and 1A aviation personnel, record time of day if near height limits. For initial Classes 1, 1A; initial Class 2 (Aviator); and continuance Class 2 (Aviator) not previously measured: Leg length, sitting height, and functional arm reach will be measured, in accordance with guidance from HQDA(DASG-PSP), on all applicants less than 68 inches in height. Data will be recorded in item 73.	71½.
52	✓	✓	Record in pounds to the nearest whole pound (without clothing and shoes).	164.
53	✓	✓	Record as black, blond, brown, gray or red.	Brown.
54	✓	✓	Record as blue, brown, gray or green.	Blue.
55	✓	✓	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For definition of obesity see appendix I.	
56	(*)	✓	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°.
★57A	✓	✓	Record for all examinees.	110/76.
★57B C	(*)	✓	Required for initial flying and diving duty.  *For Type A examinations and for continuance on flying and diving duty (Type B), required only if indicated by abnormal history, examination or findings in 57A; e.g., sitting blood pressure exceeds limits prescribed by standards of medical fitness applicable to the purpose of the examination. Abnormal readings should be rechecked as prescribed by paragraph 11-10 or by Cdr, USAAMC, for flying duty examinations.	
★58A	✓	✓	Record for all examinees.	
★58B, C, D and E	(*)	✓	Required for initial flying and diving duty.  *For Type A examinations and for continuance on flying and diving duty (Type B), required only if indicated by abnormal history, examination or findings in 58A; e.g., if A is 100 or more, or below 50. If either D or E is 100 or more, or less than 50, record pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73.	
59	✓	✓	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye.	20/100 corr. to 20/20. 20/50 corr. to 20/20.
★60	(*)	✓	*Refraction required for induction, enlistment and appointment if <i>corrected</i> vision is less than the minimum visual standards stated in paragraph 2-13a, or if deemed appropriate by the examiner regardless of visual acuity.  Cycloplegic required for initial selection for Class 1 and 1A flying duty examinations (preferred agent is cyclopentolate 1%).  The word "manifest" or "cycloplegic," whichever is applicable, will be entered after "refraction."  An emmetropic eye will be indicated by plano or 0.  For corrective lens, record refractive value.	By -150 S +0.25 CX 05. By -150 S +0.25 CX 175.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
61	✓	✓	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20) an entry will be made of the corrected vision for each eye and lens value after the word "by."	20/40 corr. to 20/20 by same. 20/40 corr. to 20/20 by + 0.50.
★62	—	✓	Identify test used; i.e., either Maddox Rod or Stereoscope, Vision Testing, and record results, Prism Div and PD not required. Not required for diving. All subjective tests will be at 20 feet or at a distance setting of SVT.  For flying duty Classes 1, 1A and 2, the following are required: A Cover Test (CT) at near and distance, with an accommodative fixation target (visual acuity letter) in primary position. Distance CT will be performed in horizontal and vertical fields of gaze. A Near Point of Convergence (NPC) will be measured from the anterior corneal surface and reported under "PC" in millimeters. For NPC, accommodative target will be used. An accommodative (Prince) rule will not be used.	Stereoscope, Vision Testing (SVT). ES° 4 EX° 0 R.H. 0 L.H. 0 Prism Div .....CT Ortho. PC 35 PD.
63	—	✓	Record values without using word "diopters" or symbols.	Right 10.0; Left 9.5
★64	✓	✓	Required for all flying duty examinations. For others required only as initial test and subsequently only when indicated. Record results in terms of test used. Pass or Fail—number of plates missed over number of plates in test. The Farnsworth Lantern (FALANT)(USN) may be utilized. If the examinee fails either of these tests, he or she will be tested for red/green color vision and results recorded as "pass" or "fail" red/green (not applicable to flying duty, see paragraph 4-12).	Pseudoisochromatic plate; or POP.  Pass 3/14. Fail 9/14.
★65	—	✓	Identify test used. Record results in "Corrected" or "Uncorrected," as applicable. Enter score for Verhoeff or VTA as "pass" or "fail" plus number missed over maximum score for that test.	Verhoeff pass 0/8. VTA pass through D; fail 1/9.
★66	—	✓	Identify test used and results. If a visual field defect is found or suspected in the confrontation test, a more exact perimetric test is made using the perimeter and tangent screen. Findings are recorded on visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.
★67	—	(*)	*Only if indicated by history, record results. If not indicated, enter "Not Indicated by History (NIBH)."	NIBH.
68	—	✓	Record test results and describe all abnormalities.	Normal.
★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.
70	—	—	Not required. Enter dash in each space.	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
71	✓	✓	Test and record results at 500, 1000, 2000, 3000, 4000 and 6000 cycles.	
★72	(*)	✓	<p>*Only if indicated.</p> <p>Adaptability Rating for Military Aeronautics (ARMA) and Reading Aloud Test (RAT) (appendix X; also AR 40-29) required for initial entry of aviation personnel, Classes 1, 1A, 2 and 3, and air traffic controllers, Class 2A. Enter as "ARMA satisfactory" or "ARMA unsatisfactory." Unsatisfactory ARMA requires a summary of defects responsible for failure in item 73. ARMA, RAT and DA Form 3742 required for service academies and preparatory schools. Results of other psychological testing, when accomplished, will be attached to SF 88.</p> <p>Military Diving Adaptability Rating (MDAR) required for initial entry for diving duty. This rating will include consideration of requirements of paragraph 7-10. If the chamber required for paragraph 7-10d(3) is not available, that test will be conducted at the Naval Diving and Salvage Training School. Include a statement in item 73 in answer to paragraph 7-10q(3) whether he or she has fear of depths, inclosed places or of the dark.</p>	<p>ARMA sat. ARMA unsat.—see item 73.</p> <p>RAT sat.</p> <p>MDAR sat. MDAR unsat.</p>
★73	✓	✓	<p>If SF 93 is not used, the examinee will enter a brief statement about the state of his or her health since his or her last examination. Examiner will enter notes on examination as necessary. Significant medical events in the individual's life, such as major illnesses or injuries, and any illness or injury since the last in-service medical examination, will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof, will be noted where appropriate. Comments from other items may also be continued in this space. If additional space is needed, use SF 507. History and related comments recorded on SF 93, when this form is used, will not be transferred or commented on except as necessary in connection with the examination. All aviation personnel will include and <i>sign</i> the following entry: "I understand I must be cleared by a flight surgeon after hospitalization or sick in quarters (AR 600-105); must inform him or her after treatment or activities which may require restriction (AR 40-8); I have read AR 40-8; I have informed the examining physician of any changes in health since last examination." (Rubber stamp may be used.)</p> <p>Other statements of medical history such as "no history of asthma, allergies, loss of consciousness, or convulsions," etc. may also be used.</p> <p>Results of cardiovascular screening will be entered as follows: Favorable or Unfavorable.</p>	<p>No significant or interval history.</p> <p>Traumatic cataract, left eye, removed 29 July 1964, no comp., see item 59-60 for vision correction.</p> <p>Item 72 cont: History of multiple idiopathic syn-copal attacks.</p>
74	✓	✓	Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect which may be of future significance, such as nonstatic defects which may become worse. Enter item number followed by short, concise diagnosis; do not repeat full description of defect which has already	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
75	✓	✓	been described under the appropriate item. Do not summarize minor, nonsignificant findings. Notation will be made of any further specialized examinations or tests that are indicated. Item 75 will also include the statement "protective mask spectacles required (AR 40-3)" whenever indicated under the criteria set forth in AR 40-3.	
76	✓	✓	The physical profile as prescribed in chapter 9 will be recorded.	1 1 1 1 2 1
77	✓	(*)	*Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5. Though not required, this item may be completed as a recommendation of the examining physician in the case of applicants or nominees for the USMA or the USNA. No entry will be made for USAFA applicants or nominees.	
78	✓	✓	List all disqualifying defects by item number. This listing is required even though the defects are stated in item 74. If qualified, enter a dash.	
★79-81	✓	✓	Enter typed or printed name of examiners. If examination is accomplished for entrance into service academies (USMA, USNA, USAFA, USCGA, USMMA) signatures of physician and dentist are required.  If examination is accomplished for entrance into aviation duty, Classes 1, 1A, 2, 2A, and 3, signature of a military or civilian employee flight surgeon (Army, Navy or Air Force) is required.  Examinations accomplished for enlistment or induction, entrance on active duty of Reserve Component members, and all periodic, discharge, relief from active duty and retirement examinations must be signed by a physician.  Dentist, optometrists, podiatrists, audiologists, nurse practitioners, and physician assistants may also sign attesting to that portion of the examination actually accomplished by them.	
82	(*)	(*)	*See paragraph 10-14d.	

★Notes: 1. When a "Repeat" Class 1 or 1A flying duty examination is required due to examinee not beginning flight training within 12 months from the date of the original Class 1 or 1A examination, the "Repeat" Class 1 or 1A will be identical to the initial examination except that:

- a. If a normal chest X-ray has been reported within the past 3 years, a repeat chest X-ray is not required unless clinically indicated. Information regarding the original X-ray will be recorded in item 45, SF 88.
- b. If a negative test for sickle cell trait is recorded in the health record, a repeat test need not be done. A notation that the test was negative will be recorded in item 50, SF 88.
- c. Anthropometric measurements, if required, may be transcribed from the original SF 88 without being repeated.

All other portions of the flying duty examination, including the cycloplegic refraction, must be repeated.

d. A new Report of Medical History (SF 93) is required in all cases.

2. When flying duty medical examinations are performed on Army personnel at USAF and USN facilities, certain tests may not be available (e.g., RAT) or tests other than those used by the Army may be the only ones available (e.g., Farnsworth Lantern rather than PIP). In such cases, the Cdr, USAAMC, is authorized to waive the requirement or accept the substitute test.

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## CHAPTER 2

### MEDICAL FITNESS STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

#### (Short Title: PROCUREMENT MEDICAL FITNESS STANDARDS)

#### Section I. GENERAL

##### 2-1. Scope

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

##### 2-2. Applicability

These standards apply to—

*a.* Applicants for appointment as commissioned or warrant officers in the Active Army, Army National Guard, and Army Reserve. (Special categories of personnel, such as physicians, dentists, and other specialists, will be procured under standards prescribed by the Secretary of the Army in appropriate personnel procurement program directives.)

*b.* Applicants for enlistment in the Active Army, Army National Guard, and Army Reserve. These standards are applicable until enlistees have completed 4 months of active duty or active duty for training for medical conditions or physical defects existing prior to original enlistment or induction. (See also AR 635-40, AR 635-200, AR 135-178, and NGR 135-178 for administrative procedure for separation for medically unfitting conditions that existed prior to service.)

*★c.* Applicants for reenlistment in the Active Army, Army National Guard, and Army Reserve after a period of more than 6 months has elapsed since discharge.

*★d.* Applicants for the Advanced Course Army ROTC, and other personnel procurement programs,

other than induction, for which these standards are prescribed.

*★e.* Retention of cadets of the United States Military Academy, students enrolled in the Uniformed Services University of Health Sciences, and the Army ROTC programs, except for such conditions that have been diagnosed since entrance into the Academy, University or the ROTC programs. With respect to such conditions, upon recommendation of the Surgeon, United States Military Academy (for USMA cadets), the President, Uniformed Services University of Health Sciences (for students enrolled in that institution), or the Commanding General, United States Army Health Services Command (for ROTC cadets), the medical fitness standards of chapter 3 are applicable for retention in the Academy, the University of Health Sciences, and the ROTC programs, and entrance on active duty or active duty for training in a commissioned or enlisted status.

*★f.* Registrants who undergo preinduction or induction medical examination, except physicians, dentists and allied medical specialists who are to be evaluated under chapter 8.

*g.* Male applicants for enlistment in the US Air Force.

*h.* Male applicants for nonprior service enlistment in the US Navy or Naval Reserve.

*i.* "Changeable accessions" for enlistment in the US Marine Corps or Marine Corps Reserve.

#### Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

##### 2-3. Abdominal Organs and Gastrointestinal System

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

*a.* *Cholecystectomy*, sequelae of, such as post-operative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or postcholecystectomy syndrome

when symptoms are so severe to interfere with normal performance of duty.

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

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

d. *Fistula* in ano.

e. *Gastritis*, chronic hypertrophic, severe.

f. *Hemorrhoids*.

(1) External hemorrhoids producing marked symptoms.

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

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

h. *Hernia*

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

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

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

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

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

l. *Rectum*, stricture or prolapse of.

m. *Resection, gastric or of bowel; or gastroenterostomy*; however, minimal intestinal resection in in-

fancy or childhood (for example: for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

n. *Scars*.

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

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

o. *Sinuses* of the abdominal wall.

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

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

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

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

r. *Ulcer*.

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

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

s. *Other* congenital or acquired abnormalities and defects which preclude satisfactory performance of military duty or which require frequent and prolonged treatment.

## Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

**2-4. Blood and Blood-Forming Tissue Diseases**

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

*a. Anemia:*

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

(2) Deficiency anemia, not controlled by medication.

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

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

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

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

*b. Hemorrhagic states:*

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

(2) Due to platelet deficiency.

(3) Due to vascular instability.

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

*d. Myeloproliferative disease (other than leukemia):*

(1) Myelofibrosis.

(2) Megakaryocytic myelosis.

(3) Polycythemia vera.

*e. Splenomegaly* until the cause is remedied.

*f. Thromboembolic disease* except for acute, nonrecurrent conditions.

## Section IV. DENTAL

### 2-5. Dental

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

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

*b. Malocclusion* severe, which interferes with the mastication of a normal diet.

*c. Oral tissues*, extensive loss of, in an amount that would prevent replacement of missing teeth with a satisfactory prosthetic appliance.

*d. Orthodontic appliances.* See special administrative criteria in paragraph 7-12.

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

## Section V. EARS AND HEARING

### 2-6. Ears

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

*a. Auditory canal.*

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

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

(3) Severe external otitis, acute or chronic.

*b. Auricle.* Agenesis, severe; or severe traumatic deformity, unilateral or bilateral.

*c. Mastoids.*

(1) Mastoiditis, acute or chronic.

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

(3) Mastoid fistula.

*d. Meniere's syndrome.*

*e. Middle ear.*

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

(2) Adhesive otitis media associated with hearing level by audiometric test of 20 dB or more aver-

age for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

(3) Acute or chronic serous otitis media.

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

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

*f. Tympanic membrane.*

(1) Any perforation of the tympanic membrane.

(2) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 20 dB or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

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

### ★ 2-7. Hearing

(See also para 2-6.)

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

*Hearing threshold level* 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. Adrenal gland*, malfunction of, of any degree.

*b. Cretinism.*

*c. Diabetes insipidus.*

*d. Diabetes mellitus.*

*e. Gigantism or acromegaly.*

*f. Glycosuria*, persistent, regardless of cause.

*g. Goiter.*

(1) Simple goiter with definite pressure symptoms or so large in size as to interfere with the wearing of a military uniform or military equipment.

(2) *Thyrotoxicosis.*

*h. Gout.*

*i. Hyperinsulinism*, confirmed, symptomatic.

j. *Hyperparathyroidism* and *hypoparathyroidism*.

k. *Hypopituitarism*, severe.

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

m. *Nutritional deficiency diseases* (including

sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established.

n. *Other endocrine or metabolic disorders* which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

## Section VIII. EXTREMITIES

### 2-9. Upper Extremities

(See para 2-11.)

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

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

(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*.

(a) Pronation to the first quarter of normal arc.

(b) 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 1/3 of the distal phalanx of either thumb.

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

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

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

(4) *Hyperdactylia*.

(5) Scars and deformities of the fingers and/or hand which impair circulation, are symptomatic, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to inter-

fere with the satisfactory performance of military duty.

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

### 2-10. Lower Extremities

(See para 2-11.)

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

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

(1) *Hip*.

(a) Flexion to 90°.

(b) Extension to 10° (beyond 0).

(2) *Knee*.

(a) Full extension.

(b) Flexion to 90°.

(3) *Ankle*.

(a) Dorsiflexion to 10°.

★(b) Plantar flexion to 10°.

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

b. *Foot and ankle*.

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

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

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

(4) *Clubfoot*.

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

(6) Flatfoot, spastic.

(7) Hallux valgus, if severe and associated with marked extostosis 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 tow nails, if severe, and not remediable.

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

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

*c. Leg, knee, thigh, and hip.*

(1) Dislocated semilunar cartilage, loose or foreign bodies within the knee joint, or history of surgical correction of same if—

(a) Within the preceding 6 months.

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

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

*d. General.*

(1) Deformities of one or both lower extremities which have interfered with function to such a degree as to prevent the individual from following a *physically active* vocation in civilian life or which would interfere with the satisfactory completion of

prescribed training and performance of military duty.

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

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

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

**2-11. Miscellaneous**

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

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

*a. Arthritis.*

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

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

(3) Documented clinical history of rheumatoid arthritis.

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

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

*c. Dislocation*, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint, symptomatic and more than mild; or if, subsequent to surgery, there is evidence of more than mild instability in comparison with the normal joint, weakness or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

*d. Fractures.*

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

(3) Any old or recent fracture in which a plate, pin, or screws were used for fixation and left in place and which may be subject to easy trauma; i.e., as a plate tibia, etc.

*e. Injury of a bone or joint* within the preceding 6

weeks, without fracture or dislocation, of more than a minor nature.

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

*f.1. Myotonia congenita*. Confirmed.

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

clinical and X-ray evidence.

*h. Osteoporosis*.

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

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

### Section VIII. EYES AND VISION

#### 2-12. Eyes

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

*a. Lids.*

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

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

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

(5) Disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball.

(6) Growth or tumor of the eyelid other than small early basal cell tumors of the eyelid, which can be cured by treatment, and small nonprogressive asymptomatic benign lesions. See also paragraphs 2-40 and 2-41.

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

(8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

*b. Conjunctiva.*

(1) Conjunctivitis, chronic, including vernal catarrh and trachoma. Individuals with acute conjunctivitis are unacceptable until the condition is cured.

(2) Pterygium:

(a) Pterygium recurring after three operative procedures.

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

*c. Cornea.*

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

(2) Keratitis, acute or chronic.

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

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

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

*e. Retina.*

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

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

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

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

*f. Optic nerve.*

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

(2) Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or

document history of attacks of retrobulbar neuritis.

(3) Optic atrophy (primary or secondary).

(4) Papilledema:

*g. Lens.*

(1) Aphakia (unilateral or bilateral).

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

(3) Opacities of the lens which interfere with vision or which are considered to be progressive.

*h. Ocular mobility and motility.*

(1) Diplopia, documented, constant or intermittent from any cause or of any degree interfering with visual function (i.e., may suppress).

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

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

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

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

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

*i. Miscellaneous defects and diseases.*

(1) Abnormal conditions of the eye or 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 of 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 with spectacle lenses to at least one of the following:

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

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

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

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

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

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

## Section IX. GENITOURINARY SYSTEM

### 2-14. Genitalia

(See also para 2-40 and 2-41.)

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

*a.* Bartholinitis, Bartholin's cyst.

*b.* Cervicitis, acute or chronic manifested by leukorrhea.

*c.* Dysmenorrhea, incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine activities.

*d.* Endometriosis, or confirmed history thereof.

*e.* Hermaphroditism.

*f.* Menopausal syndrome, either physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.

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

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

(1) Absence or nondescent of both testicles.

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

(3) Undescended testicle.

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

*o.* Uterus.

(1) Cervical polyps, cervical ulcer, or marked erosion.

(2) Endocervicitis, more than mild.

(3) Generalized enlargement of the uterus due to any cause.

(4) Malposition of the uterus if more than mildly symptomatic.

*p. Vagina.*

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

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

*q. Varicocele or hydrocele, if large or painful.*

*r. Vulva.*

(1) Leukoplakia.

(2) Vulvitis, acute or chronic.

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

## 2-15. Urinary System

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

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

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

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

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

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

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

*f. Incontinence* of urine.

*g. Kidney.*

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

(2) Acute or chronic infections of the kidney.

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

(4) Hydronephrosis or pyonephrosis.

(5) Nephritis, acute or chronic.

(6) Pyelitis, pyelonephritis.

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

*i. Peyronie's disease.*

*j. Prostate gland, hypertrophy of, with urinary retention.*

*k. Renal calculus.*

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

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

*l. Skeneitis.*

*m. Urethra.*

(1) Stricture of the urethra.

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

*n. Urinary fistula.*

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

## Section X. HEAD AND NECK

### 2-16. Head

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

*a. Abnormalities* which are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. See paragraph 2-31.

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

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

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

*e. Loss or congenital absence* of the bony

substance of the skull not successfully corrected by reconstructive material:

★(1) All cases involving absence of the bony substance of the skull which have been corrected but in which the defect is in excess of 1 square inch or the size of a 25 cent piece, will be referred to the Commander, United States Army Health Services Command together with a report of consultation;

(2) The report of consultation will include an evaluation of any evidence of alteration of brain function in any of its several spheres, i.e., intelligence, judgment, perception, behavior, motor control and sensory function as well as any evidence of active bone disease or other related complications. Current X-rays and other pertinent laboratory data will accompany such a report of consultation.

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

## Section XI. HEART AND VASCULAR SYSTEM

### 2-18. Heart

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

a. *All organic valvular diseases of the heart*, including those improved by surgical procedures.

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

c. *Electrocardiographic evidence* of major arrhythmias such as—

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

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

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

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction;

### 2-17. Neck

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

a. *Cervical ribs* if symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on X-ray is not considered to meet this criterion.)

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

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

d. (Deleted)

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

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

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

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 Commander, United States Army Health Services Command for evaluation.

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

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

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

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

## 2-19. Vascular System

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

*a. Congenital or acquired lesions of the aorta and major vessels*, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

★*b. Hypertension* evidenced by preponderant diastolic blood pressure over 90-mm or preponderant systolic blood pressure over 159 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 ob-

struction 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 by 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.* Height below 60 inches or over 80 inches (see administrative criteria in para 7-13).

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

#### *b. For enlistments and induction.*

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

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

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

## 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 paras 2-9, 2-10, and 2-11.)

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

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

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

## Section XIII. LUNGS AND CHEST WALL

### 2-24. General

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

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

*b. Acute abscess* of the lung.

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

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

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

*f. Acute nontuberculous pneumonia.*

*g. Foreign body in trachea or bronchus.*

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

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

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

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

*l. Recent fracture of ribs, sternum, clavicle, or scapula.*

*m. Significant abnormal findings on physical examination of the chest.*

## 2-25. Tuberculous Lesions

(See para 2-38.)

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

*a. Tuberculosis, active at any time within the past two years, in any form or location. A positive tuberculin skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy because of recent skin test conversion are not disqualified.*

### *b. Rescinded.*

*c. Substantiated history of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.*

## 2-26. Nontuberculous Lesions

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

*a. Acute mastitis, chronic cystic mastitis, if more than mild.*

*b. Bronchial asthma, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.*

*c. Bronchitis, chronic with evidence of pulmonary function disturbance.*

*d. Bronchiectasis.*

*e. Bronchopleural fistula.*

*f. Bullous or generalized pulmonary emphysema.*

*g. Chronic abscess of lung.*

*h. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.*

*i. Chronic mycotic diseases of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual modules demonstrated to be due to mycotic disease.*

*j. Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.*

*k. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion.*

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

*m. Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.*

*n. New growth of breast; history of mastectomy.*

*o. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.*

*p. Pleurisy with effusion of unknown origin within the previous 2 years.*

*q. Sarcoidosis. See paragraph 2-38.*

*r. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.*

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

### 2-27. Mouth

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

*a. Hard palate, perforation of.*

*b. Harelip, unless satisfactorily repaired by surgery.*

*c. Leukoplakia, if severe.*

*d. Lips, unsightly mutilations of, from*

wounds, burns, or disease.

*e. Ranula, if extensive. For other tumors see paragraphs 2-10 and 2-41.*

### 2-28. Nose

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

*a. Allergic manifestations.*

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

b. *Choana, atresia, or stenosis* of, if symptomatic.

c. *Nasal septum*, perforation of:

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

(2) If progressive.

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

d. *Sinusitis*, acute.

e. *Sinusitis*, chronic, when more than mild:

(1) Evidenced by any of the following:

Chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues, or symptoms requiring frequent medical attention.

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

## 2-29. Pharynx, Trachea, Esophagus, and Larynx

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

a. *Esophagus*, organic disease of, such as ulceration, varices, achalasia; peptic esopha-

gitis; if confirmed by appropriate X-ray or esophagosopic examinations.

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

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

★d. *Plica dysphonia 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* (para 2-42)

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

## Section XV. NEUROLOGICAL DISORDERS

### 2-31. Neurological Disorders

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

a. *Degenerative disorders*.

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

b. *Miscellaneous*.

(1) Congenital malformations if associ-

ated 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 pare-

sis, tabes dorsalis, meningovascular syphilis).

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

e. *Peripheral nerve disorder*.

## 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.

(1) Polyn neuritis.

(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.

(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.

★(5) Drug abuse characterized by—

(a) The evidence of use of any narcotic drug, barbiturate, amphetamine or hallucinogenic substance at time of examination when the use cannot be accounted for as the result of the advice of a recognized health care practitioner.

(b) Use, other than that prescribed by a recognized health care practitioner, of any narcotic drug within a 1-year period prior to examination.

(c) The repeated use of any drug or chemical substance, including marijuana; with such frequency that it appears that the examinee has accepted the use of or reliance on these substances as part of his pattern of behavior (see also: TB MED 290; NAVMED P-5116; AFP 160-33).

(d) Cases indicating use of marijuana (not habitual use) or experimental or casual use of other drugs, except as indicated in (b) above, may be waived by competent authority, as established by the respective service, providing there is no history of repeated drug uses and there is evidence of current drug abstinence and the individual is otherwise qualified for service.

★(6) Alcohol abuse. The cause of rejection for appointment, enlistment and induction is the repeated irresponsible use of alcoholic beverages which leads to misconduct, unacceptable social behavior or impairment of an individual's performance in his place of

employment or educational facility, physical or mental health, financial responsibility or personal relationships within 1 year of examination (see also: TB MED 290; NAVMED P-5116; AFP 160-33).

*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 ad-

justment in school, with employers and fellow-workers, and other society groups.

*c. Other symptomatic immaturity reactions* such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) and stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

*d. Specific learning defects* secondary to organic or functional mental disorders.

## Section XVII. SKIN AND CELLULAR TISSUES

### 2-35. Skin and Cellular Tissues

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

*a. Acne.* Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment.

*b. Atopic dermatitis.* With active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, occasionally wrists and hands), or documented history thereof.

*c. Cysts.*

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

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

*d. Dermatitis factitia.*

*e. Dermatitis herpetiformis.*

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

*f. 1 Elephantiasis or chronic lymphedema.*

*g. Epidermolysis bullosa; pemphigus.*

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

*i. Furunculosis.* Extensive, recurrent, or chronic.

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

*k. Ichthyosis.* Severe.

*l. Leprosy.* Any type.

*m. Leukemia cutis mycosis fungoides; Hodgkin's disease.*

*n. Lichen planus.*

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

*p. Neurofibromatosis* (Von Recklinghausen's disease).

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

*r. Psoriasis* or a verified history thereof.

*s. Radiodermatitis.*

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

*u. Scleroderma.* Diffuse type.

*v. Tuberculosis.* See paragraph 2-38.

*w. Urticaria.* Chronic.

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

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

*z. Any other chronic skin disorder* of a degree or nature which requires frequent outpatient treatment or hospitalization, in-

terferes with the satisfactory performance of duty, or is so disfiguring as to make the individual objectionable in ordinary social relationships.

*aa.* When in the opinion of the examining

physician tattoos will significantly limit effective performance of military service the individual will be referred to the AFEEES Commander, for final determination of acceptability.

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

#### 2-36. Spine and Sacroiliac Joints

(See also para 2-11.)

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

- a. *Arthritis*. See paragraph 2-11a.
- b. *Complaint of disease or injury of the spine or sacroiliac joints* either with or without objective signs which has prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without objective signs is required.
- c. *Deviation or curvature of spine* from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis) if—
  - (1) Mobility and weight-bearing power is poor.
  - (2) More than moderate restriction of normal physical activities is required.
  - (3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.
  - (4) Of a degree which will interfere with the wearing of a uniform or military equipment.
  - (5) Symptomatic associated with positive physical finding(s) and demonstrable by X-ray.
- d. *Diseases of the lumbosacral or sacroiliac joints* of a chronic type and obviously associated with pain referred to the lower extremities, muscular spasm, postural deformities and limitation of motion in the lumbar region of the spine.
- e. *Granulomatous diseases* either active or healed.

f. *Healed fracture of the spine or pelvic bones* with associated symptoms which have prevented the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

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

h. *Spondylolysis or spondylolisthesis* that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

#### 2-37. Scapulae, Clavicles, and Ribs

(See para 2-11.)

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

- a. *Fractures*, until well-healed, and until determined that the residuals thereof will not preclude the satisfactory performance of military duty.
- b. *Injury within the preceding 6 weeks*, without fracture, or dislocation, of more than a minor nature.
- c. *Osteomyelitis* of rib, sternum, clavicle, scapula, or vertebra.
- d. *Prominent scapulae* interfering with function or with the wearing of uniform or military equipment.

### Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

#### 2-38. Systemic Diseases

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

- a. *Dermatomyositis*.
- b. *Lupus erythematosus*, acute, subacute, or chronic.
- c. *Progressive systemic sclerosis*.
- d. *Reiter's disease*.
- e. *Sarcoidosis*.
- f. *Scleroderma*, diffuse type.
- g. *Tuberculosis*.
  - (1) Active tuberculosis in any form or location or substantiated history of active tuberculosis within the previous 2 years.
  - (2) Substantiated history of one or more reactions or relapses of tuberculosis in any form or

location or other definite evidence of poor host resistance to the tubercle bacillus.

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

#### 2-39. General and Miscellaneous Conditions and Defects

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

- a. *Allergic manifestations*.
  - (1) Allergic rhinitis (hay fever). See paragraph 2-28.
  - (2) Asthma. See paragraph 2-26b.
  - (3) Allergic dermatoses. See paragraph 2-35.

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

(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of severe generalized reaction to common foods; e.g., milk, eggs, beef, and pork.

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

c. *Any deformity which is markedly unsightly* or which impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

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

e. *Cold injury*, residuals of (example: frostbite, chilblain, immersion foot, or trench foot), such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or anklyosis.

★f. *Reactive tests for syphilis* such as the RPR or VDRL followed by a reactive, confirmatory Fluorescent Treponemal Antibody Absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clin-

ical findings, the presence of a reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified or if the test reverts to a non-reactive status during an appropriate follow-up period (3-6 months).

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

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

i. *Industrial solvent* and other chemical intoxication, chronic including carbon bisulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

j. *Mycotic infection* of internal organs.

k. *Myositis or fibrositis*; severe, chronic.

l. *Residuals of tropical fevers* and various parasitic or protozoal infestations which in the opinion of the medical examiner preclude the satisfactory performance of military duty.

## Section XX. TUMORS AND MALIGNANT DISEASES

### 2-40. Benign Tumors

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

a. *Any tumor of the—*

(1) Auditory canal, if obstructive.

(2) Eye or orbit, (para 2-12a(6)).

(3) Kidney, bladder, testicle, or penis.

(4) Central nervous system and its membranous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or of original lesion.

b. *Benign tumors of the abdominal wall* if sufficiently large to interfere with military duty.

c. *Benign tumors of bone* likely to continue to enlarge, be subjected to trauma during military service, or show, malignant potential.

d. *Benign tumors of the thyroid* or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to interfere

with the wearing of a uniform or military equipment.

e. *Tongue, benign tumor of*, if it interferes with function.

f. *Breast, thoracic contents, or chest wall*, tumors of, other than fibromata lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

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

### 2-41. Malignant Diseases and Tumors

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

a. *Leukemia*, acute or chronic.

b. *Malignant lymphomata*.

c. *Malignant tumor*, except for small early basal cell epitheliomas, at any time, even though surgically removed, confirmed by accepted laboratory procedures.

**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 ade-

quate treatment of syphilis is not in itself considered evidence of chronic venereal disease which has not responded to treatment (para 2-39f).

*b. Complications and permanent residuals* of venereal disease if progressive, of such nature as to interfere with the satisfactory performance of duty, or if subject to aggravation by military service.

*c. Neurosyphilis.* See paragraph 2-31c.

are in effect) will be processed as prescribed in AR 140-120 for members of the Army Reserve, or NGR 25-3, NGR 40-501, or NGR 40-3 for members of the Army National Guard of the United States, for disability separation or continuance in their Reserve status as prescribed in the cited regulations. Members of the Army National Guard and Army Reserve who may be unfit because of physical disability resulting from injury incurred during a period of active duty training of 30 days or less, or active duty for training for 45 days ordered because of unsatisfactory performance of training duty, or inactive duty training will be processed as prescribed in AR 40-3 and AR 635-40.

★ *d.* Members on extended active duty who meet retention medical fitness standards, but may be administratively unfit or unsuitable will be reported to the appropriate commander for processing as provided in other regulations, such as AR 635-200.

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

### 3-5. Abdominal and Gastrointestinal Defects and Diseases

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

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

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

*d. Cirrhosis of the liver.* Recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom.

*e. Gastritis.* Severe, chronic hypertrophic gastritis and repeated symptomatology and hospitalization, and confirmed by gastroscopic examination.

*f. Hepatitis, chronic.* When, after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

*g. Hernia.*

(1) *Hiatus hernia.* Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

(2) *Other.* If operative repair is contra-indicated for medical reasons or when not amenable to surgical repair.

★ *h. Ileitis, regional.*

*e.* Members on active duty who meet retention medical fitness standards, but who failed to meet procurement medical fitness standards on initial entry into the service (erroneous appointment, enlistment, or induction), may be processed for separation as provided in AR 635-120, AR 635-200, or AR 135-178 if otherwise qualified.

★ FOR ACTIVE ARMY MEMBERS; THE FOLLOWING SECTIONS II THROUGH XX SET FORTH, BY BROAD GENERAL CATEGORY, THOSE MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH REQUIRE MEDICAL BOARD ACTION AND REFERRAL TO A PHYSICAL EVALUATION BOARD. (USAR AND ARNG MEMBERS NOT ON ACTIVE DUTY WILL BE PROCESSED IN ACCORDANCE WITH AR 135-175, AR 135-178, AR 140-10 and NGR 600-200, AS APPROPRIATE.)

*i. Pancreatitis, chronic.* Frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

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

*k. Proctitis, chronic.* Moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea, and repeated admissions to the hospital.

*l. Ulcer, peptic, duodenal, or gastric.* Repeated hospitalization or "sick in quarters" because of frequent recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory and X-ray evidence of activity.

*m. Ulcerative colitis.* Except when responding well to treatment.

*n. Rectum, stricture of.* Severe symptoms of obstruction characterized by intractable constipation, pain or defecation, difficult bowel movements, requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

### 3-6. Gastrointestinal and Abdominal Surgery.

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

*b. Colostomy.* Per se, when permanent.

*c. Enterostomy.* Per se, when permanent.

*d. Gastrectomy.*

(1) Total, per se.

(2) Subtotal, with or without vagotomy, or gastro-jejunostomy with or without vagotomy, when, in spite of good medical management, the individual:

(a) Develops "dumping syndrome" which persists for 6 months postoperatively, or

(b) Develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively, or

(c) Continues to demonstrate appreciable weight loss 6 months postoperatively.

*e. Gastrostomy.* Per se, when permanent.

*f. Ileostomy.* Per se, when permanent.

*g. Pancreatectomy.* Per se.

*h. Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy.* Followed by more than mild symptoms of digestive disturbance, or requiring insulin.

*i. Proctectomy.* Per se.  
*j. Proctopexy, proctoplasty, proctorrhaphy, or proctotomy.* If fecal incontinence remains after an appropriate treatment period.

### Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

#### 3-7. Blood and Blood-Forming Tissue Diseases

When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision. See also paragraph 3-38.

*a. Anemia.*

*b. Hemolytic crisis, chronic and symptomatic.*

*c. Leukopenia, chronic.*

*d. Polycythemia.*

*e. Purpura and other bleeding diseases.*

*f. Thromboembolic disease.*

*g. Splenomegaly, chronic.*

### Section IV. DENTAL

#### 3-8. Dental Diseases and Abnormalities of the Jaws

Diseases of the jaws or associated tissues when, following restorative surgery, there remain re-

siduals which are incapacitating, or interfere with the individual's satisfactory performance of military duty, or leave unsightly deformities which are disfiguring.

### Section V. EARS AND HEARING

#### 3-9. Ears

*a. Infections of the external auditory canal.* Chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

*b. Malfunction of the acoustic nerve.* Evaluate functional impairment of hearing under paragraph 3-10.

*c. Mastoiditis, chronic.* Constant drainage

from the mastoid cavity, requiring frequent and prolonged medical care.

*d. Mastoiditis, chronic, following mastoidectomy.* Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.

*e. Meniere's syndrome.* Recurring attacks of sufficient frequency and severity as to interfere with the satisfactory performance of duty, or requiring frequent or prolonged medical care or hospitalization.

(2) *Congenital anomaly*. Bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) *Cystic kidney (polycystic kidney)*. When symptomatic and renal function is impaired or is the focus of frequent infection.

(4) *Glomerulonephritis, chronic*.

(5) *Hydronephrosis*. More than mild, bilateral, and causing continuous or frequent symptoms.

(6) *Hypoplasia of the kidney*. Symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) *Nephritis, chronic*.

(8) *Nephrosis*.

(9) *Perirenal abscess*. Residuals of a degree which preclude the satisfactory performance of duty.

(10) *Pyelonephritis or pyelitis*. Chronic, which has not responded to medical or surgical treatment, with evidence of hypertension, eye-ground changes, or cardiac abnormalities.

(11) *Pyonephrosis*. Not responding to treatment.

*g. Menopausal syndrome, physiologic or artificial*. More than mild mental and constitutional symptoms.

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

*i. Urethritis, chronic*. Not responsive to treatment and necessitating frequent absences from duty.

### 3-18. Genitourinary and Gynecological Surgery

#### *a. Cystectomy*.

*b. Cystoplasty*. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.

*c. Hysterectomy*. When residual symptoms or complications preclude the satisfactory performance of duty.

*d. Nephrectomy*. When, after treatment, there is infection or pathology in the remaining kidney.

*e. Nephrostomy*. If drainage persists.

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

*g. Pyelostomy*. If drainage persists.

*h. Ureterocolostomy*.

*i. Ureterocystostomy*. When both ureters are markedly dilated with irreversible changes.

*j. Ureteroileostomy cutaneous*.

*k. Ureteroplasty*.

(1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

(2) When bilateral, evaluate residual obstruction or hydronephrosis and consider fitness on the basis of the residuals involved.

*l. Ureterosigmoidostomy*.

*m. Ureterostomy*. External or cutaneous.

*n. Urethroostomy*. Complete amputation of the penis or when a satisfactory urethra cannot be restored.

*★o. Kidney transplant*. Recipient of a kidney transplant.

## Section X. HEAD AND NECK

### 3-19. Head

(See also para 3-27.)

Loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms such as described in paragraph 3-28.

### 3-20. Neck

(See also para 3-11.)

*Torticollis (wry neck)*: Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

## Section XI. HEART AND VASCULAR SYSTEM

### 3-21 Heart

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

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

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

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

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

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

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

#### *h. Pericarditis.*

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

(2) Chronic serous pericarditis.

*i. Rheumatic valvulitis.* Cardiac insufficiency at functional capacity and therapeutic level of Class IIC or worse as defined by the American Heart Association (app VII). A diagnosis made during the initial period of service or enlistment which is determined to be a residual of a condition which existed prior to entry in the service should be considered unfitting regardless of the degree of severity.

*j. Ventricular premature contractions.* Frequent or continuous attacks, whether or not associated with organic heart disease, accompanied by discomfort or fear of such a degree as

to interfere with the satisfactory performance of duty.

### 3-22. Vascular System

*a. Arteriosclerosis obliterans.* When any of the following pertain:

(1) Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest, or

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain, or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity, or

(3) Involvement of more than one organ, system, or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency, or

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

*★c. Aneurysms.* Aneurysms of any vessel.

*d. Periarteritis nodosa.* With definite evidence of functional impairment.

*e. Chronic venous insufficiency (post-phlebotic syndrome).* When more than mild and symptomatic despite elastic support.

*f. Raynaud's phenomenon.* Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.

*g. Thromboangitis obliterans.* Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other complications.

*h. Thrombophlebitis.* When repeated attacks requiring treatment are of such frequency as to interfere with the satisfactory performance of duty.

*i. Varicose veins.* Severe and symptomatic despite therapy.

**3-23. Miscellaneous**

*a. Erythromelalgia.* Persistent burning pain in the soles or palms not relieved by treatment.

*b. Hypertensive cardiovascular disease and hypertensive vascular disease.*

(1) Diastolic pressure consistently more than 110 millimeters of mercury following an adequate period of therapy on an ambulatory status, or

(2) Any documented history of hypertension, regardless of the pressure values, if associated with one or more of the following:

(a) More than minimal changes in the brain.

(b) Heart disease.

(c) Kidney involvement, with moderate impairment of renal function.

(d) Grade III (Keith-Wagner-Barker) changes in the fundi.

*c. Rheumatic fever, active, with or without heart damage.* Recurrent attacks.

*★d. Residual of surgery of the heart, pericardium, or vascular system* resulting in inability of the individual to perform duties without discomfort or dyspnea. When the surgery involves insertion of a pacemaker, coronary artery revascularization, reconstructive vascular surgery employing exogenous grafting material, or similar newly developed techniques or prostheses, the individual will be required to undergo medical and physical evaluation board processing.

*j. Myelopathy, transverse.*

*k. Narcolepsy.* When attacks are not controlled by medication.

*l. Paralysis, agitans.*

*m. Peripheral nerve conditions.*

(1) *Neuralgia.* When symptoms are severe, persistent, and not responsive to treatment.

(2) *Neuritis.* When manifested by more than moderate, permanent functional impairment.

(3) *Paralysis due to peripheral nerve injury.* When manifested by more than moderate, permanent functional impairment.

*n. Syringomyelia.*

★*o. General.* Any other neurological condition, regardless of etiology, when, after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

### Section XV. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS.

#### 3-29. Psychoses

Recurrent psychotic episodes, existing symptoms, or residuals thereof, or a recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.

#### 3-30. Psychoneuroses

Persistence of severity of symptoms sufficient to require frequent hospitalization, or the lack of improvement of symptoms by hospitalization, or the necessity for duty in a very protected environment. (Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder).

#### 3-31. Personality Disorders

*a. Character and behavior disorders.* Character and behavior disorders are considered to render an individual administratively unfit rather than unfit because of physical disability. Interference with

performance of effective duty will be dealt with through appropriate administrative channels.

*b. Transient personality disruptions.* Transient personality disruptions of a nonpsychotic nature and situational maladjustments due to acute or special stress do not render an individual unfit because of physical disability.

*c. Sexual deviate.* Confirmation of abnormal sexual practices which are not a manifestation of psychiatric disease provides a basis for medical recommendation for administrative separation or other nondisability disposition.

#### 3-32. Disorders of Intelligence

Individuals determined to have primary mental deficiency or special learning defect of such degree as to interfere with the satisfactory performance of duty are administratively unfit and should be recommended for administrative separation.

### Section XVI. SKIN AND CELLULAR TISSUES

#### 3-33. Skin and Cellular Tissues

*a. Acne.* Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

*b. Atopic dermatitis.* More than moderate or requiring periodic hospitalization.

*c. Amyloidosis.* Generalized.

*d. Cysts and tumors.* See section XIX.

*e. Dermatitis herpetiformis.* Which fails to respond to therapy.

*f. Dermatomyositis.*

*g. Dermographism.* Interfering with the satisfactory performance of duty.

*h. Eczema, chronic.* Regardless of type, when

there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

*i. Elephantiasis or chronic lymphedema.* Not responsive to treatment.

*j. Epidermolysis bullosa.*

*k. Erythema multiforme.* More than moderate, chronic or recurrent.

*l. Exfoliative dermatitis.* Chronic.

*m. Fungus infections, superficial or systemic types.* If not responsive to therapy and interfering with the satisfactory performance of duty.

*n. Hidradenitis suppurative and folliculitis decalvans.*

*o. Hyperhidrosis.* On the hands or feet, when

severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

*p. Leukemia cutis and mycosis fungoids.*

*q. Lichen planus.* Generalized and not responsive to treatment.

*r. Lupus erythematosus.* Chronic discoid variety with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

*s. Neurofibromatosis.* If repulsive in appearance or when interfering with the satisfactory performance of duty.

*t. Panniculitis.* Relapsing, febrile, nodular.

*u. Parapsoriasis.* Extensive and not controlled by treatment.

*v. Pemphigus.* Not responsive to treatment and with moderate constitutional or systemic symptoms, or interfering with the satisfactory performance of duty.

*w. Psoriasis.* Extensive and not controllable by treatment.

*x. Radiodermatitis.* If resulting in malignant degeneration at a site not amenable to treatment.

*y. Scars and keloids.* So extensive or adherent that they seriously interfere with the function of an extremity.

*z. Scleroderma.* Generalized, or of the linear type which seriously interferes with the function of an extremity.

*aa. Tuberculosis of the skin.* See paragraph 3-35h(7).

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

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

*ad. Xanthoma.* Regardless of type, but only when interfering with the satisfactory performance of duty.

*ae. Other skin disorders.* If chronic, or of a nature which requires frequent medical care or interferes with the satisfactory performance of military duty.

#### Section XVII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

##### 3-34. Spine, Scapulae, Ribs, and Sacroiliac Joints

(See also para 3-14.)

###### *a. Congenital anomalies.*

(1) *Dislocation, congenital, of hip.*

(2) *Spina bifida.* Demonstrable signs and moderate symptoms of root or cord involvement.

(3) *Spondylolysis or spondylolisthesis.* With

more than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization, or significant assignment limitations.

*b. Coxa vara.* More than moderate with pain, deformity, and arthritic changes.

★*c. Herniation of nucleus pulposus.* More than mild symptoms following appropriate

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

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

ing with function, or causing unmilitary appearance.

*e. Scoliosis.* Severe deformity with over 2 inches deviation of tips of spinous process from the midline.

## Section XVIII. SYSTEMIC DISEASES, AND MISCELLANEOUS CONDITIONS AND DEFECTS

### 3-35. Systemic Diseases

*a. Amyloidosis.*

*b. Blastomycosis.*

*c. Brucellosis.* Chronic with substantiated, recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.

*d. Leprosy.* Any type.

*e. Lupus erythematosus disseminated, chronic.*

*f. Myasthenia gravis.*

*g. Mycosis*—active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals which themselves are unfitting.

*h. Panniculitis,* relapsing, febrile, nodular.

*i. Porphyria cutanea tarda.*

*j. Sarcoidosis.* Progressive with severe or multiple organ involvement and not responsive to therapy.

*k. Tuberculosis.*

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis, tuberculous empyema, and tuberculous pleurisy.

(3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(4) Tuberculosis of the female genitalia.

(5) Tuberculosis of kidney.

(6) Tuberculosis of the larynx.

(7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals and complications.

### 3-36. General and Miscellaneous Conditions and Defects

*a. Allergic manifestations.*

(1) *Allergic rhinitis.* See paragraphs 3-27d and e.

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

(3) *Allergic dermatoses.* See paragraph 3-33.

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

*b. Cold injury.* Evaluate on severity and extent of residuals, or loss of parts as outlined in paragraphs 3-12 and 3-13. See also TB MED 81.

★*c. Miscellaneous conditions and defects.* Conditions and defects, individually or in combination, if—

(1) The individual is 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 impairment but a combination of two or more impairments may be considered to render

the individual unfit will be referred to physical evaluation boards.

d. Exceptionally, as regards members of the National Guard of the United States and the Army Reserve, not on active duty, medi-

cal conditions and physical defects of a progressive nature approaching the levels of severity described as unfitting in other parts of this chapter, when unfitness within a short time may be expected.

## Section XIX. TUMORS AND MALIGNANT DISEASES

### 3-37. Malignant Neoplasms

a. *Malignant neoplasms* which are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

b. *Malignant neoplasms* in individuals on active duty when they are of such a nature as to preclude satisfactory performance of duty, and treatment is refused by the individual.

c. *Presence of malignant neoplasms* or reasonable suspicion thereof when an individual not on active duty is unwilling to undergo treatment or appropriate diagnostic procedures.

d. *Malignant neoplasms*, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

### 3-38. Neoplastic Conditions of Lymphoid and Blood-Forming Tissues

Neoplastic conditions of the lymphoid and blood-forming tissues normally render an individual unfit for further military service.

### 3-39. Benign Neoplasms

a. *Benign tumors*, except as noted in b below, are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment should be considered unfit only if their condition precludes their satisfactory performance of military duty.

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

(1) Ganglioneuroma.

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

## Section XX. VENEREAL DISEASES

### 3-40. Venereal Diseases

a. *Symptomatic neurosyphilis* in any form.

b. *Complications or residuals of venereal*

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

**CHAPTER 4**  
**MEDICAL FITNESS STANDARDS FOR FLYING DUTY**  
**(Short Title: MEDICAL FITNESS STANDARDS FOR FLYING)**

**Section I. GENERAL**

**4-1. Scope**

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

*a. Army aviator or training leading to such designation.*

★ *b. Military air traffic controller.*

★ *c. Contract civilian pilot.*

*d. Flight surgeon.*

*e. Individuals ordered by competent authority to participate in regular and frequent aerial flights as nonrated personnel.*

**4-2. Classes of Medical Standards for Flying and Applicability**

The established classes of medical fitness standards for flying duties and their applicability are as follows—

★ *a. Class 1 or 1A standards apply to—*

(1) Individuals being considered for training leading to an Army aviator aeronautical rating.

(2) Student aviators until completion of flight training.

(3) Individuals being considered for the Army ROTC Flight Training Program or US Military Academy Cadet Military Specialty Training Program (Aviation).

★ *b. Class 2 standards apply to—*

(1) Individuals being considered for or performing duty as military air traffic controllers, except as noted.

(2) Individuals on flying status as an Army aviator.

(3) Army aviators being considered for return to flying status.

(4) Civilian pilots who are employees of firms under contract to Department of the Army.

★ *c. Class 3 standards apply to individuals ordered by competent authority to participate in regular and frequent aerial flights not engaged in actual control of aircraft, including flight surgeons, observers, crew chiefs, and gunners.*

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

*a. Applicants.* The reports of medical examination pertaining to applicants who do not meet the medical fitness standards for flying as prescribed herein will nevertheless be processed for review by the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362, as prescribed in the appropriate procurement regulation.

★ *b. Personnel on Flying Status.* Individuals who do not meet the medical fitness standards for flying as prescribed herein will be immediately medically restricted from flying as outlined in AR 600-107, unless they have previously been continued in flying status for the same defect by designated higher authority, in which case they may be permitted to fly until the continuance is confirmed, provided the condition is essentially unchanged and the flying safety and the individual's well-being are not compromised.

*c. Medical consultation service.* A central Army Aviation Medicine Consultation Service (AMCS) is established at the US Army Aeromedical Center, Fort Rucker, AL 36362. Consultation services are available to unit flight surgeons, command surgeons and the Commanding General, United States Army Health Services Command. Normally, requests for consultation by surgeons of higher headquarters will be initiated through unit flight surgeons to facilitate availability of essential medical records and related data. Medical consultation will not be requested by individual aviators nor by aviation unit commanders.

(1) Any individual on flying status may be referred for aviation medicine consultation by proper medical authority.

(2) An individual who is suspended from flying for medical reasons can only be referred to the AMCS by an authority equal to or higher than the one who suspended him.

(3) Army Reserve and Army National Guard personnel not on active duty may be referred

through the Army area commander or Chief, National Guard Bureau, as appropriate.

(4) Other than US Army aviation personnel may be referred to the AMCS provided prior approval of the Commanding General, US Army

Health Services Command, is obtained.

★(5) Requests for aviation medicine consultation will be forwarded direct to: Commander, US Army Aeromedical Center, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362.

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

### 4-4. Abdomen and Gastrointestinal System

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

a. *Enlargement of liver*, except when liver function tests are normal with no history of jaundice (other than simple catarrhal), and the condition does not appear to be caused by active disease.

b. *Functional bowell distress syndrome* (irritable colon).

★c. *Hernia* of any variety, other than small asymptomatic umbilical.

d. *History of bowel resection* for any cause (ex-

cept appendectomy) or operation for relief of intestinal adhesions. In addition, pylorotomy in infancy, without complications at present, will not, per se, be cause for rejection.

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

f. *Ulcer*.

(1) *Classes 1 and 1A*. See paragraph 2-3r.

(2) *Classes 2 and 3*. Until reviewed by the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362.

## Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

### 4-5. Blood and Blood-Forming Tissue Diseases.

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

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

*Sickle cell trait or sickle cell disease*. (Sickle cell trait is not disqualifying for ATC personnel.)

## Section IV. DENTAL

### 4-6. Dental

The causes of medical unfitness for flying duty

Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-5.

## Section V. EARS AND HEARING

### 4-7. Ears

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-6, plus the following:

a. *Abnormal labyrinthine function* when determined by appropriate tests.

b. *Any infectious process of the ear*, including external otitis, until completely healed.

c. *Deformities of the pinna* if associated with tenderness which may be distracting when constant pressure is exerted.

d. *History of attacks of vertigo* with or without nausea, vomiting, deafness, and tinnitus.

e. *Marked retraction of the tympanic membrane* if mobility is limited or if associated with occlusion of the eustachian tubes.

f. *Post auricular fistula*.

g. *Radical mastoidectomy*.

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

i. *Simple mastoidectomy and modified radical mastoidectomy* until recovery is complete and the ear is functionally normal.

j. *Tympanoplasty*.

(1) *Classes 1 and 1A*. Tympanoplasty at any time.

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

### ★4-8. Hearing

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are—Hearing loss in decibels greater than shown in table 2, appendix II.

## Section VI. ENDOCRINE AND METABOLIC DISEASES

### 4-9. Endocrine and Metabolic Diseases

The causes of medical unfitness for flying duty

Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-8.

## Section VII. EXTREMITIES

### 4-10. Extremities

The causes of medical unfitness for flying duty  
Classes 1, 1A, 2, 3 are the causes listed in paragraphs 2-9, 2-10, 2-11, and 4-23, plus *limitation of motion*.

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

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

## Section VIII. EYES AND VISION

### 4-11. Eyes

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

- a. *Asthenopia of any degree.*
- b. *Chorioretinitis* or substantiated history thereof.
- c. *Coloboma* of the choroid or iris.
- d. *Epiphora.*
- e. *Inflammation of the ureal tract; acute, chronic, or recurrent.*
- f. *Pterygium* which encroaches on the cornea more than 1 mm or is progressive, as evidenced by marked vascularity or a thick elevated head.
- g. *Trachoma* unless healed without cicatrices.
- ★h. *Abnormal intraocular tension* by tonometry.

### 4-12. Vision

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

- a. *Class 1.*
  - (1) *Color vision.*
    - (a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set, or
    - (b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set.
    - (c) When administered in lieu of (a) or (b) above, failure to pass the Farnsworth Lantern Test (FALANT) (USN Test).
  - (2) *Depth perception.*
    - (a) Any error in lines B, C, or D when using the Machine Vision Tester. Not applicable to ATC.
    - (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 or anatomic.

(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; 6 prism diopters for ATC.

(c) Exophoria greater than 5 prism diopters; 6 prism diopters for ATC.

(d) Hyperphoria greater than 1 prism diopter.

(e) Heterotropia, any degree.

★(f) Near point of convergence (NPC) greater than 70 mm.

★(8) *Power of accommodation* of less than minimum for age as shown in appendix V. Not applicable to continuance for ATC duty.

(9) *Refractive error.*

(a) Astigmatism in excess of 0.75 diopter.

(b) Hyperopia in excess of 1.75 diopter in any meridian.

(c) Myopia in excess of 0.25 diopter in any meridian.

b. *Class 1A.* Same as Class 1 except as listed below.

(1) *Distant visual acuity.* Uncorrected less than 20/50 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(2) *Near visual acuity.*

(a) *Individuals under age 35.* Uncorrected, less than 20/20 (J-1) in each eye.

(b) *Individuals age 35 or over.* Uncorrected, less than 20/50 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(3) *Refractive error.*

(a) Astigmatism greater than 0.75 diopter.

(b) Hyperopia.

1. *Individuals under age 35.* Greater than 1.75 diopter in any meridian.

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

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

★ *c. Class 2.* Same as Class 1 except as listed below—

(1) *Distant visual acuity.*

(a) *Air traffic controller.* Uncorrected that is worse than 20/200 in either eye or such acceptable uncorrected vision that fails to correct with spectacle lenses to 20/20 in each eye.

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

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

(a) *Near visual acuity.* Uncorrected less than

20/100 in each eye or not correctable with spectacle lenses to at least 20/20 in each eye.

(b) *Air traffic controller.*

1. For entrance into training, applicant must have 20/20 uncorrected near vision or better in each eye separately, or 20/50 or better in each eye separately correctable to 20/20.

2. For continuance, near visual acuity must be 20/20 or better in each eye separately, with or without correction.

(3) *Ocular motility.*

(a) Hyperphoria greater than 1.5 prism diopters, greater than 1 prism diopter for ATC.

(b) Failure of the Red Lens Test (suppression or diplopia within 20 inches from the center of the screen in any of the six cardinal directions) until a complete evaluation by a certified ophthalmologist has been forwarded to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker AL 36362.

d. *Class 3.*

★(1) *Color vision.* Same as Class 1, a(1) above.

(2) *Distant visual acuity.* Uncorrected less than 20/200 in each eye, not correctable to 20/20 in each eye with spectacle lenses.

(3) *Near visual acuity, field of vision, depth perception.* 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 or surgically removed 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 or surgically removed 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; or facial paralysis.*

## Section XI. HEART AND VASCULAR SYSTEM

### 4-15. Heart and Vascular System

The causes for unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-18, 2-19, and 2-20, plus the following:

a. *Abnormal slowing of the pulse, fall in blood pressure, or alteration in cerebral circulation* resulting in fainting or syncope because of digital pressure on either carotid sinus (abnormal carotid sinus reflex).

b. *A substantial history of paroxysmal supraventricular arrhythmias*, such as paroxysmal atrial tachycardia, nodal tachycardia, atrial flutter, and atrial fibrillation.

c. *A history of paroxysmal ventricular tachycardia.*

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

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

f. *Blood pressure.*

(1) *Preponderant systolic*—not less than 90 mm. or over 140 mm for individuals 35 years of age and under.

(2) *Preponderant systolic*—not less than 90 mm or over 150 mm for individuals over 35 years of age.

(3) *Diastolic*—not less than 60 mm nor more than 90 mm regardless of age.

g. *Unsatisfactory orthostatic tolerance test.*

h. *Electrocardiographic.*

(1) Borderline ECG findings until reviewed by the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362.

(2) Left bundle branch block.

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

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

(5) Short P-R interval and prolonged QRS time (Wolff-Parkinson-White syndrome) or other short P-R interval syndromes predisposing to paroxysmal arrhythmias. In cases involving Class 2 or Class 3 examinations, a complete cardiac evaluation, include ECG's will be forwarded to the Commander, USAAMC; ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 for review.

## Section XII. HEIGHT, WEIGHT, AND BODY BUILD

### 4-16. Height

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

a. *Classes 1, 1A, and 2.*

(1) *Male.* Height below 64 inches or over 76 inches.

★(2) *Female.* Height below 64 inches or over 72 inches.

★b. *Class 2 Air Traffic Controller.*

(1) *Male.* Height below 60 inches or over 80 inches.

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

★c. *Class 3.*

(1) *Male.* Height below 60 inches or over 80 inches.

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

### ★4-17. Weight

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are—Weights that fall outside the limits prescribed in table III, appendix III.

### 4-18. Body Build

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-23, plus the following:

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

### Section XIII. LUNGS AND CHEST WALL

#### 4-19. Lung and Chest Wall

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-24, 2-25, 2-26, and 4-27g, plus the following:

a. *Coccidioidomycosis* unless healed without evidence of cavitation.

b. *Lobectomy*.

(1) *Classes 1 and 1A*. Lobectomy, per se.

(2) *Classes 2 and 3*. Lobectomy—

(a) Within the preceding 6 months.

(b) With a value of less than 80 percent of the predicted vital capacity (app VI).

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

(d) With a value of less than 80 percent of the predicted maximum breathing capacity (app VI).

(e) With any other residual or complication of lobectomy which might endanger the individual's health and well-being or compromise flying safety.

c. *Pneumothorax, spontaneous*.

(1) *Classes 1 and 1A*. A history of spontaneous pneumothorax.

★(2) *Classes 2 and 3*. Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, no additional lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 12 months.

d. *Pulmonary tuberculosis and tuberculous pleurisy with effusion*.

(1) *Classes 1 and 1A*. Individuals taking prophylactic chemotherapy.

(2) *Classes 2 and 3*. During period of drug therapy or with impaired pulmonary function greater than outlined in b(2) above.

e. *Tuberculous pleurisy with effusion*.

(1) *Classes 1 and 1A*. Tuberculous pleurisy with effusion, per se.

(2) *Classes 2 and 3*. Tuberculous pleurisy with effusion until 12 months after cessation of therapy.

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

#### 4-20. Mouth

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-27, plus the following:

a. *Any infectious lesion* until recovery is complete and the part is functionally normal.

b. *Any congenital or acquired lesion* which interferes with the function of the mouth or throat.

c. *Any defect in speech* which would prevent clear enunciation or otherwise interfere with clear and effective communication over a radio communication system.

d. *Recurrent calculi* of any salivary gland or duct.

#### 4-21. Nose

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-28 and 4-27 plus the following:

a. *Acute coryza*.

b. *Allergic rhinitis*.

(1) *Classes 1 and 1A*. Any substantial history of allergic or vasomotor rhinitis, unless free of all symptoms since age 12.

(2) *Classes 2 and 3*. Allergic rhinitis unless mild

in degree and considered unlikely to limit the examinee's flying activities.

c. *Anosmia, parosmia, and paresthesia*.

d. *Atrophic rhinitis*.

e. *Deviation of nasal septum or septal spurs* which result in 50 percent or more obstruction of either airway, or which interfere with drainage of the sinus on either side.

f. *Hypertrophic rhinitis* (unless mild and functionally asymptomatic).

g. *Nasal polyps*.

h. *Perforation of the nasal septum* unless small, asymptomatic, and the result of trauma.

i. *Sinusitis*:

(1) *Classes 1 and 1A*. Sinusitis of any degree, acute or chronic. If there is only X-ray evidence of chronic sinusitis and the history reveals the examinee to have been asymptomatic for 5 years, this X-ray finding alone will not be considered as rendering the individual medically unfit.

(2) *Classes 2 and 3*. Acute sinusitis of any degree.

#### 4-22. Pharynx, Larynx, Trachea, Esophagus

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-29, plus the following:

a. Any lesion of the nasopharynx causing nasal obstruction.

b. A history of recurrent hoarseness.

c. A history of recurrent aphonia or a single attack if the cause was such as to make subsequent attacks probable.

d. History of repeated hemorrhage from naso-

pharynx 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) History of unexplained syncope.

(2) Convulsive seizures, except that seizure associated with febrile illness before age 5 years may be acceptable if the electroencephalogram is normal.

(3) History of any recurring headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

(4) History of new growth of the brain, spinal cord, or their coverings.

(5) History of diagnostic or therapeutic craniotomy.

(6) History of head injury that resulted in any of the following:

(a) Intracranial hemorrhage (epidural, subdural, or intracerebral) or subarachnoid hemorrhage.

(b) Penetrating injuries of the brain.

(c) Any skull fracture, linear or depressed, with or without dural penetration.

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

(e) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis. Damage to one or more cranial nerves is not necessarily disqualifying unless it interferes with normal function in some practical manner.

(f) Cerebral spinal fluid rhinorrhea or otorrhea, leptomenigeal cysts, aerocele, brain abscess, or arteriovenous fistula.

(g) Any post-traumatic syndrome, as manifested by changes in personality, deterioration of

higher intellectual functions, anxiety, headaches, or disturbances of equilibrium.

(h) Unconsciousness for more than 1 hour.

(i) Unconsciousness for more than 15 minutes, but less than 1 hour, unless 2 years have elapsed since the injury and a complete neurological evaluation is normal in all respects.

(j) Unconsciousness for less than 15 minutes, unless 6 months have elapsed since the injury and a complete neurological evaluation is normal in all respects.

b. Classes 2 and 3. Same as "a." In addition—

(1) All acute infections of the central nervous system, until active disease is arrested, further sequelae are not expected, and residua, if any, are nonprogressive. All such cases will be referred to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 for review.

(2) Single or multiple episodes of seizures of any type (grand mal, petit mal, focal, etc.).

(3) Fainting.

Note. Cases involving syncope of any type due to any cause will be referred to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 for review after appropriate consultations have been accomplished.

(4) Any history of new growth of the brain, spinal cord, or their coverings.

(5) Metabolic or toxic disturbance of the central nervous system.

(6) Decompression sickness with neurological involvement.

(7) Any recurring headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

(8) Electroencephalographic abnormalities in otherwise apparently healthy individuals are not necessarily disqualifying with the exception of—

(a) Spike-wave complexes.

(b) Focal spikes.

(9) Craniotomy and skull defects.

(10) Head injury associated with any of the complications listed below will be cause for permanent suspension from flying status.

(a) Unconsciousness exceeding 24 hours.

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

(c) Laceration or contusion of the brain or a history of penetrating brain injury.

(d) Epidural, subdural, or intracerebral hematoma.

(e) Post-traumatic central nervous system infections, such as abscess or meningitis.

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

(g) Generalized or focal convulsions.

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

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

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

(11) Head injury associated with any of the complications below will be cause for removal from flying duty for at least 2 years. Return to flying duty at that time will be contingent on a completely normal neurological evaluation to include skull X-rays, electroencephalogram, and psychometric examinations. Serial electroencephalograms will be obtained as soon after head injury as possible at 6, 12, and 18 months after injury. Final evaluation, at 24 months after injury, will be accomplished by the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362.

(a) Unconsciousness for a period of more than 2 hours, but less than 24 hours, with or without linear skull fracture (basilar skull fracture is considered a linear skull fracture).

(b) Post-traumatic amnesia (patchy or complete), delirium, disorientation, or impairment of judgment or intellect exceeding 48 hours.

(c) Post-traumatic syndrome, as manifested

by changes in personality, deterioration of higher intellectual function, anxiety, headaches, or disturbances of equilibrium which subside within one month of injury.

(12) Head injury when associated with any of the complications below will be cause for removal from flying duties for a period of at least 3 months and will be evaluated by a qualified neurologist or neurosurgeon just prior to consideration for return to flying duty. An electroencephalogram will be obtained as soon after the head injury as possible and again at the time of evaluation 3 months after injury. When an abnormality is found in any segment of the examination (neurological, skull X-rays, electroencephalogram, or psychometric testing), the examinee will not be cleared for flying duties and will be referred back to the consultant at 3-month intervals for reevaluation until cleared.

(a) Linear skull fracture without loss of consciousness or with loss of consciousness of 15 minutes or less.

(b) Loss of consciousness over 15 minutes, but less than 2 hours, or post-traumatic amnesia, delirium, or confusion for a period less than 48 hours, with or without linear skull fracture (basilar fracture is considered a linear skull fracture. This diagnosis does not have to be confirmed by X-rays, but may be based on clinical findings).

(c) Cerebral spinal fluid rhinorrhea or otorrhea which clears within 7 days of injury, provided there is no evidence of cranial nerve palsy.

(13) Head injury without skull fracture which results in unconsciousness for less than 15 minutes or post-traumatic amnesia, delirium, or confusion for less than 12 hours will be cause for grounding for at least 4 weeks. Return to flying duties will be contingent on a normal neurological examination at the end of that time, to include skull X-rays, electroencephalogram, and orthostatic tolerance test.

(14) Head injury that results in permanent cranial nerve deficit; or confusion exceeding 48 hours is disqualifying until a complete evaluation accomplished at a reasonable time after injury results in a recommendation for return to flying duties.

## 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 para-

graphs 2-32, 2-33, 2-34, and 4-27d, plus the following:

a. *Abnormal emotional responses* to situations of stress (either combat or noncombat) when, in the

opinion of the examiner, such reaction will interfere with the efficient and safe performance of an individual's flying duties.

★ *b. Character and behavior disorders.* See AR 40-400.

*c. Enuresis* after age 10, repeated.

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

*e. Fear of flying* when a manifestation of a psychiatric illness. Refusal to fly or fear of flying not due to a psychiatric illness is an administrative problem.

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

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

*h. Insomnia, severe and prolonged.*

*i. Night terrors, severe, repeated.*

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

*k. Psychogenic amnesia* at any time.

*l. Psychoneurosis* (see AR 40-400) when more than mild and incapacitating to any degree at any time.

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

*n. Vasomotor instability.*

### Section XVII. SKIN AND CELLULAR TISSUES

#### 4-25. Skin and Cellular Tissues

The causes of medical unfitness for flying duty

Classes 1, 1A, 2, and 3, are the causes listed in paragraph 2-35.

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

#### 4-26. Spine, Scapulae, Ribs, and Sacroiliac Joints

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-36 and 2-37, plus the following:

*a. Classes 1 and 1A.*

(1) *A history of disabling episode of back pains, especially when associated with significant objective findings.*

(2) *Healed fracture or dislocation of the vertebrae.*

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

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

### Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

#### 4-27. Systemic Diseases and Miscellaneous Conditions and Defects

★ The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in AR 40-8 and in paragraphs 2-38 and 2-39, plus the following:

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

★ *b. Blood donations—*Classes 1, 1A, 2 and 3. Personnel on flying status will not perform flying duties for a period of 72 hours following the donation of 200 cc or more of blood. Aircrew members will not be regular donors.

*c. Malaria:*

(1) *Classes 1 and 1A.* A history of malaria unless—

(a) There have been no symptoms for at least

6 months during which time no antimalarial drugs have been taken.

(b) The red cells are normal in numbers and structure, and the blood hemoglobin is at least 12 grams percent.

(c) A thick smear (to be done if the disease occurred within 1 year of the examination) is negative for parasites.

(2) *Classes 2 and 3.* A history of malaria unless adequate therapy, in accordance with existing directives, has been completed. The duration of suspension is an individual problem and will vary with the type of malaria, the severity of infection, and the response to treatment. However, personnel may not fly unless afebrile for 7 days, the red cells are normal in number and structure, the blood hemoglobin is at least 12 grams percent, and the thick smear (to be done if the disease occurred within 1 year of the examination) is negative for parasites. A thick

smear and a medical examination will be made every 2 weeks for at least 3 months after all anti-malarial therapy has been stopped.

★ *d. Mood-ameliorating, tranquilizing, or ataraxic drugs*—Classes 1, 1A, 2 and 3. Individuals who are under treatment with any of the mood-ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued. If these drugs are used for relief of acute minor conditions (e.g., nausea, muscle spasm, etc.), the period of unfitness is the duration of the illness plus 72 hours after the drug is discontinued.

*e. Motion sickness*—Classes 1 and 1A. History of

motion sickness, other than isolated instances without emotional involvement, or history of previous elimination from flight training at any time by reason of airsickness.

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

*g. Sarcoidosis:*

(1) *Classes 1, 1A, and 3.* A history of sarcoidosis, even if in remission.

(2) *Class 2.* Sarcoidosis, except when in remission, asymptomatic, and there is no loss of functional capacity.

## Section XX. TUMORS AND MALIGNANT DISEASES

### 4-28. Malignant Diseases and Tumors

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

*a. Classes 1 and 1A.* Same as paragraphs 2-40 and 2-41.

*b. Classes 2 and 3.* Except in the case of individ-

uals being processed for disability separation in accordance with paragraph 3-4, individuals having a malignant disease or tumor will be considered as medically unfit pending review and evaluation by the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Tucker, AL 36362.

## Section XXI. VENEREAL DISEASES

### 4-29. Venereal Diseases

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

*a. Classes 1, 1A, and 2: A history of syphilis, unless—*

(1) Careful examination shows no lesions of cardiovascular, neurologic, visceral, mucocutaneous, or osseous syphilis.

(2) Documentary proof is available that all provisions of treatment as contained in directives current at the time of the examination, or the equivalent thereof, have been fulfilled.

(3) Examination of the spinal fluid reveals a negative serologic test for syphilis, and a cell count

and content of protein are within normal limits.

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

*b. Class 3:*

(1) *A history or evidence of primary, secondary, or latent (spinal fluid negative) syphilis* until completion of prescribed treatment. Following completion of treatment, individuals may be considered for return to flying status only if the treatment has resulted in clinical cure without sequelae.

(2) *A history or evidence of neurosyphilis or tertiary syphilis.*

## ★ Section XXII. ADAPTABILITY RATING FOR MILITARY AERONAUTICS (ARMA) AND READING ALOUD TEST (RAT)

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

This requirement exists for all initial examinations and, when indicated, for periodic examinations, Classes 1, 1A, 2 and 3.

The cause of medical unfitness for flying duty, Classes 1, 1A, 2 and 3 is—

*Unsatisfactory ARMA* whether due to failure to

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

### 4-31. Reading Aloud Test (RAT)

The cause of medical unfitness for flying duty, Classes 1, 1A, 2 and 3, including air traffic control-

**15 August 1980**

**C 32, AR 40-501**

lers, is failure to clearly enunciate, in the English language, as determined by administration of the

RAT (app X) in a manner compatible with safe and effective aviation operations.

## CHAPTER 5

# MEDICAL FITNESS STANDARDS FOR ADMISSION TO US MILITARY ACADEMY, ★UNIFORMED SERVICES UNIVERSITY OF HEALTH SCIENCES, AND ARMY ROTC SCHOLARSHIP

## ★(Short Title: USMA, HEALTH SCIENCES UNIVERSITY, AND ROTC SCHOLARSHIP MEDICAL FITNESS STANDARDS)

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### Section I. GENERAL

#### ★5-1. Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for admission to the US Military Academy, Uniformed Services University of Health Sciences, and ROTC Scholarship.

cal fitness standards contained in chapter 2, as further restricted herein, apply to—

*a. All candidates and prospective candidates for the Military Academy.*

*b. All ex-cadets under consideration for readmission as a cadet of the US Military Academy.*

*★c. Applicants for entrance into Uniformed Services University of Health Sciences.*

*★d. Applicants for entrance into Army ROTC Scholarship Program.*

#### 5-2. Applicability

The causes for rejection are all of the causes listed in chapter 2, plus all of the causes listed in this chapter. These standards and the medi-

### Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

#### 5-3. Abdomen and Gastrointestinal System

The causes of medical unfitness 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 are the causes

listed in paragraph 2-4.

## Section IV. DENTAL

### 5-5. Dental

The causes of medical unfitness are—

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

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

*c. Prosthodontic appliances.*

(1) Appliances below generally accepted

standards of design, construction, and tissue adaptation.

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

*d. Teeth.*

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

(2) Grossly disfiguring spacing of existing anterior teeth.

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

## Section V. EARS AND HEARING

### 5-6. Ears

The causes of medical unfitness 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 are hearing acuity level by audiometer testing (regardless of conversational or whispered voice hearing acuity) less 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 are the causes listed in paragraph 2-8.

## Section VII. EXTREMITIES

### 5-9. Upper Extremities

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

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

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

**5-10. Lower Extremities**

The causes of medical unfitness 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 train-

ing 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 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) *Esotropia* of over 15 prism diopters.

(2) *Exotropia* of over 10 prism diopters.

(3) *Hypertropia* of over 2 prism diopters.

**5-12. Vision**

The causes of medical unfitness are the causes listed

in paragraph 2-13, plus the following:

a. *Color blindness.* Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or vivid green.

b. *Visual acuity.* Distant visual acuity which does not correct to at least 20/20 in each eye with spectacle lenses.

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.

**Section IX. GENITOURINARY SYSTEM****5-13. Genitourinary System**

Causes of medical unfitness are the causes listed in paragraphs 2-14 and 2-15, plus the following:

a. *Atrophy, deformity, or maldevelopment of both testicles.*

b. *Epispadias.*

c. *Hypospadias*, pronounced.

d. *Penis.* Amputation or gross deformity.

e. *Phimosis.* Redundant prepuce is not cause for rejection.

f. *Urine.*

(1) *Albuminuria.* Persistent or recurrent of any type, regardless of etiology.

(2) *Casts.* Persistent or recurrent, regardless of cause.

**Section X. HEAD AND NECK****5-14. Head and Neck**

The causes of medical unfitness are the causes listed in paragraphs 2-18 and 2-19, plus the following:

a. *Deformities of the skull* in the nature of de-

pressions, exostoses, etc., which affect the military appearance of the candidate.

b. *Loss or congenital absence of the bony substance of the skull* of any amount.

**Section XI. HEART AND VASCULAR SYSTEM****5-15. Heart and Vascular System**

The causes of medical unfitness are the causes listed in paragraphs 2-18, 2-19, and 2-20, plus the following:

a. *Any evidence of organic heart disease.*

b. *Hypertension* evidenced by preponderant readings of 140-mm or more systolic or preponderant diastolic pressure of over 90 mm.

**Section XII. HEIGHT, WEIGHT, AND BODY BUILD****5-16. Height**

Entrance to USMA, ROTC, and Uniformed Services

University of Health Sciences:

★ a. Male applicants. Height below 60 inches or

over 80 inches (see administrative criteria in para 7-18, chap. 7).

★ *b. Female applicants.* Height below 58 inches or over 72 inches (see administrative criteria in para 7-18, chap. 7).

**5-17. Weight**

Entrance to USMA, ROTC, and Uniformed Services University of Health Sciences:

*a. Male applicants.* Weight related to age and height which is below the minimum or in excess of the maximum shown in table I, appendix III.

*b. Female applicants.* Weight related to age and height which is below the minimum or in excess of

the maximum shown in table II, appendix III.

**5-18. Body Build**

The causes of medical unfitness are the causes listed in paragraph 2-23, plus the following:

*Obesity.* Even though an examinee's weight is within the maximum shown in table I, appendix III or table II, appendix III, as appropriate, he will be reported as nonacceptable when the medical examiner considers that the excess weight, in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion or immediate participation in the required physical activities.

**Section XIII. LUNGS AND CHEST WALL**

**5-19. Lungs and Chest Wall**

The causes of medical unfitness are the causes listed

in paragraphs 2-24, 2-25, and 2-26.

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

### 5-20. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness are the causes listed in paragraphs 2-27, 2-28, 2-29, and 2-30, plus the following:

*a. Septal deviation, hypertrophic rhinitis, or other conditions* which result in 50 percent or more obstruction of either airway, or which

interfere with drainage of a sinus on either side.

*b. Speech abnormalities.* Defects and conditions which interfere with the candidate's ability to pronounce and enunciate words correctly and clearly considering the requirements of class recitation and the issuing of commands to large groups of men.

## Section XV. NEUROLOGICAL DISORDERS

### 5-21. Neurological Disorders

The causes of medical unfitness are the causes listed in paragraph 2-31.

## Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

### 5-22. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness are the causes listed in paragraphs 2-32, 2-33, and 2-34, plus the following:

*a. Prominent antisocial tendencies, personality defects, neurotic traits, emotional instabil-*

ity, schizoid tendencies, and other disorders of a similar nature.

*b. Stammering or stuttering* which interferes with the candidate's ability to pronounce and enunciate words correctly and clearly, considering the requirements of class recitation and the issuing of commands to large groups of men.

## Section XVII. SKIN AND CELLULAR TISSUES

### 5-23. Skin and Cellular Tissues

The causes of medical unfitness are the causes listed in paragraph 2-35, plus the following:

*a. Acne, moderately severe, or interfering with wearing of military equipment.*

*b. Acne scarring.* Severe.

*c. Bromidrosis.* More than mild.

*d. Vitiligo* or other skin disorders which are disfiguring or unsightly.

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

### 5-24. Joints, Spine, Scapulae, Ribs, and Sacroiliac

The causes of medical unfitness are the causes listed in paragraphs 2-11, 2-36, and 2-37, plus the following:

*Defects and diseases of the spine, scapulae, ribs, or sacroiliac joints* which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

## Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

### 5-25. Systemic Diseases and Miscellaneous Conditions and Defects

The causes for rejection are the same as those listed in paragraphs 2-38 and 2-39, plus the following:

*Systemic diseases and miscellaneous medical conditions and physical defects which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.*

## Section XX. TUMORS AND MALIGNANT DISEASES

### 5-26. Tumors and Malignant Diseases

The causes of medical unfitness are the causes listed in paragraphs 2-40 and 2-41.

## Section XXI. VENEREAL DISEASES

### 5-27. Venereal Diseases

The causes of medical unfitness are the causes listed in paragraph 2-42, plus the following:

*a. Confirmed positive serologic test for syphilis.*

*b. Positive spinal fluid test for syphilis at any time.*

## ★CHAPTER 6

## MEDICAL FITNESS STANDARDS FOR MOBILIZATION

## (Short Title: MOBILIZATION MEDICAL FITNESS STANDARDS)

## Section I. GENERAL

## 6-1. Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for entry into the service during mobilization. There are numerous medical conditions and physical defects not specifically mentioned in this chapter which in themselves are not considered unfitting. They may be unfitting, however, if in the opinion of the examining physician the

residuals, complications, or underlying causes of the conditions are of such a nature that they would obviously preclude the individual's satisfactory performance of military duty.

## 6-2. Applicability

These standards will be implemented only upon specific instruction from the Service Secretaries, and will apply to personnel categories as directed.

## Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

## 6-3. Abdominal and Gastrointestinal Defects and Diseases

The causes for rejection for military service are—

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

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

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

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

*e. Gastritis:* Documented history of severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization.

*f. Hepatitis:* Within the preceding 6 months, or persistence of symptoms after a reasonable period of time when objective evidence of impairment of liver function exists.

*g. Hernia:*

- (1) Hiatus hernia: Symptoms not relieved by simple dietary or medical means, or

recurrent bleeding in spite of prescribed treatment.

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

*h. Ileitis, regional:* Confirmed diagnosis thereof.

*i. Pancreatitis, chronic:* Documented history of frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring insulin.

*j. Peritoneal adhesions:* Documented history of recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent admissions to the hospital.

*j.1. Polyposis of the colon:* Verified by examination or by documented history.

*k. Proctitis, chronic:* Documented history of moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea with repeated admissions to the hospital.

*l. Ulcer, peptic, duodenal and gastric:* Supported by laboratory and X-ray evidence and documented history of frequent recurrence of symptoms (pain, vomiting, or bleeding).

*m. Ulcerative colitis:* When supported by documented history of any of the following symptoms;

weight loss, significant abdominal pain, anemia, more than 4 bowel movements a day.

n. *Rectum*, stricture of, when supported by documented history of severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas.

#### 6-4. Gastrointestinal and Abdominal Surgery

The causes of medical unfitness for military service are—

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

b. *Colostomy*. When present.

c. *Enterostomy*. When present.

d. *Gastrectomy*, total per se. *Gastrectomy*, sub-

total with or without vagotomy; *Gastrojejunostomy*, with or without vagotomy; when residual conditions are such that an individual requires a special diet, develops "dumping syndrome," has frequent episodes of epigastric distress or diarrhea, or shows marked weight loss.

e. *Gastrostomy*. When present.

f. *Ileostomy*. When present.

g. *Pancreatectomy*.

h. *Pancreaticoduodenostomy and Pancreaticogastrostomy*: More than mild symptoms of digestive disturbance or requiring insulin.

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

j. *Proctectomy*.

k. *Proctopexy, proctoplasty, proctorrhaphy, and proctotomy*: If fecal incontinence remains.

### Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

#### 6-5. Blood and Blood-Forming Tissue Diseases

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

a. *Anemia*.

b. *Hemolytic crisis*, chronic and symptomatic.

c. *Leukopenia*, chronic and not responsive to therapy.

d. *Polycythemia*.

e. *Purpura and other bleeding diseases*.

f. *Thromboembolic disease*.

g. *Splenomegaly*, chronic and not responsive to therapy.

### Section IV. DENTAL

#### 6-6. Dental Diseases and Abnormalities

The causes for rejection are—

a. *Diseases of the jaws or associated tissues* which will incapacitate the individual or prevent the satisfactory performance of military duty.

b. *Malocclusion*, severe, which interferes with the mastication of a normal diet.

c. *Oral tissues*, extensive loss of, in an amount that would prevent replacement of missing teeth with a satisfactory prosthetic appliance.

d. *Orthodontic appliances*. See special administrative criteria in paragraph 7-12.

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

### Section V. EARS AND HEARING

#### 6-7. Ears

The causes of medical unfitness for military service are—

a. *Infections of the external auditory canal*: Chronic and severe, resulting in thickening and

excoriation of the canal or chronic secondary 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 is not corrected satis-

satisfactorily by a hearing aid or other measures, or complicated by vertigo or otitis media.

*c. Mastoiditis, chronic, following mastoidectomy.* Constant drainage from the mastoid cavity which is resistant to treatment, requiring frequent dispensary care or hospitalization, and hearing level in the better ear of 30 decibels or more.

*d. Meniere's syndrome.* Recurring attacks of sufficient frequency and severity as to require

hospitalization; and documented by the presence of objective findings of a vestibular disturbance, not adequately controlled by treatment.

*e. Otitis media.* Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent hospitalization.

### 6-8. Hearing

Uncorrected hearing, within the speech reception score, of 30 decibels or more in the better ear, is unfitting for service.

## Section VI. ENDOCRINE AND METABOLIC DISORDERS

### 6-9. Endocrine and Metabolic Disorders

The causes of medical unfitness for military service are—

*a. Acromegaly.* Severe with considerable incapacity after treatment.

*b. Adrenal hyperfunction.* Which has not responded to therapy satisfactorily or where replacement therapy presents serious problems in management.

*c. Diabetes insipidus.* Unless mild and showing good response to treatment.

*d. Diabetes mellitus.* Unless mild and controllable by diet.

*e. Goiter.* With symptoms of obstruction to breathing with increased activity, unless correctable.

*f. Gout.* Advanced cases with frequent acute exacerbations and/or bone, joint, or kidney damage of such severity as to interfere with satisfactory performance of duty.

*g. Hyperinsulinism.* When caused by a ma-

lignant tumor or when the condition is not readily controlled.

*h. Hyperparathyroidism* per se, does not render medically unfit. However, residuals or complications of the surgical correction of this condition such as renal disease, or bony deformities which would usually preclude the satisfactory performance of military duty; such individuals are medically unfit for military service.

*i. Hyperthyroidism.* Severe symptoms of hyperthyroidism which has not responded to treatment, with or without evidence of goiter.

*j. Hypofunction, adrenal cortex.*

*k. Hypoparathyroidism.* When not easily controlled by maintenance therapy.

*l. Hypothyroidism.* When not adequately controlled by medication.

*m. Osteomalacia.* Residuals after therapy of such nature or degree which would preclude the satisfactory performance of duty.

*n. Pituitary basophilism.* Confirmed.

## Section VII. EXTREMITIES

### 6-10. Upper Extremities

(See also para 6-12.)

The causes of medical unfitness for military service are—

*a. Amputation of arm, or forearm* if suitable prosthesis is not available, or double amputee regardless of available prosthesis.

*b. Loss of fingers* rendering the individual unable to perform useful military service.

★*c. Joint ranges of motion* which do not equal or exceed the measurements listed in (1) to (4) below (TM 8-640). Range of motion limitations temporarily not meeting these standards, because of disease or injury or remediable condition will be temporarily disqualifying.

(1) *Shoulder.*

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) *Elbow.*

(a) Flexion to 100°.

(b) Extension to 60°.

(3) *Wrist.* A total range of 15° (extension plus flexion).

(4) *Hand.* Pronation to the first quarter of the normal arc.

**6-11. Lower Extremities**

a. *Amputation of leg, thigh, or foot* if suitable prosthesis is not fitted or if the use of a cane or crutches is required, or double amputee regardless of suitable prosthesis.

b. *Loss of toes* rendering the individual unable to perform useful military service.

c. *Feet.*

(1) *Hallux valgus* when moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(2) *Pes Planus:* Symptomatic, more than moderate, with pronation on weight bearing which would prevent the wearing of a military shoe, or when associated with vascular changes.

(3) *Talipes cavus* when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which would prevent the wearing of a military shoe.

d. *Internal derangement of the knee.* Dislocated semilunar cartilage so disabling as to prevent gainful civilian endeavor.

★e. *Joint ranges of motion* which do not equal or exceed the measurements in (1) through (3) below (TM 8-640). Range of motion limitations temporarily not meeting these standards because of disease or remedial conditions will be temporarily disqualifying.

(1) *Hip.*

(a) Flexion to 90°.

(b) Extension to 10° (beyond 0°).

(2) *knee.*

(a) Extension to 10°.

(b) Flexion to 90°.

(3) *Ankle.*

(a) Dorsiflexion to 10°.

(b) Plantar Flexion to 10°.

f. *Shortening of an extremity* which exceeds 2 inches.

**6-12. Miscellaneous**

(See also para 6-10 and 6-11.)

The causes of medical unfitness for military service are—

a. *Arthritis.*

(1) *Arthritis due to infection* (not including arthritis due to gonococcal infection or tuberculous arthritis for which see para 6-34 and 6-39): Associated with persistent pain and marked loss of function, with objective X-ray evidence, and documented history of recurrent incapacity for prolonged periods.

(2) *Arthritis due to trauma.* When there is functional impairment to the involved joints so as to preclude the satisfactory performance of duty.

(3) *Osteoarthritis.* Frequent recurrence of symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods, history of frequent recurrences and supported by objective findings.

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

c. *Fractures.*

(1) *Malunion of fractures.* Where there is more than moderate malunion with marked deformity or more than moderate loss of function.

(2) *Nonunion of fracture.* When nonunion of a fracture interferes with function to the extent of precluding satisfactory performance of duty.

(3) *Bone fusion defect.* When manifested by more than moderate pain and loss of function.

(4) *Callus, excessive, following fracture.* When it interferes with function to the extent of precluding satisfactory performance of military duty.

d. *Joints.*

(1) *Arthroplasty.* Severe pain, limitation of motion, and the loss of function.

(2) *Bony or fibrous ankylosis of weight bearing joints* if either fusion is such as to require the use of a cane or crutches or if there is evidence of active or progressive disease.

- f. Pyelostomy:* If permanent drainage persists.
- g. Ureterocolostomy.*
- h. Ureterocystostomy:* When both ureters were noted to be markedly dilated with irreversible changes.
- i. Ureteroileostomy cutaneous.*
- j. Ureteroplasty:*
- (1) When unilateral operative procedure was unsuccessful and nephrectomy was resorted to (c above).
  - (2) When the obstructive condition is bilateral the residual obstruction or hydro-nephroses must be evaluated on an in-

dividual basis by a genitourinary consultant and medical fitness for military service determined on the basis of expected productivity in the service.

*k. Ureterosigmoidostomy.*

*l. Ureterostomy:* External or cutaneous.

*m. Urethrostomy:* Complete amputation of the penis or when a satisfactory urethra has not been restored.

*n. Medical fitness for military service following other genitourinary and gynecological surgery* will depend upon an individual evaluation of the etiology, complication, and residuals.

## Section X. HEAD AND NECK

### 6-17. Head

See paragraphs 6-28 and 6-29.

### 6-18. Neck

(See also par. 6-9.)

The causes of medical unfitness for military service are—

*Torticollis (wry neck):* Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

## Section XI. HEART AND VASCULAR SYSTEM

### 6-19. Heart

The causes of medical unfitness for military service are—

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

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

*c. Endocarditis:* Bacterial endocarditis resulting in myocardial insufficiency.

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

*e. Infarction of the myocardium:* Documented, symptomatic, and acute.

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

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

*h. Pericarditis:*

- (1) Chronic constructive pericarditis unless successful remediable surgery has been performed and the individual is able to perform at least relatively sedentary duties without discomfort of dyspnea.

- (2) Chronic serous pericarditis.

*i. Rheumatic valvulitis:* Inability to perform duties at a functional level of Class IIC, American Heart Association (app. VII).

*j. Ventricular premature contractions:* Documented history of frequent or continuous attacks, whether or not associated with organic heart disease, accompanied by discomfort or fear of such a degree as to interfere with the satisfactory performance of duties.

### 6-20. Vascular System

The causes of medical unfitness for military service are—

*a. Arteriosclerosis obliterans:* Intermittent claudication of sufficient severity to produce discomfort and disability during a walk of 200 yards or less on level ground at 112 steps per minute.

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

- c. *Aneurysm of aorta.*
- d. *Periarteritis nodosa.* Confirmed.
- e. *Chronic venous insufficiency (post-phlebotic syndrome):* When more than mild in degree and symptomatic despite elastic support.
- f. *Raynaud's phenomena:* Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.
- g. *Thromboangiitis obliterans:* Intermittent claudication of sufficient severity to produce discomfort and disability during a walk of 200 yards or less on level ground at 112 steps per minute, or with other complications.
- h. *Thrombophlebitis:* When supported by a history of repeated attacks requiring treatment of such frequency as would interfere with the satisfactory performance of duty.
- i. *Varicose veins:* When more than mild in degree and symptomatic despite elastic support.

#### 6-21. Miscellaneous

The causes of medical unfitness for military service are—

- a. *Aneurysms:*
  - (1) Acquired arteriovenous aneurysm when more than minimal vascular symptoms remain following remediable treatment or if associated with cardiac involvement.

### Section XII. HEIGHT, WEIGHT AND BODY BUILD

#### ★6-22. Height

The causes for rejection are—

- a. Height less than 60 inches or more than 80 inches for Army and Air Force.
- b. Height less than 60 inches or more than 78 inches for Navy and Marine Corps.

#### 6-23. Weight

The causes for rejection are—

- a. *Weight related to height* which is below the minimum shown in table I, appendix III.
- b. *Weight related to height and age* which is in excess of the maximum shown in table I, appendix III.

#### 6-24. Body Build

The causes for rejection are—

- a. *Congenital malformation of bones and*

(2) Other aneurysms of the artery will be individually evaluated based upon the vessel involved and the residuals remaining after appropriate treatment.

b. *Erythromelalgia:* Persistent burning pain in the soles or palms not relieved by treatment.

c. *Hypertensive cardiovascular disease and hypertensive vascular disease:*

(1) Systolic blood pressure consistently over 150 mm of mercury or a diastolic pressure of over 90 mm of mercury following an adequate period of oral therapy while on an ambulatory status.

(2) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

- (a) More than minimal changes in the brain.
- (b) Heart disease.
- (c) Kidney involvement.
- (d) Grade 2 (Keith-Wagner-Barker) changes in the fundi.

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

e. *Residuals of surgery of the heart, pericardium, or vascular system* resulting in limitation of physical activity at functional level of Class IIC, American Heart Association (app. VII).

*joints.* See paragraphs 6-10, 6-11, and 6-12.

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

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

d. *Obesity.* Even though the individual's weight is within the maximum shown in table I, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and the musculature, constitutes obesity of such a degree as would interfere with the satisfactory completion of mandatory training (para 8, app. I).

## Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

### 6-30. Psychoses

The causes for rejection are—

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

### 6-31. Psychoneuroses

The causes for rejection 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).

### 6-32. Personality Disorders

The causes for rejection 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 seriously will interfere with adjustment in the military service as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other society groups.

c. *Other symptomatic immaturity reactions* such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 6-15c) occurring beyond early adolescence (age 12 to 14) and stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

## Section XVII. SKIN AND CELLULAR TISSUES

### 6-33. Skin and Cellular Tissues

The causes of medical unfitness for military service are—

a. *Acne*. Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by, or would interfere with the wearing of military equipment.

b. *Atopic dermatitis*. More than moderate or requiring periodic hospitalization.

c. *Amyloidosis*: Confirmed.

d. *Cysts and tumors*. See paragraph 6-37 and 6-38.

e. *Cyst, pilonidal*. To be evaluated under provisions of af below.

f. *Dermatitis herpetiformis*. When symptoms have failed to respond to medication.

g. *Dermatomyositis*. Confirmed.

h. *Dermographism*. Which would interfere with the satisfactory performance of duty.

i. *Eczema*. Any type which is chronic and resistant to treatment.

- j. *Elephantiasis or chronic lymphedema.*
- k. *Epidermolysis bullosa.* Confirmed.
- l. *Erythema multiforme.* More than moderate, chronic or recurrent.
- m. *Exfoliative dermatitis.* Of any type, confirmed.
- n. *Fungus infections, systemic or superficial types.* If extensive and not amenable to treatment.
- o. *Hidradenitis suppurativa and folliculitis decalvans.* More than minimal degree.
- p. *Hyperhidrosis.* Of the hands or feet when severe or complicated by a dermatitis or infection, either fungal or bacterial, not amenable to treatment.
- q. *Leukemia cutis and mycosis fungoides.* In the tumor stage.
- r. *Lichen planus.* Generalized and not responsive to treatment.
- s. *Lupus erythematosus.* Systemic acute or subacute and occasionally the chronic discoid variety with extensive involvement of the skin and mucous membranes or when the condition has not responded to treatment after an appropriate period of time.
- t. *Neurofibromatosis (Von Recklinghausen's Disease).* If repulsive in appearance or when it would interfere with the satisfactory performance of duty.
- u. *Panniculitis, nodular, nonsuppurative, febrile, relapsing.* Confirmed.
- v. *Parapsoriasis.* Extensive and when it

would interfere with the satisfactory performance of duty.

w. *Pemphigus vulgaris, pemphigus foliaceus, pemphigus vegetans and pemphigus erythematous.* Confirmed.

x. *Psoriasis.* Extensive and not controllable by treatment and when it would interfere with the satisfactory performance of military duty.

y. *Radiodermatitis.* If the site of malignant degeneration, or if symptomatic to a degree not amenable to treatment.

z. *Scars and keloids.* So extensive to adherent that they would seriously interfere with function or with the satisfactory performance of duty or preclude the wearing of necessary military equipment.

aa. *Scleroderma.* Generalized or of the linear type which seriously interferes with the function of an extremity.

ab. *Tuberculosis of the skin.* See paragraph 6-35.

ac. *Ulcers of the skin.* Has not responded to treatment or which would interfere with the satisfactory performance of duty.

ad. *Urticaria.* Chronic, severe, and not amenable to treatment.

ae. *Xanthoma.* Regardless of type, only when it would preclude the satisfactory performance of duty.

af. *Other skin disorders.* If chronic, or of a nature which requires frequent medical care or would interfere with the satisfactory performance of military duty.

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

### 6-34. Spine, Scapulae, Ribs, and Sacroiliac Joints

(See also para 6-37.)

The causes of medical unfitness for military service are—

#### a. Congenital anomalies:

- (1) *Dislocation, congenital, of hip.*
- (2) *Spina bifida:* Associated with pain to the lower extremities, muscular spasm, and limitation of motion which has not been amenable to treatment.

★(3) *Spondylolysis or spondylolisthesis* with more than mild symptoms on normal activity.

(4) *Others.* Associated with muscular spasm, pain to the lower extremities, postural deformities, and limitation of motion which have not been amenable to treatment.

b. *Coxa vara.* More than moderate with pain, deformity, and arthritic changes.

c. *Disarticulation of hip joint.*

d. *Herniation of nucleus pulposus.* Mor

than mild symptoms with sufficient objective findings.

*e. Kyphosis.* More than moderate, interfering with function, or causing unmilitary appearance.

*f. Scoliosis.* Severe deformity with over 2 inches deviation of tips of spinous processes from the midline.

## Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

### 6-35. Systemic Diseases

The causes of medical unfitness for military service are—

- a. Blastomycosis.*
- b. Brucellosis.* Documented history of chronicity with substantiated recurring febrile episodes, more than mild fatigability, lassitude, depression, or general malaise.
- c. Leprosy of any type.*
- d. Myasthenia gravis.* Confirmed.
- e. Porphyria cutanea tarda.* Confirmed.
- f. Sarcoidosis.* Not responding to therapy or complicated by residual pulmonary fibrosis.

### ★*g. Tuberculosis.*

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

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

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

(4) Tuberculosis of the male genitalia: Involvement of prostate or seminal vesicles and other instances not corrected by surgical excision or when residuals are more than minimal or are symptomatic.

(5) Tuberculosis of the larynx, female genitalia, and kidney.

(6) Tuberculosis of the lymph nodes, skin, bone, joints, intestines, eyes, and peritoneum or mesenteric glands will be evaluated on an individual basis considering the associated involvement, residuals and complications.

### 6-36. General and Miscellaneous Conditions and Defects

The causes for rejection are—

#### a. Allergic manifestations:

(1) Allergic rhinitis (hay fever) (para 6-28d).

(2) Asthma (para 6-26a).

(3) Allergic dermatoses (para 6-33).

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

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

c. Any deformity which is markedly unsightly or which impairs general functional ability to such an extent as would prevent satisfactory performance of military duty.

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

e. Cold injury, residuals of (example: frostbite, chillblain, immersion foot, or trench

foot), such as combination of deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

f. Positive tests for syphilis with negative TPI test unless there is a documented history of adequately treated lues or any of the several conditions which are known to give a false positive S.T.S. (vaccinia, infectious hepatitis, immunizations, atypical pneumonia, etc.) or unless there has been a reversal to a negative S.T.S. during an appropriate followup period (3 to 6 months).

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

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

i. Industrial solvent and other chemical intoxication, chronic including carbon bisulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

j. Mycotic infection of internal organs.

k. Myositis or fibrositis; severe, chronic.

l. Residuals of tropical fevers and various parasitic or protozoal infestations which in the opinion of the medical examiner would preclude the satisfactory performance of military duty.

## Section XX. TUMORS AND MALIGNANT DISEASES

### 6-37. Benign Tumors

The causes for rejection are—

#### a. Any tumor of the—

(1) Auditory canal, if obstructive.

(2) Eye or orbit. See also paragraph 6-13.

(3) Kidney, bladder, testicle, or penis.

(4) Central nervous system and its membranous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or original lesion.

b. Benign tumors of the abdominal wall if sufficiently large to interfere with military duty.

c. *Benign tumors of the thyroid* or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to interfere with the wearing of a uniform or military equipment.

d. *Tongue, benign tumor of*, if it interferes with function.

e. *Breast, thoracic contents, or chest wall*, tumors of, other than fibromata lipomata, and inclusion or sebaceous cysts which are of such size as to interfere with wearing of a uniform or military equipment.

f. *For tumors of the internal or external female genitalia*, see paragraph 6-16.

g. *Ganglioneuroma*.

h. *Meningeal fibroblastoma*, when the brain is involved.

### 6-38. Malignant Neoplasms

The causes of medical unfitness for military service are—

*Malignant growths* when inoperable, metastasized beyond regional nodes, have recurred subsequent to treatment, or the residuals of the remedial treatment are in themselves incapacitating.

### 6-39. Neoplastic Condition of Lymphoid and Blood-Forming Tissues

Neoplastic conditions of the lymphoid and blood-forming tissues are generally considered as rendering an individual medically unfit for military duty.

## ★Section XXI. VENEREAL DISEASES

### 6-40. Venereal Disease

The causes of medical unfitness for military service are—

a. *Aneurysm of the aorta* due to syphilis.

b. *Atrophy of the optic nerve* due to syphilis.

c. *Symptomatic neurosyphilis* in any form.

d. Complications or residuals of venereal disease of such chronicity or degree that the individual would not be expected to perform useful duty.

## CHAPTER 7

### MEDICAL FITNESS STANDARDS FOR MISCELLANEOUS PURPOSES (Short Title: MISCELLANEOUS MEDICAL FITNESS STANDARDS)

#### Section I. GENERAL

##### 7-1. Scope

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

- a. Airborne training and duty, ranger training and duty, and special forces training and duty.
- b. Army service schools.
- c. Diving training and duty.
- d. Enlisted military occupational specialties.

- e. Geographical area assignments.
- f. Service academies other than the US Military Academy.

##### 7-2. Applicability

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

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

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

The causes of medical unfitness for initial selection for airborne training, ranger training, and special forces training are all the causes listed in chapter 2, plus all the causes listed in this section.

- 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, emesis, deafness, or tinnitus.

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

##### f. *Extremities.*

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

##### g. *Eyes and vision.*

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

(2) For airborne and ranger training and duty. Distant visual acuity of any degree that does not correct to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.

(3) For special forces training and duty. Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye. Vision which does not correct to 20/20 in at least one eye with spectacle lenses.

- (4) Color vision. Failure to identify red and/or

green as projected by the Ophthalmological Projector or the Stereoscope, Vision Testing. (No requirement for ranger training.)

*h. Genitourinary system.* Paragraphs 2-14 and 2-15.

*i. Head and neck.*

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull.

(3) Persistent neuralgia; tic douloureux; facial paralysis.

(4) A history of subarchnoid hemorrhage.

*j. Heart and vascular system.* Paragraphs 2-18, 2-19, and 2-20.

*k. Height.* No special requirement.

*l. Weight.* No special requirement.

*m. Body build.* Paragraph 2-23.

*n. Lungs and chest wall.*

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

(2) Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying if discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

*o. Mouth, nose, pharynx, larynx, trachea and esophagus.* Paragraphs 2-27, 2-28, 2-29 and 2-30.

*p. Neurological disorders.*

(1) Paragraph 2-31.

(2) Active disease of the nervous system of any type.

(3) Craniocerebral injury (para 4-23a(6)).

*g. 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 and 2-37.

(2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than inch.

(3) Spondylolysis, spondylolisthesis.

(4) Healed fractures or dislocations of the vertebrae.

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

*t. Systemic disease and miscellaneous conditions and defects.*

(1) Paragraphs 2-38 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.

#### **7-5. Medical Fitness Standards for Initial Selection for Free Fall Parachute Training**

The causes of medical unfitness for initial selection for free fall parachute training are the causes listed in chapter 2 plus the causes listed in this section. Disposition of Medical Reports: The appropriate medical reports, SF 88, SF 93 or DA Form 4497-R, will be forwarded to the Commandant, US Army Institute for Military Assistance, ATTN: AFJK-MD, Fort Bragg, NC 28307 for review and approval.

*a. Abdomen and gastrointestinal system.* Paragraph 2-3.

*b. Blood and blood-forming disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

*c. Dental.*

(1) Paragraph 2-5.

- (2) Any unserviceable teeth until corrected.
- d. Ears and hearing.*
- (1) Paragraphs 2-6 and 2-7.
- (2) Abnormal labyrinthine function.
- (3) Any infectious process of the ear, including external otitis, until completely healed.
- (4) History of attacks of vertigo with or without nausea, emesis, deafness or tinnitus.
- (5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of eustachian tube.
- (6) Perforation, marked scarring or thickening of the ear drum.
- e. Endocrine and metabolic diseases.* Paragraph 2-8.
- f. Extremities.*
- (1) Paragraphs 2-9, 2-10 and 2-11.
- (2) Any limitation of motion of any joint which might compromise safety.
- (3) Any loss of strength which might compromise safety.
- (4) Instability of any degree or pain in a weight bearing joint.
- g. Eyes and vision.*
- (1) Paragraphs 2-12 and 2-13.
- (2) Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye.
- (3) Distant visual acuity of any degree that does not correct to at least 20/30 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.
- (4) Color vision. Failure to identify red and green.
- h. Genitourinary system.* Paragraphs 2-14 and 2-15.
- i. Head and neck.*
- (1) Paragraphs 2-16 and 2-17.
- (2) Loss of bony substance of the skull if retention of personal protective equipment is affected.
- (3) A history of subarachnoid hemorrhage.
- j. Heart and vascular system.* Paragraphs 2-18, 2-19 and 2-20.
- k. Height.* Paragraph 2-21.
- l. Weight.* Paragraph 2-22.
- m. Body Build.* Paragraph 2-23.
- n. Lungs and chest wall.*
- (1) Paragraphs 2-24, 2-25 and 2-26.
- (2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation/perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the examination and clinical evaluation shows complete recovery with normal pulmonary function.

*o. Mouth, nose, pharynx, larynx, trachea and esophagus.* Paragraphs 2-27, 2-28, 2-29 and 2-30.

*p. Neurological disorders.*

(1) Paragraph 2-31.

(2) The criteria outlined in paragraph 4-23 for Class 2 and 3 flying duty apply.

*q. Psychoses, psychoneuroses and personality disorders.*

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

(2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress. When in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

*r. Skin and cellular tissues.* Paragraph 2-35.

*s. Spine, scapulae, ribs and sacroiliac joints.*

(1) Paragraphs 2-36 and 2-37.

(2) Spondylolysis, spondylolisthesis.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

*t. Systemic diseases and miscellaneous conditions and defects.*

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

(2) Blood donations. Personnel will not perform free fall parachute duties for a period of 72 hours following the donation of blood.

(3) Chronic motion sickness.

(4) Any severe illness, operation, injury or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

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

v. *Venereal diseases.* Paragraph 2-42.

#### **7-6. Medical Fitness Standards for Retention for Free Fall Parachute Duty**

Retention of an individual in free fall parachute

### **★ Section III. MEDICAL FITNESS STANDARDS FOR ARMY SERVICE SCHOOLS**

#### **7-7. Medical Fitness Standards for Army Service Schools**

The medical fitness standards for Army service

duty will be based on—

a. The service member's demonstrated ability to perform satisfactorily free fall parachute duty.

b. The effect upon the individual's health and well-being by remaining on free fall parachute duty.

schools, except as provided elsewhere herein, are covered in DA Pam 351-4.

### **★ Section IV. MEDICAL FITNESS STANDARDS FOR DIVING TRAINING AND DUTY**

#### **7-8. Medical Fitness Standards for Initial Selection for Marine (SCUBA) Diving Training (Special Forces and Ranger Combat Diving)**

The causes of medical unfitness for initial selection for marine (SCUBA) diving training are the causes listed in chapter 2 plus the causes listed in this section. Disposition of Medical Reports: The appropriate medical reports, SF 88, SF 93 or DA Form 4497-R will be forwarded to the Commandant, US Army Institute for Military Assistance, ATTN: AFJK-MD, Fort Bragg, NC 28307 for review and approval.

a. *Abdomen and gastrointestinal system.* Paragraph 2-3.

b. *Blood and blood-forming disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

c. *Dental.*

(1) Paragraph 2-5.

(2) Any unserviceable teeth until corrected.

(3) Moderate malocclusion, extensive restoration or replacement by bridges or dentures which interfere with use of self-contained underwater breathing apparatus (SCUBA).

d. *Ears and hearing.*

(1) Paragraphs 2-6 and 2-7.

(2) Abnormal labyrinthine function.

(3) Any infectious process of the ear, including external otitis, until completely healed.

(4) History of attacks of vertigo with or without nausea, emesis, deafness or tinnitus.

(5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of eustachian tube.

(6) Perforation, marked scarring or thickening of the ear drum.

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

f. *Extremities.*

(1) Paragraphs 2-9, 2-10 and 2-11.

(2) Any limitation of motion of any joint which might compromise safety.

(3) Any loss of strength which might compromise safety.

(4) Instability of any degree or pain in a weight bearing joint.

(5) History of aseptic necrosis of bone.

g. *Eyes and vision.*

(1) Paragraphs 2-12 and 2-13.

(2) Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye.

(3) Distant visual acuity of any degree that does not correct to at least 20/30 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.

(4) Uncorrected distant visual acuity of worse than 20/70 in either eye.

(5) Color vision. Failure to identify red and green.

h. *Genitourinary system.* Paragraphs 2-14 and 2-15.

i. *Head and neck.*

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected.

(3) History of subarachnoid hemorrhage.

j. *Heart and vascular system.* Paragraphs 2-18, 2-19 and 2-20.

k. *Height.* Paragraph 2-21.

*l. Weight.*

- (1) Paragraph 2-22.
- (2) Weight related to height which is below the minimum shown in table IV, appendix III.
- (3) Weight related to height which is above the maximum shown in table IV, appendix III.

*m. Body build.*

- (1) Paragraph 2-23.
- (2) Obesity of any degree.

*n. Lungs and chest wall.*

- (1) Paragraphs 2-24, 2-25 and 2-26.
- (2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation/perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the examination and clinical evaluation shows complete recovery with normal pulmonary function.

*o. Mouth, nose, pharynx, larynx, trachea and esophagus.* Paragraphs 2-27, 2-28, 2-29 and 2-30.

*p. Neurological disorders.*

- (1) Paragraph 2-31.
- (2) The criteria outlined in paragraph 4-23 for Class 2 and 3 flying duty apply.

*q. Psychoses, psychoneuroses and personality disorders.*

- (1) Paragraphs 2-32, 2-33 and 2-34.
- (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress. When in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

(8) Fear of depths, inclosed places or of the dark.

*r. Skin and cellular tissues.* Paragraph 2-35.

*s. Spine, scapulae, ribs and sacroiliac joints.*

- (1) Paragraphs 2-36 and 2-37.
- (2) Spondylolysis, spondylolisthesis.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

*t. Systemic diseases and miscellaneous conditions and defects.*

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

(2) Chronic motion sickness.

(3) Any severe illness, operation, injury or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

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

*v. Venereal diseases.* Paragraph 2-42.

### **7-9. Medical Fitness Standards for Retention for Marine (SCUBA) Diving Duty (Special Forces and Ranger Combat Diving)**

Retention of an individual in marine (SCUBA) diving duty will be based on—

*a.* The service member's demonstrated ability to perform satisfactorily marine (SCUBA) diving duty.

*b.* The effect upon the individual's health and well-being by remaining on marine (SCUBA) diving duty.

### **7-10. Medical Fitness Standards for Initial Selection for Other Marine Diving Training (MOS 00B)**

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.
- (3) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

*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.
- (4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures, which interfere with use of self-contained underwater breathing apparatus (SCUBA).

*d. Ears and hearing.*

- (1) Paragraph 2-6.
- (2) Perforation, marked scarring or thickening of the ear drum.
- (3) Inability to equalize pressure on both sides of the ear drums while under 50 pounds of pressure in a compression chamber.
- (4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.
- (5) Hearing acuity level in either ear by audiometric testing (regardless of conversational or whispered voice hearing acuity) which exceeds 15 decibels at any of the frequencies 256, 512, 1024, 2048, or which exceeds 40 decibels at frequency 4096.
- (6) History of otitis media or otitis externa at any time.

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

- (1) Paragraphs 2-9, 2-10, and 2-11.
- (2) History of any chronic or recurrent orthopedic pathology.
- (3) Loss of any digit of either hand.
- (4) Fracture or history of disease or operation involving any major joint.
- (5) Any limitation of the strength or range of motion of any of the extremities.

*g. Eyes and vision.*

- (1) Paragraph 2-12.
- (2) Distant visual acuity, uncorrected, of less than 20/40 in each eye.
- (3) *Color vision:*
  - (a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set, or
  - (b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set.
  - (c) When administered in lieu of (a) or (b) above, failure to pass the Farnsworth Lantern Test (FALANT) (USN Test).
- (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 4-14.
- j. Heart and vascular system.*
  - (1) Paragraphs 2-18, 2-19, and 2-20.
  - (2) Varicose veins of any degree.
  - (3) Marked or symptomatic hemorrhoids.
  - (4) Persistent tachycardia or arrhythmia except of sinus type.

*k. Height.* No special requirement.*l. Weight.*

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

*m. Body build.*

- (1) Paragraph 2-23.
- (2) Obesity of any degree.

*n. Lungs and chest wall.*

- (1) Paragraphs 2-24, 2-25, and 2-26.
- (2) Congenital or acquired defects which restrict pulmonary function, cause air trapping or affect ventilation-perfusion ratio.
- (3) Any pulmonary disease at the time of examination.
- (4) Inability to hold breath for 60 seconds subsequent to deep breathing.

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

- (1) Paragraphs 2-27, 2-28, 2-29, and 2-30.
- (2) History of chronic or recurrent sinusitis at any time.
- (3) Any nasal or pharyngeal respiratory obstruction.
- (4) Chronically diseased tonsils until removed.
- (5) Speech impediments due to organic defects.

*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 defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe driving.

u. *Tumors and malignant diseases.* 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.

#### **7-11. Medical Fitness Standards for Retention for Other Marine Diving Duty (MOS 00B)**

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

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

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

c. Must maintain their ability to equalize air pressure.

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

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

#### **7-12. Medical Fitness Standards for Enlisted Military Occupational Specialties ★**

a. The medical fitness standards to be utilized in the initial selection of individuals to enter a specific enlisted military occupational specialty (MOS) are contained in AR 611-201. Visual acuity requirements for this purpose will be based upon the individuals' vision corrected by spectacle lenses.

b. Individuals who fail to meet the minimum medical fitness standards established for a particular enlisted MOS, but who perform the duties of the MOS to the satisfaction of the commander concerned are medically fit to be retained in that specialty except when there is medical evidence to the effect that continued performance therein will adversely affect their health and wellbeing.

### **Section VI. MEDICAL FITNESS STANDARDS FOR CERTAIN GEOGRAPHICAL AREAS**

#### **7-13. Medical Fitness Standards for Certain Geographical Areas ★**

a. All individuals considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States are medically qualified to serve in similar or corresponding areas outside the continental United States.

b. Certain individuals, by reason of certain medical conditions or certain physical defects, may require administrative consideration when assignment to certain geographical areas is contemplated to insure that they are utilized within their medical

capabilities without undue hazard to their health and well-being. In many instances, such individuals can serve effectively in a specific assignment when the assignment is made on an individual basis considering all of the administrative and medical factors. Guidance as to assignment limitations indicated for various medical conditions and physical defects is contained in chapter 9 and c below.

★c. MAAG's, military attachés, military missions and duty in isolated areas (see AR 55-46, AR 600-200, and AR 612-2).

(1) The following medical conditions and defects will preclude assignments or attachment to

duty with MAAG's, military attachés, military missions, or any type duty in isolated oversea stations requiring residence in areas where US military treatment facilities are limited or nonexistent:

(a) A history of peptic ulcer which has required medical or surgical management within the preceding 3 years.

(b) A history of colitis.

(c) A history of emotional or mental disorders, including character disorders, of such a degree as to have interfered significantly with past adjustment or to be likely to require treatment during this tour.

d. Any medical condition where maintenance medication is of such toxicity as to require frequent clinical and laboratory followup.

e. Inherent, latent, or incipient medical or dental conditions which are likely to be aggravated by climate or general living environment prevailing in the area where individual is expected to reside, to such a degree as to preclude acceptable performance of duty.

(2) Of special consideration is a thorough evaluation of a history of chronic cardiovascular respiratory, or nervous system disorders. This is especially important in the case of individuals with these disorders who are scheduled for assignment and/or residence in an area 6,000 feet or more above

sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Colombia; and Addis Ababa, Ethiopia.

(3) Remediable medical, dental, or physical conditions or defects which might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure from CONUS.

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

★d. The medical fitness standards set forth in c above are prescribed for the purpose of meeting selection criteria for military personnel under consideration for assignment or attachment to duty with MAAG's, military attachés, military missions or any type duty in isolated oversea stations. These fitness standards also pertain to dependents of personnel being considered.

### Section VII. MEDICAL FITNESS STANDARDS FOR ADMISSION TO SERVICE ACADEMIES OTHER THAN US MILITARY ACADEMY

#### 7-14. Medical Fitness Standards for Admission to US Naval Academy ★

The medical fitness standards for admission to the United States Naval Academy are set forth in chapter 15 of the Manual of the Medical Department, US Navy as well as NAVPERS 15.010 Regulations Governing the Admission of Candidates into the United States Naval Academy as Midshipmen.

#### 7-15. Medical Fitness Standards for Admission to US Air Force Academy

The medical fitness standards for admission to the United States Air Force Academy are set forth in section VI of AFM 160-1, Medical Examination. The special administrative criteria in paragraphs 7-16 through 7-19 are listed for the information and guidance of all concerned.

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

#### 7-16. Dental—Induction, Enlistment or Appointment ★ (See para 2-5.)

★a. Except for physicians, dentists and allied medical specialists, individuals who have orthodontic appliances and who are under active treatment are administratively unacceptable for enlist-

ment or induction into the Active or Reserve Components of the Army, Air Force, Navy and Marine Corps for an initial period not to exceed 12 months from the date that treatment was initiated. Selective service registrants will be reexamined after the 12-month period. After the 12-month period, wherein a longer period of treatment is allegedly re-

quired, the registrant will be scheduled by the examining AFEES for consultation by a civilian or military orthodontist, and the report of this consultation will be forwarded through the Chief, Medical Section, Headquarters, United States Army Recruiting Command, Fort Sheridan, IL 60037 to the Commander, United States Army Health Services Command, Fort Sam Houston, TX 78234 for final determination of acceptability. The Commanding General, United States Army Health Services Command will coordinate, as appropriate with the Surgeon General, US Air Force or the Chief, Bureau of Medicine and Surgery, Department of the Navy on individuals whose induction into the Air Force, Navy, or Marine Corps is being considered. Physicians, dentists, and allied medical specialists liable for induction will be evaluated in accordance with the standards prescribed by chapter 8 of this regulation.

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

*c.* Officers and enlisted personnel of the Active Army, Army National Guard, and the Army Reserve are acceptable for active duty, or active duty for training if the orthodontic appliances were affixed subsequent to the date of original appointment or enlistment.

*d.* Cadets at the USMA or in the ROTC are also acceptable for appointment and active duty if the orthodontic appliances were affixed prior to or since entrance into these programs.

*e.* Individuals with retainer orthodontic appliances who are not required to undergo active treatment are administratively acceptable for appointment, enlistment, or induction.

#### **7-17. Height—Regular Army Commission ★**

(See para 2-21a(1).)

Individuals being considered for appointment in the Regular Army who are over the maximum or under the minimum height standards will automatically be considered on an individual basis for an administrative waiver by Headquarters, Department of the Army, during the processing of their applications.

#### **7-18. Height—United States Military Academy ★**

(See para 5-16.)

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

Candidates for admission to the United States Military Academy who are over the maximum height or below the minimum height will automatically be recommended by the Department of Defense Medical Review Board for consideration for an administrative waiver by Headquarters, Department of the Army, during the processing of their cases, which may be granted provided they have exceptional educational qualification, have an outstanding military record, or have demonstrated outstanding abilities.

#### **7-19. Vision—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps ★**

*a.* Individuals being initially appointed or assigned as officers in Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps may possess uncorrected distance visual acuity of any degree that corrects with spectacle lenses to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, and be able to identify without confusion the colors vivid red and vivid green.

*b.* Retention of an officer in any of the branches listed in *a* above will be based on:

(1) The officer's demonstrated ability to perform appropriate duties commensurate with his age and grade.

(2) The officer's medical fitness for retention in Army service shall be determined pursuant to chapter 3, including paragraphs 3-15 and 3-16.

(3) If the officer is determined to be medically unfit for retention in Army service, but is continued on active duty or in Reserve Component service not on active duty under appropriate regulations, such continuance may also constitute a basis for retention of the officer in any of the branches listed in *a* above.

**Section IX. MEDICAL FITNESS STANDARDS FOR TRAINING AND DUTY AS NUCLEAR  
POWERPLANT OPERATORS AND/OR OFFICER-IN-CHARGE (OIC) NUCLEAR POWERPLANT  
(Ref. TB MED 267)**

**7-20. Medical Fitness Standards for Training and Duty at Nuclear Powerplants ★**

The causes for medical unfitness for initial selection, training, and duty as nuclear powerplant operators and/or Officer-in-Charge (OIC) nuclear powerplants are all the causes listed in chapter 2, plus the following:

- a. Paragraph 7-9d.
- b. Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or a vivid green.
- c. Familial history of any of the following (refer to TB MED 267):
  - (1) Congenital malformations.
  - (2) Leukemia.
  - (3) Blood clotting disorders.
  - (4) Mental retardation.

(5) Cancer.

(6) Cataracts (early).

d. Abnormal results from the following studies which will be accomplished (see TB MED 267):

(1) White cell count (with differential).

(2) Hematocrit.

(3) Hemoglobin.

(4) Red cell morphology.

(5) Sickle cell preparation (for individuals of susceptible groups).

(6) Platelet count.

(7) Fasting blood sugar.

e. Presence or history of psychiatric illness requiring hospitalization or extensive treatment, or personality disorders, including alcoholism, where either, in the opinion of the examining officer, would make assignment at this specialty inadvisable.

**Section X. SPECIAL MEDICAL FITNESS STANDARDS FOR AVIATION TRAINING**

**7-21. Standards ★**

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

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

b. *Refractive error*.

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

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

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

**7-22. Senior Career Officers ★**

Selected senior career officers of the Army in the grades of Lieutenant Colonel, promotable, and Colonel may be medically qualified for initial flight training under the following medical fitness standards:

a. Class 2, medical fitness standards for flying as prescribed in chapter 4, except—

(1) *Vision*. Uncorrected distant visual acuity of less than 20/100 in each eye or not correctable with spectacle lenses to 20/20 in each eye. Near visual acuity not correctable to 20/20 in each eye with spectacle lenses.

(2) *Refractive error*.

(a) *Astigmatism*. Greater than 1.00 diopter.

(b) *Hyperopia*. Greater than 1.75 diopters for individuals under the age of 35 years and greater than 2.00 diopters for individuals age 35 and over, in any meridian.

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

b. Unsatisfactory ARMA.

## CHAPTER 8

# MEDICAL FITNESS STANDARDS FOR PHYSICIANS, DENTISTS, AND ALLIED MEDICAL SPECIALISTS

### (Short Title: MEDICAL SPECIALISTS MEDICAL FITNESS STANDARDS)

#### Section I. General

##### 8-1. Scope

This chapter sets forth the minimum level of medical fitness standards for physicians, dentists, and allied medical specialists, including applicants for The Armed Forces Health Professions Scholarship Program.

##### 8-2. Applicability

a. These standards apply only in evaluating physicians, dentists, or allied medical specialists, including applicants for The Armed Forces Health Professions Scholarship Program for—

(1) Induction.

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

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

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

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

★c. As used further in this chapter, all references to "physicians, dentists, and allied medical specialists" is meant to include applicants for and participants in The Armed Forces Health Professions Scholarship Program, and postgraduate medical and dental education programs.

##### 8-3. Department of Defense Policy

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

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

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

##### 8-4. Questionable Cases

Questionable cases involving the diagnoses listed below will be referred in accordance with current procedures to the Commander, United States Army Health Services Command, 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.*

*f. Nephrolithiasis.*

## Section II. MEDICAL FITNESS STANDARDS

### 8-5. Basic Medical Fitness Standards

*a.* The nature of the duties expected of physicians, dentists, and allied medical specialists is such, in general, that although they may have physical defects or medical conditions which would ordinarily be cause for rejection for original entry into the military service, they may be expected to perform appropriate military duties in their specialties.

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

### 8-6. Abdomen and Gastrointestinal System

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

*a.* Paragraphs 3-5 and 3-6.

*b. Amebiasis.* A history of amebiasis when active hepatic involvement is present.

*c. Anal fistula* with extensive multiple sinus tracts.

*d. Chronic cholecystitis or cholelithiasis* if disabling for civilian practice.

*e. Liver disease.* A history of liver disease when presence of liver disease is manifested by hepatomegaly or abnormal liver function studies. If disease is considered temporary: deferment for reexamination at a later date.

*f. Peptic ulcer.* A history of peptic ulcer complicated by obstruction, verified history of perforation, or recurrent hemorrhage is disqualifying. An individual with X-ray evidence of an active ulcer will be deferred for reexamination at a later date. A history of peptic ulcer or a healed ulcer, with scarring, but without a niche or crater as demonstrated by X-ray, is acceptable.

*g. Splenectomy.* A history of splenectomy except when the surgery was for trauma, surgery unrelated to disease of the spleen, hereditary spherocytosis, or disease involving the spleen where splenectomy was followed by correction of the condition for a period of at least 2 years.

*h. Ulcerative colitis.* Confirmed by proctosigmoidoscopic or X-ray findings.

### 8-7. Blood and Blood-Forming Tissue Diseases

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

### 8-8. Dental

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

### 8-9. Ears and Hearing

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

*a.* Paragraph 3-9.

*b. Auditory acuity.* Hearing which cannot be improved in one ear with a hearing aid to an average hearing level of 20 decibels or less in the speech reception range. Unilateral deafness is not disqualifying.

*c. Meniere's syndrome.* An individual who suffers Meniere's syndrome is disqualified when he has severe recurring attacks which cannot be controlled by treatment or requires hospitalization of sufficient frequency to interfere materially with civilian practice.

*d. Otitis media,* if chronic, suppurative, resistant to treatment, and necessitating hospitaliza-

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tion of sufficient frequency to interfere materially with civilian practice.

dentists, and allied medical specialists are the causes listed in paragraph 8-11.

**8-10. Endocrine and Metabolic Diseases**

**8-11. Extremities**

The causes of medical unfitness for physicians,

The causes of medical unfitness for physi

cians, dentists, and allied medical specialists are—

a. Paragraphs 3-12, 3-13, 3-14, and 8-22.

b. *Amputation of leg or thigh* if suitable prosthesis is not available or if the use of a cane or crutch is required.

c. *Weight bearing joints.* Inability to bear weight. Instability of a weight bearing joint or any disease processes of weight bearing joints requiring use of a cane or crutch.

*d. Congenital or acquired deformities* of the feet when shoes cannot be worn or if the individual is required to use a cane or crutches.

*e. Dislocated semilunar cartilage* when disabling for civilian practice.

*f. Loss of fingers or toes.* Qualification will be based upon the individual's ability to perform civilian practice in his speciality.

*g. Osteomyelitis.* Where there has been X-ray or other evidence of bone infection, drainage, or disturbance of weight bearing function in the preceding 12 months.

*h. Paralysis secondary to poliomyelitis* when suitable brace cannot be worn or if cane or crutches are required for the lower extremities. Mobility of the extremities should be adequate to assure useful function thereof and a military appearance.

*i. Old ununited or malunited fractures,* involving weight-bearing bones when there is sufficient shortening or deformity to prevent the performance of military duty.

### 8-12. Eyes and Vision

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

*a.* The causes listed in paragraphs 3-17 and 3-16, except as modified below.

*b.* Absence of an eye or when visual acuity has been reduced to light perception only when there is active eye disease in the other eye or the vision in the other eye does not correct to at least 20/30.

### 8-13. Genitourinary System

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

*a.* The causes listed in paragraphs 3-17 and 3-18.

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

*c. Kidney.*

(1) Absence of one kidney where there is progressive disease or impairment of function

in the remaining kidney.

(2) Cystic (polycystic kidney). Asymptomatic, history of.

*d. Nephritis.* A history of nephritis, with residuals such as hypertension or abnormal urinary or blood findings.

*e. Nephrolithiasis. (Rescinded.)*

### 8-14. Head and Neck

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

*a.* Paragraphs 3-19 and 3-20.

*b.* Skull defects are acceptable unless residual signs and symptoms are incapacitating in civilian practice.

### 8-15. Heart and Vascular System

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

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

*b. Auricular fibrillation.* Paroxysmal auricular fibrillation with evidence of organic heart disease, or persistent auricular fibrillation from any cause.

*c. Auriculoventricular block,* when due to organic heart disease.

*d. Coarctation of the aorta and other significant congenital anomalies of the vascular system* unless satisfactorily treated by surgical correction.

*e. Hypertension.* Blood pressure frequently elevated to 200/120 or more (which returns to normal limits with rest and sedatives) or a persistent diastolic pressure over 110-mm mercury even though cerebral, renal, cardiac, and retinal findings are normal.

*f. Phlebitis.* Recurrent phlebitis, other than mild. Residuals of phlebitis, such as persistent edema, dermatitis, ulceration, or claudication, which interfere materially with civilian practice, also make the individual medically unfit.

*g. Valvular heart disease.* Cardiac insufficiency at a functional capacity level of Class IIC

or worse, American Heart Association (app VII).

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

*i. Rheumatic fever.*

(1) Residuals involving the heart at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

(2) Verified history of recurrent attacks, cardiac involvement, or subacute bacterial endocarditis within the past 2 years.

### 8-16. Height, Weight, and Body Build (Rescinded.)

### 8-17. Lungs and Chest Wall

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

*a. Paragraphs 3-24 and 3-25.*

*b. Bronchial asthma.* Associated with emphysema of sufficient degree to interfere with performance of duty, or with frequent attacks controlled only by continuous systemic corticosteroid therapy, or with frequent attacks which are not controlled by oral medication.

*c. Bronchiectasis and emphysema.* When outpatient treatment or hospitalization is of such frequency as to interfere materially with civilian practice. Bronchiectasis confined to one lobe is usually acceptable; however, the saccular, systic, and dry types, involving more than one lobe, make the individual medically unfit.

*d. Chronic bronchitis* complicated by disabling emphysema or requiring outpatient treatment or hospitalization of such frequency as to interfere materially with civilian practice.

★*e. Pleurisy with effusion* of unknown etiology within the previous year.

*f. Sarcoidosis.* Symptomatic pulmonary sarcoidosis which has not responded promptly to therapy or which is complicated by residual pulmonary fibrosis.

*g. Spontaneous pneumothorax* with recovery is acceptable.

*h. Tuberculosis.*

(1) Tuberculosis, active in any form or location. A positive skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy

because of recent skin test conversion are not disqualified.

(2) A history of active tuberculosis within the past two years which has not been treated with adequate drug therapy.

(3) A history of active tuberculosis within one year which has been or continues to be treated with drug therapy. A person in whom tuberculosis has been inactive for more than one year and who may reasonably be expected to be physically capable of performing satisfactory professional and associated military duties is acceptable even though on active drug therapy.

(4) Tuberculosis which has caused pulmonary or other organ function impairment which would preclude satisfactory performance of duty.

### 8-18. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

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

*a. Paragraph 3-27.*

*b. Polyps or mucocles,* when moderate to severe, suppurative, and unresponsive to treatment.

*c. Chronic sinusitis,* when moderate to severe, suppurative, and unresponsive to treatment.

### 8-19. Neurological Disorders

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the causes listed in paragraph 3-28.

### 8-20. Psychoses, Psychoneuroses, and Personality Disorders

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

*a. Paragraphs 3-29, 3-30, 3-31, and 3-32.*

★*b. Psychoneurosis* when severe and incapacitating for practice in civilian life. An individual who is undergoing continuous active neuropsychiatric therapy should be deferred and reconsidered at a later date. Neuropsychiatric consultation, in addition to Standard Forms 88 and 93 on an individual who is or claims to be a sexual deviate will be referred

to the Commander, United States Army Health Services Command, for an opinion of acceptability prior to qualification.

*c. Psychosis* of organic or functional etiology, except if in complete remission for 2 years or more. Neuropsychiatric consultation, in addition to Standard Forms 88 and 93, will be sent to the Commander, United States Army Health Services Command, Fort Sam Houston, TX 78234, for an opinion of acceptability prior to qualification.

### 8-21. Skin and Cellular Tissues

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

*a. Paragraph 3-33.*

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

*c. Pilonidal cysts* are acceptable.

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

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

*a. The causes listed in paragraph 3-34.*

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

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

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

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

### 8-23. Systemic Diseases and Miscellaneous Conditions and Defects

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

★*a. The causes listed in paragraphs 3-35 and 3-36.*

*b. Tuberculosis.*

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

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

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

### 8-24. Tumors and Malignant Diseases

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

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

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

### 8-25. Venereal Diseases

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

## CHAPTER 9 PHYSICAL PROFILING

### Section I. GENERAL

#### 9-1. Scope

This chapter sets forth a system of classifying individuals according to functional abilities.

#### 9-2. Applicability

The physical profile system is applicable to the following categories of personnel:

★*a.* Registrants who undergo an induction or preinduction medical examination related to Selective Service processing.

*b.* Applicants for enlistment or appointment in the United States Army (Active and Reserve Components).

*c.* Applicants for enlistment or appointment in the United States Marine Corps.

*d.* Applicants for enlistment in the United States Air Force.

*e.* Applicants for enlistment in the United States Navy when examined at Armed Forces examining stations.

*f.* Members of any component of the United States Army throughout their military service, whether or not on active duty.

#### 9-3. General

*a.* The physical profile serial system described herein is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential. The limitations must be fully described for the various codes in paragraph 9-5. This information will assist the unit commander and personnel officer in their determination of individual assignment or reclassification action. In developing the system, the func-

tions have been considered under six factors. For ease in accomplishing and applying the profile system, these factors have been designated "P-U-L-H-E-S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, rather than the defect per se, will be evaluated carefully in determining the numerical designation 1, 2, 3, or 4.

*b.* Aids such as X-ray films, electrocardiograms, and other specific tests which give objective findings will also be given due consideration. The factor to be considered, the parts affected, and the bodily function involved in each of these factors are as follows:

(1) *P—Physical capacity or stamina.* This factor concerns general physical capacity. It normally includes conditions of the heart; respiratory system; gastrointestinal system; genitourinary system; nervous system; allergic, endocrine, metabolic, and nutritional diseases; diseases of the blood and blood-forming tissues; dental conditions; diseases of the breast; and other organic defects and diseases which do not fall under other specific factors of the system. In arriving at a profile under this factor, it may be appropriate to consider build, strength, endurance, height-weight-body build relationship, agility, energy, and muscular coordination.

(2) *U—Upper extremities.* This factor concerns the hands, arms, shoulder girdle, and spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) *L—Lower extremities.* This factor concerns the feet, legs, pelvic girdle, lower back musculature, and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) *H—Hearing and ear.* This factor concerns auditory acuity and diseases and defects of the ear.

(5) *E—Eyes.* This factor concerns visual acuity

and diseases and defects of the eye.

(6) *S—Psychiatric*. This factor concerns personality, emotional stability, and psychiatric diseases.

c. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical (physical and mental) fitness and, consequently, is medically fit for any military assignment.

(2) A physical profile "2" under any or all factors indicates that an individual meets procurement (entry) standards, but possesses some medical condition or physical defect which may impose some limitations on initial MOS classification (see AR 611-201) and assignment. As an exception to the provisions of paragraph 9-5, individuals with numerical designator "2" under one or more factors, who are determined by a medical board to require an assignment limitation, will be awarded specific assignment limitations under code U.

(3) A profile containing one or more numerical designations "3" signifies that the individual has medical condition(s) or physical defect(s) which require certain restrictions in assignment, within which the individual is physically capable of performing full military duty. Such individuals are not acceptable under procurement (entry) standards in time of peace, but may be acceptable in time of partial or total mobilization. They meet the retention standards, while in service, but should receive assignments commensurate with their functional capability.

(4) A profile serial containing one or more numerical designators "4" indicates that the individual has one or more medical conditions or physical defects listed in chapter 3 of this regulation. The numerical designator "4" does *not* necessarily mean that the member is unfit because of physical disability as defined in AR 635-40. When a numerical designator "4" is used, there are significant assignment limitations which must be fully described if such an individual is returned to duty. Code "V" "W" or "Y" is required (para 9-5).

★*d*. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and

the possibility of further aggravation must also be considered. IN THIS RESPECT, PROFILING OFFICERS MUST CONSIDER THE EFFECT OF THEIR RECOMMENDATIONS UPON THE SOLDIER'S ABILITY TO PERFORM DUTY. PROFILES INCLUDING ASSIGNMENT LIMITATIONS, TEMPORARY OR PERMANENT, WHICH ARE RECORDED ON DA FORM 3349 PRESCRIBED BY THIS CHAPTER OR ON DD FORM 689, INDIVIDUAL SICK SLIP (FOR TEMPORARY PROFILES NOT TO EXCEED 30 DAYS AS PRESCRIBED BY AR 600-6) MUST BE REALISTIC. ALL PROFILES AND ASSIGNMENT LIMITATIONS MUST BE LEGIBLE, SPECIFIC AND WRITTEN IN LAY TERMS. SINCE PERFORMANCE OF ARMY DUTY AND ARMY UNIT EFFECTIVENESS ARE MAJOR CONSIDERATIONS, A CLOSE PERSONAL RELATIONSHIP MUST EXIST BETWEEN PHYSICIANS AND UNIT COMMANDERS/PERSONNEL MANAGEMENT OFFICERS.

(1) DETERMINATION OF INDIVIDUAL ASSIGNMENT OR DUTIES TO BE PERFORMED ARE COMMAND/ADMINISTRATIVE MATTERS. LIMITATIONS SUCH AS "NO FIELD DUTY," "NO OVERSEA DUTY," "MUST HAVE SEPARATE RATIONS," ARE NOT PROPER MEDICAL RECOMMENDATIONS.

(2) IT IS THE RESPONSIBILITY OF THE COMMANDER/PERSONNEL MANAGEMENT OFFICER TO DETERMINE PROPER ASSIGNMENT AND DUTY, BASED UPON KNOWLEDGE OF THE SOLDIER'S PROFILE, ASSIGNMENT LIMITATIONS, AND THE DUTIES OF HIS GRADE AND MILITARY OCCUPATIONAL SPECIALTY (MOS).

(3) APPENDIX VIII CONTAINS THE PHYSICAL PROFILE CAPACITY GUIDE.

#### ★ 9-4. Modifier to Serial

To make a profile serial more informative, the modifier will be used as indicated below. These modifiers to the profile serial are not to be confused with code designation. Indicating permanent limitation, as described in paragraph 9-5.

a. "*P*"—*Permanent*. this modifier indicates that the profile is permanent and change may only be made by authority designated in paragraph 9-6.

b. "*T*"—*Temporary*. This modifier indicates that the condition necessitating numerical designation "3" or "4" is considered temporary, the correction or

treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Individuals on active duty and Reserve Component members not on active duty with a "T" modifier will be medically evaluated at least once every 3 months with a view to revising the profile. In no case will individuals in military status carry a "T" modifier for more than 12 months without positive action being taken either to correct the defect or to effect other appropriate disposition. As a general rule, the physician initiating the "T" modifier will initiate appropriate arrangements for the necessary correction or treatment of the temporary condition.

c. *Records.* Whenever a temporary medical condition is recorded on the DA Form 3349 (Physical Profile Board Proceedings) or SF 88 (Report of Medical Examination) or is referred to in a routine personnel

action, the modifier "T" will be entered immediately following each PULHES numerical designator when a temporary condition exists.

**9-5. Representative Profile Serial and Codes**

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, the following code designations have been adopted to represent certain combinations of numerical designators in the various factors and most significant assignment limitations. The alphabetical coding system will be recorded on Personnel Qualification Records. This coding system will not be used on medical records to identify limitations. The numerical designations under each profile factor, PULHES, are set forth in appendix VIII.

	<i>Description/assignment limitation</i>	<i>Medical criteria</i>
(1) Profile Serial 111111. CODE A.....	No assignment limitation. Is considered medically fit for initial assignment under all PULHES factors for Ranger, Airborne, Special Forces training, and training in any MOS.	No demonstrable anatomical or physiological impairment within standards established in appendix VIII.
★(2) Profile serial with a "2" as the lowest numerical designator. CODE B.....	May have assignment limitations which are intended to protect against further physical damage/injury. Combat fit. May have minor impairment under one or more PULHES factors which disqualify for certain MOS training or assignment.	Minor loss of digits, minimal loss of joint motion, visual and hearing loss below those prescribed for Code A in appendix VIII.
★(3) Profile serial with a "3" or "4" as the lowest numerical designator in any factor or as specified by a PPBD. CODE C.....	Meets retention standards. Possesses impairment of function limiting assignment within which individual is physically capable of performing full military duty.	
CODE D.....	No crawling, stooping, running, jumping, marching, or standing for long periods. (State time permitted in item 8.)	Vascular insufficiency; symptomatic flat feet; low back pathology; arthritis of low back or lower extremities.
CODE E.....	No mandatory strenuous physical activity. (State time in item 8.)	Organic cardiac disease; pulmonary insufficiency; hypertension, more than mild.
CODE F.....	No assignment to units requiring continued consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.
CODE G.....	No assignments to isolated areas where definitive medical care is not available (MAAG, Military Missions, etc.)	Individuals who require continued medical supervision or periodic followup: Cases of established pathology likely to require frequent outpatient care or hospitalization.
★CODE G.....	No assignment requiring handling of heavy materials including weapons (except individual weapon; e.g., rifle, pistol, carbine, etc.). No overhead work; no pullups or pushups. (State time permitted in item 8.)	Arthritis of the neck or joints of the upper extremities with restricted motion. Cervical disk disease; recurrent shoulder dislocation.

*Description/assignment limitation*

*Medical criteria*

CODE H. ....	No assignment where sudden loss of consciousness would be dangerous to self or others such as work on scaffolding, handling ammunition, vehicle driving, work near moving machinery.	Epileptic disorders (cerebral dysrhythmia) of any type; other disorders producing syncope attacks or severe vertigo, such as Meniere's syndrome.
★ CODE J. ....	<ol style="list-style-type: none"> <li>1. No exposure to noise in excess of 85dBA or weapon firing without use of properly fitted hearing protection. Annual hearing test required. No change in duty recommended.</li> <li>2. Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85dBA or weapon firing. (Not to include firing for POR Qualifications with proper ear protection.) Annual hearing test required. A SSI change is indicated.</li> <li>3. No exposure to noise in excess of 85dBA or weapon firing without use of properly fitted hearing protection. This individual is "deaf" in one ear. Any permanent hearing loss in good ear will cause serious handicap. Careful consideration must be given when assigning SSIs or special duty. Annual hearing test required.</li> <li>4. Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85dBA or weapon firing. (Not to include firing for POR Qualifications with proper ear protection.) No duty requiring acute hearing. A hearing aid must be worn to meet Medical Fitness standards.</li> </ol>	Susceptibility to acoustic trauma.
CODE L. ....	No assignment which requires daily exposure to extreme cold. (List specific time or areas in item 8.)	Documented history of cold injury; vascular insufficiency; collagen disease, with vascular or skin manifestations.
CODE M. ....	No assignment requiring exposure to high environmental temperature. (List specific time or areas in item 8.)	History of heat stroke; history of skin malignancy or other chronic skin diseases which are aggravated by sunlight or high environmental temperatures.
CODE N. ....	No continuous wearing of combat boots. (State the length of time in item 8.)	Any vascular or skin condition of the feet or legs which, when aggravated by continuous wear of combat boots, tends to develop unfitting skin lesions.
CODE P. ....	No continuous wearing of woolen clothes. (State the length of time in item 8.)	Established allergy to wool, moderate.
CODE U. ....	Limitation not otherwise described, to be considered individually. (Briefly define limitation in item 8.)	Any significant functional assignment limitation not specifically identified elsewhere. Includes conditions described under Profile S-3.
(4) Profile serial with a "4" as the lowest numerical designator in any factor.		

	Description/assignment limitation	Medical criteria
★ CODE V . . . . .	<i>Department of Army Flag.</i> This code identifies the case of a member with a disease, injury, or medical defect which is below the prescribed medical criteria for retention who is continued in the military service pursuant to AR 140-120, AR 635-40, or predecessor directives. The numerical designation "4" will be inserted under the appropriate factor in all such cases. Such individuals generally have rigid and strict limitations as to duty, geographic, or climatic area utilization. In some instances the individual may have to be utilized only within close proximity to a medical facility capable of handling such cases.	Chapter 3, AR 40-501.
★ CODE W . . . . .	<i>Waiver.</i> This code identifies the case of an individual with disease, injury, or medical defect which is below the prescribed medical criteria for retention who is accepted under the special provisions of chapter 8 or who is granted a waiver by direction of the Secretary of the Army. The numerical designation "4" will be inserted under the appropriate factor in all such cases. Such members generally have rigid and strict limitations as to duty, geographical, or climatic area utilization. In some instances the member may have to be utilized only within close proximity to a medical facility capable of handling such cases.	Chapters 3, 6, and 8, AR 40-501.
CODE Y . . . . .	<i>Fit for duty.</i> This code identifies the case of a member who has been determined to be fit for duty (not entitled to separation or retirement because of physical disability) after complete processing under AR 635-40, but who has medical conditions/physical impairments of such a degree that a numerical designator "4" in one or more factors of profile serial is appropriate.	

**★ 9-6. Profiling Officer**

a. Commanders of Army medical treatment facilities (MTFs) are authorized to designate one or more physician(s), dentist(s), optometrist(s), podiatrist(s), audiologist(s), nurse practitioner(s), and physician assistant(s) as profiling officers. The commander will assure that those so designated are thoroughly familiar with the contents of these regulations. Profiling officer limitations are:

(1) *Physicians.* No limitations. Changing from or to a permanent numerical designator "3" or "4" requires a Physical Profile Board (PPBD) (para 9-8).

(2) *Dentists, optometrists, podiatrists and audiologists.* No limitation within thier specialty

for awarding permanent numerical designators "1" and "2." Temporary numerical designator "3" may be awarded for a period not to exceed 30 days. Any extension of a temporary numerical designator "3" beyond 30 days must be confirmed by a physician. (The second member of the PPBD must always be a physician (see para 9-8).)

(3) Physician assistants and nurse practitioners are limited to awarding temporary numerical designators "1," "2" and "3" for a period not to exceed 30 days. Any extension of a temporary profile beyond 30 days must be confirmed by a physician. (Physician assistants and nurse practitioners will not be appointed as members of PPBDs.)

b. Physical therapists and occupational thera-

pists, when operating in an extended role, may be designated to authenticate a temporary profile assigning duty limitations not to exceed 72 hours or removing such profiles. All extensions beyond these limitations must be confirmed by a physician. (Physical therapists and occupational therapists will not be appointed as members of PPBDs.)

c. Physicians (full-time or part-time civilian employees or fee-for-service physicians) on duty at an Armed Forces Examining and Entrance Station (AFEES) will be designated profiling officers.

### 9-7. Recording and Reporting of Initial Physical Profile

a. Individuals accepted for initial appointment, enlistment or induction in peacetime normally will be given a numerical designator "1" or "2" physical profile in accordance with the instructions contained herein. Initial physical profiles will be recorded on Standard Form 88 (Report of Medical Examination) by the medical profiling officer at the time of the initial appointment, enlistment or induction medical examination.

★b. The initial physical profile serial will be entered on SF 88 and also recorded on DD Form 47 (Record of Induction) or DD Form 1966 (Application for Enlistment—Armed Forces of the United States), in the items provided on these forms for this purpose. When modifier "T" or "P" is entered on the profile serial, or in those exceptional cases where numerical designator "3" or "4" is used on initial entry, a brief description of the defect expressed in nontechnical language will always be recorded in item 74, SF 88, in addition to the exact diagnosis required to be reported in summarizing the defects under item 74. All assignment, geographic or climatic area limitations, applicable to the defect recorded in item 74, will be entered in this item. If sufficient room for a full explanation is not available in item 74 of SF 88, proper reference will be made in that item and an additional sheet of paper will be added to SF 88.

★c. Individuals who are found unacceptable under medical fitness standards of chapters 4, 5 or 7 will not be given a physical profile based on the provisions of those chapters. Profiling will be accomplished under the provisions of this chapter whenever such individuals are found to meet the medical procurement standards applicable at the time of examination.

### ★9-8. Physical Profile Boards (PPBD)

a. Physical profile boards will be appointed by the MTF commander and will normally consist of two qualified physical profiling officers, one of whom must always be a physician. A third physical profiling officer may be appointed in complicated or controversial cases or to resolve disagreement between the members of a two-member board.

b. Situations which require consideration of PPBD are:

(1) Return to duty of a member hospitalized over 6 months. The board will insure that the patient has the correct physical profile, assignment limitation(s) and medical follow-up instructions, as appropriate.

(2) Permanent revision of a member's physical profile from or to a numerical designator "3" or "4" when, in the opinion of a profiling officer, the functional capacity of the individual has changed to the extent that it permanently alters the individual's functional ability to perform duty.

(3) When an individual with a permanent numerical designator "2" under one or more PULHES factors requires significant assignment limitations. PPBD action is required in these cases because the profile serial "2" normally denotes a minor impairment requiring no significant limitation(s).

(4) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(5) Upon request of the unit commander.

c. Temporary profiles. A temporary revision of profile will be accomplished when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it temporarily alters the individual's ability to perform duty. A profiling officer is authorized to issue a temporary profile without referring the case to the physical profile board or to the PPBD approving authority. Temporary profiles written on DA Form 3349 will not exceed 3 months. Temporary profiles written on DD Form 689, Sick Slip, will not exceed 30 days.

d. Individuals being returned to a duty status, pursuant to the approved finding of physically fit by a physical evaluation board, the Army Physical Disability Agency or the Army Physical Disability Appeal Board under AR 635-40, will be given a physical profile commensurate with their physical condition under the appropriate factors by The Sur-

geon General. Assignment limitations will be established concurrently. Records will be forwarded by the Commanding General, MILPERCEN to HQDA (DASG-PSP-O), WASH, DC 20310, before notification of final action is returned to the medical facility having custody of the patient. After an appropriate period of time, such profile and limitations may be reviewed by a PPBD if the individual's functional capacity warrants such action. Changing of a designator "4" with a code V may be accomplished by a PPBD only with approval of MILPERCEN.

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

f. The physical profile in controversial or equivocal cases may be verified or revised by a PPBD, hospital commander or command surgeon. Unusual cases may be referred to the Commanding General, United States Army Health Services Command, for final determination of an appropriate profile.

g. Revision of the physical profile for reservists not on active duty will be accomplished by the ARCOM/GOCOM Staff Surgeons, Medical Corps Commander (05 and higher) of USAR hospitals, or the Surgeon, RCPAC, without medical board procedure. For members of the Army National Guard not on active duty, such profile revision will be accomplished by the Surgeon, National Guard Bureau, the State Surgeon or his designated medical officer. (See NGR 40-501) Direct communication is authorized between units and the profiling authority, and in questionable cases with the Commanding General, United States Army Health Services Command.

h. Individuals whose period of service expires and whose physical profile code is "V," "W" or "Y" will appear before a medical board to determine if processing, as provided in AR 635-40, is indicated.

#### ★ 9-9. Profiling Pregnant Members

a. *Intent.* The intent of these provisions is to protect the fetus while insuring productive utilization of the service member. Common sense, good judgment and cooperation must prevail between policy, patient and patient's commander to insure a viable program.

b. *Responsibility.*

(1) *Service member* - Will seek medical confirmation of pregnancy. If pregnancy is confirmed, will comply with the instructions issued by medical personnel and unit commander.

(2) *Medical personnel* - A physician will confirm pregnancy. If confirmed, will initiate prenatal care of the patient and issue physical profile. Will ensure that the unit commander is provided a copy of the profile. Will advise the unit commander as required.

(3) *Unit commander* - Will counsel all women as required by AR 635-120, AR 635-100 or AR 635-200. Will consult with medical personnel as required.

#### c. *Physical Profiles.*

(1) Profiles will be issued for the duration of the pregnancy. Profiles for members experiencing difficulty with the pregnancy will include additional limitations. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information.

(2) Physical profile will be issued as follows:

(a) Under physical stamina indicate "T-3."

(b) List diagnosis as "pregnancy, estimated delivery date \_\_\_\_\_."

(c) Profile will indicate the following limitations:

1. Except under unusual circumstances, member should not be reassigned (within CONUS, to or from oversea commands) until pregnancy is terminated.

2. Exempt from regular PT program of unit; physical fitness testing; exposure to chemical agents in NBC training; standing at parade rest or attention for longer than 15 minutes; all immunizations except influenza and tetanus-diphtheria; participating in weapons training, swimming qualifications, drown proofing and field training exercises when excused from wearing of uniform by unit commander.

3. No assignment to duties where nausea, easy fatigability or sudden light-headedness would be hazardous to member or others, to include all aviation duty, Classes 1, 1A, 2 and 3.

4. May work shifts.

5. During last 3 months of pregnancy, member must rest 20 minutes every 4 hours (sitting in a chair with feet up is acceptable). Work week should not exceed 40 hours, however, it does not preclude assignment as CQ and other like duties performed in a unit, to include normal housekeep-

ing duties.

*d. Performance of Duty.*

A member who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those members experiencing unusual and complicated problems (e.g., pregnancy induced hypertension) will be excused from all duty, in which case the member may be hospitalized or placed sick in quarters. Medical personnel will assist unit commanders in determining duties.

*e. Sick in Quarters.*

A pregnant member *will not* be placed sick in quarters solely on the basis of her pregnancy unless there are complications present which would preclude any type of duty performance.

*f. Convalescent Leave.* (as prescribed by AR 630-5).

(1) Convalescent leave after delivery of 4 to 6 weeks, as determined by attending physician, would be appropriate.

(2) Convalescent leave after abortion will be determined on an individual case basis by the attending physician.

**★ 9-10. Preparation, Approval and Disposition of DA Form 3349 (Physical Profile Board Proceedings)**

*a. Preparation of DA Form 3349.* (See fig 9-1.)

(1) DA Form 3349 will be used to record both temporary and permanent profiles.

(2) DA Form 3349 will be prepared as follows:

(a) *Items 1 through 5.* Self-explanatory. Obtain information from the member's medical and/or personnel record.

(b) *Item 6.* Enter under each PULHES factor, the appropriate profile serial code (1, 2, 3 or 4, as prescribed) and T (temporary) or P (permanent) prefix modifier. (Double profiling is not authorized. Double profiling is the placement of the numerical designator 2, 3 or 4 under a U, L, H, E or S factor and then placing the same designator under the "P" factor solely because it was awarded under the other factor.)

(c) *Item 7.* Record medical condition(s) and/or physical defect(s) in common usage, nontechnical language which a layman can understand. For example, "compound comminuted fracture, left tibia," might simply be described as "broken shin bone."

(d) *Item 8.* Record assignment limitation code(s) and describe assignment limitation(s) as set

forth in this chapter.

(e) *Item 9.* Check appropriate box. If profile is temporary, enter expiration date.

(f) *Items 10 and 11.*

1. *Permanent profiles.* Permanent 3 profiles and permanent 2 profiles requiring major assignment limitation(s) require signatures of a minimum of two profiling officers. In exceptional cases, as required by paragraph 9-7a, a third member will also sign in Item 11.

2. *Temporary profiles* not requiring major assignment limitations require only the signature of the profiling officer in Item 10.

(g) *Items 12 and 13.* Will be completed by the approving authority when required by subparagraph b(1) below. Items 12 and 13 are not required for temporary profiles and permanent 2 profiles not involving major assignment limitations.

(h) *Items 14 and 15.* Will be completed by the unit commander upon receipt of the permanent profile.

(i) *Remarks.* Use for continuation of any item. Identify by item number.

*b. Approval of DA Form 3349.*

(1) The appointing authority is the approving authority for all permanent profiles requiring a "3" numerical designator and all permanent profiles requiring a "2" numerical designator and a major assignment limitation.

(2) If the approving authority does not concur with the PPBD recommendation, the board will be returned to the PPBD for reconsideration. If the approving authority does not concur in the reconsidered PPBD findings, the case will be referred to a medical evaluation board convened under the provisions of section II, chapter 7, AR 40-3.

*c. Disposition of DA Form 3349 (Permanent Profiles).*

(1) *By MTF.*

(a) Original and one copy to unit commander.

(b) Copy to health record.

(c) Copy to clinic file.

(2) *By unit commander.* Upon completion of Item 15, the unit commander will forward the original to the unit's military personnel office for inclusion in the member's Military Personnel Records Jacket (MPRJ).

*d. Disposition of DA Form 3349 (Temporary Profiles).*

(1) Original and one copy to unit commander.

(2) Record temporary profile in health record.

**★ 9-11. Assignment Restrictions, or Geographical or Climatic Area Limitations**

Paragraph 7-13 establishes that personnel fit for continued military status are medically fit for duty on a worldwide basis. Assignment restrictions or geographical or climatic area limitations are contained in paragraph 9-5 and on the reverse of DA Form 3349 (Physical Profile Board Proceedings). Policies applying to assignment restrictions or geographical or climatic limitations with physical profiles are as follows:

a. There are no assignment restrictions or geographical or climatic area limitations associated with a numerical designator "1." An individual with "1" under all factors is medically fit for any assignment, including training in Ranger or assignment in Airborne or Special Forces.

b. There are normally no geographic assignment limitations associated with a numerical designator "2." The numerical designator "2" is one or more factors of the physical profile serial indicates that the individual possesses some medical condition or physical defect which may impose some limitation on MOS classification and duty assignment.

c. There are usually significant assignment restrictions or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designators "3."

d. There are always major assignment restrictions or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designators "4."

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

f. Assignment restrictions or geographical or climatic area limitations must be realistic and in accordance with accepted medical principles rather than based upon the personal beliefs or feelings of the profiling officer or the desires of the individual or the individual's family. Permanent limitations should be confirmed periodically, particularly in conjunction with inpatient or outpatient medical care and periodic medical examinations. (Every 4 years for Reserve Component personnel not on active duty, in conjunction with their periodic medical examination.)

**★ 9-12. Responsibility for Personnel Actions**

Unit commanders/personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations. The unit commander's copies of the DA Form 3349 will be delivered by means other than the individual on whom the report is made.

<b>PHYSICAL PROFILE BOARD PROCEEDINGS</b>						MEDICAL TREATMENT FACILITY	DATE
For use of this form, see AR 40-501; the proponent agency is the Office of The Surgeon General						WRAMC	1 May 1980
1. NAME (Last, First, MI)			2. SSN		3. GRADE		
SMITH, HAROLD F.			111-11-1111		SSG		
4. ORGANIZATION				5. COMPONENT			
Co B, 55th Eng Bn, Ft Belvoir, VA				RA			
<b>PHYSICAL PROFILE</b>							
6. FACTORS						7. PHYSICAL DEFECTS (Non-technical language)	
P	U	L	H	E	S	Stomach Ulcer	
3	1	1	1	1	1		
<i>(Enter T when applicable)</i>							
8. ASSIGNMENT LIMITATIONS ARE AS FOLLOWS:							
No assignment to units requiring continued consumption of combat rations No assignment to isolated areas where definitive medical care is not available							
9. This profile							
<input checked="" type="checkbox"/> is permanent <input type="checkbox"/> is temporary and expires on _____ (Enter date).							
10. TYPED NAME AND GRADE OF PROFILING OFFICER					SIGNATURE		
James A. Smith, MD (DAC)							
11. TYPED NAME AND GRADE OF PROFILING OFFICER					SIGNATURE		
Louis L. James, Major MC							
<b>ACTION BY APPROVING AUTHORITY</b>							
12. Permanent change of profile is <input type="checkbox"/> approved <input type="checkbox"/> is not approved.							
13. TYPED NAME, GRADE AND TITLE OF APPROVING AUTHORITY					SIGNATURE		DATE
Robert E. Grant, Colonel, MC, Chief, Prof Svcs							2 May 1980
<b>ACTION BY UNIT COMMANDER</b>							
14. The permanent change in the physical profile serial <input type="checkbox"/> does <input type="checkbox"/> does not require a change in the member's <input type="checkbox"/> military occupational specialty <input type="checkbox"/> duty assignment because: <i>(State the specific details concerning the physical functions required of the member and why the member can or cannot continue satisfactory performance of duty).</i>							
15. TYPED NAME AND GRADE OF UNIT COMMANDER					SIGNATURE		DATE
REMARKS							
DISTRIBUTION: Unit Commander - Original and 1 copy (to be delivered by means other than the individual on whom report is made); Health Record Jacket - 1 copy; Clinic File - 1 copy.							
SEE CODES ON REVERSE							

DA FORM 1 JUN 80 3349

PREVIOUS EDITIONS ARE OBSOLETE.

★ Figure 9-1

## ASSIGNMENT RESTRICTIONS, GEOGRAPHICAL OR CLIMATIC AREA LIMITATIONS

- CODE: A - None.
- B - None.
- C - No crawling, stooping, running, jumping, marching, or standing for long periods. *(State time permitted in item 8)*
- D - No mandatory strenuous physical activity. *(State time permitted in item 8)*
- 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 handling of heavy materials including weapons *(except individual weapon, e.g., rifle, pistol, carbine, etc.)*. No overhead work, no pullups or pushups. *(State time permitted in item 8)*
- H - No assignment to unit where sudden loss of consciousness would be dangerous to self or others such as work on scaffolding, handling ammunition, vehicle driving, work near moving machinery.
- J - No assignment or duty in an area where safety of individual or others requires acute hearing. Hearing protection is required when exposed to hazardous noise for protection of individual's health.
- L - No assignment requiring daily exposure to extreme cold. *(List specific time or areas in item 8)*
- M - No assignment requiring exposure to high environmental temperature. *(List specific time or areas in item 8)*
- N - No continuous wearing of combat boots. *(State length of time in item 8)*
- P - No continuous wearing of woolen clothes. *(State length of time in item 8)*
- U - Limitation not otherwise described to be considered individually. *(Briefly define limitation in item 8)*

## CHAPTER 10 MEDICAL EXAMINATIONS—ADMINISTRATIVE PROCEDURES

### Section I. GENERAL PROVISIONS

#### 10-1. Scope

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

*b.* Requirements for periodic, promotion, separation, mobilization, and other medical examinations.

*c.* Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record, and

*d.* Policies relative to the scope and recording of medical examinations accomplished for stated purposes.

#### 10-2. Applicability

The provisions contained in this chapter apply to all medical examinations accomplished at US Army medical facilities or accomplished for the US Army.

#### 10-3. Physical Fitness

Maintenance of physical fitness is an individual military responsibility, particularly with reference to remediable defects. Each member has a definite obligation to maintain himself in a state of good physical condition in order that he may perform his duties efficiently. Each individual, therefore, should seek timely medical advice whenever he has reason to believe that he has a medical condition or a physical defect which affects, or is likely to affect, his physical or mental well-being. He should not wait until the time of his periodic medical examination to make such a condition or defect known. The medical examinations prescribed in this regulation can be of material assistance in this regard by providing a means of determining the existence of conditions requiring attention. Commanders will bring this matter to the attention of all members during initial orientation and periodically throughout their period of service. In addition, medical examiners will counsel members as part of the periodic medical examination.

#### 10-4. Consultations

*a.* The use of specialty consultants, either military or civilian, for the accomplishment of consultations necessary to determine an examinee's medical fitness is authorized in AR 40-3 and AR 601-270.

*b.* A consultation will be accomplished in the case of an individual being considered for military service, including USMA and ROTC, whenever—

(1) Verification, or establishment, of the exact nature or degree of a given medical condition or physical defect is necessary for the determination of the examinee's medical acceptability or unacceptability based on prescribed medical fitness standards, or

(2) It will assist higher headquarters in the review and resolution of a questionable or borderline case, or

(3) It is prescribed in chapter 11, or

(4) The examining physician deems it necessary.

*c.* A consultation will be accomplished in the case of an individual on active duty as outlined in *a* above or whenever it is indicated to ensure the proper professional care and disposition of the service member.

*d.* A consultation will be accomplished by a physician, either civilian or military, qualified therefor by training in or by a practice devoted primarily to the specialty. In some instances, a physician who practices in another specialty may be considered qualified by virtue of the nature of that specialty and its relationship to the specialty required.

*e.* A medical examiner requesting a consultation will routinely furnish the consultant with—

(1) The purpose or reason for which the individual is being examined; for example, induction.

(2) The reason for the consultation; for example, persistent tachycardia.

(3) A brief statement on what is desired of the consultant.

(4) Pertinent extracts from available medical records.

(5) Any other information which will assist the consultant in the accomplishment of the consultation.

*f.* Reports of consultation will be appended to Standard Form 88 (Report of Medical Examination) as outlined in paragraph 10-5.

*g.* A guide as to the types and minimum scopes of the more frequently required consultations is contained in appendix IX.

#### 10-5. Distribution of Medical Reports

A minimum of two copies (both signed) of SF 88 and SF 93 (when required) will be prepared. One copy of each will be retained by the examining facility and disposed of in accordance with AR 340-18-9. The other copy will be filed as a permanent record in the Health Record (AR 40-66) or comparable permanent file for nonmilitary personnel. Special instructions for preparation and distribution of additional copies are contained elsewhere in this chapter or in other regulations dealing with programs involving or requiring medical examinations. Copies may be reproduced from signed copies by any duplicating process which produces legible and permanent copies. Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies should not be made to unauthorized personnel or agencies.

#### 10-6. Documentary Medical Evidence

*a.* Documentary medical records and other documents prepared by physicians or other individuals may be submitted by, or in behalf of, an examinee as evidence of the presence, absence, or treatment of a defect or disease, and will be given due consideration by the examiner(s). Submission and use of such documentary medical evidence is encouraged. If insufficient copies are received, copies will be reproduced to meet the needs of *b* and *c* below.

*b.* A copy of each piece of documentary medical evidence received will be appended to *each* copy of the Standard Form 88 (Report of Medical Examination) and a statement to this effect made in item 73, except as prescribed in *c* below.

*c.* When a report of consultation or special test is obtained for an examinee, a copy will be attached to each Standard Form 88 as an integral part of the medical report, and a statement to this effect will

be made in item 73 and cross-referenced by the pertinent item number.

#### 10-7. Facilities and Examiners

★*a.* For the purpose of this regulation, a physician is defined as any individual who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures in the area concerned. Any individual so qualified may perform medical examinations of any type except where a specific requirement exists for the examination to be conducted by a physician qualified in a specialty. Dentists, physician assistants, nurse practitioners, optometrists, audiologists and podiatrists may sign the SF 88 for the portions of the examination they actually accomplish but the supervising physician will sign the SF 88 and SF 93 in all cases.

★*b.* In general, medical examinations conducted for the Army will be accomplished at facilities of the Armed Forces, using military medical officers on duty, or full-time or part-time civilian physician employees, with the assistance of dentists, physician assistants, nurse practitioners, optometrists, audiologists and podiatrists.

★*c.* Medical examinations for the purpose of entrance into Army Aviation Pilot Training (Class 1 or 1A) and entrance into training as air traffic controllers (Class 2) will be accomplished only at medical facilities of the Armed Forces, by or under the immediate supervision of an assigned or attached flight surgeon. Medical Corps officers who by training/experience have been previously designated military flight surgeons or military aviation medicine officers, but who, at the time of examination, are performing duty in a specialty other than aviation medicine, may accomplish these medical examinations. In all cases, the flight surgeon will review the reports of medical examination (SF 88 and SF 93 and allied papers) and sign the reports. Other physicians, dentists, physician assistants, nurse practitioners, optometrists, audiologists and podiatrists may sign the SF 88 for the portions of the examination they actually accomplish but the supervising flight surgeon must sign the report in all cases.

(1) Medical examinations for entrance into training (Class 3) as flight surgeons, aviation mechanics, crew chiefs, observers, door gunners, etc. may be accomplished by any physician assigned or attached to a military medical facility, but will be

accomplished and/or signed by a flight surgeon, if circumstances permit.

(2) Medical examinations for continuance of aviation duty (Class 2 and Class 3) (military members, civilian employees, and employees of civilian contractors) will be accomplished by a flight surgeon, if available within 60-minute travel time; or may otherwise be accomplished by any physician assigned or attached to active military medical facilities. Army National Guard and Army Reserve members not on active duty may be examined by Medical Corps officers of the Reserve Components of the Army, Navy or Air Force. All Class 2 and 3 examinations will be accomplished and/or signed by a flight surgeon, if circumstances permit.

d. The periodic medical examination, required by AR 635-40 in the case of an individual who is on the Temporary Disability Retired List, will be accomplished at a medical treatment facility designated by Headquarters, Department of the Army.

e. Medical examinations for qualification and admission to the United States Military Academy, the United States Naval Academy, the United States Air Force Academy, and the respective preparatory schools will be conducted at medical facilities specifically designated in the annual catalogs of the respective academies.

f. Medical examinations for ARNG and USAR purposes will be conducted by medical officers or civilian physicians at medical facilities in the order of priority specified in AR 140-120 or NGR 40-501, as appropriate.

g. Additional tests, procedures, or consultations, that are necessary to supplement a medical examination, normally will be accomplished at a medical facility (including an Armed Forces Examining and Entrance Station) designated by the commander of the facility requesting the supplemental medical examination. Only on the authority of that commander will supplementary examinations be obtained from civilian medical sources. Funds available to the requesting commander will be used for payment of the civilian medical services he authorized.

h. Physician assistants, nurse clinicians, enlisted members of the medical department, and civilian employees properly qualified by appropriate training and experience, may accomplish such phases of the medical examination as are deemed appropriate by the supervising physician. The supervising

physician is responsible for the quality of all procedures so accomplished.

### 10-8. Hospitalization

Whenever hospitalization is necessary for evaluation in connection with a medical examination, it may be furnished as authorized in AR 40-3 in the following priority:

- a. Army medical treatment facilities.
- b. Air Force and Navy medical treatment facilities.
- c. Medical treatment facilities of other Federal agencies.
- d. Civilian medical treatment facilities.

### 10-9. Medical Examination Techniques

See chapter 11.

### 10-10. Objectives of Medical Examinations

The objectives of military medical examinations are to provide information—

- a. On the health of the individual.
- b. Needed to initiate treatment of illness.
- c. To meet administrative and legal requirements.

### 10-11. Recording of Medical Examinations

The results of a medical examination will be recorded on SF 88 (Report of Medical Examination), SF 93 (Report of Medical History), and such other forms as may be required. See appendix IX and paragraph 10-14 for administrative procedures for filing out SF 88.

### 10-12. Remediable Medical Conditions and Physical Defects

★ When a medical examination reveals that an individual of the military service has developed a remediable defect during the course of his duties, he will be offered the opportunity of medical care if such is medically indicated. Determinations regarding corrective care for such conditions will be governed by the provisions of AR 600-9 and paragraph 48, AR 600-20. For US Army Reserve members, see paragraph 4a, AR 140-120 and for ARNG, see NGR 40-501.

### 10-13. Scope of Medical Examinations

a. The scope of a medical examination, Type A or B, is prescribed in appendix IX and will conform to

the intended use of the examination.

b. Limited or screening examinations, special tests, or inspections required for specific purposes and which do not reflect the scope of a Type A or B examination are prescribed by other regulations. Such examinations, tests, and inspections falling outside the evaluative purposes of this chapter include those for drivers, personnel exposed to industrial or occupation hazards, tuberculin and Schick tests administered in the absence of illness, blood donors, chest X-ray surveys, food handlers, barbers, and others.

#### **10-14. Standard Form 88 (Report of Medical Examination)**

a. Each abnormality, whether or not it affects the examinee's medical fitness to perform military duty, will be routinely described and made a matter of record whenever discovered. The part or parts of the body will be specified whenever the findings (diagnoses) are not sufficient to localize the condition. (Manifestations or symptoms of a condition will not be used in lieu of a diagnosis.)

b. Only those abbreviations authorized by AR 40-400 may be used.

c. Medical examiners will not routinely make recommendations for waivers of individuals who do not meet prescribed medical fitness standards. However, if a waiver is requested by the examinee, each disqualifying defect or condition will be fully described and a statement included as to whether the defect or condition—

(1) Is progressive.

(2) Is subject to aggravation by military service.

(3) Precludes satisfactory completion of prescribed training and subsequent military service.

(4) Constitutes an undue hazard to the individual or to others in the military environment.

Such information will facilitate evaluation and determination by higher authority in acting upon waiver requests. In addition, a notation will be made listing any assignment limitations which would have to be considered in view of the described defect(s). Such notation is not required in waiver cases where the individual obviously is not medically fit, even under the criteria for mobilization outlined in chapter 6.

d. When feasible, an adequate review of the Report of Medical Examinations, to include review of the Health Record, if available, will be performed

and is the responsibility of the commander of the medical facility at which the examination is accomplished. Review by a field grade or senior company grade medical officer is desirable if circumstances permit. This review will be indicated by signature in item 82, Standard Form 88.

e. The scopes of Types A and B medical examinations and instructions for recording the examinations on Standard Form 88 are set forth in appendix IX. Administrative data entered in items 1 through 17 will be typewritten or printed in ink. Whenever possible, trained clerical personnel will perform this function.

#### **10-15. Standard Form 93 (Report of Medical History)**

a. *Standard Form 93.* Standard Form 93 (Report of Medical History) is prepared by the examinee prior to being examined. It provides the examining physician with an indication of the need for special discussion with the examinee and the areas in which detailed examination, special tests or consultation referral may be indicated. It is important that the questions on the form be answered spontaneously by the examinee. Completeness of all answers and comments is essential to the usefulness and value of the form. The information entered on this form is considered confidential and will not be released to unauthorized sources. The examinee should be apprised of the confidential nature of his entries and comments. Trained enlisted medical service personnel and qualified civilians may be used to instruct and assist examinees in the preparation of the report but will make no entries on the form other than the information required in items 6 (date of examination) and 7 (examining facility or examiner, and address). Any help given the examinee will be only as an aid in his understanding of the question, not as suggested answers. A Spanish version (Historia Medica) is available for use by Spanish speaking examinees. Standard Form 93 will normally be prepared in an original and one copy. Interleaved carbon paper may be used if forms are carefully aligned and the carbon copy is legible. The form will be prepared in all instances indicated in paragraph 10-16 and whenever: (1) Required by some other directive, (2) considered desirable by the examining physician, or (3) directed by Headquarters, Department of the Army.

b. *Identification and administrative data.* Items 1 through 7 will be typewritten or printed in ink.

Whenever possible, trained clerical personnel will perform this function.

*c. Medical history and health data.*

(1) *Item 8.* A brief statement by the examinee expressing his opinion of his present state of health. If unsatisfactory health is indicated in generalized terms such as "fair" or "poor," the examinee will elaborate briefly to include pertinent information on his past medical history.

★(2) *Examinee's medical history:* This includes items 9-25.

(a) Items 9 and 11 provide a means of determining the examinee's state of health, past and present, and possibly identifying medical conditions which should be evaluated in the course of the medical examination. The examinee will complete all items by checking "yes" or "no" for each.

(b) Item 12 will be completed by all female examinees.

(c) Items 13 and 14 will be completed by each examinee. Students who have not had full-time employment will enter the word "student" in item 13. Members of the Active Army who had no full-time employment prior to military service will enter "soldier" or "Army officer" as appropriate in item 13.

(d) Items 15 through 24—these questions and the answers are concerned with certain other environmental and medical conditions which can contribute to the physician's evaluation of the examinee's present and future state of health. All answers checked "yes" will be fully explained by the examinee to include dates, locations, and circumstances. The examinee will sign the form in black or dark-blue ink.

*d. Physician's summary and elaboration of examinee's medical history.*

(1) The physician will summarize and elaborate upon the examinee's medical history as revealed in items 8 through 24 and, in the case of military personnel, the examinee's Health Record, cross-referencing his comments by item number. All items checked in the affirmative will be clarified and the examiner will fully describe all abnormalities including those of a nondisqualifying nature. This information is needed to assist in evaluating the examinee's background and to protect the individual and the Government in the event of future claims for disability or aggravation of disability.

(2) If the examinee's answers reveal that he was previously rejected for military service (item 22) or was discharged for medical reasons (item 23),

the exact reasons should be ascertained and recorded. Such examinees, if found medically fit, will be considered of "doubtful acceptability" until such time as the cause for previous rejection or discharge has been thoroughly reviewed and evaluated (para 4-22b, AR 601-270).

(3) Rubber stamps will not be used to elaborate nor will a facsimile stamp be used for signature. The typed or printed name of the physician and date will be entered in the designated blocks. The physician will sign in black or dark-blue ink.

### 10-16. Types of Medical Examinations

*a. General.* There are two general types of medical examination, Type A and Type B, which meet the requirements for evaluation of individuals for most purposes. The scope of each of these examinations is indicated in appendix IX. Additional examination to extend or complement a Type A or Type B medical examination is appropriate when indicated or directed to permit use of the examination for special purposes.

*b. Type A medical examination.* A Type A medical examination is required to determine medical fitness of personnel under the circumstances enumerated below. Standard Form 93 (Report of Medical History) must be prepared in all cases except as indicated by an asterisk (\*).

(1) Active duty.

(2) Active duty for training for more than 30 days.

(3) \*Airborne, ranger, and special forces.

(4) Allied and foreign military personnel.

(5) Appointment as a commissioned or warrant officer regardless of component.

(6) \*Army service schools, except Army aviation and Marine diving.

★(7) Deserters who return to military control, except those being administratively discharged under the provisions of chapter 10 or section V, chapter 14 of AR 635-200.

★(8) Enlistment (initial) and reenlistment if validity period of separation examination has expired.

★(9) \*General prisoners when prescribed.

★(10) Induction and preinduction pursuant to UMTS Act as amended.

★(11) \*Medical board processing except when done solely for profiling.

★(12) Military Advisory Assistance Group, Army Attache, Military Mission assignment, and

assignment to isolated areas where adequate US military medical care is not readily available.

★(13) Mobilization of members of Army Reserve components.

★(14) Officer Candidate School.

★(15) \*Oversea duty when prescribed except as outlined under Type B medical examination.

★(16) Periodic for Army Reserve components.

★(17) \*Periodic for active duty members, other than Army aviation and diving.

★(18) Prisoners of war, when required, internees and repatriates.

★(19) ROTC. Enrollment in ROTC, all levels except for enrollment in the 4-year Scholarship program which requires a Type B examination.

★(20) Separation, resignation, retirement and relief from active duty, if accomplished. (SF 93 is not required in connection with separation examination for immediate reenlistment.)

★(21) Free fall parachuting. (SF 93 required for initial selection only.)

★(22) Marine (SCUBA) diving (Special forces and ranger combat diving). (SF 93 required for initial selection only.)

★*c. Type B medical examination.* A Type B medical examination is required to determine the medical fitness of personnel under the circumstances enumerated below. Standard Form 93 (Report of Medical History) will be prepared except as noted.

(1) Army aviation including selection, continuance, or periodic annual medical examination: Pilot, aircraft mechanic, air traffic controller, flight simulator specialist, or participant in frequent or regular flights as nondesignated or nonrated personnel not engaged in the actual control of aircraft, such as flight surgeons, observers, etc. (SF 93 required for initial selection and for Class 2 continuance for pilots if the examinee's health record is not available to the examining physician.)

(2) Marine diving (MOS 00B), including selection, continuance or periodic annual medical examination. (SF 93 required for initial selection only.) (For periodic examinations, individual Health Record and DA Form 3475-R (Diving Duty Summary Sheet) must be available to the examiner.)

(3) US Air Force Academy.

(4) US Air Force Academy Preparatory School.

(5) US Military Academy.

(6) US Military Academy Preparatory School.

(7) US Naval Academy.

(8) US Naval Academy Preparatory School.

(9) Four-year ROTC Scholarship.

(10) Entrance into Uniformed Services University of Health Sciences.

#### 10-17. Validity—Reports of Medical Examination

*a.* Medical examinations will be valid for the purpose and within the periods set forth below, provided there has been no significant change in the individual's medical condition.

(1) Two years from date of medical examination for entrance into the United States Military Academy, the Uniformed Services University of Health Sciences, and the ROTC Scholarship Programs. (This period may be modified to any period less than 2 years, and reexamination required as determined by the Director, Department of Defense Medical Examination Review Board (DODMERB).)

★(2) One year from date of medical examination to qualify for induction, enlistment, reenlistment, appointment as a commissioned officer or warrant officer, active duty, active duty for training, advanced ROTC, OCS, admission to USMA Preparatory School, entry into training for aviation Classes 1, 1A, 2 and 3, diving and free fall parachuting.

(3) Six months from date of medical examination for discharge or release from active duty. All individuals on active duty for training for more than 30 days must have a medical examination prior to discharge or release from active duty for training (see also para 10-25).

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

*b.* Except for discharge or release from active duty, a medical examination conducted for one purpose is valid for any other purpose within the prescribed validity periods, provided the examination is of the proper scope specified in this chapter. If the examination is deficient in scope, only those tests and procedures needed to meet additional requirements need be accomplished and results recorded.

*c.* The periodic examination obtained for members of the Army National Guard and Army Reserve (para 10-31) within the past 4 years will be valid for the purpose of qualifying for immediate reenlistment in the Army National Guard and Army

Reserve of personnel not on active duty, provided there has been no change in the individual's medical

condition since his last complete medical examination.

## Section II. PROCUREMENT MEDICAL EXAMINATIONS

### 10-18. Procurement Medical Examinations

For administrative procedures pertaining to procurement medical examinations (para 2-1) conducted at Armed Forces Examining and Entrance Stations, see AR 601-270. For procedures pertain-

ing to appointment and enlistment in the Army National Guard and Army Reserve, see AR 140-120 and NGR 40-501. For procedures pertaining to enrollment in the Army ROTC, see AR 145-1.

## Section III. RETENTION, PROMOTION, AND SEPARATION MEDICAL EXAMINATIONS

### 10-19. General

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

### 10-20. Active Duty For Training and Inactive Duty Training

★*a.* Individuals on active duty for 30 days or less and those ordered to active duty for training without their consent under the provisions of AR 135-91 are not routinely required to undergo medical examination prior to separation. A medical examination will be given when—

(1) The individual has been hospitalized for an illness or an injury which may result in disability, or

(2) Sound medical judgment indicates the desirability of a separation medical examination, or

★(3) The individual alleges medical unfitness or disability at the time of completion of active duty for training, or

(4) The individual requests a separation examination.

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

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

(2) He alleges medical unfitness or disability.

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

### 10-21. Health Records

★*a.* Medical examiners will review the Health Record (AR 40-66) of each examinee whenever an examination is conducted for the purpose of relief from active duty, relief from active duty for training, resignation, retirement, separation from the

service, or when accomplished in connection with a periodic medical examination. The examinee's medical history as recorded in the Health Record is an important part of the physician's total evaluation. Health records include a medical evaluation and summary of each medical condition treated which is of clinical importance and materially affects the health of the individual.

*b.* In the accomplishment of medical examinations conducted under the provisions of this regulation for purposes other than those noted above, the health records of examinees should be reviewed by the examiner whenever such records are available.

### ★ 10-22. Mobilization of Units and Members of the Reserve Components of the Army

Members of ARNGUS and USAR will be given medical examinations every 4 years as prescribed in AR 135-300, AR 140-120, and NGR 40-501 (10 U.S.C. 1004). Medical examinations incident to mobilization are not required.

### 10-23. Periodic Medical Examinations

*a. Application and scope.*

★(1) The periodic medical examination is required for all officers, warrant officer and enlisted personnel of the Army regardless of component. Individuals undergoing this examination should assist the physician by a frank and complete discussion of their past and present health, which, combined with appropriate medical examinations and clinical tests, will usually be adequate to determine any indicated measures or remedies. The purpose of the periodic medical examination is to assist in the maintenance of health. (In the event of mobilization, except for Class 2 aviators and air traffic controllers, all periodic medical examinations prescribed by this paragraph for active Army members are suspended.)

★(2) Retired personnel are authorized, but not required, to undergo a periodic medical examination. They will make advance arrangements with the medical examining station before reporting for such examination (DA Pam 600-5).

★(3) Other than required medical surveillance, the periodic medical examination is not required for an individual who has undergone or is scheduled to undergo, within 1 year, a medical examination, the scope of which is equal to or greater than that of the required periodic medical examination. Member will be furnished DA Form 3081-R, Periodic Medical Examination (Statement of Exemption), who will prepare it and submit it to unit commander/personnel officer for appropriate action. DA Form 3081-R (fig. 10-1) will be reproduced locally on 8½ by 11-inch paper. The form number, title, and date should appear on each reproduced copy.

**(Locate fig. 10-1, a fold-in page,  
at the end of the regular size pages.)**

(4) The examining physician will thoroughly investigate the examinee's current medical status. When medical history, the examinee's complaints, or review of any available past medical records indicate significant findings, these findings will be described in detail, using SF 507 (Clinical Record—Report on—or Continuation of SF), if necessary. If, as a result of the personal discussion of health between the medical officer and the examinee, it appears that there has been a change in the functional capacity of any component of the physical profile serial, the medical officer will recommend a change in the serial in accordance with chapter 9.

(5) Members will be found qualified for retention on active duty if they meet the requirements of chapters 1 and 3 (chaps. 1, 3, and 8 in the case of medico-dental registrants). Special attention is directed to paragraphs 1-4 and 3-3 in this regard.

(6) Members who appear to be medically unfit will be referred to a medical board (AR 40-3).

★(7) General Considerations. All reports of periodic medical examinations will be reviewed by a physician designated by the medical treatment facility commander. (Those administered by AFEES will be reviewed by the Chief Medical Officer.) The review will be accomplished in the following manner:

(a) The Individual Health Record and the SF 88 will be reviewed in the presence of the examinee

during which the reviewing physician will counsel the examinee regarding:

1. Remedial conditions found upon examination (appointments will be made for the purpose of instituting care).

2. Continuing care for conditions already under treatment.

3. General health education matters including, but not limited to, smoking, alcohol and drug abuse, sexual behavior, overweight or underweight and methods for correction.

(b) When the review is completed, and there is a need to change the member's physical profile and/or assignment limitations, DA Form 3349 (Medical Condition - Physical Profile Record) will be prepared and distributed as prescribed in chapter 9 of this regulation. SF 88 or extracts of the Individual Health Record will not be released to the Unit Commander/Personnel Officer.

★(8) The medical examination for general officers and full colonels should be performed on an individual appointment basis. The duplicate report (SF 88) in the case of each general officer will be forwarded by the examining facility direct to HQDA(DAPE-GO), WASH, DC 20310. In the case of each full colonel, the duplicate SF 88 will be forwarded to the examining facility direct to HQDA(DAPC-PSR), Alexandria, VA 22332 for file in the individual's Official Military Personnel File (OMPF).

(9) In addition to the periodic medical examination prescribed by paragraph c(2) below, all women in the Army, regardless of age, on active duty or active duty for training tours in excess of 1 year will undergo two annual breast and pelvic examinations, to include a Papanicolaou cancer detection test, following initial entry on active duty. At age 25, and annually thereafter, this special examination is mandatory and will be accomplished during the anniversary month of the individual's birthday, and should be conducted by a qualified specialist whenever possible. A record of the examination and test results will be maintained in the Health Record.

★(10) All personnel with potential hazardous exposures in their work environment, for which medical surveillance examinations are required to issue that there is no harmful effect to their health, will receive appropriate medical surveillance examinations. Such examinations will be specific to job exposure.

★b. *Followup.* A member of the ARNGUS or US-

AR who is not on active duty will be scheduled for follow-up appointment and consultations at Government expense when necessary to complete the examination. Treatment or correction of conditions or remediable defects as a result of examination will be scheduled if authorized. If the individual is not authorized treatment, he will be advised to consult a private physician of his own choice at his own expense.

★ *c. Frequency.*

(1) Air traffic controllers. Regardless of age, an air traffic controller must have an annual Class 2 Type B examination. (This is a Federal Aviation Administration requirement.) The examination must be taken during the birthday month.

(2) Aviators. Rated aviators who meet and continue to work under Class 2 medical fitness standards for flying must have periodic examinations. They will be given Type B examinations.

(a) The first periodic examination must be taken within 6 to 18 months after the last examination that was taken for initial flight training. Aviators up to age 35 will then take an examination every 2 years. In addition, they will take annually an eye examination, blood pressure, height, weight, and audiometric and electrocardiographic tests. (This annual examination will be recorded on DA Form 4497-R (Interim Medical Examination—Aviation), Free Fall Parachuting and Marine (SCUBA) Diving Personnel.) See figure 10-3.

After age 35, aviators will take a Type B examination annually.

(b) An aviator must take the examination cited in (a) above within 90 days preceding the last day of the birthday month. All examinations taken within this period will be considered to have been taken during the birthday month.

(c) For some reasons (such as hospitalization), off-cycle Type B examinations may be given. An off-cycle examination is an examination taken either before or after the times that are required for periodic examinations (i.e., taken before or after the period described in (a) above or before or after the 90-day period described in (b) above). The next Type B examination must be taken within 6 to 18 months; and it must be taken within the 90-day period described in (b) above.

(d) When DA Form 4186 (Medical Recommendation for Flying Duty) is completed after a periodic examination or special tests, the last day of the birthday month will be entered in block 8 of the

form as the date medical clearance expires.

(3) Flight surgeons and other Class 3 aviation personnel.

(a) Members who meet and continue to work under Class 3 medical fitness standards for flying must have periodic examinations. (This includes flight surgeons and other aviation personnel who do not control aircraft.) They will be given Type B examinations; the results of these examinations will be recorded on SF 88 and, if needed, on SF 502 (Clinical Record - Narrative Summary).

(b) The first periodic examination must be taken within 6 to 18 months after the most recent examination for initial training. Type B periodic examinations must then be taken within 3 calendar months before the end of their birthday month at ages 20, 25, 30, 35, 40, 45, 50, 55, 60 and annually thereafter. In addition, each member will take annually an eye examination, blood pressure, height, weight, and audiometric and electrocardiographic tests. (These annual tests will be recorded on DA Form 4497-R (fig. 10-3) which will be locally reproduced on 8½ by 11-inch paper.)

**(Locate fig. 10-3, a fold-in page,  
at the end of the regular size pages)**

(4) Diving Personnel.

(a) Marine (SCUBA) divers must have a Type B examination every 2 years. In addition, they will take annually an eye examination, blood pressure, height, weight, and audiometric and electrocardiographic tests. (This annual examination will be recorded on DA Form 4497-R; see figure 10-3.) After age 35, they will take a Type B examination annually.

(b) Marine divers (MOS 00B, other than SCUBA) must have an annual Type B examination, regardless of age. (This is an Occupational Safety and Health Act requirement.) This examination must be taken within 3 months before the end of the diver's birthday month. The results of the above tests will be reviewed by a flight surgeon and filed in the individual Health Record.

(5) All other personnel on active duty will undergo a periodic examination within 3 calendar months before the end of the birthday month, at ages 20, 25, 30, 35, 40, 45, 50, 55, 60 and annually thereafter. Periodic examinations of active duty members prior to age 20 are not required. Reserve Component members not on active duty must con-

tinue to have periodic examinations every 4 years, as required by law.

(6) An examination accomplished within the 3 calendar months before the end of the anniversary month will be considered as having been accomplished during the anniversary month.

(7) The frequency of medical surveillance examinations varies according to job exposure. Annual or less frequent examinations will be performed during the birthday month. More frequent examinations will be scheduled during the birthday month and at appropriate intervals thereafter.

(8) All members of the Ready Reserve not on active duty—

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

(b) Members of the Ready Reserve not on active duty will accomplish a statement of medical fitness annually.

(9) Under exceptional circumstances, where conditions of the service preclude the accomplishment of the periodic examination, it may be deferred by direction of the commander having custody of field personnel files until such time as its accomplishment becomes feasible. An appropriate entry explaining the deferment will be made in the Health Record and on Health Record—Chronological Record of Medical Care (SF 600) when such a situation exists.

(10) Individuals on duty at stations or locations having inadequate military medical facilities to accomplish the complete medical examination will be given as much of this examination as local military medical facilities permit, and will undergo a complete medical examination when official duties take

them to a station having adequate facilities.

*d. Reporting of medical conditions.*

(1) 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.

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

**10-24. Promotion**

a. Officers, warrant officers, and enlisted personnel on active duty, regardless of component, are considered medically qualified for promotion on the basis of the periodic medical examination outlined in paragraph 10-23.

b. Army Reserve officers and warrant officers not on active duty who have been selected for promotion will be considered medically qualified for promotion on the basis of a type A medical examination accomplished within 1 year of the effective date of promotion. Army National Guard officers and warrant officers will be governed by NGR 40-501.

**★ 10-25. Separation**

a. There is no statutory requirement for 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:

	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).		X	X
Upon review of Health Record, evaluating physician or Physician Assistant (PA)** at servicing MTF determines that, because of record of medical care received 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*		
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 (10 USC 3502).	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 active duty after complete physical disability processing (chap. 6, AR 335-40 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		
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		

	Required	Not required	Can be requested by member (in writing)
Discharge in absentia (Officers and enlisted members):			
Civil confinement.		X	
When BCD or DD is upheld by appellate review and individual is on excess leave.		X	
Deserters who do not return to military control.		X	
Enlisted members being processed for separation under all other provisions of AR 635-200 not listed above.		X	X

\* Examination will be accomplished not earlier than 4 months or later than 1 month prior to scheduled date of 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 supervising physician and approved by MTF Cdr, or unit staff surgeon.

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

c. Voluntary requests for medical examinations will be submitted to the commander of the servicing medical treatment facility (MTF) not earlier than 4 months nor later than 1 month prior to the anticipated date of separation/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 examination.)

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

#### SECTION IV. FLYING DUTY MEDICAL EXAMINATIONS

##### 10-26. Flying Duty

a. *General.* This section sets forth administrative procedures applicable to flying duty medical examinations (para 4-1). The flying duty medical examination will be used to supervise, maintain, and control the medical fitness of individuals performing such duty. When properly done, this medical examination presents an accurate medical inventory of the individual in the light of the special medical requirements for flying. Abnormal findings on the medical examination constitute a starting point for careful evaluation and treatment. Special emphasis will be given to the eye, ear, and psychiatric examinations, as well as to a detailed elaboration of pertinent data on the Report of Medical History (SF 93). The Standard Form 88 forwarded to the commander having personnel jurisdiction over the examinee will include sufficient information to

show what was done concerning treatment and investigation.

b. *Definitions.* For the purpose of this section, the following terms will be employed with the meanings given:

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

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

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

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

★(5) *Rating.* The term rating means currently effective aeronautical ratings officially granted by the Chief of Staff, US Army, or other property designated authority.

(6) *Serious illness or serious injury.* This term means any illness or injury that is adjudged by competent medical authority to have future significance in relationship to flying safety or efficiency regardless of duration; i.e., cranial fractures, unexplained loss of consciousness, epilepsy, cardiac arrhythmias, encephalitis, renal calculus, rheumatic heart disease, coronary disease, neurological disability, and any disease interfering with normal binocular visual function.

★(7) *Restriction.* A restriction imposed by a commander after recommendation by an appropriate medical officer. It restricts personnel on flying status from performing flight duty during periods of physical incapacity of 1 day to 6 months' duration.

★(8) *Suspension.* See AR 600-107.

c. *Disqualification.*

★(1) When a commander believes an individual on flying status in his command is medically unfit for flying duty, he may suspend the individual concerned and order him to report for the prescribed medical examination for flying (see AR 600-107). The serious effect of suspension of trained flight personnel, including the loss to the Government of their services, demands careful and comprehensive consideration. However, the safety and well-being of the air crew and/or passengers and the need to safeguard valuable aircraft and their contents are of paramount importance.

★(2) Personnel donating 200 cc or more of blood will not perform flying duty for a period of 72 hours following the donation. If he deems it necessary, the medical examiner may recommend suspension in accordance with AR 600-107. Aircrew members will not be regular blood donors.

(3) Hospitalization, preferably in a military hospital, for a period not to exceed 3 days is authorized for applicants not in the active military service when fitness for flying duty cannot be determined otherwise. However, this period is to be used for diagnostic purposes only and not for the treatment of correction of disqualifying defects.

(4) A finding of qualification or disqualification for flying duty in any specific capacity will be made on the basis of the medical examination. Elaboration of this recommendation will be made when needed to clarify the individual's status. If an examinee is regarded as medically unfit for flying duty by reason of defects not specifically mentioned in this regulation, he nevertheless will be disqualified.

(5) An individual on flying status who, at any time, is found to be disqualified for flying duty as a result of a medical examination prescribed in this regulation, will be suspended from flying status or excused from meeting flight requirements. The examining medical officer will officially notify the commanding officer of the examinee concerned in writing and in the most expeditious manner feasible (DA Form 4186). This officer will act on the basis of such notification. An individual will not be restored to flying status until he is again able to qualify medically or has received a waiver for his disqualifying defect granted by duly constituted authority (see AR 600-107).

★d. *Medical examination reports.*

(1) Complete reports of medical examination for flying, accomplished in conjunction with application for flight training pursuant to AR 611-85 and AR 611-110, will be forwarded direct by the Commander having personnel jurisdiction over the applicant for medical review as outlined below. Army National Guard applicants will be processed in accordance with NGR 611-110. The Chief, National Guard Bureau will forward the report of medical examination to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362, who will make final determination of the medical fitness of the applicant for Army aviation training. In no case will reports of medical examination be given to the applicant. Entrance into flight training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362. Reports of medical examination (SF 88, SF 93, SF 520, and allied documents) accomplished for continuance on flight duty and diving duty (MOS OOB) for Active Army and USAR personnel, to include the periodic examinations prescribed by the examining facility, will be forwarded direct to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 for review. Reports of medi-

cal examination (SF 88, SF 93, SF 520, and allied documents) accomplished for Army National Guard personnel, to include the periodic examinations prescribed in paragraph 10-23, will be forwarded by the State Adjutant General to the Chief, National Guard Bureau, ATTN: NGB-ARS, WASH, DC 20310 for review, who, in turn, will forward the reports of medical examination of the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 for final review. Requests for Army National Guard officer and warrant officer flying status orders will be processed in accordance with NGR 611-110. The Chief, National Guard Bureau (NGB-ARS), will review the reports of medical examination (SF 88, SF 93, SF 520 and allied documents) and forward those reports not previously reviewed to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 for final review and return to Chief, National Guard Bureau, ATTN: NGB-ARS, WASH, DC 20310. The State Adjutant General may utilize current reports of medical examination that have previously been reviewed by the Commander, USAAMC for attachment to the Report of Proceedings of the Flying Evaluation Board submitted to the Chief, National Guard Bureau. Direct communication between the State Adjutant General and Commander, USAAMC, for this purpose is authorized.

(2) Clinical medical summaries, including indicated consultations, will accompany all unusual flying evaluation board cases forwarded to higher headquarters. Reports of hospital, medical, and physical evaluation boards will be used as a source of valuable medical documentation although their recommendations have no direct bearing on qualification for flying duty.

★(3) Concurrent use of the annual medical examination for flying for Federal Aviation Agency certification is no longer authorized by the Federal Aviation. Both sides of the FAA Report of Medical Examination must be completed.

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

★*f. Suspension.* See AR 600-107.

★*g. Type B medical examinations.* In addition to the personnel noted in paragraph 4-2, a Type B medical examination, unless otherwise specified below, will be given to—

(1) Military personnel on flying status who

have been absent from, or who have been suspended from a flying status by reason of a serious illness or injury, or who have been suspended or absent from flying status in excess of 6 months for any other reason.

(2) All designated or rated military personnel ordered to appear before a flying evaluation board when a medical question is involved.

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

★*h. Waivers.*

(1) *General.* A separate request for waiver need not accompany a Report of Medical Examination. Recommendation concerning waivers will be made on the Report of Medical Examination. In any case requiring waiver or special consideration, full use will be made of consultations. These will be identified and attached to the Report of Medical Examination on an appropriate clinical form or a plain sheet of lettersize paper. Waiver of minor defects must in no way compromise flying safety or affect the efficient performance of flying duty or the individual's well-being.

(2) *Designated or rated personnel.* Designated or rated personnel who, by reason of minor defects, do not meet the requirements of this regulation may request a waiver from HQDA(DAPC-OPP-V), Alexandria, VA 22332.

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

(4) *Nondesignated or nonrated personnel.* In nondesignated or nonrated personnel, minor physical defects which will in no way affect the scope and

efficient performance of flying duties will be waived by the commander of the unit or station upon recommendation of a flight surgeon. Notification of such disqualification will be forwarded, in all instances in writing, by the hospital commander or the medical officer concerned to the disqualified individual's commanding officer with appropriate recommendations for waiver of defects or suspension from flying status in accordance with existing directives. See AR 600-107.

★i. Review and waiver action.

(1) The Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362 will review and make final determination (utilizing the procedures outlined in paragraph 10-26d(1) for ARNG personnel) concerning medical fitness for—

- (a) Class 1—Entrance into flight training.
- (b) Class 1A—Entrance into flight training.
- (c) Class 2—Entrance into and continuance in training and on duty as an air traffic controller.
- (d) Class 2—Individuals on flight status as an aviator (military members and civilian employees).
- (e) Class 3—Entrance into training and continuance on flight status as a flight surgeon.

(2) The US Army Military Personnel Center HQDA(DAPC-OPP-V), Alexandria, VA 22332 for officers, or DAPC-OPE-L-T for enlisted air traffic controllers) and the National Guard Bureau are the only HQDA agencies authorized to grant administrative waivers for medically unfitting conditions for entrance into flight training (Classes 1 and 1A); continuance of Active Army and Reserve Component personnel on flight status (Class 2); entry into and continuance in training and on duty as air traffic controller. Such waivers may be granted only upon the written recommendations of the review authority designated in paragraph 10-26i(1). Consideration for limited flying status, as defined in AR 600-107, or referral to inflight evaluation, per AR 600-108, will be given on a case basis and will be approved only on the recommendation of the Commander, USAAMC. The Surgeon General, HQDA(SGPE-MC), is the only Army agency authorized to grant administrative waivers for medically unfitting conditions for entrance into training and continuance on duty of flight surgeons.

(3) Personnel required to meet Class 3 medical fitness standards for flying (crew chiefs, aerial observers, air ambulance attendants, door gunners and others, not including flight surgeons). Determination of medical fitness for entrance into training

and continuance on duty may be made by the reviewing flight surgeon who renders aviation medicine support to the post, camp, station, or command to which these members are assigned or attached. Unit commanders may grant administrative waivers, upon recommendation of the flight surgeon, for minor physical defects which will in no way affect the safe and efficient performance of flying duties and which will not be aggravated by aviation duties.

j. Use of DA Form 4186 (*Medical Recommendation for Flying Duty*). (Applies to all Aviation Personnel, Including Civilian Employee Pilots, Civilian Contractor Pilots, and Military and Civilian Air Traffic Controllers). DA Form 4186 is to be completed at the time of: (1) Periodic examination; (2) after an aircraft accident; (3) reporting to a new duty station; (4) when admitted to a medical treatment facility or sick in quarters; (5) when returned to flight status following (4) above; (6) when treated as an outpatient for conditions or with drugs which are disqualifying for aviation duty; (7) when being returned to flight status following restriction imposed under (6) above; (8) other occasions, as required. A total of three copies will be completed at all times. One copy will be filed in the examinee's Health Record; one copy will be sent to the examinee's unit commander who forwards it to the flight records clerk for inclusion in the flight records, in accordance with paragraph 7-5b(2), AR 95-1; and the third copy will be forwarded to the Commander, USAAMC, ATTN: ATZQ-AAMC-AA-ER, Fort Rucker, AL 36362. Health Record copies will be filed as follows:

- Most recent DA Form 4186. . . . . File on top left
- If above grants clearance to fly, then most recent DA Form 4186, if any, which shows a medical restriction from flying. . . . . File next under
- If a waiver has been granted for any cause of medical unfitness for flying, the most recent DA Form(s) 4186 showing such waiver(s) . . . . . File next under
- Any additional DA Form(s) 4186 which the flight surgeon determines to be required as a permanent record (Enter "Permanent Record" in "Remarks" section) . . . . . File next under
- Other DA Form(s) 4186. . . . . Destroy

Issuance of this form, following a periodic medical examination, will constitute authority for medical clearance for flying duty pending return of final re-

view from the approving authority, Fort Rucker, AL, if the examinee is found qualified for flying duty in accordance with chapter 4. If a newly discovered, medically unfitting condition requiring waiver exists, such waiver must be obtained before further flying duty is authorized. If a previously waived condition has changed significantly (e.g., condition worsens), a new waiver must be obtained before further flying duty is authorized. Block No. 9 of DA Form 4186 will show date when waiver was first granted for each waived condition as well as date and nature of any significant changes in condition(s) which have been waived. DA Form 4186 may be used by a flight surgeon to extend a currently valid medical examination for a period not to exceed 3 calendar months beyond the end of the birthday month for the purpose of aligning medical examinations with the individual's birthday month. It may also be used by a flight surgeon to extend a currently valid medical examination for a period not to exceed 3 calendar months beyond the end of the birthday month if the flight surgeon determines that such extension is necessary due to medical examination workload, nonavailability of the aircrew member for examination, or related reasons. However, the flight surgeon must have sufficient knowledge of the aircrew member's health to be reasonably assured that the aircrew member meets appropriate medical fitness flying standards. When

used for this purpose, the Remarks section of DA Form 4186 will be completed to reflect the length of time for which the extension is being given. In determining when the next following examination is due, any examination conducted within 3 calendar months before or 3 calendar months after the end of the birthday month will be considered to have been accomplished during the birthday month. The medical clearance expiration date in item 8, DA Form 4186, will then normally be the end of the birthday month approximately 1 year later. Diagnostic coding in item 9 of DA Form 4186 will be completed in accordance with section II, chapter 1, AR 40-400. DA Form 4186 may be signed by a flight surgeon, other physician, or physician assistant when used to medically restrict aircrew members from flying duty. It may be signed only by a flight surgeon when used to return aircrew members to flying duty, except that return to flying duty by health care providers other than flight surgeons may be accomplished with telephonic concurrence of a flight surgeon if a flight surgeon is not locally available at a given installation. This clearance, to include the name of the consulting flight surgeon, will be recorded in the medical record and on DA Form 4186. The term "Flight Surgeon" will be blocked out on DA Form 4186 if the signing official is not a flight surgeon.

### Section V. USMA MEDICAL EXAMINATIONS

#### 10-27. US Military Academy

Medical examinations for entrance into the United

States Military Academy are governed by AR 40-29.

### Section VI. MOBILIZATION MEDICAL EXAMINATIONS

#### 10-28. Mobilization Medical Examinations

For administrative procedures applicable to mobil-

ization medical examinations (para 6-1), see paragraph 10-22.

### Section VII. MISCELLANEOUS MEDICAL EXAMINATIONS

#### 10-29. Miscellaneous Medical Examinations

*a. Specialized duties.* Medical examination of individuals for initial selection or retention in certain specialized duties requires verification of the absence of disease or anomalies which may affect performance of those duties. As examples, most military occupational specialties in the electronics field require good color vision; marine divers must be free of diseases of the ear; airborne personnel

must have full strength and range of motion of extremities. In evaluating such personnel, the examiner will be guided by the requirements for special physical qualifications set forth in pertinent publications, such as chapters 4 and 7 of this regulation, AR 40-5, AR 611-201, TB MED 270, TB MED 279, and TB MED 501.

#### *b. Certain geographical areas.*

(1) When an individual is alerted for movement

or is placed on orders for assignment to duty with the system of Army attachés, military missions, military assistance advisory groups, or in isolated areas, the commander of the station to which he is assigned will refer the individual and his dependents, if any, to the medical facility of the command. The physician of the facility will carefully review the health records and other available medical records of these individuals. Medical fitness standards for certain geographical areas are contained in paragraph 7-9 and will be used in the evaluation and examination processes. In assessing the individual's potentiality for assignment in certain geographical areas, the examiner is urged to make use of other materials such as the Departmental Study, Medical Survey, by Country, published by the US Army Medical Intelligence and Information Agency, Department of the Army, Office of The Surgeon General which provide valuable information on environmental conditions in foreign countries. Particular attention will be given to ascertaining the presence of any disease or anomaly which may make residence of one or more members of the family inadvisable in the country of assignment. Review of the medical records will be supplemented by personal interviews when the individuals to obtain pertinent information concerning their state of health. The physician will consider such other factors as length of time since the last medical examination, age, and the physical adaptability of the individual to the new area. Additional considerations of importance which bear on the advisability of residence in a given country are the scarcity or nonavailability of certain care and hospital facilities, and dependence on the host government for care. If, after review of records and discussion, it appears that a complete medical examination is indicated, a type A examination will be accomplished. Sponsors and dependents who are particularly anxious for assignments to certain areas are often inclined to minimize their medical deficiencies or hesitate to offer complete information to medical examiners regarding their medical condition or physical defect. The examiner must be especially alert to recognize such situations and fully investigate the clinical aspects of all suspected or questionable areas of medical deficiency. The commander having processing responsibility will insure that this medical action is completed prior to the individual's departure from his home station.

(2) The importance of this medical processing cannot be overemphasized. It is imperative that a

thorough screening be accomplished as noted in (1) above for the best interests of both the individual and the Government. Individuals in these assignments function in a critical area. Their duties do not permit unscheduled absences. The peculiarities of the environment in which they and their dependents must live are often deleterious to health and present problems of adaptability for many individuals. In view of the unfavorable environments incident to many of these assignments, it is of prime importance that only those individuals will be qualified whose medical status is such as to provide reasonable assurance of continued effective performance and a minimum likelihood of becoming medical liabilities.

★(3) If as a result of his review of available medical records, discussion with the individual and his dependents, and findings of the medical examination, if accomplished, the physician finds them medically qualified in every respect under paragraph 7-9d, and to meet the conditions which will be encountered in the area of contemplated assignment, he will complete and sign DA Form 3083-R (Medical Examination for Certain Geographical Areas). This form will be reproduced locally on 8½ by 11-inch paper in accordance with figure 10-2. The top margin of the form will be approximately ¼-inch for filing in Health Record and Outpatient Record. A copy of this statement will be filed in the Health Record or Outpatient Record (AR 40-66) and a copy forwarded to commander who referred the individual to the medical facility. If the physician finds a dependent member of the family disqualified for the proposed assignment, he will notify the commander of the disqualification. The examiner will not disclose the cause of the disqualification of a dependent to the commander without the consent of the dependent, if an adult, or a parent if the disqualification relates to a minor. If the military member or dependent is considered disqualified temporarily, the commander will be so informed and a re-examination scheduled following resolution of the condition. If the disqualification is permanent or if it is determined that the disqualifying condition will be present for an extended period of time, the physician will refer the military member to a medical board for documentation of the condition and recommendations concerning limitation of activities or areas of assignment. Either DA Form 3947 (Medical Board Proceedings) or DA Form 3349 (Physical Profile Board Proceedings)

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

(4) Periodic medical examinations and medical examinations conducted for the purpose of separation and immediate reenlistment may be waived by the commanding officer concerned for those individuals stationed in isolated areas; i.e., Army attachés, military missions and military assistance advisory groups, where medical facilities of the US

Armed Forces are not available. Medical examinations so waived will be accomplished at the earliest opportunity when the individuals concerned are assigned or attached at a military installation having a medical facility. Medical examination of such individuals for separation or retirement purposes may not be waived.

**(Locate fig. 10-2, a fold-in page,  
at the end of the regular size pages)**

### **Section VIII. MEDICO-DENTAL REGISTRANTS MEDICAL EXAMINATIONS**

#### **10-30. Medico-Dental Registrants Medical Examinations**

Administrative procedures applicable to medical

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

**★ 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)**

Maximum Auditory Threshold Levels (Both Ears) Not Greater Than Indicated Below.

Cycles Per Second (Hz)	
500	35 dB
1000	30 dB
2000	30 dB
3000	55 dB
4000	55 dB
6000	55 dB

If the examinee does not meet the above standard, reevaluate the better ear only in accordance with the following table of acceptability.

500	30 dB
1000	25 dB
2000	25 dB
3000	35 dB
4000	35 dB
6000	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)		500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz
Classes 1 & 1A	Each ear	25	25	25	55	55	55
Class 2	Better ear	25	25	25	35	35	35
	Poorer ear	25	35	35	45	45	45
Class 3	Better ear	30	25	25	35	35	35
	Poorer ear	*	*	*	*	*	*

\*No requirement

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

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

## APPENDIX III

### TABLE 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	21-30 years	31-35 years	36-40 years	41 years and over
60	100	158	163	162	157	150
61	102	163	168	167	162	155
62	103	168	174	173	168	160
63	104	174	180	178	173	165
64	105	179	185	184	179	171
65	106	185	191	190	184	176
66	107	191	197	196	190	182
67	111	197	203	202	196	187
68	115	203	209	208	202	193
69	119	209	215	214	208	198
70	123	215	222	220	214	204
71	127	221	228	227	220	210
72	131	227	234	233	226	216
73	135	233	241	240	233	222
74	139	240	248	246	239	228
75	143	246	254	253	246	234
76	147	253	261	260	252	241
77	151	260	268	266	259	247
78	153	267	275	273	266	254
*79	159	273	282	281	273	260
*80	166	280	289	288	279	267

\*Applies only to personnel enlisted, inducted, or appointed in Army and enlisted or inducted into Air Force. Does not apply to Navy or Marine Corps enlistees or inductees.

Table II. Table of Militarily Acceptable Weight (in Pounds) as Related to Age and Height for Females—  
Initial Procurement

Height (inches)	Minimum (regardless of age)	Maximum					
		18-20 years	21-24 years	25-30 years	31-35 years	36-40 years	41 years and over
58	90	121	123	126	124	135	135
59	92	123	125	129	126	139	138
60	94	125	127	132	128	142	141
61	96	127	129	135	131	145	141
62	98	129	132	139	132	148	147
63	100	135	136	141	136	151	150
64	102	136	140	144	140	155	154
65	104	140	144	148	145	159	158
66	106	144	149	151	150	164	163
67	109	147	151	156	154	168	167
68	112	152	158	159	159	172	171
69	115	158	160	164	162	176	175
70	118	162	166	168	167	181	180
71	122	168	171	171	171	185	184
72	125	171	175	176	175	189	188

**Table III. Table of Acceptable Weights for Army Aviation  
(Classes 1, 1A, 2, 3)  
(See para 4-16, chap. 4, for Minimum and Maximum Heights)**

Male (regardless of age)	Weight (pounds)	
Height (inches)	Minimum	Maximum
60 .....	100	141
61 .....	102	146
62 .....	103	150
63 .....	104	155
64 .....	105	160
65 .....	106	165
66 .....	107	170
67 .....	111	176
68 .....	115	181
69 .....	119	186
70 .....	123	192
71 .....	127	197
72 .....	131	203
73 .....	135	208
74 .....	139	214
75 .....	143	220
76 .....	147	226
77 .....	151	232
78 .....	153	238
79 .....	159	244
80 .....	166	250

Female (regardless of age)	Weight (pounds)	
Height (inches)	Minimum	Maximum
58 .....	90	113
59 .....	92	117
60 .....	94	121
61 .....	96	125
62 .....	98	130
63 .....	100	134
64 .....	102	138
65 .....	104	142
66 .....	106	147
67 .....	109	151
68 .....	112	156
69 .....	115	160
70 .....	118	165
71 .....	122	170
72 .....	125	175

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

Height (inches)	Minimum	Maximum
	Regard- less of age	Regard- less 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

★APPENDIX V

TABLE OF MINIMUM VALUES OF VISUAL ACCOMMODATION FOR ARMY AVIATION

Age	Diopters	Age	Diopters
17.....	8.8	32.....	5.1
18.....	8.6	33.....	4.9
19.....	8.4	34.....	4.6
20.....	8.1	35.....	4.3
21.....	7.9	36.....	4.0
22.....	7.7	37.....	3.7
23.....	7.5	38.....	3.4
24.....	7.3	39.....	3.1
25.....	6.9	40.....	2.8
26.....	6.7	41.....	2.4
27.....	6.5	42.....	2.0
28.....	6.2	43.....	1.8
29.....	6.0	44.....	1.0
30.....	5.7	45.....	0.6
31.....	5.4		

## APPENDIX VIII PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE

Profile serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing—Ears	E Vision—Eyes	S Psychiatric
★ 1 . . . . .	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits, or limitation of motion; no demonstrable abnormality; able to do hand-to-hand fighting.	No loss of digits, or limitation of motion; no demonstrable abnormality; be capable of performing long marches, standing over long periods.	Audiometer level each ear not more than 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz. Not over 45 dB at 3000, 4000 and 6000 Hz.	Uncorrected visual acuity 20/200 correctible to 20/20, in each eye.	No psychiatric pathology. May have history of a transient personality disorder.
★ 2 . . . . .	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculoskeletal defects which do not prevent hand-to-hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness or other musculoskeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.	Audiometer level not more than 35 dB at 500 Hz, 30 dB at 1000 and 2000 Hz and 55 dB at 3000, 4000, 6000 Hz in both ears, or 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz and 35 dB at 3000, 4000 and 6000 Hz in the better ear.	Distant visual acuity correctible to 20/40-20/70, 20/30-20/100, 20/20-20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcoholic or drug addiction. Individuals who have been evaluated by a physician (psychiatrist) and found to have a character and behavior disorder will be processed through appropriate administrative channels.
★ 3 . . . . .	Unable to perform full effort except for brief or moderate periods.	Defects or impairments which interfere with full function requiring restriction of use.	Defects or impairments which interfere with full function requiring restriction of use.	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	Uncorrected distant visual acuity of any degree which is correctible not less than 20/40 in the better eye or an acute or chronic eye disease not falling below	Satisfactory remission from an acute psychotic or neurotic disorder which permits utilization under specific conditions (assignment when outpatient psy-

Profile serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing—Ears	E Vision—Eyes	S Psychiatric
4 . . . . . Factors to be considered.	Below Retention Standards. Organic defects, age, build, strength, stamina, weight, height, agility, energy, muscular coordination, function, and similar factors.	Below Retention Standards. Strength, range of motion, and general efficiency of upper arm, shoulder girdle and back, including cervical, thoracic, and lumbar vertebrae.	Below Retention Standards. Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back.	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. Below Retention Standards. Auditory acuity, and organic disease of the ears.	retention standards.  Below Retention Standards. Visual acuity, and organic disease of the eyes and lids.	chiatric treatment is available or certain duties can be avoided).  Below Retention Standards. Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Pre-disposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorder impairment of functional capacity.

## APPENDIX IX

### SCOPE AND RECORDING OF MEDICAL EXAMINATIONS

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
1	✓	✓	The entire last name, first name, and middle name are recorded. If the individual's first and/or middle name consists of initial(s) only, indicate by adding (IO). When Jr. or similar designation is used, it will appear after the middle name. If there is no middle name or initial, put a dash after the first name.	Jackson, Charles Guy Rush, Benjamin— Osler, William Z. (IO) Jenner, Edward Thomas Jr. Baird, J.T.
2	✓	✓	Enter examinee's grade and component. The entry USA is used for all personnel on active duty with the United States Army. Reserve components of the Army are indicated by USAR or ARNGUS. If examinee has no military status, enter the word "civilian," leaving space for later insertion of grade and component upon entry into the military service.	CPT, USA MAJ, USAR SGT, USA SFC, ARNGUS Civilian
3	✓	✓	Examinee's social security number. If none, enter a dash.	396-38-0699 —
4	✓	✓	Examinee's current civilian mailing address. Do not confuse with military organization or present temporary mailing address.	
5	✓	✓	Enter purpose of examination. If for more than one purpose, enter each.	Induction RA Enlistment Periodic RA Commission Retirement
6	✓	✓	Enter date on which the medical examination is accomplished. Record in military style. This item is to be completed at the medical examining facility.	10 Feb 1965 3 Mar 65
7	✓	✓	Do not use abbreviation.	Male Female
8	✓	✓	As appropriate, enter the first three letters of one of the following: Caucasian, Negroid, Mongolian, Indian (American) or Malayan. Do not confuse with nationality or religion.	Cau Neg Mon Ind (American) Mal
9	✓	✓	Enter total active duty time in the military and/or full time Civil Service or Federal employment only. Express as years plus twelfths. Reserve time may be entered in item 16.	7 6/12; 4 3/12
10	✓	✓	Enter branch of military service or civilian agency as appropriate. Do not confuse with components of the services.	DA    FBI DAF    CIA DN    State Dept USMC
11	✓	✓	The examinee's current military unit of assignment, active or reserve. If no current military affiliation, enter a dash.	
12	✓	✓	Record in military style; i.e., day, month and year, followed by age, in parentheses, to the nearest birthday.	14 Jan 43 (21) 26 Mar 20 (45)
13	✓	✓	Name of city and State of examinee's birth. If not born in a city or town, enter county and State. If born in a foreign country, enter city or town and country.	Baltimore, Md. Dinwiddie County, Va. Marseilles, France
14	✓	✓	Name, followed by relationship in parentheses, and address of next of kin. This is the person to be notified in the event of death or emergency. If there is no next of kin, enter "none."	Mrs. Annie F. Harris (Wife) 1234 Fairfax Ave. Atlanta, GA 20527

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
15	✓	✓	Name of examining facility or examiner and address.	Armed Forces Examining Station 310 Gaston Ave. Fairmont, WV 12441 Dr. Raymond T. Fisher 311 Marcy Street Phoenix, AZ 39404
16	✓	✓	List any prior service number(s) and service(s). In the case of service academy examinees, enter the title, full name, and address of sponsor (individual who requested the examination). For Selective Service registrants list the examinee's Selective Service number and identify as such. Identifying or administrative data for the convenience of the examining facility should be entered either in item 16, if space allows, or otherwise in the upper right hand corner of the SF 88. If the examination is for an aviation procurement program and the examinee has prior military service, enter the branch of service.	
★ 17	✓	✓	The individual's current military job or specialty, including total time in this capacity expressed in years and/or twelfths. In the case of pilots, enter current aircraft and total flying time in hours. In the case of free fall parachuting and/or marine (SCUBA) diving, so state and report the time in months or years of qualification.	
18	✓	✓	Record all swollen glands, deformities, or imperfections of head or face. In the event of detection of a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If enlarged lymph nodes of the neck are detected they will be described in detail and a clinical opinion of the etiology will be recorded.	2 in. vertical scar right forehead, well healed no symptoms. 3 discrete, freely movable, firm 2 cm. nodes in the right anterior cervical chain, probably benign.
19	✓	✓	Record all abnormal findings. Record estimated percent of obstruction to air flow if septal deviation, enlarged turbinates, or spurs are present.	20 percent obstruction to air flow on right due to septal deviation.
20	✓	✓	Record all abnormal findings.	Marked tenderness over left maxillary sinus.
21	✓	✓	Record any abnormal findings. If tonsils are enucleated, this is considered abnormal, thus check this item abnormal.	Tonsils enucleated.
22	✓	✓	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered.	Bilateral severe swelling, injection and tenderness of both ear canals.
★ 23	✓	✓	Record all abnormal findings. If tested, a definite statement will be made as to whether the ear drums move on valsalva maneuver or not. In the event of scarring of the tympanic membrane the percent of involvement of the membrane will be recorded as well as the mobility of the membrane. Valsalva required for all diving, free fall parachuting, and flying duty examinations.	Valsalva normal bilaterally. 2 mm oval perforation, left posterosuperior quadrant. No motion on valsalva maneuver, completely dry. No evidence of inflammation at present.

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

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
35	✓	✓	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as, for example, a history of a broken arm with no significant finding at time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the "normal" column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is desired.	No weakness, deformity, or limitation of motion, left arm.
36	✓	✓	Record any abnormality. When the flat feet are detected, a statement will be made as to the stability of the foot, presence of symptoms, presence of eversion, bulging of the inner border, and rotation of the astragalus. Pes planus will not be expressed in degrees, but should be recorded as mild, moderate, or severe.	Flat feet, moderate. Foot stable, asymptomatic, no eversion or bulging; no rotation.
37	✓	✓	Record as for item 35.	
38	✓	✓	Include pelvis, sacroiliac, and lumbrosacral joints. Check history. If scoliosis is detected, the amount and location of deviation, in inches from the midline, will be stated.	Scoliosis, right, ½ inch from midline at level of T-8.
39	✓	✓	Only scars or marks of purely identifying significance or which interfere with function are recorded here. Tattoos which are obscene or so extensive as to be unsightly will be described fully.	1-inch vertical linear scar, dorsum left forearm. 3-inch heart-shaped tattoo, nonobscene, lateral aspect middle ¼ left arm.
40	✓	✓	Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment.	Small, discrete, angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping. Similar lesion on glans penis.
41	✓	✓	Record complete description of any abnormality.	
★ 42	✓	✓	Record all abnormalities. This is not to be confused with ARMA. (Item 72)	
43	✓	✓	Check vaginal or rectal. Record any abnormal findings.	Acceptable.
★ 44	✓	✓	Dental examination accomplished by a dentist is required for applicants for Service Academy, Uniformed Services University of Health Sciences, the 4-year ROTC Scholarship Program, and diving training and duty (see also AR 40-29 and chapter 7 of this regulation). Examinations accomplished for appointment as commissioned or warrant officers, enlistment or induction in the Army, Army National Guard, and Army Reserve, aviation training and duty, entrance on active duty or active duty for training, periodic (Active Army, Army National Guard, and Army Reserve) discharge, relief from active duty, or retirement <i>do not</i> require dental examinations accomplished by a dentist. Examining physicians will apply the appropriate standards prescribed by chapters 2, 3, 4, 6, or 8, and indicate "acceptable" or "non-acceptable".	Nonacceptable.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
45 A B C D	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	Identify tests used and record results. Items A and D not routinely required for Type "A" medical examinations accomplished for initial entrance, or for routine separation. Must be accomplished for all Type B examinations and for periodic or retirement examinations.	
★ 46	✓	✓	Required for initial examination for appointment, enlistment or induction into the active or reserve component, and for discharge and relief from active duty or retirement (if a medical examination is accomplished). Not required for periodic examinations unless clinically indicated. Note facility, place and date taken, film size, number, and findings.	14 x 17 film No. 54321 Womack Army Hospital, Ft Bragg, NC, 11 July 1979, negative.
47	✓	✓	Kahn, Wasserman, VDRL, or cardiolipin microflocculation tests recorded as negative or positive. On positive reports note date, place and titre. Serology not required for periodic examination.	Cardiolipin. Microflocculation. Negative. Normal. Abnormal—see attached report.
48	(*)	✓	*Required for retirement or if age 40 or over; also if indicated. Representative samples of all leads (including precordial leads) properly mounted and identified on Standard Form 520 (EKG report) will be attached to the original of SF 88. Standard Form 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 (or 73 if necessary) on all copies of SF 88.	Normal. Abnormal—see attached report.
49			(Rescinded)	
★ 50	✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓	Hematocrit required for all periodic and separation examinations. Mammography—After age 50, during periodic examinations and at least once in-between. Stool Guaiac—All personnel age 40 and over. White Blood Cell Count—All marine divers. Cholesterol )All personnel age Triglycerides )40 and over or as Fasting Blood Sugar )clinically indicated.	Identify test(s) and record results.
★ 51	✓	✓	Record in inches to the nearest quarter inch (without shoes). For Class 1, 1A aviation personnel, record time of day if near height limits.	71½
52	✓	✓	Record in pounds to the nearest whole pound (without clothing and shoes).	164.
53	✓	✓	Record as black, blond, brown, gray or red.	Brown.
54	✓	✓	Record as blue, brown, gray or green.	Blue.
55	✓	✓	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For definition of obesity see appendix I.	
56	(*)		*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6*
★ 57 A, B and C	(*)	✓	*Only if indicated by abnormal findings in A; i.e., if sitting blood pressure exceeds the limits prescribed by the standards of medical fitness applicable to the purpose of the examination. Abnormal readings should be rechecked as prescribed by paragraph 11-10, chapter 11.	110/76.
★ 58 A	✓	✓	Record for all examinees.	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
B, C, D and E	(*)	✓	*Record only if indicated by abnormal findings in 58A, i.e., if A is 100 or more, or below 50. If either D or E is 100 or more, or less than 50, record pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73.	
59	✓	✓	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye.	20/100 corr. to 20/20. 20/50 corr. to 20/20.
★ 60	(*)	✓	*Refraction required for induction enlistment and appointment if <i>corrected</i> vision is less than the minimum visual standards stated in paragraph 2-13a, or if deemed appropriation by the examiner regardless of visual acuity.  Cycloplegic required for initial selection for Class 1 and 1A flying duty. The word "manifest" or "cycloplegic," whichever is applicable, will be entered after "refraction."  An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value.	By - 1.50 S + 0.25 CX 05. By - 1.50 S + 0.25 CX 175.
61	✓	✓	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20) an entry will be made of the corrected vision for each eye and lens value after the word "by."	20/40 corr. to 20/20 by same. 20/40 corr. to 20/20 by +0.50.
★ 62	-	✓	Identify test used; i.e., either Maddox Rod or Stereoscope, Vision Testing, and record results. Prism Div and PD not required. Not required for dependents. All tests will be at 20 feet or at distance setting of SVT. Cover Test (CT) will be done at near and distance with an accommodative fixation target (visual acuity letter) in primary position. Distance CT will be performed in horizontal and vertical fields of gaze for initial entry flying duty Classes 1, 1A, 2 and 3.	Stereoscope, Vision Testing (SVT) ES° 4 EX° 0 R.H. 0 L.H. 0 Prism Div . . . . . CT Ortho PC 35 PD . . . . .
★ 63	-	✓	Record values without using word "diopters" or symbols.	Right 10.0 Left 9.5.
★ 64	✓	✓	Required only as initial test and subsequently only when indicated. Record results in terms of test used. Passed or Failed—number of plates missed over number of plates in test. The Farnsworth Lantern (FALANT) (USN) may be utilized. If examinee fails either of these tests, he will be tested for red/green color vision and results recorded as "passed" or "failed" red/green.	Pseudoisochromatic plate; or PIP  Passed $\frac{3}{4}$ . Failed $\frac{1}{4}$ .
65	-	✓	Identify test used and record results for corrected and uncorrected. Enter dash in corrected space if applicable. Score is entered for Howard-Dolman; passes or fails is used for Verhoeff.	Howard-Dolman 25. Verhoeff passes.
66	-	✓	Identify test used and results. If a visual field defect is found or suspected in the confrontation test, a more exact perimetric is made using the perimeter and tangent screen. Findings are recorded on visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.
67	-	(*)	*Only if indicated by history, record results. If not indicated, enter NIBH.	NIBH.
68	-	✓	Record test results and describe all abnormalities.	Normal.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
69	(*)	(*)	<p>* Only if indicated.</p> <p>Tonometry on all personnel age 40 and over.</p> <p>Tonometry required on all ATC personnel, regardless of age.</p> <p>Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities; continue in item 73 if necessary.</p>	<p>Normal.</p> <p>O.D. 18.9.</p> <p>O.S. 17.3.</p>
70	—	—	Not required. Enter dash in each space.	
71	✓	✓	Test and record results at 500, 1000, 2000, 3000, 4000 and 6000 cycles.	
★ 72	(*)	✓	<p>* Only if indicated.</p> <p>Adaptability Rating for Military Aeronautics (ARMA) and Reading Aloud Test (RAT) (appendix X) required for initial entry of aircrew members, Classes 1, 1A, 2 and 3, and air traffic controllers, Class 2. Enter as "ARMA satisfactory" or "ARMA unsatisfactory." Unsatisfactory ARMA requires a summary of defects responsible for failure in item 73. ARMA, RAT and DA Form 3742 required for service academies and preparatory schools. Results of other psychological testing, when accomplished, will be attached to SF 88.</p> <p>Adaptability Rating for Military Diving (MDAR) required for initial entry for diving duty. This rating will include consideration of requirements of paragraph 7-10. If the chamber required for paragraph 7-10d(3) is not available, that test will be conducted at the Navy Diving School.</p>	<p>ARMA sat.</p> <p>ARMA unsat.—see item 73.</p>
★ 73	✓	✓	<p>If SF 93 is not used, the examinee will enter a brief statement about the state of his health since his last examination. Examiner will enter notes on examination as necessary. Significant medical events in the individual's life, such as major illnesses or injuries, and any illness or injury since the last in-service medical examination, will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof, will be noted where appropriate. Do not use "NS." Comments from other items may also be continued in this space. If additional space is needed, use SF 507. History and related comments recorded on SF 93, when this form is used, will not be transferred or commented on except as necessary in connection with the examination. All aviation personnel will include and <i>sign</i> following entry: "I understand I must be cleared by a flight surgeon after hospitalization or sick in quarters (AR 600-107); must inform him after treatment or activities which may require restriction (AR 40-8); I have read AR 40-8; I have informed the examining physician of any changes in health since last examination." (Rubber stamper may be used.)</p> <p>Other statements of medical history such as "no history of asthma, allergies, loss of consciousness, or convulsions, etc." may be used.</p>	<p>No significant or interval history.</p> <p>Traumatic cataract, left eye, removed 29 July 1964, no comp., see item 59-60 for vision correction.</p> <p>Item 72 cont: History of multiple idiopathic syn-copal attacks.</p>
74	✓	✓	<p>Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect which may be of future significance, such as nonstatic defects which may become worse. Enter item number followed by short, concise diagnosis; do not repeat full description of defect which has already been described under appropriate item. Do not summarize minor, nonsignificant findings.</p>	
75	✓	✓	<p>Notation will be made of any further specialized examinations or tests that are indicated. Item 75 will also include the statement "gas mask spectacles required (AR 40-3)" whenever indicated under the criteria set forth in AR 40-3.</p>	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
76	✓	✓	The physical profile as prescribed in chapter 9 will be recorded.	1 1 1 1 2 1
77	✓	(*)	*Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5. Though not required, this item may be completed as a recommendation of the examining physician in the case of applicants or nominees for the USMA or the USNA. No entry will be made for USAFA applicants or nominees.	
78	✓	✓	List all disqualifying defects by item number. This listing is required even though the defects are stated in item 74. If qualified, enter a dash.	
★79-81	✓	✓	Enter typed or printed name of examiners. If examination is accomplished for entrance into service academies (USMA, USNA, USAFA, USCGA, USMMA) signatures of physician and dentist are required. If examination is accomplished for entrance into Aviation duty, Classes 1, 1A and 2, signature of a Flight Surgeon (Army, Navy or Air Force) is required. Examinations accomplished for enlistment or induction, entrance on active duty of reserve component members, and all periodic, discharge, relief from active duty and retirement examinations must be signed by a physician. Dentists, optometrists, podiatrists, audiologists, nurse practitioners, and physician assistants may also sign attesting to that portion of the examination actually accomplished by them.	
★82	(*)	(*)	*See paragraph 10-14d.	

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