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Army Regulation 40-501

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Medical Services

## Standards of Medical Fitness

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Department of the Army  
Washington, DC  
15 May 1989

# SUMMARY of CHANGE

AR 40-501  
Standards of Medical Fitness

This change--

- o Expands paragraph 5-12 to include medical restrictions for officer and enlisted occupational specialties and to give guidance for the assignment of asplenic soldiers.
- o Rescinds certain procedures for soldiers being returned to duty status by a Physical Evaluation Board (PEB), Army Physical Disability Agency, or Army Physical Disability Appeal Board (para 7-8d).
- o Adds procedures for referrals to a PEB (para 7-8i).
- o Adds explanation for the use of serial codes C through J (table 7-2).
- o Amends validity dates of some medical procedures (chap 8).
- o Requires that, when available, dentists will accomplish item 44 of SF 88 (para 8-7a).
- o Changes procedures for air traffic controllers (paras 8-24 and 9-10).
- o Adds Survival, Evasion, Resistance, and Escape (SERE) Medical Examination Reports; makes the Commander, U.S. Army John F. Kennedy Special Warfare Center, the review and waiver authority for Special Forces Initial Qualification, HALO, SCUBA, and SERE Medical Examination Reports (para 8-26c).
- o Rescinds "Standards may not be waived, however, for officers who are being considered for promotion to general officer" (para 9-12c).
- o Revises the Cardiovascular Screening Program and adds the requirement for a Health Risk Appraisal (para 8-27).
- o Revises vision standards for Reserve Officers' Training Corps and U.S. Military Academy applicants.

~~Check out the book~~

Effective 14 June 1989

Medical Services

Standards of Medical Fitness

This publication was last revised on 1 July 1987.

This UPDATE printing publishes a Change 1. The portions of the text being revised by this change are highlighted.

By Order of the Secretary of the Army:

CARL E. VUONO  
General, United States Army  
Chief of Staff

Official:



MILTON H. HAMILTON  
Administrative Assistant to the  
Secretary of the Army

**Summary.** This regulation provides information on medical fitness standards for induction, enlistment, appointment, and retention and related policies and procedures.

**Applicability.** This regulation applies to candidates for military service and Active Army personnel. It also applies in specified paragraphs to the Army National Guard (ARNG) and the U.S. Army Reserve (USAR).

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

**Internal control systems.** This regulation is not subject to the requirements of

AR 11-2. It does not contain internal control provisions.

**Supplementation.** Supplementation of this regulation and establishment of command or local forms are prohibited without prior approval from HQDA (SGPS-CP-B), 5109 Leesburg Pike, Falls Church, VA 22041-2358.

**Interim changes.** Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

**Suggested improvements.** The proponent agency of this regulation is the Office

of the Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (SGPS-CP-B), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

**Distribution.** Distribution of this publication is made in accordance with the requirements on DA Form 12-09-E, block number 2524, intended for command level A for Medical Activities only of Active Army, ARNG, and USAR, and command level B for all other elements of Active Army, ARNG, and USAR.

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## Chapter 1 General Provisions

### 1-1. Purpose

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

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

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

### 1-2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

### 1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

### 1-4. Responsibilities

a. The Surgeon General will develop, revise, and disseminate current Army medical fitness standards and ensure Army compliance with DOD directives pertaining to those standards.

b. Director, Department of Defense Medical Examination Review Board (DODMERB); Chief, Army National Guard (ARNG); Chief, U.S. Army Reserve (USAR); and commanders of the Military Entrance Processing Command (MEPCOM), U.S. Army Recruiting Command (USAREC), U.S. Army Training and Doctrine Command (TRADOC), U.S. Army Health Services Command (HSC), Army Reserve Personnel Center, and all Army medical treatment facilities (MTFs) worldwide, will implement policies prescribed in this regulation applicable to all Active Army and Reserve Component personnel and applicants for appointment, enlistment, and induction.

c. Commanders and military personnel officers at all levels of command will implement administrative and command provisions of chapters 5, 7, 8, and 9.

### 1-5. Medical classification

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

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

b. *Medically unacceptable.* Medical examiners will report as "medically unacceptable" by reason of medical unfitness all individuals who possess any one or more of the medical conditions or physical defects listed in this regulation as a cause for rejection for the specific purpose for which examined, except as noted in c below. Examinees reported as medically unacceptable by reason of medical unfitness when the medical fitness standards in chapters 2, 3, or 6 apply will be given a physical profile. Examinees found medically unacceptable when the medical fitness standards in chapters 4 or 5 apply will not be given a physical profile. Individuals found to be medically unacceptable for military service will not be reported as permanently medically unfit for military service except upon the finding of Headquarters, Department of the Army (HQDA), or of a medical or physical evaluation board.

c. *Medically unacceptable—prior administrative waiver granted.* Medical examiners will report as "medically unacceptable—prior administrative waiver granted" all individuals who do not meet the medical fitness standards established for the particular purpose for which examined when a waiver has been previously granted, and all of the provisions of paragraph 1-6c apply. Such individuals will be given a physical profile.

### 1-6. Waivers

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

b. Examinees initially reported as medically unacceptable by reason of medical unfitness when the medical fitness standards in chapters 2, 3, 4, 5, or 6 apply, may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action. Upon such request, the designated administrative authority or his or her designee for the purpose may grant such a waiver in accordance with current directives.

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

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

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

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

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

within the retention medical fitness standards prescribed for the program or purpose involved.

## Chapter 2 Physical Standards for Enlistment, Appointment, and Induction

### 2-1. General

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

### 2-2. Application and responsibilities

#### a. Application.

(1) This chapter prescribes the medical conditions and physical defects which are causes for rejection for military service. Those individuals found medically qualified based on the medical standards of chapter 2 that were in effect prior to March 9, 1987, will not be reevaluated or medically disqualified solely on the basis of the new standards. Other standards may be prescribed in the event of mobilization or a national emergency.

(2) The standards of chapter 2 apply to—

(a) Applicants for appointment as commissioned or warrant officers in the Regular Army; the Army of the United States (AUS), or in the Reserve Components of the Army, including the ARNG of the United States and the USAR;

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

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

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

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

(f) Cadets at the USMA and in Army ROTC programs, except for such conditions that have been diagnosed since entrance into an academy or ROTC program. With respect to such conditions, upon recommendation of the Surgeon, USMA (for USMA cadets), or the Surgeon, TRADOC (for ROTC cadets), the medical fitness standards of chapter 3 are applicable for retention in the Academy, the ROTC program, appointment or enlistment, and entrance on active duty or active duty for training in a commissioned or enlisted status. However, the standard in paragraph 2-39m applies to USMA and ROTC cadets whether chapter 2 or 3 standards of this regulation are applicable.

(g) All individuals being inducted into the Army.

#### b. Responsibilities.

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

(2) The Secretary of the Army will—

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

(b) Recommend to the ASD(HA) suggested changes in the standards after Service coordination has been accomplished.

(c) Review all the standards on a quadrennial basis and recommend changes to the ASD(HA). This review will be initiated and coordinated by the DODMERB.

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

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

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

### 2-3. Abdominal organs and gastrointestinal system

The causes for rejection for appointment, enlistment, and induction are as follows:

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

#### b. Stomach and duodenum.

(1) Gastritis, chronic hypertrophic, severe.

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

(3) Authenticated history of surgical operation(s) for gastric or duodenal ulcer; that is, partial or total gastric resection, gastrojejunostomy, pyloroplasty, truncal or selective vagotomy (or history of such

operative procedures for any other cause or diagnosis).

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

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

(6) History of surgical correction of hypertrophic pyloric stenosis of infancy is not disqualifying if currently asymptomatic.

#### c. Small and large intestine.

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

(2) Symptomatic Meckel's diverticulum.

(3) Megacolon of more than minimal degree.

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

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

(6) Malabsorption syndromes.

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

#### e. Hepato-pancreatico-biliary tract.

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

(2) Hepatic cysts—congenital cystic disease; parasitic, protozoal, or other cysts.

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

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

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

(6) Bile duct abnormalities or strictures.

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

#### f. Anorectal.

(1) Fistula in ano.

(2) Incontinence.

(3) Anorectal stricture.

(4) Excessive mucous production with soiling.

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

(6) Rectal prolapse.

(7) Symptomatic rectocele.

(8) Symptomatic anal fissure.

(9) Chronic diarrhea, regardless of cause. g. *Spleen.*

(1) Splenomegaly until the cause is corrected.

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

(a) Trauma.

(b) Causes unrelated to diseases of the spleen.

(c) Hereditary spherocytosis.

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

h. *Tumors.* See paragraph 2-41.

#### i. Abdominal wall.

(1) Scars.

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

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

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

(2) *Hernia.*

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

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

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

### 2-4. Blood and blood-forming tissue diseases

The causes for rejection for appointment, enlistment, and induction are as follows:

#### a. Anemia.

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

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

(3) Abnormal destruction of red blood cells (or corpuscles) (RBCs): Hemolytic anemia, to include enzyme deficiencies, with evidence of ongoing hemolysis; microangiopathic and any other hemolytic anemia, acquired or inherited.

(4) Faulty RBC construction and miscellaneous anemias including hemoglobinopathies, sideroblastic anemias, thalassemia major, and sickle-cell disease. Heterozygous conditions such as glucose-6-phosphate dehydrogenase (G6PD) deficiency, thalassemia minor and sickle-cell trait may be acceptable if the hemoglobin is within the examining laboratory's normal limits, hemoglobin, sickle cell (Hgb S) is less than hemoglobin A; normal (Hgb A) and there is no history or evidence of crisis, decreased exercise tolerance, or other complications.

(5) Myelophthitic anemias from any cause.

(6) Macroglubulinemia.

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

*b. Hemorrhagic states.*

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

(2) Due to quantitative or qualitative platelet deficiency.

(3) Due to vascular instability (for example, hereditary hemorrhagic telangiectasia).

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

*d. Myeloproliferative disease.*

(1) Myelofibrosis/myeloid metaplasia.

(2) Primary thrombocythemia.

(3) Polycythemia rubra vera.

(4) Di Guglielmo's syndrome.

(5) Chronic granulocytic leukemia. (See para 2-41 below).

*e. Splenomegaly.* Splenomegaly until the cause is remedied.

*f. Thromboembolic disease.*

Thromboembolic disease except for acute, nonrecurrent thrombophlebitis.

*g. Immundeficiency diseases.* (See also para 2-39m.)

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

## 2-5. Dental

The causes for rejection for appointment, enlistment, and induction are as follows:

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

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

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

*d.* Orthodontic appliances. (See para 5-14.)

## 2-6. Ears

The causes for rejection for appointment, enlistment, and induction are as follows:

*a. Auditory canal.*

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

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

(3) Severe external otitis, acute or chronic.

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

*c. Mastoids.*

(1) Mastoiditis, acute or chronic.

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

(3) Mastoid fistula.

*d. Meniere's syndrome.*

*e. Middle ear.*

(1) Acute or chronic suppurative otitis media.

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

(3) Acute or chronic serous otitis media.

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

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

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

(7) Cholesteatoma.

*f. Tympanic membrane.*

(1) Any perforation of the tympanic membrane.

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

(3) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 30 dB or more average for the speech frequencies (500, 1000, and 2000 Hertz) in either ear regardless of the hearing level in the other ear.

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

## 2-7. Hearing (See also para 2-6)

The cause for rejection for appointment, enlistment, and induction is a hearing threshold level greater than that described in c below. (As an exception to guidelines in table 7-1 and for administrative purposes only, personnel examined at the Military Entrance Processing Stations (MEPS) for initial entrance into Active or Reserve Component Army service, who are disqualified because of failure to meet the hearing standards described in c below, will be given the numerical designator "3E" under the "H" factor of the physical profile. Personnel evaluated under chapter 3 will be profiled in accordance with table 7-1.)

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

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

*c.* Acceptable Audiometric Hearing Level for Appointment, Enlistment, and Induction (ISO 1964—ANSI 1969) for both ears: Pure tone at 500, 1000, and 2000 Hertz of not more than 30 dB on the average (either ear), with no individual level greater than 35 dB at these frequencies; and a level not more than 45 dB at 3000 Hertz each ear, and 55 dB at 4000 Hertz each ear.

## 2-8. Endocrine and metabolic disorders

The causes for rejection for appointment, enlistment, and induction are as follows:

*a.* Adrenal dysfunction of any degree.

*b.* Cretinism.

*c.* Diabetes mellitus, any type or a history of diabetes mellitus in both natural parents. A history of juvenile onset (insulin-dependent, type I) is also disqualifying even if there is no current need for insulin and blood sugars are normal.

*d.* Gigantism or acromegaly.

*e.* Gout.

*f.* Hyperinsulinism, confirmed, symptomatic.

*g.* Hyperparathyroidism and hypoparathyroidism.

*h.* Hypopituitarism.

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

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

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

*l.* Thyroid disorders.

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

(2) Hyperthyroidism or thyrotoxicosis.

(3) Hypothyroidism, even when the individual is maintained euthyroid with replacement therapy.

(4) Thyroiditis.

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

## 2-9. Upper extremities (See also para 2-11)

The causes for rejection for appointment, enlistment, and induction are as follows:

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

(1) Shoulder.

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow.

(a) Flexion to 100 degrees.

(b) Extension to 15 degrees.

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

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

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

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

*b. Hand and fingers.*

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

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

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

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

(5) Hyperdactylia.

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

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

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

## 2-10. Lower extremities (see also para 2-11)

The causes for rejection for appointment, enlistment, and induction are as follows:

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

*(1) Hip.*

(a) Flexion to 90 degrees (minimum).

(b) No demonstrable flexion contracture.

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

(d) Abduction to 45 degrees.

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

*(2) Knee.*

(a) Full extension.

(b) Flexion to 90 degrees.

*(3) Ankle.*

(a) Dorsiflexion to 10 degrees.

(b) Plantar flexion to 30 degrees.

(c) Eversion and inversion (total to 5 degrees).

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

*b. Foot and ankle.*

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

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

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

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

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

(6) Flatfoot, tarsal coalition.

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

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

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

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

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

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

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

*c. Leg, knee, thigh, and hip.*

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

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

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

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

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

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

(7) Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease), if symptomatic or with obvious prominence of the part and x-ray evidence of a separated bone fragment.

*d. General.*

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

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

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

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

## 2-11. Miscellaneous conditions of the extremities (see also paras 2-9 and 2-10)

The causes for rejection for appointment, enlistment, and induction are as follows:

*a. Arthritis.*

(1) Active, subactive, or chronic arthritis.

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

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

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

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

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

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

e. Fractures.

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

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

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

g. Joint replacement.

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

i. Myotonia congenita. Confirmed.

j. Osteochondritis desiccans, if symptomatic.

k. Osteochondromatosis or multiple cartilaginous exostoses.

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

m. Osteoporosis.

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

## 2-12. Eyes

The causes for rejection for appointment, enlistment, and induction are as follows:

### a. Lids.

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

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

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

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

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

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

(8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

### b. Conjunctiva.

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

(2) Pterygium.

(a) Recurring after three operative procedures.

(b) Encroaching on the cornea in excess of 3 millimeters, interfering with vision, or

is progressive (as evidenced by marked vascularity on a thickened elevated head).

(3) Xerophthalmia.

### c. Cornea.

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

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

(3) Keratitis, acute or chronic.

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

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

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

### e. Retina.

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

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

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

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

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

### f. Optic nerve.

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

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

(3) Optic atrophy (primary or secondary).

(4) Papilledema.

### g. Lens.

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

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

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

### h. Ocular mobility and motility.

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

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

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

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

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

(6) However, for entrance into the USMA or Army ROTC Scholarship programs, the following conditions are also disqualifying:

(a) Esotropia of over 15 prism diopters.

(b) Exotropia of over 10 prism diopters.

(c) Hypertropia of over 25 prism diopters.

### i. Miscellaneous defects and diseases.

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

(a) Temporal: 85 degrees.

(b) Superior temporal: 55 degrees.

(c) Superior: 45 degrees.

(d) Superior nasal: 55 degrees.

(e) Nasal: 60 degrees.

(f) Inferior nasal: 50 degrees.

(g) Inferior: 65 degrees.

(h) Inferior temporal: 85 degrees.

(2) Absence of an eye.

(3) Asthenopia, severe.

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

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

(6) Hemianopsia of any type.

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

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

(9) Night blindness.

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

(11) Retained intraocular foreign body.

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

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

## 2-13. Vision

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

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

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

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

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

(4) However, for entrance into the USMA or Army ROTC Scholarship Programs, distant visual acuity which does not correct to 20/20 in each eye is disqualifying. For Army ROTC Programs, distant visual acuity which does not correct to 20/20 in one eye and 20/100 in the other is disqualifying. For entrance into OCS, the provisions of paragraph 5-17 are applicable.

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

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

(1) Anisometropia over 3.50 diopters. (*Rescinded.*)

(2) Astigmatism, all types over 3 diopters.

(3) Hyperopia over 5.508.00 diopters in any meridian, spherical equivalent.

(4) Myopia over 5.506.75 diopters in any meridian, spherical equivalent.

(5) Refractive error corrected by orthokeratology or keratorefractive surgery.

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

e. *Color vision.* Although there is no standard, color vision will be tested, since adequate color vision is a prerequisite for entry into many military specialties. However, for entrance into the USMA or Army ROTC Scholarship Programs, the inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or vivid green is disqualifying. For entrance into OCS, the provisions of paragraph 5-17 are applicable.

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

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

a. Bartholinitis, Bartholin's cyst;

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

c. Dysmenorrhea, incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

d. Endometriosis, or confirmed history thereof.

e. Hermaphroditism.

f. Hydrocele or left varicocele; if larger than the attendant testicle, painful, or any right varicocele unless urological evaluation reveals no disease.

g. Menopausal syndrome, physiologic or artificial if manifested by more than mild constitutional or mental symptoms; or artificial menopause if less than 13 months have

elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.

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

i. New growths of the internal or external genitalia, except a single uterine fibroid, subserous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus may be acceptable. (See also para 2-41.)

j. Oophoritis, acute or chronic.

k. Ovarian cysts, persistent, clinically significant.

l. Pregnancy.

m. Salpingitis, acute or chronic.

n. Testicle(s). (See also para 2-41.)

(1) Absence of both testicles.

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

(3) Undescended testicle(s).

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

p. Uterus.

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

(2) Endocervicitis, more than mild.

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

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

(5) Pap smears graded Class 2, 3, or 4 (Class 2 smears are acceptable if the diagnosis is benign), or any smear in which the descriptive terms dysplasia, carcinoma-in-situ, or invasive cancer are used.

q. Vagina.

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

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

r. Vulva.

(1) Leukoplakia.

(2) Vulvitis, acute or chronic.

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

## 2-15. Urinary system (see also paras 2-8 and 2-41)

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

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

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

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

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

e. Incontinence of urine.

f. Kidney.

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

(2) Acute or chronic infections of the kidney.

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

(4) Horseshoe kidney.

(5) Hydronephrosis or pyonephrosis.

(6) Nephritis, acute or chronic.

(7) Pyelitis, pyelonephritis.

g. Orchitis, chronic, or chronic epididymitis.

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

i. Peyronie's disease.

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

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

l. Renal calculus.

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

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

m. Skenitis.

n. Urethra. Stricture of the urethra.

o. Urinary fistula.

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

## 2-16. Head

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

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

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

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

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

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

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

g. All cases involving absence of the bony substance of the skull that have been corrected but in which the defect is in excess of 1 square inch (6.45 cm<sup>2</sup>) or the size of a 25-cent piece.

## 2-17. Neck

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

a. Cervical ribs if symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on x-rays is not considered to meet 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. Nonspastic contraction of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or is so disfiguring as to make the individual objectionable in common social relationships.

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

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

## 2-18. Heart

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

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

b. Coronary heart disease.

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

(1) Supraventricular tachycardia, atrial flutter, atrial fibrillation, ventricular tachycardia or fibrillation. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment. Multifocal premature ventricular contractions are disqualifying irrespective of symptoms or treatment. (However, commonly, healthy, highly trained individuals can have multifocal premature ventricular contractions or nonsustained ventricular tachycardia with a normal prognosis; therefore, these may be unwarranted disqualifications. Cases should be considered on an individual basis for waiver consideration.) Ventricular arrhythmias are disqualifying when associated with physiologic or actuarial significance. Supraventricular tachycardia, atrial flutter, and atrial fibrillation are not disqualifying if there has been no recurrence during the preceding 2 years off all medication.

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

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

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

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

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

## 2-19. Vascular system

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

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

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

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

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

## 2-20. Miscellaneous cardiovascular conditions

a. Rheumatic fever during the previous 2 years; Sydenham's chorea at any age.

b. Pulmonary or systemic embolization, history of.

## 2-21. Height

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

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

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

## 2-22. Weight

The causes for rejection for appointment, enlistment, and induction in relation to weight standards are established by each of the military Services. Standards for the Army are contained in tables 2-1 and 2-2 (located after the last appendix of this regulation). Effective 1 August 1987, all Army applicants for initial appointment as a commissioned officer (to include appointment as a commissioned warrant officer)

must meet the standards of AR 600-9. Body composition measurements may be used as the final determinant in evaluating an applicant's acceptability.

## 2-23. Body build

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

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

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

c. Evidence of congenital asthenia or body build which would interfere with the completion of required training.

## 2-24. Lungs, chest wall, pleura, and mediastinum

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

a. Abnormal elevation of the diaphragm, either side.

b. Abscess of the lung.

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

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

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

f. Bronchiectasis.

g. Rhothopleural fistula.

h. Bullous or generalized pulmonary emphysema.

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

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

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

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

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

n. Foreign body in trachea or bronchus.

o. Foreign body of the chest wall causing symptoms.

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

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

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

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

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

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

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

w. Pneumothorax during the year preceding examination if due to simple trauma or surgery; during the 3 years preceding examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and pulmonary function tests fall within normal limits. Recurrent spontaneous pneumothorax is disqualifying regardless of cause.

x. Pulmonary embolus, history of.

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

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

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

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

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

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

## 2-25. Mouth

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

a. Hard palate, perforation of.

b. Harelip, unless satisfactorily repaired by surgery.

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

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

e. Salivary fistula or obstruction of the salivary duct.

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

## 2-26. Nose and sinuses

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

a. Allergic manifestations.

(1) Atrophic rhinitis.

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

b. Anosmia or parosmia.

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

d. Epitaxis, chronic recurrent.

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

f. Nasal septum, perforation of—

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

(2) If progressive.

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

g. Sinusitis, acute.

h. Sinusitis, chronic when more than mild—

(1) Evidenced by any of the following: Chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues, or symptoms requiring frequent medical attention.

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

## 2-27. Pharynx, trachea, and larynx

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

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

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

c. Dysphonia plicae ventricularis.

d. Tracheostomy or tracheal fistula.

## 2-28. Other defects and diseases of the mouth, nose, throat, pharynx, and larynx

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

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

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

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

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

## 2-29. Neurological disorders

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

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

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

c. Degenerative disorders. Any evidence or history of—

(1) Basal ganglia disease.

(2) Cerebellar and Friedreich's ataxia.

(3) Cerebral arteriosclerosis.

(4) Dementia.

(5) Multiple sclerosis or other demyelinating processes.

(6) Muscular atrophies and dystrophies of any type.

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

e. Head injury.

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

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

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

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

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

(e) Central nervous system shunts of all types.

(2) Applicants with a history of severe head injury with any of the following complications are unacceptable for at least 5 to 10 years after injury but may be acceptable after that time if complete neurological and neurophysiological examination and history show no residual dysfunction or complications. (See table 2-3.)

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

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

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

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

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

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

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

(h) Focal neurological signs.

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

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

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

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

(b) Linear skull fracture.

(4) History of mild head injury; that is, loss of consciousness or amnesia or the combination of the two for less than 30 minutes, without linear skull fracture, is disqualifying for at least 1 month but may be acceptable if neurological evaluation shows no residual dysfunction or complications. (See table 2-3.)

(5) Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

**Table 2-3**  
**Evaluation for risk of head injury sequelae**

**Degree of head injury:** Mild (para 2-29e(4)).  
**Minimum observation time/evaluation requirements:** 1 month/complete neurological examination by a physician.

**Degree of head injury:** Moderate (para 2-29e(3)).  
**Minimum observation time/evaluation requirements:** 2 years/complete neurological evaluation by a neurologist or internist. CT scan.

**Degree of head injury:** Severe (para 2-29e(2)).  
**Minimum observation time/evaluation requirements:** 5 years for closed head trauma, 10 years for penetrating head trauma/complete neurological evaluation by a neurologist or neurosurgeon. CT scan. Neuropsychological evaluation.

f. Hereditary disturbances. Personal or family history of hereditary disturbances, such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis. A strong family history of such a syndrome indicating a heredity component, will be cause for rejection in the absence of clinical symptoms or signs since the onset of these illnesses may occur later in adult life.

g. Infectious diseases.

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

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

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

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

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

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

j. Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause if there is any indication that such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent.

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

(1) No seizure since age 5.

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

l. Peripheral nerve disorder.

(1) Polyneuritis, whatever the etiology, unless—

(a) Limited to a single episode.

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

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

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

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

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

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

o. Tremors that will interfere with normal function.

p. Central nervous system shunts of all types.

Note: Diagnostic concepts and terms utilized in paragraphs 2-30 through 2-35 are in consonance with the DSM-III-R Manual, American Psychiatric Association, 1980, 1987. The minimum psychiatric evaluation will include axis I, II, and III.

## 2-30. Disorders with psychotic features

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

## 2-31. Affective disorders (mood disorders)

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

## 2-32. Anxiety, somatoform, dissociative, or factitious disorders

(alternatively may be addressed as neurotic disorders)

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

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

(1) Hospitalization.

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

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

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

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

## 2-33. Personality, behavior, or learning/academic skills disorders

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

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

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

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

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

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

#### 2-34. Psychosexual conditions

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

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

b. Transsexualism and other gender identity disorders.

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

#### 2-35. Substance misuse

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

a. Chronic alcoholism or alcohol addiction or dependence.

b. Drug addiction or dependence.

c. Drug abuse characterized by—

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

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

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

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

#### 2-36. Skin and cellular tissues

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

a. Acne, severe, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment.

b. Atopic dermatitis, with active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, 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) Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus.

d. Dermatitis factitia.

e. Dermatitis herpetiformis.

f. Any type of eczema that is chronic and resistant to treatment.

g. Elephantiasis or chronic lymphedema.

h. Epidermolysis bullosa, pemphigus.

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

j. Extensive furunculosis, recurrent, or chronic.

k. Hyperhidrosis of hands or feet, chronic or severe.

l. Ichthyosis, severe.

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

n. Leprosy, any type.

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

p. Lichen planus.

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

r. Neurofibromatosis (Von Recklinghausen's disease).

s. Nevi or vascular tumors, if extensive, interferes with function, or exposed to constant irritation.

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

u. Psoriasis or a verified history thereof.

v. Radiodermatitis.

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

x. Scleroderma.

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

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

aa. Urticaria, chronic.

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

ac. Xanthoma, if disabling or accompanied by hyperlipemia.

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

#### 2-37. Spine and sacroiliac joints (see also para 2-11)

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

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

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

c. Deviation or curvature of spine from normal alignment, structure, or function (lumbar scoliosis over 20 degrees or dorsal scoliosis over 30 degrees as measured by the Cobb method, kyphosis over 55 degrees, or lordosis) or if—

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

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

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

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

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

f. Granulomatous diseases either active or healed.

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

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

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

j. Spina bifida when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

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

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

#### 2-38. Scapulae, clavicles, and ribs

(see para 2-11)

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

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

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

c. Osteomyelitis.

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

## 2-39. General and miscellaneous conditions and defects

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

a. Allergic manifestations.

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

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

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

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

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

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

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

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

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

f. Cold urticaria.

g. Reactive tests for syphilis such as the rapid plasma reagin (RPR) or venereal disease research laboratory (VDRL) followed by a reactive, confirmatory fluorescent treponemal antibody absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified or if the test reverts to a non-reactive status during an appropriate follow-up period (3 to 6 months).

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

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

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

k. Mycotic infection of internal organs.

l. Myositis or fibrositis, severe, chronic.

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

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

## 2-40. Systemic diseases

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

a. Amyloidosis.

b. Ankylosing spondylitis.

c. Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, should not be a cause for rejection once healing has occurred. All other forms of the histiocytosis X spectrum should be rejected.

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

e. Mixed connective tissue disease.

f. Polymyositis dermatomyositis complex.

g. Progressive systemic sclerosis, including calcinosis, Raynaud's phenomenon, esophageal dysfunction, sclerodactyly, and telangiectasis (CREST) variant.

h. Psoriatic arthritis.

i. Reiter's disease.

j. Rheumatoid arthritis.

k. Rhabdomyolysis, or history thereof.

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

m. Sjogren's syndrome.

n. Tuberculosis.

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

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

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

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

of the American Thoracic Society and U.S. Public Health Service.

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

## 2-41. Tumors and malignant diseases

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

a. Benign tumors

(1) Benign tumors of the head or face that interfere with function or preclude the wearing of a face or protective mask or a helmet.

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

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

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

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

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

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

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

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

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

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

(4) Malignant tumors of the heart.

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

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

(7) Malignant tumors of the musculoskeletal system.

(8) Malignant tumors of the central nervous system and its membranous coverings, unless 5 years postoperative and without

otherwise disqualifying residuals of surgery or the original lesion.

(9) Malignant tumors of the endocrine glands.

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

(11) Malignant tumors of the hematopoietic system.

(a) Lymphomatous diseases.

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

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

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

(c) Multiple myeloma.

### 2-42. Sexually transmitted diseases

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

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

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

c. Neurosyphilis (see para 2-29).

## Chapter 3 Medical Fitness Standards for Retention and Separation, Including Retirement

### 3-1. General

This chapter gives the various medical conditions and physical defects which may render a soldier unfit for further military service.

### 3-2. Application

a. These standards apply to the following individuals:

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

(2) All enlisted members of the Regular Army, ARNG, and USAR. For those members found to have an service EPTS medical

condition or physical defect that should have precluded original enlistment (see chap 2) but not listed in this chapter, see paragraph 2-2 of this regulation, AR 635-200, or AR 135-178.

(3) Cadets of the USMA, Army ROTC, and USUHS programs for whom the standards of this chapter apply according to paragraph 2-2.

(4) Soldiers placed on the Temporary Disability Retired List (TDRL). (See AR 635-40.)

(5) Soldiers of the ARNG or USAR who apply for enlistment in the Regular Army.

(6) Soldiers of the ARNG and USAR who reenter active duty training under the "split-training" option (Phase II). Note that weight standards in table 2-1 or table 2-2 apply to split option trainees.

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

(1) Retention of officers, warrant officers, and enlisted personnel of the Active Army, ARNG, and USAR in Army aviation, Airborne, marine diving, Ranger, or Special Forces training and duty, or other duties for which special medical fitness standards are prescribed.

(2) All officers, warrant officers, and enlisted personnel of the Active Army, ARNG, and USAR who have been permanently retired.

### 3-3. Policies

a. Soldiers with conditions listed in this chapter will be evaluated by a medical board and **WILL BE REFERRED TO A PHYSICAL EVALUATION BOARD (PEB)** (except for members of the Reserve Components not on active duty).

(1) This chapter only provides general guidelines; possession of one or more of the listed conditions does not mean automatic retirement or separation from the service. Determination of fitness or unfitness will be made by the PEB dependent upon the soldier's ability to perform the duties of his or her office, grade, rank, or rating. The duties must be performed in such a manner as to reasonably fulfill the purpose of his or her employment in the military service.

(2) If the medical board determines that referral to a PEB is not appropriate, the soldier may request, in writing, an additional review by the MTF commander of the medical board findings and recommendations. The MTF commander will provide the soldier a written report of the review and will attach a copy to the medical board proceedings. Cases that are not resolved in this manner will be forwarded to the Commander, United States Army Health Services Command, Fort Sam Houston, TX 78234-6000 (for all medical treatment facilities in the 50 States, the Commonwealth of Puerto Rico, and medical treatment facilities in Panama); Chief Surgeon, United States Army, Europe, and Seventh Army, APO New York 09102 (for all MTFs in Europe); or the Surgeon, Eighth United States Army, Korea, APO San Francisco 96301

(for all medical treatment facilities in Korea and Japan).

b. Not all medical conditions and physical defects which may render a soldier unfit to perform the duties of his or her office, grade, rank, or rating by reason of physical disability are listed in this chapter. Further, a soldier may be unfit because of physical disability resulting from the overall effect of two or more impairments even though no one of them, alone, would cause unfitness. A single impairment or the combined effect of two or more impairments may make a soldier unfit because of physical disability if—

(1) The soldier is unable to perform the duties of his or her office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his or her employment in the military service, or

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

(3) In view of the soldier's physical condition, his or her retention in the military service would prejudice the best interests of the Government (for example, a carrier of communicable disease who poses a threat to others).

c. A soldier will not be referred to a PEB because of impairments which were known to exist at the time of his or her acceptance for military service, and which have remained essentially the same in degree of severity since acceptance and have not interfered with his or her performance of effective military service.

d. A soldier who has remained in military service under one of the programs for retention of disabled personnel (AR 635-40, chap 6; chap 9 below, and NGR 40-501) will be referred to a PEB prior to separation or retirement processing.

e. Lack of motivation for service should not influence the medical examiner in evaluating disabilities under these standards except as it may be symptomatic of some disease process. Poorly motivated soldiers who are medically fit for duty will be recommended for administrative disposition.

f. A soldier who is accepted for and enters the military service is presumed to be in sound physical condition except for those conditions and abnormalities recorded in his or her procurement medical records. This presumption may be overcome by conclusive evidence that an impairment was incurred while the individual was not entitled to receive basic pay. Likewise, the presumption that an increase in severity of such an impairment is the result of service must be overcome by conclusive evidence. Statements of the accepted medical principles used to overcome these presumptions will be made. These statements must clearly state why the impairment could not reasonably have had its inception while the soldier was entitled to receive basic pay, or that an increase in severity represents normal progression.

g. An impairment, its severity, and effect on a soldier may be determined by carefully

evaluated subjective findings based upon medical principles and judgments as well as objective evidence. Contradiction of these findings must be supported by conclusive evidence. Every effort will be made to accurately record the physical condition of each soldier throughout his or her Army career. It is important, therefore, that all medical conditions and physical defects be recorded, no matter how minor they may appear.

### 3-4. Disposition of soldiers who may be unfit because of physical disability

a. Soldiers who have one or more of the conditions listed in this chapter will be referred to a PEB as prescribed in AR 40-3 and AR 635-40. When mobilization fitness standards (chap 6) are in effect, or as directed by the Secretary of the Army, individuals who may be unfit under these standards but fit under the mobilization standards will not be referred to a PEB until termination of the mobilization or as directed by the Secretary of the Army. During mobilization, those who may be unfit under both retention and mobilization standards will be processed to determine their eligibility for physical disability benefits unless disability separation or retirement is deferred as indicated below.

b. Soldiers on extended active duty who are being referred to a PEB under the provisions of this chapter will be advised that they may apply for continuance on active duty as provided in chapter 6, AR 635-40.

c. Soldiers not on extended active duty who do not meet retention medical fitness standards (mobilization medical fitness standards when these are in effect) will be processed as prescribed in chapter 9 for members of the USAR, or NGR 600-200; NGR 40-501, or NGR 40-3 for members of the ARNG, for disability separation or continuation in their Reserve status as prescribed in the cited regulations. Members of the ARNG and USAR 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. Soldiers on extended active duty who meet retention medical fitness standards but who 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. Soldiers 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.

Note: For Active Army soldiers, paragraphs 3-5 through 3-45 below prescribe, by broad general category, those medical conditions and physical defects which require medical board action and referral to a PEB. ARNG and USAR soldiers 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.

### 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, confirmed by gastroscopic examination.

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

g. *Hernia*.

(1) *Hiatus hernia*. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

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

h. *Ileitis, regional*.

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

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

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

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

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

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.

### 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 3-43.

a. Anemia.

b. Hemolytic crisis, chronic and symptomatic.

c. Leukopenia, chronic.

d. Polycythemia.

e. Purpura and other bleeding diseases.

f. Thromboembolic disease.

g. Splenomegaly, chronic.

h. HTLV-III (HIV) confirmed antibody positivity, with the presence of progressive clinical illness or immunological deficiency. For Regular Army soldiers and Reserve Component soldiers on active duty for more than 30 days (except for evaluation under the Walter Reed Staging System or for training under 10 USC 270(b)), a MEBD must be accomplished and, if appropriate, the soldier must be referred to a PEB under AR 635-40. For Reserve Component soldiers not on active duty for more than 30 days or on active duty for training under 10 USC 270(b), convening of a MEB and referral to a PEB will be determined under chapter 8; AR 635-40. Records of official diagnoses provided by private physicians (that is, civilian doctors providing evaluations under contract with DA or DOD, or civilian public health officials) concerning the presence of progressive clinical illness or immunological deficiency in Reserve Component soldiers may be used as a basis for administrative action under, for example, AR 135-133, AR 135-175, AR 135-178, AR 140-10, NGR 600-200, or NGR 635-100, as appropriate.

### 3-8. Dental diseases and abnormalities of the jaws

Diseases of the jaws or associated tissues when, following restorative surgery, there remain residuals which are incapacitating, or interfere with the individual's satisfactory performance of military duty, or leave unsightly deformities which are disfiguring.

### 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.

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 individual soldiers having a hearing defect can be returned to duty with appropriate assignment limitations. The following is a guide for referring individual soldiers with hearing defects for physical disability separation or retirement processing:

a. When a soldier 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 soldier may be considered for physical disability separation or retirement if, at the time he or she is being considered for separation or retirement for some other administrative reason, the medical examination discloses a substantial hearing defect.

### 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 the 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 when increased activity causes breathing obstruction, unless correctable.*

f. *Gout* in 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* with severe symptoms or 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* with residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

### 3-12. Upper extremities (see para 3-14)

a. *Amputations.* Amputation of part or parts of an upper extremity equal to or greater than—

(1) A thumb proximal to the interphalangeal joints.

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

(3) 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/AFP 160-14.

(1) *Shoulder.*

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) *Elbow.*

(a) Flexion to 100 degrees.

(b) Extension to 60 degrees.

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

(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/AFP 160-14).

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

(b) An active extensor value of combined joint motions of 75 degrees 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 prevents the wearing of a military shoe, or when associated with vascular changes.

(3) *Talipes cavus* when moderately severe, with moderate discomfort on prolonged standing and walking, matatarsalgia, 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/AFP 160-14.

(1) *Hip.*

(a) Flexion to 90 degrees.

(b) Extension to 0 degree.

(2) *Knee.*

(a) Flexion to 90 degrees.

(b) Extension to 15 degrees.

(3) *Ankle.*

(a) Dorsiflexion to 10 degrees.

(b) Plantar flexion to 10 degrees.

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

### 3-14. Miscellaneous conditions of the extremities (see also paras 3-12 and 3-13)

a. *Arthritis.*

(1) *Arthritis due to infection.* Arthritis due to infection associated with persistent pain and marked loss of function, with objective x-ray evidence and documented history of recurrent incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection, see paragraphs 3-40k and 3-45b.

(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 fractures*. 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*. Severe pain involving major joints or spinal segments in an 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*. Prosthetic replacement of major joints.

e. *Muscles*.

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

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

f. *Myotonia congenita*.

g. *Osteitis deformans (Paget's disease)*. Involvement of single or multiple bones with resultant deformities or symptoms severely interfering with function.

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

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

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

### 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 fields 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 degrees.

b. *Aphakia, bilateral*.

c. *Atrophy of the 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 degrees.

(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 a zone less than 20 degrees 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 a soldier unfit.

d. *Night blindness*. Of such a degree that the soldier 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 degrees.

### 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*. When bilateral, symptomatic, and not responsive to treatment.

(2) *Congenital anomaly*. When 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*. When chronic.

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

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

(7) *Nephritis*. When chronic.

(8) *Nephrosis*.

(9) *Perirenal abscess*. With residuals of a degree which precludes the satisfactory performance of duty.

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

(11) *Pyonephrosis*. When not responding to treatment.

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

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

*i. Urethritis, chronic.* When 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 it 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.* If there is complete amputation of the penis or when a satisfactory urethra cannot be restored.

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

### 3-19. Head (see also para 3-29)

Loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms such as described in paragraph 3-30.

### 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.

### 3-21. Heart

*a. Coronary heart disease associated with—*

(1) Myocardial infarction, angina pectoris or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm.

(2) Myocardial infarction with normal coronary artery anatomy.

(3) Angina pectoris in association with objective evidence of myocardial ischemia in the presence of normal coronary artery anatomy.

(4) Fixed obstructive coronary artery disease, asymptomatic, but with objective evidence of myocardial ischemia.

*Note:* Soldiers with myocardial infarction and with or without coronary artery bypass surgery or percutaneous coronary angioplasty should have the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessment (such as coronary angiography, exercise testing, and newly developed techniques) indicates that it is medically advisable. Prior to commencing the trial of duty period, a medical board will be accomplished in all cases and a physical activity prescription provided by a physician on DA Form 3349. (Physical Profile). Upon completion of the trial of duty period, a detailed report from the commander or supervisor will be incorporated in the medical board record and will clearly describe the individual's ability to accomplish assigned duties and ability to perform physical activity will be incorporated into the medical board record. An addendum to the medical board will be accomplished by a cardiologist or internist and will include the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component soldiers not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

*b. Supraventricular tachyarrhythmias,* when life threatening or symptomatic enough to interfere with performance of duty and when not adequately controlled. This includes atrial fibrillation, atrial flutter, paroxysmal supraventricular tachycardia, and others.

*c. Endocarditis* with any residual abnormality or if associated with valvular, congenital, or hypertrophic myocardial disease.

*d. Heart block* (second degree or third degree AV block) and symptomatic bradyarrhythmias, even in the absence of organic heart disease or syncope. Wenckebach second degree heart block occurring in healthy asymptomatic individuals without evidence of organic heart disease is not a cause for referral to a PEB. None of these conditions is cause for medical board referral to a PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, acute illness.

*e. Myocardial disease,* New York Heart Association or Canadian Cardiovascular Society Functional Class II or worse. (See table 3-1.)

*f. Ventricular flutter and fibrillation,* ventricular tachycardia when potentially life threatening (for example, when associated with forms of heart disease which are recognized to predispose to increased risk of death and when there is no definitive therapy available to reduce this risk) and when symptomatic enough to interfere with the performance of duty. None of these ventricular arrhythmias is a cause for medical board referral to a PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or acute illness.

*g. Sudden cardiac death* when an individual survives sudden cardiac death that is not associated with a temporary or treatable cause, and when there is no definitive therapy available to reduce the risk of recurrent sudden cardiac death.

*h. Pericarditis* as follows: Chronic—

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

(2) Serous pericarditis.

*i. Valvular heart disease* with cardiac insufficiency at functional capacity of Class II or worse as defined by the New York Heart Association. (See table 3-1.) 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 is a cause for medical board referral to a PEB regardless of the degree of severity.

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

*k. Recurrent syncope* or near syncope of cardiovascular etiology that is not controlled, or when it interferes with the performance of duty, even if the etiology is unknown.

*l. Any cardiovascular disorder* requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that would interfere with duty performance worldwide under field conditions.

### 3-22. Vascular system

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

(1) Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest.

(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.

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

*b. Major cardiovascular anomalies* including coarctation of the aorta, unless satisfactorily treated by surgical correction or other newly developed techniques, and without any residual abnormalities or complications.

*c. Aneurysm* of any vessel not correctable by surgery and aneurysm corrected by surgery after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. Prior to commencing the trial of duty period a medical board will be accomplished in all cases. At the completion of the trial of duty period a detailed report from the commander or

supervisor will be incorporated with an addendum to the medical board in all cases. For Reserve Components not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

d. 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. Thromboangiitis obliterans with 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 that are severe and symptomatic despite therapy.

### 3-23. Miscellaneous cardiovascular conditions

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 mmHg following an adequate period of therapy in an ambulatory status, or

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

(a) More than minimal changes in the brain.

(b) Heart disease.

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

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

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

### 3-24. Surgery and other invasive procedures involving the heart, pericardium, or vascular system (including newly developed techniques or prostheses not otherwise covered in this paragraph)

a. Permanent prosthetic valve implantation.

b. Implantation of permanent pacemakers, antitachycardia and defibrillator devices, and similar newly developed devices.

c. Reconstructive cardiovascular surgery employing exogenous grafting material.

d. Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, that results in the individual's inability to perform satisfactory duty. When the surgery includes a median sternotomy, the trial of duty period will be 120 days and the individual will be restricted from lifting

25 pounds or more, performing pullups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349. Prior to commencing the trial of duty period, a medical board will be accomplished in all cases. Upon completion of the ~~Medical Board trial of duty period~~, a detailed report from the commander or supervisor describing the individual's ability to accomplish the assigned duties and ability to perform physical activity will be incorporated into the medical board record. An addendum to the medical board ~~will be accomplished and will include~~ the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component soldiers not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

e. Coronary artery revascularization. Individuals should have the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pullups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349. Prior to commencing the trial of duty period, a medical board will be accomplished in all cases. Upon completion of the trial of duty period, a detailed report from the commander or supervisor will be incorporated in the medical board record and will clearly describe the individual's ability to accomplish assigned duties and perform physical activity will be incorporated into the medical board record. An addendum to the medical board ~~will be accomplished by~~ a cardiologist or internist and will include the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component soldiers not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

f. Heart or heart-lung transplantation.

g. Coronary or valvular angioplasty procedures. Individuals should have the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. Prior to commencing a trial of duty period, a medical board will be accomplished in all cases and a physical activity prescription provided by a physician on DA Form 3349. Upon completion of the trial of duty period, a detailed report from the commander or supervisor describing the

individual's ability to accomplish assigned duties and perform physical activity will be incorporated into the medical board record. An addendum to the medical board ~~will be accomplished by~~ a cardiologist or internist and will include the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component soldiers not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

h. Cardiac arrhythmia ablation procedures. Individuals should have the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia as noted in paragraph 3-21. Prior to commencing the trial of duty period, a medical board will be accomplished by a cardiologist or internist and will include the individual's interim history, present condition, prognosis and an addendum that reflects the final recommendations. For Reserve Component soldiers not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

### 3-25. Trial of duty and profiling

The following guidelines supplement chapter 7. Individuals returning to a trial of duty will be given a temporary P3 profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349. When the addendum to the medical board is accomplished, a permanent numerical designator in the "P" factor of the physical profile will be given based on functional assessment as follows:

a. Numerical designator "1"—Individuals who are asymptomatic, without objective evidence of myocardial ischemia or other cardiovascular functional abnormality. (New York Heart Association Functional Class I.)

b. Numerical designator "3"—Individuals who are asymptomatic, but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality.

c. Numerical designator "4"—Individuals who are symptomatic. (New York Heart Association Functional Class II or worse.)

### 3-26. Tuberculous lesions

a. *Pulmonary tuberculosis*.

(1) When the disease of a soldier 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 an expiration of service will occur before completion of the period of hospitalization. (Career soldiers who express a desire to reenlist after treatment may extend their enlistment to cover the period of hospitalization.)

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

(3) A member of the ARNG, not on active duty, will be separated from the ARNG in accordance with the provisions of NGR 635-100 (officers) or NGR 600-200 (enlisted). Such members will be permitted to reenlist or be reappointed in the ARNG if they meet the standards of this chapter following a 12- to 15-month period of treatment including an appropriate period of convalescence.

*b. Tuberculous emphysema.*

### 3-27. Nontuberculous disorders

*a. Asthma.* Asthma of sufficient severity to interfere with satisfactory performance of duty, or with frequent attacks not controlled by oral bronchodilators or inhaled medication.

*b. Atelectasis, or massive collapse of the lung.* Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications which require repeated hospitalization.

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

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

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

*f. Diaphragm, congenital defect.* Symptomatic.

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

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

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

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

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

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

*m. Pulmonary emphysema.* Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

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

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

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

### 3-28. Surgery of the lungs and chest

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

### 3-29. 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 requires 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.

### 3-30. Neurological disorders

*a. Amyotrophic sclerosis, lateral.*

*b. Atrophy, muscular, myelopathic—*includes severe residuals of poliomyelitis.

*c. Progressive muscular atrophy.*

*d. Chorea—*chronic, progressive.

*e. Convulsive disorders.* (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) When seizures are not adequately controlled (complete freedom from seizure of any type) by standard drugs which are relatively nontoxic and which do not require frequent clinical and laboratory re-evaluation. Seizure disorders and epilepsy:

(1) Definitions.

(a) Seizure: Transient neurologic dysfunction due to excessive repetitive discharge of neurons.

(b) Pseudoseizure: A behavioral event resembling a seizure but caused by psychological factors and not associated with abnormal discharge of neurons.

(c) Epilepsy: Recurrent seizures over a 30-day period or longer without definable extrinsic cause.

(2) Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. However, they may be considered along with other disabilities in judging fitness.

(3) In general, epilepsy is disqualifying unless the soldier can be maintained free of clinical seizures of all types by nontoxic doses of medications.

(a) All active duty soldiers with suspected epilepsy must be evaluated by a neurologist who will determine whether epilepsy exists and whether the soldier should be given a trial of therapy on active duty or be referred directly to a MEBD for referral to a PEB. In making this determination the neurologist may consider the underlying cause, EEG findings, type of seizure, duration of epilepsy, family history, soldier's likelihood of compliance with a therapeutic program, history of substance abuse, or any other clinical factor influencing the probability of control or the soldier's ability to perform duty during the trial of treatment.

(b) If a trial of duty on treatment is elected by the neurologist, the soldier will be given a temporary P3 profile with as few restrictions as possible.

(c) Once the soldier has been seizure free for one year, the profile may be reduced to a P2 with restrictions specifying no assignment to an area where appropriate medical care is not available.

(d) If seizures recur beyond 6 months after the initiation of treatment, the soldier will be referred to a MEBD.

(e) Should seizures recur during a later attempt to withdraw medications or during a transient illness, referral to PEB is at the discretion of the physician or MEBD.

(f) If the soldier has remained seizure free for 36 months, he may be removed from profile restrictions.

(4) Recurrent pseudoseizures are disqualifying under the same rules as epilepsy.

*f. Friedreich's ataxia.*

*g. Hepatolenticular degeneration.*

*h. Migraine—*when the cause is, unknown, and manifested by frequent incapacitating attacks or attacks which last for

several consecutive days, and unrelieved by treatment.

i. Multiple sclerosis.

j. Myelopathy, transverse.

k. Narcolepsy—when attacks are not controlled by medication.

l. Paralysis agitans (Parkinson's Disease).

m. Peripheral nerve conditions.

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

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

(3) *Injury to peripheral nerves*. When manifested by paralysis or other permanent severe functional impairments.

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.

*Note:* Diagnostic concepts and terms utilized in paragraphs 3-31 through 3-37 below are in consonance with the DSM-III-R Manual, American Psychiatric Association, 1980-1987. The minimum psychiatric evaluation will include Axis I, II, and III.

### 3-31. Disorders with psychotic features

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

### 3-32. 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.

### 3-33. 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.

### 3-34. Organic mental disorders

Persistence of symptoms or associated personality change sufficient to interfere definitively with the performance of duty or social adjustment.

### 3-35. Personality, psychosexual, or factitious disorders; disorders of impulse control not elsewhere classified; substance use/psychoactive 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.

### 3-36. 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 causing interference with military duty.

### 3-37. 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.

### 3-38. 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 paras 3-42 through 3-44.)

e. *Dermatitis herpetiformis*. Not responsive to therapy.

f. *Dermatomyositis*.

g. *Dermoglyphism*. 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 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 3-40k.

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.

### 3-39. 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 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.

### 3-40. 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 desseminated, 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 the kidney.

(6) Tuberculosis of the larynx.

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

### 3-41. General and miscellaneous conditions and defects

a. Allergic manifestations.

(1) Allergic rhinitis. (See para 3-29d and e.)

(2) Asthma. (See para 3-27a.)

(3) Allergic dermatoses. (See para 3-38.)

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

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

(3) In view of the soldier's condition, his or her retention in the military service would prejudice the best interests of the Government (for example, a carrier of communicable disease who poses a health threat to others). Subject to the limitations given in paragraph 3-3b of this regulation, questionable cases, including those involving latent impairment and/or those when no

single impairments may be considered to render the individual unfit; will be referred to PEBs.

d. Other. Exceptionally, as regards members of the ARNG and the USAR, 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.

### 3-42. 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.

### 3-43. Neoplastic conditions of lymphoid and blood-forming tissues

Neoplastic conditions of the lymphoid and blood-forming tissues.

### 3-44. 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.

### 3-45. Sexually transmitted diseases

a. Symptomatic neurosyphilis in any form.

b. Complications or residuals of sexually transmitted disease of such chronicity or degree that the individual is incapable of performing useful duty.

## Chapter 4 Medical Fitness Standards for Flying Duty

### 4-1. General

a. In this regulation, "flying duty" is synonymous with "flight status" and "qualified for aviation service." All provisions

apply to the Reserve Components except as noted.

b. This chapter lists medical conditions and physical defects which are causes for rejection for selection, training, and retention of—

(1) Army aviators.

(2) Military and Department of the Army civilian (DAC) air traffic controllers (ATCs). (Provisions of this chapter applicable to civilian personnel have been reviewed by the Federal Aviation Administration (FAA).)

(3) Department of the Army and contract civilian pilots.

(4) Flight surgeons.

(5) Individuals ordered by competent authority to participate in regular and frequent aerial flights as nonrated personnel.

### 4-2. Classes of medical standards for flying and applicability

The established classes of medical fitness standards for flying duties and their applicability are as follows:

a. Class 1 or 1A standards apply (AR 611-85 and AR 611-110) to—

(1) Individuals being considered for training leading to an Army aviator aeronautical rating.

(2) Personnel selected for such training, until the beginning of flight training.

(3) Individuals being considered for the Army ROTC Flight Training Program or USMA Specialty Training Program (Aviation).

b. Class 2 standards apply to—

(1) Individuals who have successfully completed an ROTC or USMA flight training course.

(2) Student aviators in flight training.

(3) Applicants for HQDA programs withfor appointment and rating by reason of civilian-acquired aeronautical skills. (See para 5-20.)

(4) Individuals qualified for aviation served as Army aviators.

(5) Flight surgeons and aeromedical physician assistants. (For administrative purposes only, Commander, U.S. Army Aeromedical Center (USAAMC), designates these as "Class 2F.")

(6) Medical officers, medical students, physician assistants, and all other personnel being considered for or in the Army flight surgeon's course; and Army personnel applying for and/or enrolled in Navy or Air Force primary courses in aviation medicine. (For administrative purposes only, Commander, USAAMC, designates these as "Class 2F.")

(7) Department of the Army DAC pilots and civilian pilots who are employees of firms under contract to the DA (not including aircraft manufacturers). (See paras 4-3b and 8-24k for further guidance on DAC and contract personnel.)

(8) Army aviators being considered for return to aviation service.

(9) Certain senior career officers. (See para 5-21.)

c. Class 2A standards apply to Army military and DAC ATCs.

(1) ~~Class 2A standards are currently identical to those contained in Part 67, Federal Aviation Regulations (FAR) (administered per the FAA Guide to Aviation Medical Examiners) except that military ATC personnel must also meet the applicable procurement or retention standards of chapters 2 and 3, and tables 2-1 and 2-2, which apply to general military service. Class 2A standards are identical to Class 2 as noted.~~

(2) ~~The standards specified in part 67, FAR are the basis on which FAA Form 8420-2 (Airman Medical and student Pilot Certificate, 2nd Class) may be issued to qualified military and civilian ATC personnel (see para 8-24k), with the following exceptions: (Rescinded.)~~

(a) ATC personnel, civilian or military, who illegally use drugs are medically unfit for further ATC duty.

(b) The Adaptability Rating for Military Aeronautics (ARMA) and Reading Aloud Test (RAT) apply to ATC personnel. (See paras 4-30 and 4-31; and app B.)

(c) Local national, third country, or other non-U.S. citizen ATCs employed by or on behalf of the U.S. Army are included in the requirement for ATCs to meet the standards of part 67, FAR, however, host nation laws or status of forces agreements may take precedence. Medical standards for local, national, third-country, or other non-U.S. citizen ATCs employed by or on behalf of the U.S. Army may be dictated by host national laws, status of forces agreements, or contractual requirements. Local flight surgeons will advise local commanders as to whether or not such ATCs have, or may have, a conditions deemed unsafe in the aviation environment.

(d) Genitourinary system. (See para 4-13.)

(e) Malaria. (See para 4-27d.)

(f) Other diseases and conditions disqualifying under paragraph 4-27h.

(g) Vision. (See para 4-12c.)

(3) Active duty ATC personnel who do not meet standards specified in FAR Part 67 but who have been found qualified by the FAA on the basis of demonstrated ability (waiver) or with a limitation will be allowed to continue Army ATC duties only with the concurrence of Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333. The Cdr, USAAMC will, in evaluation of senior ATC personnel (E8 and E9) whose duties are normally administrative or supervisory, generally consider the decreased risk of direct adverse impact on aviation safety by reason of such duties in determining whether or not an Army waiver is recommended for disqualifying conditions. When evaluating senior ATC personnel (E8 and E9) with administrative or supervisory duties and civilian ATC personnel, the Commander, USAAMC, will generally consider the decreased risk of direct adverse impact to aviation safety and military readiness.

d. Class 3 standards apply to soldiers ordered by competent authority to participate in regular and frequent aeriaflights but who are not engaged in actual control of aircraft. These include air ambulance attendants, aeromedical physician assistants (after completion of training in aviation medicine; Class 2 standards apply for selection and while in training); crew chiefs, observers, gunners, and others.

e. Provisions of this chapter are the subject of international standardization agreements (NATO STANAG 3526 and Air Standardization Coordinating Committee Air Standards (AIR STD 61/32)), which international agreements may take precedence for when establishment of medical standards for foreign aircrews while serving with U.S. forces or while attending U.S. Army flight training courses of instruction. These same international agreements may apply to U.S. aircrews while serving with foreign forces. All questionable cases will be referred to Commander, USAAMC (HSXY-AER), Fort Rucker, AL 36362-5333 for final review and determination of fitness to fly.

#### **4-3. Disposition of medical examination reports of personnel who do not meet these standards**

a. Applicants (Classes 1, 1A and 2). The reports of Medical examination reports of 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 (HSXY-AER), Fort Rucker, AL 36362-5333, as prescribed in following the appropriate procurement regulation.

b. Personnel on flying status/qualified for aviation service:

(1) Military personnel who do not meet medical fitness standards for flying will be immediately medically suspended from flying as prescribed by AR 600-105 unless they have previously been continued in flying status for the same defect by designated higher authority. In this which case, they may be permitted to fly until continuance of waiver is confirmed. This provided the condition has not significantly worsened, and flying safety and the individuals' soldier's well-being are not compromised.

(2) DAC pilots and contract civilian pilots who do not meet Army Class 2 standards will be evaluated for fitness for flying duty under FAA Second Class medical standards. Those who meet these standards will normally be medically cleared for flying Army aircraft (using DA Form 4186 (Medical Recommendation for Flying Duty)) (see para 8-24j); disqualified pending review of the disqualifying condition by Commander, USAAMC. Those who have a minor disqualification that is ordinarily waived by the FAA and the Army may be given a DA 4186, indicating a temporary medical clearance for flying Army aircraft. However, the supervisor or contractor must determine whether or not the individual must possess a current medical certificate. Those who are

issued FAA Form 8420-2 by the FAA on the basis of demonstrated ability (waiver) will not be granted local medical clearance to fly Army aircraft if they have an established medical history or clinical diagnosis of any of the following conditions:

(a) A character or behavior disorder that is severe enough to have repeatedly manifested itself by overt acts.

(b) A psychotic disorder.

(c) Chronic alcoholism.

(d) Drug addiction.

(e) Epilepsy.

(f) Disturbance of consciousness without satisfactory explanation of the cause.

(g) Myocardial infarction.

(h) Angina pectoris or other evidence of coronary disease (see para 4-15e).

(i) Diabetes requiring insulin or oral hypoglycemics.

(j) Treatment with antihistamine, narcotic, barbiturate, mood-ameliorating, tranquilizing, motion sickness, steroid, antihypertensive, or ataraxic drugs.

(k) 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 Commander, 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 8-24k.)

(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 Commander, 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 drug use of any drug at any time by DAC pilots and contract civilian pilots is medically unfitting for flying duty.

(d) Any civilian pilot employed by DA or by a firm under contract to DA, even though he or she holds a valid FAA Form 8420-2, may be denied medical clearance to

fly Army aircraft if, in the opinion of the flight surgeon determines that the individual poses an unacceptable risk to him- or herself, to Government property, or to other individuals. Questionable cases will be referred to Commander, 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 Commander, 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 and agreed to 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 USAAMC, Fort Rucker AL 36362-5333. Consultation services are available to unit flight surgeons, command surgeons, and the Commanding General (CG), HSC. Normally, Requests for consultation by surgeons of higher headquarters will be initiated through unit flight surgeons to facilitate availability of essential medical records and related data. Medical consultation will not be requested by individual aviators nor by aviation unit commanders.

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

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

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

(4) Non-U.S. Army aviation personnel may be referred to the AMCS with prior approval of the Commanding General, HSC.

(5) Requests for aviation medicine consultation will be forwarded direct to Commander, USAAMC (HSXY-AER), Fort Rucker, AL 36362-5333.

(6) The Commander, USAAMC, may utilize or authorize utilization of the aeromedical consultation services of the U.S. Navy and U.S. Air Force, with the when approved by appropriate medical authority within those departments.

(7) The ADR will be used to assess the adequacy of existing aeromedical fitness standards through an epidemiological study of medical qualifications of the population group and to form the basis of proposed changes to standards. The ADR mission will be conducted in coordination with the U.S. Army Aeromedical Research Laboratory.

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

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

c. Hernia.

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

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

d. History of bowel resection for any cause except—

(1) Appendectomy.

(2) Intussusception in childhood or infancy.

e. Any other operations for relief of intestinal adhesions or intussusception. Pylorotomy in infancy, without complications at present will not, per se, be cause for rejection.

f. Ulcer.

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

(2) Classes 2 and 3. Until reviewed and found fit by the Commander, USAAMC (HSXY-AER), Fort Rucker, AL 36362-5333.

g. Cholecystectomy.

(1) Classes 1 and 1A. Cholecystectomy within the preceding 60 days or sequelae of cholecystectomy such as post-operative stricture of the common bile duct, re-forming 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 (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 Commander, USAAMC.

#### 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.

#### 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.

a. The causes of medical unfitness for flying duty classes 1, 1A, 2, and 3 are as listed in paragraph 2-5a, b, and c. Orthodontic appliances are disqualifying only if a dentist so recommends because they interfere with

normal function or communication. Aviators must meet a minimum standard of Dental Fitness Category 2 as defined in AR 40-3 and AR 40-35. Those in Dental Fitness Category 3 are to be temporarily suspended or granted a Temporary Flying Duty Clearance, depending on the severity of the causative condition as determined by the aviation medicine qualified dentist or flight surgeon. Personnel in Dental Fitness Category 4 who have a dental record with a panoramic radiograph on file at the servicing clinic with a copy forwarded to the Central Processing and Storage Facility in Monterey, CA may be granted a Temporary Flying Duty Clearance. Personnel who are Category 4 due to no record and/or no paragraph on file are suspended from flying duty until the situation is corrected.

b. Conditions that would normally result in classification into Dental Fitness Category 3 are: teeth with carious lesions which are radiographically within 2 mm of the pulp; impacted teeth with clinical or radiological evidence of pathology or a history of pericoronitis; oral lesions requiring biopsy or indicative of infection or other active disease processes; teeth with active periodontitis plus a history of periodontal abscess; ill-fitting dentures with a history of soreness; teeth with pulpal necrosis and/or clinical or radiographical evidence of apical pathology; and teeth with incomplete endodontic treatment that are not currently under treatment.

#### 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 applied (for example, 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 ear-nose-throat (ENT) evaluation and contingent upon review by Cdr, USAAMC.

(2) Classes 2 and 3. Tympanoplasty, until completely healed with acceptable hearing

(table 4-1) and good motility. (Table 4-1 is located after the last appendix of this regulation.)

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 4-1.

#### 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.

#### 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.

#### 4-11. Eyes

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

a. Asthenopia of any degree including convergence insufficiency.

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

c. Coloboma of the choroid or iris.

d. Epiphora.

e. Inflammation of the uveal tract: acute, chronic, or recurrent, or history thereof, including anterior uveitis, peripheral uveitis or pars 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 mmHg 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 mmHg or higher or a persistent difference of 4 or more mmHg 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 Commander, 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 Class 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 (PIP), or

(b) Four or more errors in reading the 17 test plates of the PIP set, or

(c) One or more errors in reading the nine test lights of the Farnsworth Lantern (FALANT) are disqualifying. But if there are one or more errors in the reading of nine FALANT test lights, then there may be no more than two errors on repeat challenge with 18 FALANT test lights (two sets of nine).

(2) Depth perception.

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

(b) Any error in any eight test presentations with the Verhoeff Stereometer, or

(c) Any error in any eight test presentations with the Randot Circles Test (Randot Form Test is not authorized).

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

(4) Field of vision.

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

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

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

(6) Night blindness, as noted by history and confirmed by failure to pass night vision test.

(7) Ocular motility.

(a) Any detectable ocular motion on the Cover Test in any four cardinal directions of gaze, or heterotropia of any degree.

(b) Esophoria greater than 8 prism diopters.

(c) Exophoria greater than 8 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(e) Any detectable ocular motion on the Cross-Cover Test in any four cardinal directions of gaze until a complete evaluation by a qualified ophthalmologist has been forwarded to the Commander, USAAMC, for review.

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

(8) Refractive error.

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

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

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

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

(1) Distant visual acuity. Uncorrected less than 20/50 in each eye or not correctable 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 2/2A. Same as Class 1, except as listed below:

(1) Distant visual acuity. Uncorrected, less than 20/100 in each eye (flight surgeons, aeromedical physician assistants, and ATC: 20/200) and/or not correctable with spectacle lens to 20/20 in each eye.

(2) Near visual acuity. Uncorrected, less than 20/100 in each eye (flight surgeons, aeromedical physician assistants, and ATC: 20/200) and/or not correctable with spectacle lens to 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.

(5) Refractive error. Refractive error of such magnitude that the individual cannot be fitted with aviation spectacles.

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.* Near visual acuity, field of vision, depth perception, refractive error: same as Class 2.

#### 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 Commander, USAAMC. Evaluation will follow guidance provided by Commander, 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 soldier 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.

#### 4-14. Head and neck (see also para 4-23)

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 the skull.

d. Persistent neuralgia, tic douloureux, or facial paralysis.

#### 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 through 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 an 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 paragraph 2-18a.

e. Cardiac enlargement or dilated cardiomyopathy as determined by complete cardiac evaluation, including M-mode or two-dimensional echocardiography.

f. Blood pressure with a preponderant— (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) Systolic of less than 90 mmHg or greater than 140 mmHg, regardless of age.

(2) Diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age.

g. Unsatisfactory orthostatic tolerance test.

h. Electrocardiographic tracings which show—

(1) Borderline electrocardiogram (ECG) findings (Classes 1, 1A, and 2) until reviewed by the Commander, USAAMC. Review and final determination is made locally on Class 3; assistance will be provided by the Commander, USAAMC, upon request Commander, USAAMC (HSXY-AER), Fort Rucker, AL36362-5333).

(2) Left bundle branch block.

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

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

(5) Short P-R interval and prolonged QRS interval (Wolff-Parkinson-White syndrome) or other pre-excitation syndrome predisposing to paroxysmal arrhythmias. In asymptomatic patients requiring Class 2 or Class 3 examinations, a complete cardiac evaluation, including ECGs, will be forwarded to the Commander, USAAMC.

i. Pericarditis, history of finding thereof, except for a history of a single episode of acute idiopathic or viral pericarditis with no residuals at least 6 months after discontinuing all medications. ECGs must have returned to normal. Complete cardiac evaluation ECGs will be forwarded to the Commander, USAAMC.

j. Mitral valve prolapse, as shown by auscultatory or echocardiographic evidence of

late systolic or holosystolic prolapse, is disqualifying for Classes 1 and 1A. If symptoms are present, any evidence of mitral valve prolapse is also disqualifying for Classes 2 and 3 until reviewed and found fit by Commander, USAAMC.

k. Hypertrophic cardiomyopathy, as shown by clinical or echocardiographic evidence of hypertrophic cardiomyopathy (obstructive or non-obstructive), is disqualifying for Classes 1, 1A, 2, and 3 examinations.

l. Coronary artery disease, as shown by any clinical or angiographic evidence of coronary artery disease, is disqualifying for all classes of flight physicals. Suspected or proven coronary artery disease as shown by any clinical or angiographic evidence, based on evaluation of results according to criteria established by Commander, USAAMC, is disqualifying for all classes of flight physicals. A coronary risk index as determined by Commander, USAAMC, is presumptive evidence of coronary artery disease until further evaluation as needed, to include graded exercise stress test, thallium scan, and cardiac catheterization.

#### 4-16. Height

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

a. Classes 1, 1A, and 2. Failure to meet linear anthropometric criteria (sitting height, total arm reach, crouch height, leg length) established by Commander, USAAMC (HSXY-AMC), Ft Rucker, AL 36362-5333. Anthropometry does not apply to ATCs or to civilian pilots. (See para 4-3b(3) above.)

b. Class 3. Height below 64 inches or over 76 inches.

#### 4-17. Weight

a. The causes of medical unfitness of military personnel for flying duty Classes 1, 1A, 2, and 3 are body weight less than initial procurement standards prescribed in tables 2-1 or 2-2, or body weight and composition that exceed the limits prescribed by AR 600-9.

b. Body composition in excess of limits prescribed by AR 600-9 is not disqualifying for Class 2A ATC duties.

c. Military personnel exceeding the limits prescribed in the weight for height table (screening table weight) in AR 600-9 will have their maximum allowable weight recorded annually on SF 88 (Report of Medical Examination) or DA Form 4497-R (Interim Medical Examination—Aviation, Free Fall Parachuting & Marine (SCUBA) Diving Personnel) at the time of their flying duty medical examination. Additionally, composition (percent body fat) will be recorded upon entry into each new age category for these personnel.

d. See paragraph 4-3b(3) for civilian pilots.

#### 4-18. Body build

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

listed in paragraph 2-23, plus obesity. Even though the individual's weight or body composition is within the limits prescribed by AR 600-9, he or she will be found medically unfit if the examiner considers that his or her weight and/or associated conditions in relationship to the bony structure, musculature and/or total body fat content would adversely affect flying safety or endanger the individual's well-being if permitted to continue in flying status. See paragraph 4-3b(3) for civilian pilots.

#### 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 and 4-27g, plus the following:

a. Coccidioidomycosis unless healed without evidence of cavitation.

b. Lobectomy.

(1) *Classes 1 and 1A.* Lobectomy, per se.

(2) *Classes 2 and 3.* Lobectomy—

(a) Within the preceding 6 months.

(b) With a value of less than 80 percent of predicted vital capacity.

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

(d) With a value of less than 80 percent of the predicted maximum breathing capacity.

(e) With any other residual or complication of lobectomy which might endanger the individual's health and well-being or compromise flying safety.

c. Pneumothorax, spontaneous.

(1) *Classes 1 and 1A.* A history of spontaneous pneumothorax.

(2) *Classes 2 and 3.* Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung and normal pulmonary function, no additional lung pathology or other contraindication to flying is discovered, and the incident of spontaneous pneumothorax has not occurred within the preceding 12 months.

d. Pulmonary tuberculosis and tuberculous pleurisy with effusion.

(1) *Classes 1 and 1A.* Individuals taking prophylactic chemotherapy.

(2) *Classes 2 and 3.* During the period of drug therapy or with impaired pulmonary function greater than outlined in b(2) above.

e. Tuberculous pleurisy with effusion.

(1) *Classes 1 and 1A.* Tuberculous pleurisy with effusion, per se.

(2) *Classes 2 and 3.* Tuberculous pleurisy with effusion until 12 months after cessation of therapy.

f. Presence of bullae until reviewed and found fit by Commander, USAAMC.

g. Bronchial asthma or recurrent bronchospastic conditions except for childhood asthma with a trustworthy history of freedom from symptoms of asthma or recurrent bronchospasm since the 12th birthday, until reviewed and found fit by the Commander, USAAMC.

#### 4-20. Mouth

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-25, plus the following:

a. Any infectious lesion until recovery is complete and the part is functionally normal.

b. Any congenital or acquired lesion which interferes with the function of the mouth or throat.

c. Any defect in speech which would prevent clear enunciation or otherwise interfere with clear and effective communication in the English language over a radio communication system (see table 8-1, item 72, and app B).

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 2-26 and 4-27 plus the following:

a. Acute coryza.

b. Allergic rhinitis.

(1) *Classes 1 and 1A.* Any substantial history of allergic or vasomotor rhinitis, unless free of all symptoms since age 12.

(2) *Classes 2 and 3.* Allergic rhinitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

c. Anosmia, parosmia, and paresthesia.

d. Atrophic rhinitis.

e. Deviation of nasal septum or septal spurs which result in 50 percent or more obstruction of either airway, or which interfere with drainage of the sinus on either side.

f. Hypertrophic rhinitis (unless mild and functionally asymptomatic).

g. Nasal polyps or history thereof.

h. Perforation of the nasal septum unless small, asymptomatic, and the result of trauma.

i. Sinusitis.

(1) *Classes 1 and 1A.* Sinusitis of any degree, acute or chronic. If there is only x-ray evidence of chronic sinusitis and the history reveals the examinee to have been asymptomatic for 5 years, this x-ray finding alone will not be considered as rendering the individual medically unfit.

(2) *Classes 2 and 3.* Acute sinusitis of any degree; chronic sinusitis (*Class 2 only*) until reviewed and found fit by Commander, USAAMC.

#### 4-22. Pharynx, larynx, trachea, and esophagus

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 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 the nasopharynx unless a benign lesion is identified and eradicated.

e. Occlusion of one or both eustachian tubes which prevents normal ventilation of the middle ear.

f. Tracheotomy occasioned by tuberculosis, angioneurotic edema, or tumor. Tracheotomy for other reasons will be cause for rejection until 3 months have elapsed without sequelae.

#### 4-23. Neurological disorders

See paragraph 4-14 and table 4-3. (Table 4-3 is located after the last appendix of this regulation). The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-29 and 4-14, plus the following:

a. *Classes 1 and 1A.*

(1) History of unexplained syncope.

(2) History of convulsive seizures, single or multiple; of any type (grand mal, petit mal, focal, etc.) due to any causes, except that seizures associated with febrile illness before age 5 years may be acceptable if the electroencephalogram is normal.

(3) History of any headache of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

(4) History of new growth of the brain, spinal cord, or their coverings.

(5) History of diagnostic or therapeutic craniotomy or any procedure involving penetration of the dura mater or the brain substance.

(6) Any defect in the bony substance of the skull, regardless of cause.

(7) Encephalitis, unless 6 years have elapsed since recovery, no sequelae or residuals have been present during the period beginning 6 months after complete recovery from the acute phase of the illness, and a current complete neurological evaluation is normal in all respects.

(8) Meningitis, unless 1 year has elapsed since recovery, no residuals or sequelae have been present during the period beginning 1 month after complete recovery from the acute phase of the illness, and a current complete neurological evaluation is normal in all respects.

(9) Any history of metabolic or toxic disturbances of the central nervous system until reviewed by Commander, USAAMC, and found fit.

(10) Any history of dysbarism (decompression sickness) with neurological involvement until reviewed by Commander, USAAMC, and found fit.

(11) Electroencephalographic abnormalities of any kind. Borderline or questionable tracings until reviewed by Commander, USAAMC, and found fit.

(12) Any history of narcolepsy, cataplexy or similar states.

(13) Injury of one or more peripheral nerves, unless not expected to interfere with normal function or flying safety.

(14) Any history of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriovenous malformation or aneurysm involving the central nervous system.

(15) Personal or familial history of hereditary disturbances such as hepatolenticular degeneration, neurofibromatosis, acute intermittent porphyria, or familial periodic paralysis. A strong family history of such syndromes indicating a hereditary component will be cause for disqualification even in the absence of current clinical symptoms or signs, since the onset of these illnesses may occur later in adult life.

(16) Any evidence or history of degenerative or demyelinating process such as multiple sclerosis, dementia, or basal ganglia disease.

(17) History of head injury associated with any of the following:

(a) Intracranial hemorrhage or hematoma (epidural, subdural or intracerebral) or subarachnoid hemorrhage.

(b) Any penetration of the dura mater or brain substance.

(c) Radiographic or other evidence of retained intracranial foreign bodies or bony fragments.

(d) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis or hemianopsia. Damage to one or more cranial nerves is not necessarily disqualifying unless it interferes with normal function in some practical manner.

(e) Persistent focal or diffuse abnormalities of the electroencephalogram reasonably assumed to be a result of the injury.

(f) Any skull fracture, linear or depressed, with or without dural penetration.

(g) Post-traumatic syndrome as manifested by personality changes, impairment of higher intellectual functions, anxiety, headache, or disturbances of equilibrium. Duration of symptoms—

1. For 48 hours or more.

2. More than 12 but less than 48 hours until at least 2 years have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

3. Less than 12 hours until at least 6 months have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

(h) Amnesia (post-traumatic and retrograde, patchy or complete), delirium, disorientation, confusion or impairment of judgment or intellect. Duration—

1. Forty-eight hours or more.

2. Less than 48 hours, but more than 12 hours until 2 years have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

3. Less than 12 hours, until 6 months have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

(i) Post-traumatic headaches. Persistence of headaches for—

1. Fourteen days or more.

2. More than 7 but less than 14 days, until at least 2 years have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

3. Less than 7 days, until at least 6 months have elapsed since the injury and a

current complete neurological evaluation is normal in all respects.

(j) Cerebrospinal fluid rhinorrhea or otorrhea, leptomeningeal cyst, arachnoid, brain abscess or arteriovenous fistula.

(k) Loss of consciousness for—

1. Two hours or more.

2. Less than 2 hours but more than 15 minutes, until 2 years have elapsed since the injury and complete neurological evaluation is normal in all respects.

3. Less than 15 minutes, until 6 months have elapsed since the injury and complete neurological evaluation is normal in all respects.

b. Classes 2 and 3. Same as a except as modified below;

(1) Fainting or syncope of any type due to any cause until appropriate consultations have been accomplished and the case reviewed (Class 2) by Commander, USAAMC.

(2) All acute infections of the central nervous system (meningitis, encephalitis, etc.) until—

(a) Active disease is arrested.

(b) Further sequelae are not expected.

(c) Residuals, if any, are resolved.

(d) Case has been reviewed by Commander, USAAMC.

(3) Electroencephalographic abnormalities in otherwise apparently healthy individuals are not necessarily disqualifying with the exception of—

(a) Spike-wave complexes.

(b) Spikes or sharp waves.

(c) Other abnormalities as determined by Commander, USAAMC.

(4) Head injury.

(a) Head injury resulting in the following will be cause for permanent disqualification for flying duty:

1. All causes listed in a(17)(a) through (e) above.

2. Depressed skull fracture with or without dural penetration.

3. Linear skull fracture with unconsciousness for more than 2 hours.

4. Post-traumatic syndrome as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches or disturbances of equilibrium which does not resolve within 1 month after the injury.

5. Unconsciousness exceeding 24 hours.

6. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

7. Permanent cranial nerve deficit, until reviewed by Commander, USAAMC.

(b) Head injury associated with any of the complications below will be cause for removal from flying duty for at least 2 years.

Electroencephalograms will be obtained as soon after the injury as possible and at 1-year intervals until completely normal or until the examinee is determined to be permanently disqualified in accordance with (a) above. Prior to return to flying status, a current complete neurological evaluation by a qualified neurologist or neurosurgeon, including skull x-rays, electroencephalogram

and neuropsychological test battery (for example, Halstead-Reitan), will be accomplished and the case reviewed by the Commander, USAAMC.

1. Linear or basilar skull fracture with loss of consciousness for more than 15 minutes but less than 2 hours.

2. Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, which persists for more than 2 weeks, but resolves within 1 month of the injury.

3. Amnesia (post-traumatic and retrograde, patchy or complete), delirium, disorientation, or impairment of judgment which exceeds 48 hours.

4. Unconsciousness for a period greater than 2 but less than 24 hours.

(c) Head injury associated with any of the following will be cause for removal from flying duties for at least 3 months. Complete evaluation by a qualified neurologist or neurosurgeon is required just prior to return to flying duty. An electroencephalogram will be obtained as soon after the injury as possible and another at the time of consideration for return to flying duty. If an abnormality is found in any portion of the evaluation (neurologic examination, skull x-rays, electroencephalogram, or neuropsychological test battery), the examinee will not be cleared for return to flight duties but will be referred back to the consultant at appropriate intervals for reevaluation until cleared or determined to be permanently disqualified in accordance with (a) above.

1. Linear or basilar skull fracture with loss of consciousness for less than 15 minutes. This diagnosis does not have to be confirmed by x-rays, but may be based on clinical findings.

2. Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, which persists for more than 48 hours, but resolves within 14 days of the injury.

3. Post-traumatic headaches alone which persist more than 14 days after the injury, but resolve within 1 month.

4. Amnesia (post-traumatic and retrograde, patchy or complete), delirium, or disorientation which lasts less than 48 but more than 12 hours after injury.

5. Confusion lasting more than 48 hours.

6. Unconsciousness for more than 15 minutes but less than 2 hours.

7. Cerebrospinal fluid rhinorrhea or otorrhea which clears within 7 days of injury, provided there is no evidence of cranial nerve palsy.

(d) Head injury associated with any of the following will be cause for removal from flying duty for at least 4 weeks. Return to flying duty will be contingent upon a normal neurological evaluation by a qualified neurologist or neurosurgeon, including skull x-rays, electroencephalogram and neuropsychological test battery, at the end of that time.

1. Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual function or anxiety, which resolves within 48 hours of injury.
2. Post-traumatic headaches alone, which resolve within 14 days of injury.
3. Amnesia (post-traumatic and retrograde, patchy or complete), delirium, or disorientation for less than 12 hours.
4. Confusion lasting less than 48 hours.
5. Unconsciousness lasting less than 15 minutes.

#### 4-24. Mental disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-30, 2-31, 2-32, 2-33, 2-34 and through 2-35, except as modified below:

- a. Any psychotic episode evidenced by impairment in reality testing, to include transient disorders, from any cause except transient delirium secondary to toxic or infectious processes before age 12.
- b. Any history of an affective mood disorder fitting the diagnostic criteria outlined in DSM III-R to include major affective mood disorders, cyclothymic disorder, dysthymic disorder, and atypical affective disorders mood disorders, not otherwise specified.
- 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-R. Additionally, the presence or history of any phobias or severe or prolonged anxiety episodes, after age 12, even if they do not meet the fully diagnostic criteria of DSM III-R.
- d. Any history of an episode that fits the criteria for any of the diagnoses listed in the DSM III-R chapters on factitious disorders and disorders of impulse control not listed elsewhere classified.
- e. Any history of pervasive or specific developmental disorders usually first seen in childhood as outlined in DSM III-R. 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-R 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-R.
- h. Excessive use of alcohol or history thereof which has interfered with the performance of duty, physical health, social relationships, or family relationships.
  - (1) Such individuals, as well as those medically unfit in accordance with paragraph 2-35, can be returned to flying duties only in accordance with paragraph 8-24i (that is, 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 (that is, 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 or her continued medical fitness for such duty. One year after return to flying duty, the flight surgeon will submit an aeromedical summary to the Commander, USAAMC. This summary will be used by the Commander, 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 once approximately 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 (that is, without waiver) will contain an entry (item 73, SF-88 or item 14, DA Form 4497-R) 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 Commander, 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 Alcohol and Drug Abuse Prevention and Control Program (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 (para 2-35 will apply). A history of illicit use of any psychoactive substance not disqualifying under paragraph 2-35 must be reviewed by the Commander, 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, that is, 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.
- Note:* Diagnostic concepts and terms used in paragraph 4-24 are in consonance with DSM-III-R Manual, American Psychiatric Association, 1987. The minimum psychiatric evaluation will include Axis I, II, III.
- #### 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 2-36 plus any condition which interferes with the use of aviation clothing and equipment.
- #### 4-26. Spine, scapulae, ribs, and sacroiliac joints
- The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-37 and 2-38 plus the following:
- a. *Classes 1 and 1A.*
    - (1) A history of a 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.

#### 4-27. Systemic diseases and miscellaneous conditions and defects

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-39 and 2-40, except as modified below.

##### a. Sarcoidosis.

(1) Classes 1, 1A, and 3. A history of sarcoidosis, even if in remission.

(2) Class 2. Sarcoidosis, even if in remission, until evaluated and found fit by Commander, USAAMC.

b. Tuberculosis. See paragraphs 4-19d and e.

c. Allergic manifestations. See paragraphs 2-26, 2-39, 4-19, and 4-21.

##### d. Malaria.

(1) Classes 1 and 1A. A history of malaria unless—

(a) There have been no symptoms for at least 6 months during which time no antimalarial drugs have been taken.

(b) The red blood cells are normal in number and structure, and the blood hemoglobin is at least 12 grams percent.

(c) A thick smear (which must be done if the disease occurred within 1 year of the examination) is negative for parasites.

(2) Classes 2, 2A, and 3. A history of malaria unless adequate therapy in accordance with existing directives has been completed. The duration of removal from flying or ATC 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, however, 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, and 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.

g.1. HIV positivity. Classes 1, 1A, 2, and 3. Until each case is individually evaluated and reviewed by Commander, USAAMC.

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 The initial determination will be made initially, and recommendations made to the individual's commander will be made by the local flight surgeon. Final determination of fitness for flying duty in questionable cases will be made by Commander, USAAMC.

#### 4-28. Malignant diseases and tumors

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

a. Classes 1 and 1A. Same as paragraph 2-41.

b. Classes 2 and 3. Individuals having a malignant disease or tumor will be considered as medically unfit pending review and evaluation by Commander, USAAMC.

#### 4-29. Sexually transmitted diseases

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

a. Classes 1, 1A, and 2. A history of syphilis, unless—

(1) Careful examination shows no lesions of cardiovascular, neurologic, visceral, mucocutaneous, or osseous syphilis.

(2) Documentary proof is available that all provisions of treatment as contained in directives current at the time of examination, or equivalent treatment, have been fulfilled.

(3) Examination of the spinal fluid (if indicated by current medical protocol) reveals a negative serologic test for syphilis, and a cell count and protein content are within normal limits.

(4) The individual concerned has been clinically cured with no evidence of recurrence for a period of 6 months subsequent to treatment.

b. Class 3.

(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.

#### 4-30. Adaptability rating for military aeronautics

a. The ARMA is required for all initial flying duty examinations, Classes 1, 1A, 2, 2A, and 3 and, when indicated, for periodic examinations. The cause of medical unfitness for flying duty, all classes, is an unsatisfactory ARMA due to failure to meet minimum standards of aptitude or psychological factors, or otherwise considered not to be adaptable for military aeronautics.

b. An unsatisfactory ARMA is mandatory if any of the following conditions are present:

(1) Concealment of significant and/or disqualifying medical conditions on the history form or during interviews.

(2) Presence of any psychiatric condition which in itself is disqualifying under chapter 2 or chapter 4.

(3) An attitude toward military flying that is clearly less than optimal: for example, the person appears to be motivated overwhelmingly by the prestige, pay, or other secondary gain rather than the flying itself.

(4) Clearly noticeable personality traits such as immaturity, self-isolation, difficulty with authority, poor interpersonal relationships, impaired impulse control, or other traits which are likely to interfere with group functioning as a team member in a military setting, even though there are insufficient criteria for a personality disorder diagnosis.

(5) Review of the history or medical records reveals multiple or recurring physical complaints that strongly suggest either a somatization disorder or a propensity for physical symptoms during times of psychological stress.

(6) A history of arrests, illicit drug use, or social "acting out" which indicates immaturity, impulsiveness, or antisocial traits. Experimental use of drugs during adolescence, minor traffic violations, or clearly provoked isolated impulsive episodes may be accepted but should receive thorough psychiatric and psychological evaluation. (See also para 4-24n.)

(7) Significant prolonged or currently unresolved interpersonal or family problems (for example, marital dysfunction, significant family opposition or conflict concerning the soldier's aviation career), as revealed through record review, interview, or other sources, which would be a potential hazard to flight safety or would interfere with flight training or flying duty.

c. An unsatisfactory ARMA may be given for lower levels (symptoms and signs) than those mentioned in b above if, in the opinion of the flight surgeon, the mental or physical factors might be exacerbated under the stresses of military aviation or the person might not be able to carry out his or her duties in a mature and responsible fashion.

Additionally, a person may be disqualified for any of a combination of factors listed in b above and/or due to personal habits or appearance indicative of attitudes of carelessness, poor motivation, or other characteristics which are unsafe or undesirable in the aviation environment:

**4-31. Reading Aloud Test**

The cause of medical unfitness for flying duty, Classes 1, 1A, 2, 2A, and 3 is failure to clearly enunciate in the English language, as determined by administration of the Reading Aloud Test (RAT) (app B), in a manner compatible with safe and effective aviation operations. In questionable cases, the aviation unit commander, ATC supervisor or other appropriate aviation official will provide a written recommendation to the flight surgeon.

**Chapter 5  
Medical Fitness Standards for  
Miscellaneous Purposes**

**5-1. General**

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 (MOS).
- e. Geographical area assignments.
- f. Service academies other than the USMA.

**5-2. Application**

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

**5-3. 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 paragraph and paragraphs 5-4 through 5-6. Entrance into the Special Forces Qualification Course requires disposition of medical reports as described in paragraph 8-26c.

- 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.
  - (6) For Special Forces initial training and duty, asplenia (absence of the spleen) for any reason.

b. Blood and blood-forming tissue diseases.

- (1) Paragraph 2-4.
  - (2) 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 through 2-11.
  - (2) Less than full strength and range of motion of all joints.
  - (3) Loss of any digit from either hand.
  - (4) Deformity or pain from an old fracture.
  - (5) Instability of any degree of major joints.

- (6) Poor grasping power in either hand.
- (7) Locking of a knee joint at any time.
- (8) Pain in a weight-bearing joint.

g. Eyes and vision.

- (1) Paragraphs 2-12 and 2-13 with exceptions noted below. *see ch 101-101141*
- (2) For Airborne and Ranger, and Special Forces 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 Airborne and Special Forces training and duty: Failure to identify red and/or green as projected by the Ophthalmological Projector or the Stereoscope, Vision Testing. ~~(No requirement for Ranger training.)~~

(4) For Special Forces training and duty: ~~Uncorrected distant visual acuity of worse than 20/70 in the better eye and 20/200 in the poorer eye or vision which does not correct to 20/20 in both eyes within 8 diopters of plus or minus refractive error, with spectacle lenses.~~ *see ch 101-101141*

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 through 2-20, exception for Special Forces training and duty: blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. Unsatisfactory orthostatic tolerance test is also disqualifying.

k. Height. No special requirement.

l. Weight. No special requirement.

m. Body build. Paragraph 2-23.  
n. Lungs and chest wall.  
(1) Paragraph 2-24.

(2) Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2-25 through 2-28.

- p. Neurological disorders.
  - (1) Paragraph 2-29.
  - (2) Active disease of the nervous system of any type.
  - (3) Craniocerebral injury. (para 4-23a(6)).

q. Mental disorders.  
(1) Paragraphs 2-30 through 2-35.  
(2) Evidence of excessive anxiety, tenseness, or emotional instability.  
(3) Fear of flying as a manifestation of psychiatric illness.

(4) Abnormal emotional responses to situations of stress (both combat and noncombat) when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the soldier's duties.

r. Skin and cellular tissues. Paragraph 2-36.

s. Spine, scapulae, and sacroiliac joints.

- (1) Paragraphs 2-37 and 2-38.
- (2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than an inch.
- (3) Spondylolysis; spondylolisthesis.
- (4) Healed fractures or dislocations of the vertebrae.
- (5) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic disease and miscellaneous conditions and defects.

- (1) Paragraphs 2-39 and 2-40.
- (2) Chronic motion sickness.
- (3) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing, or ataraxic drugs and for a period of 4 weeks after the drug has been discontinued.
- (4) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual.

u. Tumors and malignant diseases. Paragraph 2-41.

v. Sexually transmitted diseases. Paragraph 2-42.

**5-4. 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 or her continued demonstrated ability to perform satisfactorily his or her duty as an Airborne officer or enlisted soldier, 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.

### 5-5. 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 paragraph and paragraphs 5-3, 5-5, and 5-6. Disposition of medical reports will be as described in paragraph 8-26c.

a. *Abdomen and gastrointestinal system.* Paragraph 2-3.

b. *Blood and blood-forming tissue disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

(3) Sickle cell disease.

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 the 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 through 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, with exceptions noted in (2) and (3) below.

(2) Visual acuity which does not correct to 20/20 in one eye and 20/100 in the other eye. Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye or vision which does not correct in both eyes within 8 diopters of plus or minus refractive error, with spectacle lenses.

(3) 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 through 2-20, except blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. An unsatisfactory orthostatic tolerance test is also disqualifying.

k. *Height.* Paragraph 2-21.

l. *Weight.* Paragraph 2-22.

m. *Body build.* Paragraph 2-23.

n. *Lungs and chest wall.*

(1) Paragraph 2-24.

(2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping, or affect ventilation-perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the examination and with clinical evaluation showing complete recovery with normal pulmonary function.

o. *Mouth, nose, pharynx, larynx, trachea, and esophagus.* Paragraphs 2-25 through 2-28.

p. *Neurological disorders.*

(1) Paragraph 2-31.

(2) The criteria outlined in paragraph 4-23 for Classes 2 and 3 flying duty apply.

q. *Mental disorders.*

(1) Paragraphs 2-30 through 35.

(2) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness, or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress when, in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

r. *Skin and cellular tissues.* Paragraph 2-36.

s. *Spine, scapulae, ribs, and sacroiliac joints.*

(1) Paragraphs 2-37 and 2-38.

(2) Spondylolysis; spondylolisthesis.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

t. *Systemic diseases and miscellaneous conditions and defects.*

(1) Paragraphs 2-39 and 2-40.

(2) Blood donations. Personnel will not perform free fall parachute duties for 72 hours following the blood donation.

(3) Chronic motion sickness. History of motion sickness, other than isolated instances without emotional involvement.

(4) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

u. *Tumors and malignant disease.* Paragraph 2-41.

v. *Sexually transmitted diseases.* Paragraph 2-42.

### 5-6. 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 soldier's demonstrated ability to satisfactorily perform free fall parachute duty.

b. The effect upon the individual's health and well-being by remaining on free fall parachute duty.

### 5-7. 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.

### 5-8. Medical fitness standards for initial selection for marine 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 paragraph and paragraphs 5-9 through 5-11. Disposition of medical reports will be as described in paragraph 8-26c.

a. *Abdomen and gastrointestinal system.* Paragraph 2-3.

b. *Blood and blood-forming tissue disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

(3) Sickle cell disease.

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 (subpara w below).

(6) Perforation, marked scarring or thickening of the eardrum.

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

*f. Extremities.*

(1) Paragraphs 2-9 through 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, with exceptions noted below:

(2) Vision which does not correct to 20/20 in one eye and 20/100 in the other eye. Uncorrected distant visual acuity of worse than 20/70 in the better eye and 20/200 in the poorer eye. Vision which does not correct to 20/20 in both eyes within 8 diopters of plus or minus refractive error, with spectacle lenses.

(3) 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 through 2-20, except blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. An unsatisfactory orthostatic tolerance test is also disqualifying.

*k. Height.* Paragraph 2-21.

*l. Weight.* 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) Paragraph 2-24.

(2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation or perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the

date of the examination and clinical evaluation shows complete recovery with normal pulmonary function.

*o. Mouth, nose, pharynx, larynx, trachea, and esophagus.* Paragraphs 2-25 through 2-28.

*p. Neurological disorders.*

(1) Paragraph 2-29.

(2) The criteria outlined in paragraph 4-23 for Classes 2 and 3 flying duty apply.

*q. Psychotic disorders.* Disorders with psychotic features, affective disorders (mood disorders), anxiety, somatoform, or dissociative disorders (neurotic disorders).

(1) Paragraphs 2-30 through 2-35.

(2) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness, or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

(8) Fear of depths, enclosed places, or of the dark.

*r. Skin and cellular tissues.* Paragraph 2-36.

*s. Spine, scapulae, ribs, and sacroiliac joints.* (Consultation with an orthopedist and, if available, diving medical officer will be obtained in questionable cases.)

(1) Paragraphs 2-37 and 2-38.

(2) Spondylolisthesis, spondylolysis which is symptomatic or likely to interfere with diving duty.

(3) Healed fracture or dislocation of the vertebrae except a mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

*t. Systemic diseases and miscellaneous conditions and defects.*

(1) Paragraphs 2-39 and 2-40.

(2) Chronic motion sickness.

(3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

*u. Tumors and malignant diseases.* Paragraph 2-41.

*v. Sexually transmitted diseases.* Paragraph 2-42.

*w. Pressure equalization and oxygen intolerance.* If a hyperbaric chamber is available, examinees will be tested for the following disqualifying conditions:

(1) *Failure to equalize pressure.* All candidates will be subjected, in a compression

chamber, to a pressure of 50 pounds (32.5 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 will be tested by determining the candidate's ability to breathe oxygen without deleterious effects at a pressure of 27 pounds (12.15 kg) (60 feet) (18 meters) for a period of 30 minutes.

### 5-9. Medical fitness standards for retention for marine diving duty (Special Forces and Ranger combat diving)

Retention of a soldier in marine (SCUBA) diving duty will be based on—

a. The soldier's demonstrated ability to satisfactorily perform marine (SCUBA) diving duty.

b. The effect upon the soldier's health and well-being by remaining on marine (SCUBA) diving duty.

### 5-10. Medical fitness standards for initial selection for other marine diving training (MOS 00B)

SF 88; SF 93; and allied documents will be sent to HQDA (SGPS-CP-B), Falls Church, VA 22041-3258, for review and approval. (See also para 8-16c(2) and table 8-1 for medical examination requirements.) The causes of medical unfitness for initial selection for diving training are all of the causes listed in chapter 2, plus all of the causes listed in paragraphs 5-8 through 5-11.

*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 with no radiographic or endoscopic evidence of active disease or severe scarring or deformity.

(5) Laparotomy or celiotomy within the preceding 6 months.

*b. Blood and blood-forming tissue diseases.*

(1) Paragraph 2-4.

(2) Sickle cell disease.

(3) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

*c. Dental.*

(1) Paragraph 2-5.

(2) Any infectious process and any conditions which contribute to recurrence until eradicated.

(3) Edentia; any unserviceable teeth until corrected.

(4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures, which interfere with 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) 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 5-8w.

(4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.

(5) Audiometric average level for each ear not more than 25 dB at 500, 1000, and 2000 Hz with no individual level greater than 30 dB. Not over 45 dB at 4000 Hz.

(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 disease.* Paragraph 2-8.

*f. Extremities.*

(1) Paragraphs 2-9 through 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, 20/200; not correctable to 20/20, each eye.

(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 FALANT USN test.

(d) Waivers may be granted by the reviewing authority if the examinee can correctly identify the red and green colors used in diving operations. Such testing will include sufficient repetitions to ensure against an 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 through 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) Even though the soldier's weight or body composition is within the limits prescribed by AR 600-9, he or she will be found medically unfit if the examiner considers that his weight and/or associated conditions in relationship to the bony structure, musculature and/or total body fat content would adversely affect diving safety or endanger the soldier's well-being if permitted to continue in diving status.

*n. Lungs and chest wall.*

(1) Paragraph 2-24.

(2) Congenital or acquired defects which restrict pulmonary function, cause air trapping or affect ventilation-perfusion ratio.

(3) Any chronic obstructive or restrictive pulmonary disease at the time of examination.

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

(1) Paragraphs 2-25 through 2-28.

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

(3) Any nasal or pharyngeal respiratory obstruction.

(4) Chronically diseased tonsils until removed.

(5) Speech impediments of any origin, any condition which interferes with the ability to communicate clearly in the English language.

*p. Neurological disorders.*

(1) Paragraph 2-29.

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

*q. Mental disorders.*

(1) Paragraphs 2-30 through 2-35.

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

(3) The Military Diving Adaptability Rating (MDAR) may be considered MDAR satisfactory if the applicant meets the standards of paragraph 4-30 with the addition of having no fear of depths, enclosed places, or of the dark.

*r. Skin and cellular tissues.* Any active or chronic disease of the skin.

*s. Spine, scapulae, ribs, and sacroiliac joints.*

(1) Paragraphs 2-37 and 2-38.

(2) Spondylolysis; spondylolisthesis.

(3) Healed fractures or dislocations of the vertebrae until reviewed by a diving medical officer.

(4) 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 2-39 and 2-40.

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

*u. Tumors and malignant diseases.* Paragraph 2-41.

*v. Sexually transmitted diseases.*

(1) Active sexually transmitted disease until adequately treated.

(2) History of clinical or serological evidence of active or latent syphilis, unless adequately treated, or of cardiovascular or central nervous system involvement at any time. Serological test for syphilis required.

*w. Oxygen intolerance.* See paragraph 5-8w.

**5-11. Medical fitness standards for retention for other marine diving duty (MOS 00B)**

The medical fitness standards contained in paragraph 5-10 apply to all personnel performing diving duty except that divers of long experience and a high degree of efficiency must—

*a.* Be free from disease of the auditory, cardiovascular, respiratory, genitourinary, and gastrointestinal systems.

*b.* Maintain their ability to equalize air pressure.

*c.* Have visual acuity, near and far, which corrects to 20/30 in the better eye.

**5-12. Medical fitness standards for enlisted military occupational specialties and specific medical restrictions for officer and enlisted occupational specialties**

*a.* The medical fitness standards to be utilized in the initial selection of soldiers to enter a specific enlisted MOS are contained in AR 611-201. Visual acuity requirements for this purpose will be based upon the soldier's vision corrected by spectacle lenses.

*b.* Soldiers 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.

c. Asplenic soldiers are disqualified from initial training and duty in military specialties involving significant occupational exposure to dogs or cats.

d. Asplenic soldiers are disqualified from initial Special Forces training and duty.

### **5-13. Medical fitness standards for certain geographical areas**

a. All soldiers 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 Some soldiers, because of certain medical conditions or certain physical defects, may require administrative consideration when assignment to certain geographical areas is contemplated to ensure that they are utilized within their medical capabilities without undue hazard to their health and well-being. In many instances, such soldiers can serve effectively in a specific assignment when the assignment is made on an individual basis that considers all of the administrative and medical factors. Guidance as to for assignment limitations indicated for various medical conditions and physical defects is contained in chapter 7 and c below.

c. Military Assistance Advisory Groups (MAAGs), military attaches, military missions, and duty in isolated areas. (See AR 55-46, AR 600-200, and AR 612-2.)

(1) The following medical conditions and defects will preclude assignments or attachment to duty with MAAGs, military attaches, military missions, or any type duty in isolated oversea stations requiring residence in areas where U.S. 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 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 the climate or general living environment prevailing in the area where the soldier is expected to reside, to such a degree as to preclude acceptable performance of duty.

(f) 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 soldiers 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.

(g) 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.

(2) 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.

(3) The medical fitness standards prescribed in c above are for the purpose of meeting selection criteria for military personnel under consideration for assignment or attachment to duty with MAAGs, military attaches, military missions, or any type duty in isolated oversea stations. These fitness standards also pertain to dependents of personnel being considered.

### **5-14. Dental—induction, enlistment, or appointment (see para 2-5)**

a. 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 MEPS for consultation by a civilian or military orthodontist, and the report of this consultation will be forwarded through the Chief, Medical Section, Headquarters, USAREC, Fort Sheridan, IL 60037-5570, to the Commander, HSC, Fort Sam Houston, TX 78234-6000, for final determination of acceptability. The Commander, HSC, will coordinate, as appropriate, with The Surgeon General, U.S. Air Force, or The Surgeon General of the Navy on individuals whose induction into the Air Force, Navy, or Marine Corps is being considered.

b. Officers and enlisted personnel of the Active Army, ARNG, and the USAR 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.

c. 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.

d. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program or a Reserve Component of the Army, Air Force, Navy, or Marine Corps only if a civilian or military orthodontist provides documentation that active orthodontic treatment will have been completed prior to entry on initial active duty for training or active duty. Individuals with retainer orthodontic appliances who are not required to undergo further active treatment are administratively acceptable for appointment, enlistment, induction, initial active duty for training, or active duty status.

### **5-15. Height—Regular Army commission (see para 2-21)**

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 HQDA, during the processing of their applications.

### **5-16. Height—United States Military Academy, Reserve Officers' Training Corps, and Uniformed Services University of the Health Sciences**

The following applies to all candidates to the USMA, ROTC, and the USUHS. Candidates for admission to the USMA, ROTC, and the USUHS, who are over the maximum height or below the minimum height, will automatically be recommended by the DODMERB for consideration for an administrative waiver by HQDA, 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.

### **5-17. Vision—Officer assignment to Armor, Field Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps**

a. Individuals being initially appointed or assigned as officers in Armor, Field Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps may possess uncorrected distance visual acuity of any degree that corrects with spectacle lenses to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, and be able to identify without confusion the colors vivid red and vivid green. Refractive error corrected by orthokeratology or keratorefractive surgery is disqualifying.

b. Retention of an officer in any of the branches listed in a above will be based on the officer's—

(1) Demonstrated ability to perform appropriate duties commensurate with his or her age and grade.

(2) Medical fitness for retention in Army service determined pursuant to chapter 3, including paragraphs 3-15 and 3-16.

(3) Continuance on active duty or in Reserve Component service not on active duty under appropriate regulations although determined to be medically unfit for retention in Army service.

#### **5-18. Hearing—Officer assignment to Armor, Field 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, table 7-1.

b. Retention of an officer in any of the branches listed in a above will be based on the officer's—

(1) Demonstrated ability to perform appropriate duties commensurate with his or her age and grade, and

(2) Medical fitness for retention in Army service under paragraph 3-10.

#### **5-19. Medical fitness standards for training and duty at nuclear power plants (see TB MED 267)**

The causes for medical unfitness for initial selection, training, and duty as nuclear power plant operators and/or officer-in-charge (OIC) of nuclear power plants are all the causes listed in chapter 2, plus the following:

(a) Paragraph 5-13c.

(b) Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or a vivid green.

c. Familial history of any of the following:

(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.

#### **5-20. Federal Aviation Administration-rated personnel**

When so directed in special procurement programs prescribed by the DA or the NGB, 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.

#### **5-21. 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 for individuals age 35 and over, in any meridian.

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

(d) *Refractive error corrected by orthokeratology or keratorefractive surgery.*

b. Unsatisfactory ARMA.

## **Chapter 6 Medical Fitness Standards for Mobilization**

### **6-1. General**

This chapter gives lists 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. Application**

These standards will be implemented only upon specific instruction from the Service secretaries and will apply to personnel categories as directed, including recall of Army retirees for mobilization purposes.

### **6-3. Abdominal and gastrointestinal defects and diseases**

The causes of medical unfitness for military service are—

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

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

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

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

e. *Gastritis:* Documented history of severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization.

f. *Hepatitis:* Within the preceding 6 months, or persistence of symptoms after a reasonable period of time when objective evidence of liver function impairment 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.

k. *Polyposis of the colon:* Verified by examination or by documented history.

l. *Proctitis, chronic:* Documented history of moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea with repeated admissions to the hospital.

m. *Ulcer, peptic, duodenal, and gastric:* Supported by laboratory and x-ray evidence and documented history of frequent recurrence of symptoms (pain, vomiting, or bleeding).

n. *Ulcerative colitis:* When supported by documented history of any of the following symptoms: Weight loss, significant abdominal pain, anemia, more than four bowel movements a day.

o. *Rectum, stricture of:* When supported by documented history of severe symptoms of obstruction characterized by intractable constipation, pain of defecation, or 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 there are more than mild symptoms of diarrhea or if complicated by colostomy.

b. *Colostomy,* when present.

c. *Enterostomy,* when present.

d. *Gastrectomy, total per se.* Gastrectomy, subtotal with or without vagotomy; gastrojejunostomy, with or without vagotomy; when residual conditions are such that

an individual requires a special diet, develops "dumping syndrome," has frequent episodes of epigastric distress or diarrhea, or shows marked weight loss.

e. Gastrectomy, when present.

f. Ileostomy, when present.

g. Pancreatectomy.

h. Pancreaticoduodenostomy and pancreaticogastronomy with 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.

### 6-5. Blood and blood-forming tissue diseases

Any of the following diseases makes an individual 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.

### 6-6. Dental diseases and abnormalities

The causes of medical unfitness for military service are—

a. Diseases of the jaws or associated tissues which will incapacitate the individual or prevent the satisfactory performance of military duty.

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

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

d. Orthodontic appliances: See special administrative criteria in paragraph 5-14.

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

### 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 dB hearing level (by audiometer) in

the better ear, severe tinnitus which is not corrected satisfactorily by a hearing aid or other measures, or complicated by vertigo or otitis media.

c. Mastoiditis, chronic, following mastoidectomy: Constant drainage from the mastoid cavity which is resistant to treatment, requiring frequent dispensary care or hospitalization, and a hearing level in the better ear of 30 dB 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

Hearing level (with hearing aid) at speech reception score of worse than 30 decibels is unfitting for service.

### 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 satisfactorily responded to therapy or where replacement therapy presents serious management problems.

c. Diabetes insipidus, unless mild and showing good response to treatment.

d. Diabetes mellitus, unless mild and controllable by diet. However, for nondeployable recalled Army retirees, diabetes mellitus adequately controlled by diet or hypoglycemic medication (oral or insulin) is acceptable.

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 the satisfactory performance of duty.

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

h. Hyperparathyroidism per se, does not render an individual medically unfit. However, in the case of residuals or complications of the surgical correction of this condition, such as renal disease or bony deformities which would usually preclude the satisfactory performance of military duty, such individuals are medically unfit for military service.

i. Hyperthyroidism: Severe symptoms of hyperthyroidism which have 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. Confirmed pituitary basophilism: Confirmed.

### 6-10. Upper extremities (see also para 6-12)

The causes of medical unfitness for military service are—

a. Amputation of an 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 (1) to (4) below (TM 8-640/AFP 160-14). Range of motion limitations temporarily not meeting these standards because of disease, injury, or remedial condition will be temporarily disqualifying.

(1) *Shoulder*.

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) *Elbow*.

(a) Flexion to 100 degrees.

(b) Extension to 60 degrees.

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

(4) *Hand*. Pronation to the first quarter of the normal arc.

### 6-11. Lower extremities

The causes of medical unfitness for military service are—

a. Amputation of leg, thigh, or foot if suitable prosthesis is not fitted or if the use of a cane or crutches is required, or double amputee regardless of suitable prosthesis.

b. Loss of toes rendering the individual unable to perform useful military service.

c. Problems of the feet as follows:

(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 of 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; and metatarsalgia, 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/AFP 160-14). 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 degrees.

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

(2) *Knee.*

(a) Extension to 10 degrees.

(b) Flexion to 90 degrees.

(3) *Ankle.*

(a) Dorsiflexion to 10 degrees.

(b) Plantar flexion to 10 degrees.

f. Shortening of an extremity which exceeds 2 inches.

## 6-12. Miscellaneous conditions of the extremities (see also paras 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 (See paras 6-33 and 6-38.)): Associated with persistent pain and marked loss of function, with objective x-ray evidence, and documented history of recurrent incapacity for prolonged periods.

(2) Arthritis due to trauma, when there is functional impairment to the involved joints so as to preclude the satisfactory performance of duty.

(3) Osteoarthritis: Frequent recurrence of symptoms associated with impairment of function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods; history of frequent recurrences and supported by objective findings.

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

c. *Fractures.*

(1) *Malunion of fractures.* Where there is more than moderate malunion with marked deformity or more than moderate loss of function.

(2) *Nonunion of fracture.* When nonunion of a fracture interferes with function to the extent of precluding satisfactory performance of duty.

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

(4) *Callus, excessive, following fracture.* When it interferes with function to the extent of precluding satisfactory performance of military duty.

d. *Joints.*

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

(2) Bony or fibrous ankylosis of weight-bearing joints, if either fusion is such as to require the use of a cane or crutches or if there is evidence of active or progressive disease.

(3) *Contracture of joint:* More than moderate and if loss of function is severe.

(4) Loose foreign bodies within a joint: Complicated by arthritis, not remediable and seriously interfering with function.

e. *Muscles.*

(1) Paralysis secondary to poliomyelitis: If the use of a cane or crutches is required.

(2) Progressive muscular dystrophy: Confirmed.

f. *Myotonia congenita.* Confirmed.

g. *Osteitis deformans (Paget's disease):* Involvement in single or multiple bones with resultant 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 involving 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.

## 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. *Detached 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 degrees 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 correctable by isekonic lenses.

b. *Binocular diplopia.* Not correctable by surgery, and which is severe, constant, and in a zone less than 20 degrees 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 degrees in diameter.*

## 6-15. Genitourinary system

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 1 day from a civilian occupation.

b. *Endometriosis:* Symptomatic and incapacitating to a degree which necessitates recurrent absences of more than a day from a civilian occupation.

c. *Enuresis,* determined to be a symptom of an organic defect not amenable to treatment.

d. *Hypospadias,* accomplished 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 a 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) Chronic, confirmed pyelonephritis.

(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. Chronic urethritis not responsive to treatment.

l. Proteinuria, if persistent or recurrent, including so-called orthostatic or functional proteinuria.

## 6-16. Genitourinary and gynecological surgery

The causes of medical unfitness for military service are—

a. Cystectomy.

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

c. Nephrectomy, performed as a result of trauma, simple pyogenic infection, unilateral hydronephrosis, or nonfunctioning kidney when, after the treatment period, the remaining kidney is functioning abnormally. Residuals of nephrectomy performed for polycystic disease, renal tuberculosis and malignant neoplasm of the kidney must be individually evaluated by a genitourinary consultant and the medical unfitness must be determined on the basis of expected productivity in the service.

d. Nephrostomy, if permanent drainage persists.

e. Oophorectomy, when more than mild mental or constitutional symptoms remain.

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, residual obstruction or hydronephroses must be evaluated on an individual basis by a genitourinary consultant. Medical fitness for military service will be 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(s), and residuals.

## 6-17. Head (see paras 6-25 and 6-26)

### 6-18. Neck (see also para 6-9)

The causes of medical unfitness for military service is torticollis (wry neck): Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

### 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 of 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 (table 3-1).

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 IC, American Heart Association (table 3-1).

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 the aorta.

d. Confirmed periarteritis nodosa.

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 cardiovascular conditions

The causes of medical unfitness for military service are—

a. Aneurysms:

(1) Acquired arteriovenous aneurysm when more than minimal vascular symptoms remain following remediable treatment or if associated with cardiac involvement.

(2) Other aneurysms of the artery will be individually evaluated based upon the vessel involved and the residuals remaining after appropriate treatment.

b. Erythromelalgia: Persistent burning pain in the soles or palms not relieved by treatment.

c. Hypertensive cardiovascular disease and hypertensive vascular disease.

(1) Systolic blood pressure consistently over 159 mmHg or a diastolic pressure of over 90 mmHg following an adequate period of oral therapy while in an ambulatory status. However, for non-deployable recalled Army retirees, systolic pressure consistently over 160 mmHg or a diastolic pressure of over 100 mmHg following an adequate period of oral therapy while on ambulatory status is disqualifying.

(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 the functional level of Class IIC, American Heart Association (table 3-1).

## 6-22. Tuberculous lesions

The causes of medical unfitness for military service are the same as paragraph 2-24.

a. *Tuberculous empyema.*

b. *Tuberculous pleurisy.* Except when inactive 2 or more years without impaired pulmonary function or associated active pulmonary disease.

## 6-23. Nontuberculous disorders

The causes of medical unfitness for military service are—

a. *Bronchial asthma:* Associated with emphysema of sufficient degree to interfere with performance of duty, or frequent attacks controlled only by continuous systemic corticosteroid therapy or not controlled by oral medication.

b. *Atelectasis or massive collapse of the lung:* Moderately symptomatic, with or without paroxysmal cough at frequent intervals throughout the day, mild emphysema, or weight loss.

c. *Confirmed bronchiectasis and/or bronchiolectasis.*

d. *Bronchitis:* Chronic state with persistent cough, considerable expectoration, more than mild emphysema, or dyspnea at rest or on slight exertion.

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

f. *Diaphragm, congenital defects:* Symptomatic.

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

h. *Histoplasmosis:* Chronic disease not responding to treatment.

i. *Pleurisy, chronic, or pleural adhesions:* More than moderate dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions.

j. *Pneumothorax, spontaneous:* Recurring spontaneous pneumothorax requiring hospitalization or outpatient treatment of such frequency as would interfere with the satisfactory performance of duty.

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

l. *Pulmonary emphysema:* Evidence of more than mild emphysema with dyspnea on moderate exertion.

m. *Pulmonary fibrosis:* Linear fibrosis or fibrocalcific residuals of such degree as to cause more than moderate dyspnea on mild exertion.

n. *Pneumoconiosis:* More than moderate, with moderately severe dyspnea on mild exertion, or more than moderate pulmonary emphysema.

o. *Sarcoidosis:* See paragraph 6-33f.

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

q. *Stenosis, trachea.*

## 6-24. Surgery of the lungs and chest

The cause of medical unfitness for military service is—

Lobectomy of more than one lobe or if pulmonary function is seriously impaired.

## 6-25. Mouth, nose, pharynx, trachea, esophagus, and larynx

The causes of medical unfitness for military service are—

a. *Esophagus.*

(1) *Achalasia* unless controlled by medical therapy.

(2) *Severe esophagitis.*

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

(4) *Stricture of the esophagus* of such a degree as to almost restrict diet to liquids, which has required frequent dilatation and hospitalization, and has caused the individual to have difficulty in maintaining weight and nutrition, when the condition has not responded to treatment.

b. *Larynx.*

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

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

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

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

e. *Sinusitis:* Severe, chronic sinusitis which is suppurative, complicated by polyps, and which has not responded to treatment.

## 6-26. Neurological disorders

The causes of medical unfitness for military service are—

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

b. *Convulsive disorders,* except when there are infrequent convulsions while under standard drugs which are relatively nontoxic and which do not require frequent clinical and laboratory followings.

c. *Narcolepsy,* when attacks are not controlled by medication.

d. *Peripheral nerve condition.*

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

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

(3) *Paralysis due to peripheral nerve injury.* When manifested by more than moderate permanent functional impairment.

e. *Miscellaneous neurological disorders.*

(1) *Migraine.* Cause unknown, when manifested by frequent incapacitating attacks occurring or lasting for several consecutive days and unrelieved by treatment.

(2) *Multiple sclerosis.* Confirmed.

Note: Diagnostic concepts and terms utilized in paragraphs 6-27 through 6-30 below are in consonance with DSM-III-R Manual. The minimum psychiatric evaluation will include Axis I, II, and III.

## 6-27. Disorders with psychotic features

The cause of medical unfitness for military service is a history of a medical disorder with gross impairment in reality testing. This does not include transient disorders associated with intoxication or severe stress or secondary to a toxic, infectious, or other organic process.

## 6-28. Affective disorders (mood disorders)

The cause for rejection for appointment, enlistment, and induction of medical unfitness for military service is persistence or recurrence of symptoms sufficient to require hospitalization or necessity for work in a protected environment.

## 6-29. Anxiety, somatoform, or dissociative disorders (neurotic disorders)

The causes for rejection for appointment, enlistment, and induction of medical unfitness for military service are—

a. *History of such disorder(s), and—*

(1) *Hospitalization.*

(2) *Prolonged care by a physician or other professionals.*

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

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

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

## 6-30. Personality, behavior, or learning disorders academic skills, or language and speech disorders

The causes of medical unfitness for military service are—

a. *Personality and behavior disorders,* as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not a cause of administrative rejection, are tangible evidence of

impaired characterological capacity to adapt to the military service.

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

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

d. Specific learning defects secondary to organic or functional mental disorders.

e. Alcohol ~~addiction~~ dependence or drug ~~addiction~~ dependence that has failed rehabilitation.

### 6-31. 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. Confirmed amyloidosis.

d. Cysts and tumors: See paragraphs 6-35 and 6-36.

e. Cysts, pilonidal: To be evaluated under provisions of *af* below.

f. Dermatitis herpetiformis, when symptoms have failed to respond to medication.

g. Confirmed dermatomyositis.

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. Confirmed epidermolysis bullosa.

l. Erythema multiforme: More than moderate, chronic or recurrent.

m. Exfoliative dermatitis, of any type, confirmed.

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

o. Hidradenitis suppurativa and folliculitis decalvans: More than minimal degree.

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

q. Leukemia cutis and mycosis fungoides in the tumor stage.

r. Lichen planus: Generalized and not responsive to treatment.

s. Lupus erythematosus: Systemic acute or subacute and occasionally the chronic discoid variety with extensive involvement

of the skin and mucous membranes or when the condition has not responded to treatment after an appropriate period of time.

t. Neurofibromatosis (Von Recklinghausen's Disease), if repulsive in appearance or when it would interfere with the satisfactory performance of duty:

u. Panniculitis, nodular, nonsuppurative, febrile, relapsing: Confirmed.

v. Parapsoriasis: Extensive and when it would interfere with the satisfactory performance of duty.

w. Pemphigus vulgaris, pemphigus foliaceus, pemphigus vegetans and pemphigus erythematosus: Confirmed.

x. Psoriasis: Extensive and not controllable by treatment and when it would interfere with the satisfactory performance of military duty.

y. Radiodermatitis, if the site of malignant degeneration, or if symptomatic to a degree not amenable to treatment.

z. Scars and keloids, so extensive or 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 6-33.

ac. Ulcers of the skin which have 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.

### 6-32. Spine, scapulae, ribs, and sacroiliac joints (see also para 6-12)

The causes of medical unfitness for military service are—

a. Congenital anomalies.

(1) Congenital dislocation of hip.

(2) Spina bifida associated with pain to the lower extremities, muscular spasm, and limitation of motion and 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 and which have not been amenable to treatment.

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

c. Disarticulation of the hip joint.

d. Herniation of nucleus pulposus: More than mild symptoms with sufficient objective findings.

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

f. Scoliosis: Severe deformity with over 2 inches deviation of tips of spinous processes from the midline.

### 6-33. 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. Confirmed myasthenia gravis.

e. Confirmed porphyria cutanea tarda.

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.

### 6-34. General and miscellaneous conditions and defects

The causes of medical unfitness for military service are—

a. Allergic manifestations.

(1) Allergic rhinitis (hay fever) (para 6-25d).

(2) Asthma (para 6-23a).

(3) Allergic dermatoses (para 6-31).

(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. Residuals of cold injury (examples: 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 false positive STS (vaccinia, infectious hepatitis, immunizations, atypical pneumonia, etc.) or unless there has been a reversal to a negative STS during an appropriate follow-up 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.

### 6-35. 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. Benign tumor of the tongue, if it interferes with function.

e. Tumors of the breast, thoracic contents, or chest wall, 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.

### 6-36. Malignant neoplasms

The cause of medical unfitness for military service is malignant growths when inoperable, metastasized beyond regional nodes, have recurred subsequent to treatment, or the residuals of the remedial treatment are in themselves incapacitating.

### 6-37. Neoplastic conditions of lymphoid and blood-forming tissues

Neoplastic conditions of the lymphoid and blood-forming tissues are generally considered as rendering an individual medically unfit for military duty.

### 6-38. Sexually transmitted diseases

The causes of medical unfitness for military service are—

a. Aneurysm of the aorta due to syphilis.

b. Atrophy of the optic nerve due to syphilis.

c. Symptomatic neurosyphilis in any form.

d. Complications or residuals of venereal disease of such chronicity or degree that the individual would not be expected to perform useful duty.

## Chapter 7 Physical Profiling

### 7-1. General

This chapter prescribes a system for classifying individuals according to functional abilities.

### 7-2. Application

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. All applicants examined for enlistment, appointment, or induction.

c. Members of any component of the U.S. Army throughout their military service, whether or not on active duty.

### 7-3. Physical profile serial system

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 for the various codes are fully described in paragraph 7-5. 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, those 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 in determining the numerical designation 1, 2, 3, or 4.

b. Aids such as x-ray films, ECGs, 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, general physical capacity, 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 ears.* 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 a 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 one or more medical conditions

or physical defects which require certain assignment restrictions. The individual should receive assignments commensurate with his or her functional physical capability for military duty.

(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 soldier 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 7-5).

d. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. IN THIS RESPECT, PROFILING OFFICERS MUST CONSIDER THE EFFECT OF THEIR RECOMMENDATIONS UPON THE SOLDIER'S ABILITY TO PERFORM DUTY. PROFILES INCLUDING ASSIGNMENT LIMITATIONS, TEMPORARY OR PERMANENT, WHICH ARE RECORDED ON DA FORM 3349 (PHYSICAL PROFILE) PRESCRIBED BY THIS CHAPTER OR ON DD FORM 689, (INDIVIDUAL SICK SLIP) (FOR TEMPORARY PROFILES NOT TO EXCEED 30 DAYS AS PRESCRIBED BY AR 600-6), MUST BE REALISTIC. ALL PROFILES AND ASSIGNMENT LIMITATIONS MUST BE LEGIBLE, SPECIFIC, AND WRITTEN IN LAY TERMS. SINCE PERFORMANCE OF ARMY DUTY AND ARMY UNIT EFFECTIVENESS ARE MAJOR CONSIDERATIONS, A CLOSE PERSONAL RELATIONSHIP MUST EXIST BETWEEN PHYSICIANS AND UNIT COMMANDERS OR PERSONNEL MANAGEMENT OFFICERS. THIS RELATIONSHIP IS ESPECIALLY IMPORTANT WHEN RESERVE COMPONENT PERSONNEL ARE PROFILED.

(1) Determination of individual assignment or duties to be performed are command/administrative matters. Limitations such as "no field duty," "no oversea duty," or "must have separate rations" are not proper medical recommendations.

(2) It is the responsibility of the commander or personnel management officer to determine proper assignment and duty, based upon knowledge of the soldier's profile, assignment limitations, and the duties of his or her grade and MOS.

(3) Table 7-1 contains the physical profile functional capacity guide.

#### 7-4. 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, as described in paragraph 7-5.

a. "P"—Permanent. This modifier indicates that the profile is permanent and change may only be made by authority designated in paragraph 7-6. A profile is considered permanent unless a specific temporary modifier is added as indicated below. A permanent profile may only be changed by the authority designated in paragraph 7-6.

b. "T"—Temporary. This modifier indicates that the condition necessitating a 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 arrangements for the necessary correction or treatment of the temporary condition.

c. Records. Whenever a temporary medical condition is recorded on the DA Form 3349 or SF 88 or is referred to in a routine personnel action, the modifier "T" will be entered immediately following preceding each PULHES numerical designator when a temporary condition exists.

#### 7-5. Representative profile serial and codes

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, code designations have been adopted to represent certain combinations of numerical designators in the various factors and most significant assignment limitations, (see table 7-2). 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 given in table 7-1.

#### 7-6. Profiling officer

a. Commanders of Army 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 this regulation. 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 7-8).

(2) Dentists, optometrists, podiatrists, audiologists, physical therapists, and occupational therapists: No limitation within their specialty for awarding permanent numerical designators "1" and "2." A 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 7-8).)

(3) Physician assistants, nurse midwives, 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, except when the provisions of paragraph 7-9 apply. (Physician assistants and nurse practitioners will not be appointed as members of PPBDs.)

(4) Physicians (full-time or part-time civilian employees or fee-for-service physicians) on duty at a MEPS will be designated profiling officers.

#### 7-7. 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 SF 88 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 1966/1 through 6 (Record of Military Processing Armed Forces of the United States), in the appropriate items provided on these forms for this purpose spaces. When modifier "T" or "P" is entered on the profile serial, or in those exceptional cases where the numerical designator "3" or "4" is used on initial entry, a brief, nontechnical 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 the SF 88 attached.

c. Individuals who are found unacceptable under medical fitness standards of chapter 4 and 5 will 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:

### 7-8. Physical profile boards

a. PPBDs 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 soldier hospitalized over 6 months. The board will ensure that the patient has the correct physical profile, assignment limitation(s) and medical followup instructions, as appropriate.

(2) Permanent revision of a soldier'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 soldier has changed to the extent that it permanently alters the soldier'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 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. 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 PEB, the Army Physical Disability Agency or the Army Physical Disability Appeal Board under AR 635-40, will be given a physical profile commensurate with their physical condition under the appropriate factors by the Surgeon General. Assignment limitations will be established concurrently. Records will be forwarded by the Commanding General, MILPERCEN to HQDA (SGPS-CP-B) Falls Church, VA, 22041-3258, before notification of final action is returned to the medical facility having custody of the patient. After an appropriate period of time, such profile and limitations may be reviewed by a PPBD if the individual's functional capacity warrants such action. Changing of a designator "4" with a code V may be accomplished by~~

~~a PPBD only with approval of MILPERCEN (Rescinded.)~~

e. Tuberculous patients returned to a duty status who require antituberculous chemotherapy following hospitalization will be given a Temporary P-3-F profile for a period of 1 year with recommendation that the soldier 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, HSC, for final determination of an appropriate profile. For controversial cases following an MEBD, see paragraph 7-8i.

g. Revision of the physical profile for Reservists not on active duty will be accomplished by the United States Army Reserve Command/United States Reserve General Officer Command (ARCOM/GOCOM) staff surgeons, medical corps commander (lieutenant colonel and higher) of USAR hospitals, or the Surgeon, U.S. Army Reserve Personnel Center, without medical board procedure. For members of the ARNG not on active duty, such profile revisions 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, HSC. Revision of physical profile for Reserve Component members will be based on relationship to military duties. Secondary evidence concerning the civilian milieu may be considered by medical personnel in determining the effect of their recommendation upon Reserve Component soldiers. The profiling authority will use DA Form 3349.

h. Individuals whose period of service expires and whose physical profile code is "V," "W," or "Y" will appear before a medical board to determine if processing, as provided in AR 635-40, is indicated.

i. Physical profile and assignment limitations as determined by MEBD proceedings will take precedence over all previously issued temporary and permanent profiles awarded on DA Form 3349 in the soldier's medical records. Accordingly, medical board members must ensure that the physical profile and assignment limitations are fully recorded on DA Form 3349 (item 30). In cases where the soldier is referred to a PEB, DA Form 3349 should be forwarded to the PEB with the MEBD proceedings. In unusual or controversial cases, the MEBD proceedings, medical records, and PEB proceedings (if applicable) may be forwarded to The Surgeon General (SGPC-CP-B) for an appropriate profile determination. Cooperation between the MEBDs, PEB liaison officers, and the PEB is essential when additional medical information or profile reconsideration is requested. The limitations described on the profile form will affect the decision of fitness by the PEB. Table 7-1,

Physical Profile Capacity Guide, should be used when determining the numerical designator of the PULHES factors (e.g., a soldier should not be given a 3 or 4 solely on the basis of a referral to a PEB).

j. For specific instructions when profiling a soldier for a cardiac conditions, see paragraph 3-25.

### 7-9. Profiling pregnant servicewomen

a. ~~Intent. The intent of these provisions is to protect the fetus while ensuring productive utilization of the servicewoman. Common sense, good judgment, and cooperation must prevail between policy, patient, and patient's commander to ensure a viable program. (TB MED 295.)~~

b. ~~Responsibility.~~

(1) ~~Servicewomen. The servicewoman will seek medical confirmation of pregnancy. If and, when 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, he or she will initiate prenatal care of the patient and issue a physical profile (nurse midwives may issue routine or standard pregnancy profiles for the duration of the pregnancy). The profiling officer should ensure that the unit commander is provided a copy of the profile, and will advise the unit commander as required.~~

(3) ~~Unit commander. He or she will counsel all women as required by AR 635-100 or AR 635-200. The unit commander will consult with medical personnel as required.~~

c. ~~Physical profiles.~~

(1) ~~Profiles will be issued for the duration of the pregnancy. Profiles for soldiers 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 profiles will be issued as follows:~~

(a) ~~Under physical stamina indicate "T-3."~~

(b) ~~List diagnosis as pregnancy, estimated delivery date.~~

(c) ~~The profile will indicate the following limitations:~~

1. ~~Except under unusual circumstances, the soldier should not be reassigned (within continental United States (CONUS), unless cleared by her physician, or to or from overseas commands until pregnancy is terminated. (See AR 614-30 for waiver provisions.) She may be assigned within CONUS. Any reassignment must be cleared by her physician.~~

2. ~~Exempt from the regular physical training (PT) program of the unit; physical fitness testing; exposure to chemical agents in nuclear, biological, chemical (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 soldier or others; to include all aviation duty, Classes 1, 1A, 2, and 3. Class 2A, ATC 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 soldier 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 charge of quarters (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 (for example, 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.

f. *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.

## 7-10. Preparation, approval, and disposition of DA Form 3349

a. *Preparation of DA Form 3349.* (See fig 7-1.)

(1) DA Form 3349 will be used to record both permanent profiles and temporary profiles. DD Form 689 (Individual Sick Slip) may be used in lieu of DA Form 3349 for temporary profiles not to exceed 30 days and may include information on activities the soldier can perform as well as the physical limitations.

(2) DA Form 3349 will be prepared as follows:

(a) *Item 1.* Record medical condition(s) and/or physical defect(s) in common usage, nontechnical language which a layman can understand. For example, "compound comminuted fracture, left tibia" might simply be described as "broken leg."

(b) *Item 2.* Enter under each PULHES factor the appropriate profile serial code (1, 2, 3, or 4, as prescribed) and T (temporary) or P (permanent) prefix modifier if applicable. (Double profiling is not authorized. Double profiling is the placement of the numerical designator 2, 3, or 4 under the U,

H, L, E, or S factor and then placing the same designator under the P (physical capacity or stamina) factor solely because it was awarded the other factor.)

(c) *Item 3.* Clearly state all assignment limitations. Code designations (defined in table 7-2) are limited to permanent profiles for administrative use only and are to be completed by the MTF before sending a copy to the military personnel office (MILPO).

(d) *Item 4.* Check the appropriate block. If the profile is temporary enter the expiration date.

(e) *Item 5.* Check each block for exercises that are appropriate for the individual to do. Exercises are listed on the reverse of the form for easy reference. The individual can do all of the exercises checked.

(f) *Item 6.* Check all aerobic conditioning exercises the individual can do. The training heart rate will be assumed to be that determined by the directions in block 8 unless otherwise noted. If another training heart rate or training intensity is desired, note it here.

(g) *Item 7.* Check all functional activities the individual can do. If no values are listed in miles or pounds it will be assumed these are within the normal limitations of a healthy individual.

(g.1) *Physical Fitness Test.* Check the activities or alternative activities the soldier can perform for the Physical Fitness Test.

(h) *Item 9.* Any other activity that is felt to be beneficial for the individual may be listed here. This space may also be used locally for location-specific activities.

(i) *Signatures.*

1. Permanent 3 profiles and permanent 2 profiles requiring major assignment limitation(s) require signatures of a minimum of two profiling officers. In exceptional cases as required in paragraph 7-8, a third soldier will also sign.

2. Temporary profiles not requiring major assignment limitations require only the signature of one profiling officer.

b. *Approval of the "positive profile" form.*

(1) The appropriate approval authority is the approval authority for all permanent profiles requiring a 3 numerical designator and all permanent profiles requiring a 2 numerical designator and major assignment limitations.

(2) If the approval authority does not concur with the PPBD recommendations, the PPBD findings will be returned to the PPBD for reconsideration. If the approving authority does not concur in the reconsidered PPBD findings, the case will be referred to a medical evaluation board (MEBD) convened under the provisions of AR 40-3, chapter 7.

c. *Disposition of the positive profile form (permanent profiles) by the MTF:*

(1) Original and one copy to the unit commander.

(2) One copy to the MILPO.

(3) One copy to the soldier's health record.

(4) One copy to the clinic file.

d. *Disposition of the "positive profile" form (T (temporary) profiles).*

(1) Original and one copy to the unit commander.

(2) Record the T profile in the soldier's health record.

(3) Only in cases involving pseudofolliculitis of the beard will the soldier be furnished a copy.

## 7-11. Assignment restrictions, or geographical or climatic area limitations

Paragraph 5-13 established 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 7-5. 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 limitation 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.)

## 7-12. Responsibility for personnel actions

Unit commanders and 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 and MILPO copies of 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.

## Chapter 8 Medical Examinations—Administrative Procedures

### 8-1. General

This chapter provides—

a. General administrative policies relative to military medical examinations.

b. Requirements for periodic, separation, mobilization, and other medical examinations.

c. Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record.

d. Policies relative to the scope and recording of medical examinations accomplished for stated purposes.

### 8-2. Application

The provisions contained in this chapter apply to all medical examinations accomplished at U.S. Army medical facilities or accomplished for the U.S. Army.

### 8-3. Physical fitness

Maintenance of physical and medical fitness is an individual military responsibility, particularly with reference to preventable conditions and remediable defects. Soldiers have a definite obligation to maintain themselves in a state of good physical condition in order that they may perform their duties efficiently. Soldiers, ~~therefore~~, should seek timely medical advice whenever they have reason to believe that they have a medical condition or ~~aphysical defect which~~ affects, or is likely to affect, their physical or mental well-being. They should not wait until the time of their 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 soldiers during initial orientation and periodically throughout their period of service. In addition, medical examiners will counsel soldiers as part of the periodic medical examination.

### 8-4. 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/AFR 33-7/OPNAVINST 1100.4/MCO P-1100.75.

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 10, or

(4) The examining physician deems it necessary.

c. A consultation will be accomplished in the case of a soldier on active duty as outlined in a above or whenever it is indicated to ensure the proper professional care and disposition of the soldier.

d. A consultation will be accomplished by a physician, either civilian or military, qualified ~~therefor~~ by training in or by a practice primarily devoted 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 SF 88 as outlined in paragraph 8-5.

g. A guide as to the types and minimum scopes of the more frequently required consultations is contained in table 8-1.

### 8-5. 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 25-400-2. The other copy will be filed as a permanent record in the health record (AR 40-66) or comparable permanent file for nonmilitary personnel. Special instructions for preparation and distribution of additional copies are contained elsewhere in this chapter or in other regulations dealing with programs involving or requiring medical examinations. Copies may be reproduced from signed copies by any duplicating process which produces legible and permanent copies. Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies will not be made to unauthorized personnel or agencies.

### 8-6. Documentary medical evidence

a. Documentary medical records and other documents prepared by physicians or other individuals may be submitted by, or on behalf of, an examinee as evidence of the presence, absence, or treatment of a defect or disease, and will be given due consideration by the examiner(s). Submission and use of such documentary medical evidence is encouraged. If insufficient copies are received, copies will be reproduced to meet the needs of b and c below.

b. A copy of each piece of documentary medical evidence received will be appended to each copy of the SF 88, and a statement to this effect will be made in item 73, except as prescribed in c below.

c. When a report of consultation or special test is obtained for an examinee, a copy will be attached to each SF 88 as an integral part of the medical report, and a statement to this effect will be made in item 73 and cross-referenced by the pertinent item number.

### 8-7. 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 will accomplish item 44 of SF 88 when they are reasonably available.

Physician assistants, nurse practitioners, optometrists, audiologists, podiatrists, and civilian employees, properly qualified by appropriate training and experience, may accomplish such phases of the medical examination as are deemed appropriate by the examining physician. They may sign the SF 88 for the portions of the examination they actually accomplish but the supervising physician will sign the SF 88 and SF 93 in all cases.

b. In general, medical examinations conducted for the Army will be accomplished at facilities of the Armed Forces, using military medical officers on Active or Reserve duty, or full-time or part-time civilian employee physicians, with the assistance of dentists, physician assistants, nurse practitioners, optometrists, audiologists, and podiatrists.

c. Medical examinations for aviation applicants and aviation personnel will be accomplished as follows:

(1) For entrance into Army aviation pilot training (Class 1, 1A, or 2) and entrance into primary courses in aviation medicine (Class 2), examinations will be accomplished only at Active or Reserve facilities of the Armed Forces, by or under the immediate supervision of an assigned or attached flight surgeon. (Applicability of Class 1 and 1A standards will be in accordance with AR 611-110.) Medical Corps officers or civilian employee physicians who

by training or experience have been previously designated military flight surgeons or military aviation medicine officers but who at the time of examination are performing duty in a specialty other than aviation medicine are considered to be flight surgeons for this purpose and may accomplish these examinations. Other physicians, dentists, physician assistants, nurse practitioners, optometrists, audiologists and podiatrists may sign the SF 88 for the portions of the examination they actually accomplish but the supervising flight surgeon must, as a minimum, conduct the ARMA examination, review the SF 88, SF 93, and allied papers, and sign the SF 88 and SF 93 in all cases. FAA Form 8420-2 for entry into training and continuance on duty as an ATC (Class 2A) will be accomplished by a military flight surgeon if one is available within a 60-minute travel time (one way); if not, by a civilian aviation medical examiner designated by the FAA to administer examinations for FAA Form 8420-2 certificates. Funding will be in accordance with g below.

(2) Medical examinations for entrance into training as aviation mechanics, crew chiefs, observers, door gunners, or other Class 3 duties will be accomplished conducted by a flight surgeon if one is available within the 60-minute travel time (one way); if not, if a flight surgeon is not available, examination will be performed by any physician assigned or attached to an Active or Reserve military facility. They will and then be reviewed and signed by a flight surgeon.

(3) Medical examinations for continuance of aviation duty (Classes 2, 2A, and 3) (soldiers) will be accomplished by a flight surgeon, if available within a 60-minute travel time (one way); or may otherwise be accomplished by any physician assigned or attached to any Active or Reserve military facility. All Classes 2, 2A, and 3 examinations will be reviewed and signed by a flight surgeon. Active duty aviators on MAAG or exchange tours may be examined by host country flight surgeons if U.S. military flight surgeons are not available. SF 88 and SF 93 will be used. Allied documents may be host country forms if U.S. forms are not available. ARNG and USAR members not on active duty may be examined by Medical Corps officers of either the Active or Reserve Component of the Army, Navy, or Air Force. In the case of Classes 2, 2A, and 3 continuance, Active and Reserve Component personnel who are not located within a 60-minute travel time of an Active or Reserve military facility, may be authorized by their commander to obtain their Army Class 2 (aviators), Army Class 3, or FAA Second Class (ATC) examination from civilian FAA-designated aviation medical examiners (AMEs). SF 88 and SF 93 must be used for Class 3 (aviators) and Class 3 examinations. Allied documents will preferably be U.S. Government forms (DA, DOD, or SF). Funding will be as in g below. AMEs who are former military flight surgeons will be utilized when available. In

cases where civilian AMEs are utilized for Class 2 or Class 3 Reserve examinations, a Reserve Component flight surgeon from a State (ARNG) or an area command (USAR) must review and sign the SF 88 as the reviewing official. Such use of civilian AMEs is authorized only when the reviewing flight surgeon has determined that the scope, content, and accuracy of flying duty medical examinations done by specific civilian AMEs are at least equivalent to Army standards of quality. See paragraph 8-24 k for examination of civilians and for FAA certification.

(4) The dental portion of all flying duty medical examinations will be performed by a dentist. The examination will be a complete periodic dental examination resulting in a Dental Fitness Category, as defined in AR 40-35, and will satisfy the annual requirement of that regulation.

d. The periodic medical examination required by AR 635-40 in the case of an individual, who is on the TDRL will be accomplished at an MTF designated by HQDA.

e. Medical examinations for qualification and admission to the USMA, the United States Naval Academy (USNA), the United States Air Force Academy (USAFA), 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 chapter 9 below or NGR 40-501, as appropriate.

g. Additional tests, procedures, or consultations, that are necessary to supplement a medical examination normally will be accomplished at a medical facility (including a MEPS) designated by the commander of the facility requesting the supplemental medical examination. Only on the authority of that commander will supplementary examinations be obtained from civilian medical sources. Funds available to the requesting commander will be used for payment of the civilian medical services he or she authorized.

### 8-8. 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 MTFs.
- b. Air Force and Navy MTFs.
- c. MTFs of other Federal agencies.
- d. Civilian MTFs.

### 8-9. 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.

### 8-10. Recording of medical examinations

The results of a medical examination will be recorded on SF 88, SF 93, and such other forms as may be required. See table 8-1 and paragraph 8-14 for administrative procedures for filling out SF 88. Health Risk Appraisals are required for all periodic medical examinations; however, this is not a substitute for a complete medical history and medical examination.

### 8-11. Remediable medical conditions and physical defects

When a medical examination reveals that a soldier has developed a remediable defect during the course of his or her duties, he or she 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 AR 600-20. For USAR members, see chapter 9 below; for ARNG, see NGR 40-501.

### 8-12. Scope of medical examinations

a. The scope of a medical examination, Type A or B, is prescribed in table 8-1 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.

### 8-13. Standard Form 88

a. Each abnormality, whether or not it affects the examinee's medical fitness to perform military duty, will be routinely described and made a matter of record whenever discovered. The part or parts of the body will be specified whenever the findings diagnoses are not sufficient to localize the condition. (Manifestations or symptoms of a condition will not be used in lieu of a diagnosis.)

b. Only those abbreviations authorized by AR 40-66 may be used.

c. Medical examiners will not routinely make recommendations for waivers for individuals who do not meet prescribed medical fitness standards. However, if a waiver is requested by the examinee, each disqualifying defect or condition will be fully described and a statement included as to whether the defect or condition—

- (1) Is progressive.
- (2) Is subject to aggravation by military service.
- (3) Precludes satisfactory completion of prescribed training and subsequent military service.

(4) Constitutes an undue hazard to the individual or to others in the military environment. Such information will facilitate evaluation and determination by higher authority in acting upon waiver requests. In addition, a notation will be made listing any assignment limitations which would have to be considered in view of the described defect(s). Such notation is not required in waiver cases where the individual obviously is not medically fit, even under the criteria for mobilization outlined in chapter 6.

d. When feasible, an adequate review of SF 88, to include review of the health record if available, will be performed and is the responsibility of the commander of the medical facility at which the examination is accomplished. Review by a field grade or senior company grade medical officer is desirable if circumstances permit. This review will be indicated by signature in item 82, SF 88.

e. The scopes of Types A and B medical examinations and instructions for recording the examinations on SF 88 are in table 8-1. Administrative data entered in items 1 through 17 will be typewritten or printed in ink. Whenever possible, trained clerical personnel will perform this function.

#### 8-14. Standard Form 93

a. *Preparation of SF 93.* SF 93 is prepared by the examinee prior to being examined. It provides the examining physician with an indication of the need for special discussion with the examinee and the areas in which detailed examination, special tests, or consultation referral may be indicated. It is important that the questions on the form be answered spontaneously by the examinee. Completeness of all answers and comments is essential to the usefulness and value of the form. The information entered on this form is considered confidential and will not be released to unauthorized sources. The examinee should be apprised of the confidential nature of his or her entries and comments. Trained enlisted medical service personnel and qualified civilians may be used to instruct and assist examinees in the preparation of the report but will make no entries on the form other than the information required in items 6 (date of examination) and 7 (examining facility or examiner, and address). Any help given the examinee will be only as an aid in his or her understanding of the question, not as suggested answers. A Spanish version (*Historia Medica*) is available for use by Spanish speaking examinees. SF 93 will normally be prepared in an original and one copy. Interleaved carbon paper may be used if forms are carefully aligned and the carbon copy is legible. The form will be prepared in all instances indicated in paragraph 8-15 and whenever—

- (1) Required by some other directive.
- (2) Considered desirable by the examining physician.
- (3) Directed by HQDA, or
- (4) When required by the reviewing agency.

b. *Identification and administrative data.* Items 1 through 7 will be typewritten or printed in ink. Whenever possible, trained clerical personnel will perform this function.

c. *Medical history and health data.*

(1) *Item 8.* A brief statement by examinees expressing their opinion of their present state of health. If unsatisfactory health is indicated in generalized terms such as "fair" or "poor," examinees will elaborate briefly to include pertinent information of their past medical history:

(2) *Examinee's medical history.* This includes items 9 through 25.

(a) Items 9 and 11 provide a means of determining the examinee's state of health, past and present, and possibly identifying medical conditions which should be evaluated in the course of the medical examination. The examinee will complete all items by checking "yes" or "no" for each.

(b) Item 12 will be completed by all female examinees.

(c) Items 13 and 14 will be completed by each examinee. Students who have not had full-time employment will enter the word "student" in item 13. Members of the Active Army who had no full-time employment prior to military service will enter "soldier" or "Army officer" as appropriate in item 13.

(d) Items 15 through 24. These questions and the answers are concerned with certain other environmental and medical conditions which can contribute to the physician's evaluation of the examinee's present and future state of health. All answers checked "yes" will be fully explained by the examinee to include dates, locations, and circumstances. The examinee will sign the form in black or dark-blue ink.

d. *Physician's summary and elaboration of examinee's medical history.*

(1) The physician will summarize and elaborate upon the examinee's medical history as revealed in items 8 through 24 and in the case of military personnel, the examinee's health record, cross-referencing his or her comments by item number. All items checked in the affirmative will be clarified and the examiner will fully describe all abnormalities including those of a nondisqualifying nature. This information is needed to assist in evaluating the examinee's background and to protect the individual and the Government in the event of future claims for disability or aggravation of disability.

(2) If the examinee's answers reveal that he or she was previously rejected for military service (item 22) or was discharged for medical reasons (item 23), the exact reasons should be ascertained and recorded. Such examinees, if found medically fit, will be considered "doubtful acceptability" until such time as the cause for previous rejection or discharge has been thoroughly reviewed and evaluated (AR 601-270/OPNAVINST 1000.4/AFR 33-7/MCO P-1100.75).

(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.

#### 8-15. Types of medical examinations

a. *General.* There are two general types of medical examinations, Type A and Type B, which meet the requirements for evaluation of individuals for most purposes. The scope of each of these examinations is indicated in table 8-1. Additional examination to extend or complement a Type A or Type B medical examination is appropriate when indicated or directed to permit use of the examination for special purposes.

b. *Type A medical examination.* A Type A medical examination is required to determine medical fitness of personnel under the circumstances enumerated below. SF 93 must be prepared in all cases except as indicated by an asterisk(\*).

- (1) Active duty.
- (2) Active duty for training for more than 30 days.
- (3) \*Airborne, Ranger, and Special Forces. *See Ch 101 Vol 191*
- (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 chapters 10 or 14 of AR 635-200.

(8) Enlistment (initial).

(9) Reenlistment.

(a) Immediate reenlistment (no break in service). A medical examination is not required.

(b) Reenlistment (with a break in service). A medical examination is required unless there is a copy of a report of medical examination for separation that was accomplished within the 1-year validity period prescribed by paragraph 8-16, or medical information contained on DA Form 1811 (Physical Data and Aptitude Test Scores Upon Release From Active Duty) if reenlisting within 6 months of release from active duty.

- (10) \*General prisoners when prescribed.
- (11) Induction and preinduction.
- (12) \*Medical board processing except when done solely for profiling.
- (13) MAAG, Army attache, military mission assignment, and assignment to isolated areas where adequate U.S. military medical care is not readily available.
- (14) OCS.
- (15) \*Oversea duty when prescribed except as outlined under Type B medical examination.

(16) Periodic for Army Reserve Components.

(17) \*Periodic for Active Duty Members, other than Army aviation and diving.

(18) Prisoners of war when required, internees, and repatriates.

(19) ROTC. Enrollment in ROTC, all levels except for enrollment in the Four-

have previously been reviewed by the Commander, USAAMC for attachment to the report of proceedings of the flying evaluation board (FEB) submitted to the Chief, NGB. For this purpose, direct communication between the State adjutant general and Commander, USAAMC is authorized.

(2) Clinical medical summaries, including indicated consultations, will accompany all unusual FEB cases forwarded to higher headquarters. Reports of hospital, medical, and PEBs 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 the FAA 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 table 8-1.

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 an SF 88. If space permits, recommendation concerning waivers will be made on the SF 88 by the examiner or reviewing medical official. In any case requiring waiver or special consideration, full use will be made of consultations. These will be identified and attached to the SF 88 on the appropriate clinical form or a plain sheet of letter-size 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 Commander, 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 Commander, 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 physician assistants, 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 Commander, USAAMC. If a waiver is not recommended by the examining physician, the Commander, 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 i(2) below.

(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 AR 600-105 and AR 600-106.)

*i. Review and waiver action.*

(1) *Review action.* The Commander, USAAMC (HSXY-AER), Fort Rucker, AL 36362-5333 will review and make final determination (utilizing the procedures outlined in e(1) above 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 assistants.

(e) Class 2A—Entrance into and continuance in training and on duty as an ATC. (See 1 below.)

(f) Class 3—Continuance on duty as aeromedical physician assistants. (Class 3, other personnel; in accordance with h(4) above.)

(2) *Waiver action.* The only agencies authorized to grant administrative waivers for medically unfitting conditions for aviation personnel are—

(a) Entrance into flight training, Classes 1 and 1A, and continuance in aviation service, Class 2 aviators (except MS): HQDA (DAPC-OPA-V), Alexandria, VA 22332-0400 and Chief, NGB (NGB-AVN-OC), Building E6810, Aberdeen Proving Ground, MD 21010-5420 Class 2: Medical Service Corps aviators: through HQDA (DASG-HCO-A), Washington, DC 20310-2300 to HQDA (DAPC-OPH-MS), Washington, DC 20324-2000.

(b) Class 2, flight surgeons (all persons being considered for or while in aeromedical training): through Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333 and Chief, NGB (NGB-ARS), Washington, DC 20310-2500 to HQDA (DAPC-OPH-MC), Washington, DC 20324-2000.

(c) Class 2, DAC pilots: local civilian personnel offices. Class 2, Contract civilian pilots (Fort Rucker): Commanding General, U.S. Army Aviation Center.

(d) Class 2A, entrance into and continuance in training and on duty as a military ATC: HQDA (DAPC-OPE-L-T), Alexandria, VA 22332-0400 and Chief, NGB (NGB-AVN-OC), Building E6810, Aberdeen Proving Ground, MD 21010-5420 for conditions disqualifying for military duty even though a valid FAA medical certificate has been issued. (See 1 below.)

(e) Class 2A, civilian ATCs: local civilian personnel offices.

(f) Class 3, aeromedical physician assistants: through Commander, USAAMC, ATTN: (HSXY-AER), Fort Rucker, AL 36362-5333 to HQDA (DAPC-OPH-MC), Washington, DC 20324-2000.

(g) Class 3, other personnel: see h(4) above.

(3) *Administrative waivers.* In each of the above, administrative waivers may be granted only upon written favorable recommendation from the Commander, USAAMC, and with concurrence of intermediate authority, where specified above. This recommendation may include limited flying status (for example, co-pilot only) and may include requirements for further evaluation. The Commander, USAAMC, in fulfilling his or her 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 or she 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 or for other conditions that are normally waivable, provided there will be no adverse effect on flight safety or individual health. Serious illness or injury (para 8-24c(3)) may be waived only by TAPA. When annual re-evaluation of waivers is required, the examining flight surgeon will ensure that all information required by the Commander, 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 Commander, 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 Commanding General, U.S. Army Aviation Center, 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.* (See also para 8-21c(2).) (Applies to all aviation personnel, including civilian employee pilots, civilian contractor pilots, and military and civilian ATCs.)

(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 k below.) The DA Form 4186 is to be completed at the time

- (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 (except rated aviators not performing operational flying duty) 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.
- (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 officer for inclusion in the flight records in accordance with AR 95-1. Individuals will, upon return to their unit following issuance of DA Form 4186, inform their commander or supervisor of their status and will utilize their copy of DA Form 4186 to verify their status. Health record copies will be filed as follows:

(a) Most recent DA Form 4186—file on top left.

(b) If the above grants clearance to fly, then the most recent DA Form 4186, if any, which shows a medical restriction from flying will be filed next under.

(c) 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) will be filed next under.

(d) Any additional DA Form(s) 4186 which the flight surgeon determines to be required as a permanent record (Enter "Permanent Record" in the "Remarks" section) will be filed next under.

(e) Destroy other DA Form(s) 4186.

(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 (Commander, USAAMC) if the examinee is found qualified for flying duty in accordance with chapter 4. If a newly discovered medically unfit condition requiring waiver exists, such waiver must be granted by appropriate authority (para i(2) above) before further flying duties may be performed. 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 Commander, 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 810), 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 810 will then normally be the end of the birth month approximately 1 year later. (See also para 8-21c(2)(d) and table 8-2 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 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

approval of a flight surgeon if a flight surgeon is not locally available at a given installation. In the case of restriction due to dental reasons, an aviation medicine qualified dental officer may sign the return to duty DA Form 4186. 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 (that is, condition worsens), a new waiver must be obtained before further flying duty is authorized. Item 914 of DA Form 4186 will show the date when a waiver was first granted for each waived condition as well as the 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 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 indicating the status or outcome of such evaluation. (See also AR 40-3; para 2-11.)

(6) USAF and USN forms may be substituted when aeromedical support is provided by those Services.

k. *FAA medical certificates.* (See also para 8-7c.) Note: In the near future, facility designations will be revoked and only individually designated AMEs will be authorized to issue FAA medical certificates.

(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 that the physician or the facility to which the flight surgeon or civilian physician is assigned or attached is designated (assigned an FAA number) by the FAA. All FAA-designated physicians or 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 73125-0082 (phone: (Area Code

405) 686-4831). Applications for individual designation should be forwarded to Commander, USAAMC, ATTN: (HSXY-AER), Fort Rucker, AL 36362-5333 at the above address. 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 using facility designation 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 available. If not available in this manner, the certificate must be obtained from a civilian aviation medical examiner designated by the FAA to administer FAA First Class examinations (Senior AME).

(b) FAA Second Class—DAC pilots and pilots who are employees of firms under contract with the Army (other than aircraft manufacturers, military and civilian ATCs). These individuals are required to undergo complete annual examination by military flight surgeons, qualified civilian employee physicians, or civilian AMEs in accordance with para 8-7c to determine their fitness to fly Army aircraft (para 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, 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 a 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 (see para 8-7g for funding); and fitness for duty will be determined on the basis of this certificate. 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 Commander, USAAMC for assistance. Failure to undergo examination by a military or civilian employee physician, if so ordered by competent authority, is basis for denying medical clearance to fly or control Army aircraft.

(c) Military and civilian personnel not required to possess FAA medical certificates for their official duties but who request them for personal use may be issued such certificates in accordance with (1) and (2) above, at the discretion of the flight surgeon and workload permitting. FAA medical certificates will not be prepared for individuals who do not request them. In no case will non-flight surgeons issue FAA medical certificates.

(d) Conduct of examination, processing of FAA Form 8500-8, and issuance of FAA Medical Certificates, Second and Third Class, will be in accordance with official policy of the FAA (Guide for AMEs and any other policy issued by FAA). Normally, certificates are issued at the time of examination if the individual is found to be fully qualified. No limitations or restrictions will be imposed except as specifically authorized by the 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 the 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 ensure that their certificate does not expire before reexamination.

(g) Army flight surgeons administering examinations for FAA medical certificates will ensure that examinations are complete and accurate, all administrative requirements are met, processing of all documents is accomplished on a timely basis, and FAA policy is followed.

1. *Air traffic control personnel.* Military and civilian ATC personnel will undergo examination annually or as otherwise directed by the FAA within 3 months of their birth month or as otherwise required. This examination may be performed during the birth month to facilitate scheduling but in no case will extensions be used to align the examination with the birth month. They

will also undergo examination when directed by the flight surgeon under such conditions as post-hospitalization, when illness occurs or is suspected, or after an aviation mishap in which air traffic control may have been a factor. Use of DA Form 4186 applies to all ATC personnel (see k above); as does AR 40-8. ATC personnel will not be issued FAA medical certificates in connection with their ATC duties. In addition, all ATC personnel who receive any communication whatsoever from the FAA regarding their medical status with FAA will immediately report to the flight surgeon for a determination regarding fitness for ATC duty at Army facilities. (See also paras 4-2, 8-7, 8-16a(3), and i and k above.)

(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). They are also required by Part 65 and Part 67, FAR, to possess an FAA Form 8500-9 (Airman Medical Certificate) or FAA Form 8420-2 (or higher). Civilian ATC personnel will obtain their FAA Form 8500-9 from a military flight surgeon, if available. A photocopy of FAA Form 8500-9 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 73125-0082 (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 8-7c).

(2) Military air traffic control personnel.

(a) Military ATC personnel must meet FAA standards, must possess an FAA Form 8500-9 or FAA Form 8420-2, 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, table 8-1, 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 health record (AR 40-66); another photocopy will be sent to the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333.

(b) If the examinee meets FAA and Army-unique criteria, his or her FAA medical certificate and 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 FAA 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 a 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 FAA Form 8500-9, with or without a statement of demonstrated ability or other form of "waiver," and

2. The local flight surgeon and the Commander, USAAMC recommend a waiver, and

3. Waiver is granted by the authority indicated in *i* above (PERSCOM).

To recommend a waiver, the local flight surgeon will prepare and forward an SF 88, 93, allied documents, and an aeromedical summary to the Commander, SAAMC, ATTN: HSYX-AER, Fort Rucker, AL 36362-5333.

(e) When ATC personnel obtain their FAA medical certificate from a civilian examiner (see para 8-7c), the examinee will report the outcome of the 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 (Health Record—Chronological Record of Medical Care) in the health record jacket, and the signed entry required in item 73, table 8-1, will be made on SF 600. A copy of SF 600 will be sent to the Commander, USAAMC, ATTN: HSYX-AER, Ft. Rucker, AL 36362-5333. If the examinee fails to meet FAA or Army standards, local medical officials will consult the Commander, USAAMC, ATTN: HSYX-AER, Ft. Rucker, AL 36362-5333 for further guidance.

(3) Air traffic control trainees (military). Individuals reporting for initial ATC training must have in their possession a valid,

current FAA Form 8420-2. This may be issued by an appropriate civilian aviation medical examiner or a military flight surgeon in accordance with paragraph 8-7c.

### 8-25. Mobilization medical examinations

For administrative procedures applicable to mobilization medical examinations (para 6-1), see paragraph 8-20.

### 8-26. 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 prescribed in pertinent publications, such as chapters 4 and 5 of this regulation, AR 40-5, AR 611-201, TB MED 279, TB MED 501, and TB MED 523.

b. *Certain geographical areas.*

(1) When an individual is alerted for movement to or is placed on orders for assignment to duty with the system of Army attaches, military missions, MAAGs, or to 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 5-13 and will be used in the evaluation and examination processes. In assessing the individual's potentiality for assignment in certain geographical areas, the examiner is urged to make use of other materials such as the Medical Capabilities Study (country-by-country) published by the Armed Forces Medical Intelligence Center (AV 343-7214), which provides 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 which bear on the advisability of residence in a given country are the scarcity or non-availability 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 ensure 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 whose medical status assures a reasonable continued effective performance and a minimum likelihood of becoming medical liabilities be qualified.

(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 5-13d and to meet the conditions which will be encountered in the area of contemplated assignment, he or she will complete and sign DA Form 3083-R (Medical Examination for Certain Geographical Areas). This form, located at the back of this regulation, will be reproduced locally on 8½- by 11-inch paper. 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 soldier 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 soldier to a medical board for documentation of the condition and recommendations concerning limitation of activities or areas of assignment. Either DA Form 3947 (Medical Evaluation Proceedings) or DA Form 3349 may be used, 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; that is, Army attaches, military missions, and MAAGs, where medical facilities of the U.S. Armed Forces are not available. Medical examinations so waived will be accomplished at the earliest opportunity when the individuals concerned are assigned or attached to a military installation having a medical facility. Medical examination of such individuals for retirement purposes may not be waived.

*see also 10110191*  
**c. Special Forces Initial Qualification, Military Free Fall (HALO), Special Forces SCUBA, and Survival, Evasion, Resistance, and Escape (SERE) Medical Examination Reports.** Entrance into Special Forces Qualification Course, military free fall (HALO), Special Forces SCUBA and SERE training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, U.S. Army John F. Kennedy Special Warfare Center (Surgeon), Fort Bragg, NC 28307-5000. The review and waiver authority for Special Forces Initial Qualification, HALO, SCUBA, and SERE is the Commander, U.S. Army John F. Kennedy Special Warfare Center. The original SF 88, SF 93, and allied documents will be forwarded directly to the above address for review. The reviewed medical examination forms and allied documents will be returned directly to the sender to be incorporated in the soldier's application for training.

### 8-27. Cardiovascular Screening Program (CVSP)/Health Risk Appraisal Assessment (HRAA)

*exch 1983*  
**a. Intent.** The Cardiovascular Screening Program (CVSP) and the Health Risk Appraisal Assessment (HRAA) are intended to—

- (1) Conduct health risk factor screening for all Active Component (AC), ARNG, and USAR soldiers.
- (2) Emphasize identification of individual cardiovascular risk factors.
- (3) Provide advice and assistance in controlling risk factors.
- (4) Provide instructions for safe and regular aerobic exercise.
- (5) Use treadmill testing in only the very high risk individuals.

**b. Criteria.** The periodic physical examination will be used as the vehicle for accomplishing the CVSP/HRAA for AC, Active Guard-Reserve (AGR), ARNG, and USAR soldiers.

- (1) The medical guidelines for CVSP Phases I, II, III, and IV apply to all AC and AGR personnel only. CVSP criteria for Phases I, II, and III apply to ARNG and

USAR personnel unless they are otherwise eligible for health care in a DOD facility.

(2) Personnel are identified for the periodic physical examination and CVSP/HRAA and notified through procedures in DA Pam 600-8.

(3) For all AC and AGR soldiers, the initial CVSP/HRAA will be accomplished on the periodic physical examination coinciding with the 40th birthday. The CVSP/HRAA for all ARNG and USAR soldiers will be accomplished at the first physical examination on or immediately after the 40th birthday.

(4) Subsequent CVSP/HRAAs will be accomplished during periodic physicals at a minimum of 5-year intervals (age specific 40, 45, 50, 55, etc.) for the AC and at a minimum every 4 years for the ARNG and USAR.

(5) For all soldiers, both Active and Reserve Components, upon reaching the age of 40, who have no medical profile and have successfully passed the Army Physical Fitness Test (APFT) within the preceding 12 months, there is no need to require CVSP/HRAA prior to continuing physical training and participation in the APFT.

(6) All soldiers under age 40 not receiving the total CVSP/HRAA will continue to undergo periodic physical examinations in accordance with paragraph 8-21. The examination should include screening for cardiovascular risk factors using the HRAA when possible.

**c. Screening instructions.** The CVSP is based on the seven risk factors taken from the Framingham study. The seven risk factors will be used to calculate a risk factor index as outlined by the American Heart Association Publication 70-003-A. The CVSP will be divided into four phases.

- (1) **Phase I.**
  - (a) The examination will consist of:
    1. Physical examination, to include SF 88 and SF 93.
    2. DA Form 5675 (Health Risk Appraisal Assessment).
    3. Fasting blood sugar.
    4. Serum cholesterol and High Density Lipoprotein (HDL) ratio, if feasible.
    5. ECG.
    6. Smoking history (number of cigarettes per day).

(b) Information gathered during the Phase I examination will be used to calculate the CVSP risk index and generate the DA Form 4970 (Medical Screening Summary—Over-40 Physical Fitness Program) or DA Form 4970-E.

(c) **CVSP risk index values.**

1. 7.49 or less—See para c(2) below.
2. 7.50 or greater—Individual will not be cleared and will be referred for Phase II evaluation.

(d) Results of the CVSP risk index calculation will either clear or not clear the soldier.

1. If cleared, the DA Form 4970 or DA Form 4970-E will be completed and maintained in the soldier's medical records. See DA pamphlet (Cardiovascular Screening

Program/Health Risk Appraisal Assessment) which is to be published, for detailed information on entering risk factor information and reporting of findings.

2. If not cleared, the DA Form 4970 or DA Form 4970-E will be completed and maintained in the soldier's medical records. A DA Form 3349 will also be completed on the individual with assignment limitations (i.e., PT at own pace or no PT) as indicated until CVSP clearance is granted as described in c(2) below.

(2) **Phase II.**

- (a) Referral to Phase II is based on the presence of any one of the following criteria from the Phase I examination:

1. A Framingham risk index of equal to or greater than 7.5.

2. A total cholesterol to HDL ratio of equal to or greater than 6.0 or a total cholesterol of equal to or greater than 270 mg/dl.

3. The presence of all three of the following risk factors: cigarette smoking—equal to or greater than 10 cigarettes/day, serum cholesterol—equal to or greater than 240 mg/dl, blood pressure—systolic equal to or greater than 160 mmHg and/or diastolic equal to or greater than 90 mmHg.

(b) The Phase II screen will be performed by a cardiologist, general internist, or family practitioner who is privileged to perform and interpret the required evaluations, to include—

1. An independent history and medical examinations recorded on an SF 513.

2. A maximum symptom limited exercise tolerance test after appropriate informed consent.

(c) If these procedures result in negative or unremarkable findings, the soldier will be cleared and an updated DA Form 4970 or DA Form 4970-E filed in the soldier's medical records. See DA Pamphlet (Cardiovascular Screening Program/Health Risk Appraisal Assessment), to be published, for filing and reporting details.

(d) Referral to a Phase III examination will be based on one or more positive findings in Phase II.

(e) If not cleared, the DA Form 4970 or DA Form 4970-E will be completed and maintained in the soldier's medical records. A DA Form 3349 or DA Form 3349-E will also be completed on the individual with assignment limitations as indicated until CVSP clearance is granted.

(3) **Phase III.**

- (a) When one or more of the Phase II results are positive or the consulting physician is of the opinion that the soldier has medical contradictions to clearance, Phase III testing will be consulted to a cardiologist or internist who is privileged to perform the required tests, such as—

1. Nuclear cardiology studies (i.e., stress thallium).

2. Cardiac catheterization.

(b) If these procedures result in negative findings, the soldier will be cleared and an updated DA Form 4970 or DA Form 4970-E filed in the soldier's medical

records. See DA Pamphlet (Cardiovascular Screening Program/Health Risk Appraisal Assessment), to be published, for filing and reporting details.

(c) Referral to Phase IV is required if one of the Phase III tests gives positive findings for coronary artery disease (CAD).

(d) If Reserve Component soldiers do not obtain Phase III CVSP clearance and are not eligible for care in U.S. medical treatment facilities, they must be advised to obtain appropriate medical/surgical treatment from civilian sources.

(4) **Phase IV:**

(a) Phase IV of the CVSP will be definitive medical and/or surgical treatment for CAD. This may include:

1. Definitive medical therapy.

2. Percutaneous transluminal coronary angioplasty.

3. Coronary artery bypass surgery.

(b) Soldiers who do not obtain Phase III CVSP clearance will be processed by a MEBD to determine fitness for duty as described in paragraph 3-21.

(c) An updated DA Form 4970 or DA Form 4970-E will be completed with results of the evaluation and filed in the soldier's medical records. See DA Pamphlet (Cardiovascular Screening Program/Health Risk Appraisal Assessment), to be published, for filing and reporting details.

(d) **Reporting of information.** The reporting, storage, and access of data will be detailed in DA Pamphlet (Cardiovascular Screening Program/Health Risk Appraisal Assessment), to be published.

(e) **Effective date.** The effective date of this change is 1 January 1989. Until that time, current standards and policies are in effect.

(f) **Questions.** Address questions on the CVSP/HRAA to the program manager, HQDA (SGPS-FP), 5111 Leesburg Pike, Falls Church, VA 22041-3258.

## Chapter 9 Army Reserve Medical Examinations

### 9-1. General

This chapter sets basic policies and procedures for medical examinations. It covers those examinations used to medically qualify individuals for entrance into and retention in the USAR.

### 9-2. Application

a. This chapter applies to the following personnel:

(1) Applicants seeking to enlist or be appointed as commissioned or warrant officers in the USAR. (Medical examinations for entrance into the Army ROTC program are governed by AR 145-1 and AR 145-2.)

(2) USAR members who want to be kept in an active reserve status.

(3) USAR members who want to enter ADT and active duty.

b. This chapter does not apply to the Active Army or the ARNG.

### 9-3. Statutory authority

The statutory authority for this regulation is given in 10 USC 591, 1001, 1004, and 1162.

### 9-4. Responsibility for medical fitness

It is the responsibility of Reservists to maintain their medical fitness. This includes correcting remedial defects, avoiding harmful habits, and controlling weight. It also includes seeking medical advice quickly when they believe their physical well-being is in question. The medical examinations prescribed by this regulation can help a Reservist detect any condition that needs medical attention.

### 9-5. Travel for examinations

a. Examinations held in certain places are less expensive than others. (See para 9-7.) If travel to one of these places creates less expense for the Government, travel orders may be issued to the following persons:

(1) Applicants for enlistment or reenlistment. (See paras M5050 of the JTR.)

(2) Ready Reservists who by law or regulation must have medical examinations. These include periodic examinations required by 10 USC 1004. Also included are examinations needed to determine medical fitness for flying duty, Classes 1, 1A, 2, and 3. (See para M6003 and M6004 of the JTR, AR 135-200, and AR 135-210.)

(3) Reservists who because of possible disability need an examination to determine their medical fitness. (See AR 635-40.)

(4) Reservists who apply for voluntary orders to active duty and Reservists who are required by regulation to have an examination before entry on active duty. (See, Case 9, para M4156.)

(5) Reservists who are members of the Standby Reserve. For these persons, CG, U.S. Army Reserve Personnel Center (ARPERCEN) will arrange examinations at Government expense, using the examiners cited in paragraph 9-7 below.

b. Army area commander, major ARCOM commanders, and the Commander General, ARPERCEN may issue travel orders for medical examinations. These orders will be prepared per AR 310-10 (Formats 164 and 270).

c. When travel is authorized, it should be scheduled so that the Reservist or applicant can be examined and returned to his or her home within 1 day. An exception to this is allowed when hospitalization is needed (para 9-9d).

d. If available, transportation requests and meal tickets will be furnished to the applicant or Reservist. If not, he or she will be reimbursed for transportation, subsistence, and any quarters costs. All travel costs will be charge to Operation and Maintenance, Army Reserve. However, applicants for appointment as USAR commissioned or warrant officers are not entitled to travel allowances. (For more information on travel and transportation allowances, see AR 37-106.)

### 9-6. Cost of examinations

Medical examinations made by the examiners cited in paragraph 9-7 will be done without cost to Reservists and applicants. The cost of examinations and immunizations by Federal agencies other than DA and by civilian physicians will be charged to Operation and Maintenance, Army.

### 9-7. Examiners and examination facilities

a. Applicants who do not have any prior military service will be examined only at MEPS. Applicants with prior service and Reservists will be examined by the medical personnel listed in b and c below. To be examined, applicants with prior service and Reservists must present a letter of authorization from a unit commander, a unit advisor, an Army area commander, or Commanding General, ARPERCEN.

b. Examinations for flight training selection (Class 1 or 1A) and ATC training (Class 2) will be done only at Armed Forces facilities. These examinations will be done by or under the immediate supervision of an assigned or attached flight surgeon (para 8-7). Examinations for persons continuing in Classes 2 and 3 aviation duties will be done by a flight surgeon (Active Armed Forces or Reserve Components), if one is within 60-minute (one way) travel time. If not, the examination may be done by any physician assigned or attached to a military facility.

c. Examinations may be done by the examiners listed in (1) through (5) below. These medical personnel are listed in the order they should be chosen as examiners.

(1) Medical officers of the Armed Forces Reserve Components who are not on active duty are preferred as examiners:

(a) Upon recommendation of the area commander, Commanding General, U.S. Army Forces Command (FORSCOM) may assign examination support to USAR medical units. Medical officers assigned or attached to these units will do examinations according to their units' missions.

(b) ARNG medical officers and those of other Armed Forces Reserve Components medical units may do examinations. Such examinations must be coordinated between the components.

(c) Unit or Individual Ready Reserve (IRR) medical officers who are not on active duty may be used as examiners. Their services will be used on an individual basis and at no Government expense. Other professional services (for example x-ray, laboratory, EKG, audiometric) may be reimbursed if not performed by the medical officer or other Armed Forces personnel. Interpretations of results are not separately reimbursable, however; they are considered to be examiner services. Army Medical Department (AMEDD) personnel who provide examiner services will be awarded retirement point credits. (AR 140-1 and AR 140-185.)

(2) When the medical officers in (1) above are unavailable, those at Armed

Forces MTFs or at MEPS may be chosen as examiners. They should be used, however, only when staffing and facilities permit.

(3) When the medical officers in (2) above are unavailable, physicians or facilities of Government agencies other than DA may be used. Their services will be reimbursed per paragraph 9-6 above.

(4) When physicians of other Government agencies are unavailable, civilian physicians may be used. (Civilian-conducted professional services like those described in (1) (c) above may also be used.) Civilian physicians will be used, however, only if there are no military or Federal medical examiners within 60-minute (one way) travel time of the person's assigned or supporting USAR center or place of duty. This will be determined by the CONUS MEDDAC commander in the local area, the local area U.S. Army Medical Center (MEDCEN) commander, or CG, ARPERCEN. Fees for civilian examiners will be paid per the schedules given in AR 40-330.

(5) When civilian physicians are unavailable, military physician assistants may perform and record periodic medical examinations if supervised by a physician. (See para 8-7.)

#### 9-8. Examination reports

a. For all examinations, the examiner will prepare and sign two copies each of SF 88 and SF 93. The examining facility will keep one set of these reports. The medical examiner will send the other set of SF 88 and SF 93 to the commander who authorized the examination. (para 9-7a). The authorizing commander will then handle these two reports as follows:

(1) Reports prepared in examinations for appointment will accompany the application for appointment per AR 135-100.

(2) Reports prepared in examinations of ready Reservists will be sent to the review authorities named in paragraph 9-13. After review, they will be returned to the authorizing commander to be filed in the Reservist's health record. (To ensure against loss, the commander should keep a copy of the reports when sending them for review.)

(3) Reports prepared in examinations of standby Reservists will be sent to Commanding General, ARPERCEN for review. After review, they will be returned to the authorizing commander for filing in the Reservist's health record. (To ensure against loss, the commander should keep a copy of the reports when sending them for review.)

(4) Reports prepared in periodic examinations for enlistment and reenlistment will be handled per AR 140-111.

(5) Reports prepared in periodic examinations will be sent to the proper reviewing authority (para 9-13). After review, they will be returned to the authorizing commander to be filed in the Reservist's health record. (To ensure against loss, the commander should keep a copy of the reports when sending them for review.)

(6) Reports prepared in examinations for tours of ADT will be handled per AR 135-200.

(7) Reports prepared for examinations for active duty will be handled per AR 135-210.

b. After their entrance examinations, Reservists will complete DA Form 3081-R any time they enter or are relieved from ADT or active duty of 30 days or more. (See para 8-21a.) Not all Reservists may prepare this form; that is, aviation, airborne, diver, ROTC, and other personnel who need special medical examinations may not use it. In addition, DA Form 3081-R will be prepared only if—

(1) A valid periodic or other Type A medical examination is in the unit file.

(2) The Reservist's medical condition has not significantly changed. When completed, this form will be sent to the USAR unit commander for filing in the Reservist's health record.

c. DA Form 4186 will be completed for each Reservist whose periodic physical examination is prescribed in chapter 4. The term "Flight Surgeon" at the bottom of the form will be lined through if the examiner is not a flight surgeon. (For more information on preparing and disposing of DA Form 4186, see para 9-10a(2)(d) below and also para 8-24k.)

#### 9-9. Conduct of examinations

a. Medical examinations will be performed per chapter 8. Immunizations should be updated when Reservists are examined. (See AR 40-562/BUMEDINST 6230.1/AFR 161-13/CG COMDTINST 6230.4 for instructions on updating immunizations.)

b. A periodic examination will be valid for reenlistment. An examination taken within 18 months preceding entry on active duty will be valid for call to active duty or ADT for 30 days or more and return to the Ready Reserve. The examination will be valid only if the Reservist's medical condition has not significantly changed since it was taken. The Reservist will complete DA Form 3081-R to indicate that his or her condition has not changed.

c. Reservists chosen for tours of active duty for less than 30 days may be ordered to ADT without a medical examination. When relieved from active duty, Reservists will be given an examination if they request it; Reservists who have been injured or hospitalized for illness during their tour must be given an examination. In the latter case, examiners must be sure to record the details of the condition that required the examination. (See chap 8 for instructions on examinations for relief from active duty.)

d. If medical fitness for appointment, enlistment, or reenlistment cannot be determined otherwise, hospitalization is authorized. (See AR 40-3.) In examinations for appointment or enlistment, examiners may accept medical reports of chest x-rays, refraction (if indicated), or EKGs that were done within the preceding 18 months.

e. Preferably, medical examinations will be done during inactive duty training (IDT) periods rather than during annual training (AT). The Commanding General, FORSCOM will set detailed procedures for using training time for medical examinations and may permit examinations during AT.

#### 9-10. Types of examinations and their scheduling

a. Periodic examinations. Health Risk Appraisals are required for all periodic medical examinations; however, they are not a substitute for a complete history and physical.

(1) ATCs. Regardless of age, an ATC must have an annual Class 2 Type B examination. (This is an FAA requirement.) The examination must be taken during the birthday month. (Rescinded.)

(2) Aviators. Rated aviators. Rated aviators, flight surgeons, aeromedical physician assistants, and ATCs 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, as prescribed in chapter 8.

(a) The first periodic examination must be taken within 6 to 18 months after the last examination for initial flight training. Aviators, flight surgeons, and ATCs up to age 35 will then take an examination every 2 years. In addition, they will have an annual eye examination, blood pressure, height, and weight checks; and audiometric and electrocardiographic tests. (These annual examinations, checks, and tests will be recorded on DA Form 4497-R.) After age 35, aviators, flight surgeons, and ATCs will take a Type B examination annually.

(b) Aviators, flight surgeons, and ATCs must take the examinations cited in (a) above during their birthday month or the 2 preceding calendar months designated quarter. All examinations taken within this period will be considered to have been taken during the birthday month. (Para 8-21c(1)(b).)

(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 periods described in (a) above or before or after the 3-month period designated quarter described in (b) above). The next Type B examination must be taken within 6 to 18 months; and it must be taken within the 3-month period designated quarter described in (b) above.

(d) When DA Form 4186 is completed after a periodic examination or special tests, the last day of the birthday month or designated quarter 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) Reservists 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 as prescribed by chapter 8; the results of these examinations will be recorded on SF 88 and, if needed, SF 502.

(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 every fourth calendar year after the first periodic examination. These will be taken no later than the anniversary month of the last recorded examination. In addition, each Reservist will have an annual eye examination; blood pressure, height, and weight checks; and audiometric and electrocardiographic tests. (These annual examinations, checks, and tests will be recorded on DA Form 4497-R.)

(4) *Diving personnel.* Regardless of age, a marine diver must have an annual Type B examination. (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.

(5) *All other Reservists.* ~~They~~ All other Reservists must have a Type A periodic examination, as prescribed by chapter 8.

(a) Ready Reservists relieved from active duty or ADT of more than 30 days ~~These Reservists~~ must take their first periodic examination during the fourth calendar year after their last recorded examination ~~This first examination must be taken~~ and no later than the anniversary month of their last examination.

(b) Ready Reservists who do not go on active duty or ADT for 30 days or more ~~These Reservists~~ must take their first periodic examination during the fourth calendar year after enlistment, reenlistment, or appointment. ~~This first examination must be taken~~ and no later than the anniversary month of their last recorded examination. After the first examination, a periodic examination will be given each fourth year. ~~These will be taken~~ before the end of the month in which they took their last recorded examination. A chest x-ray is not needed with the periodic examination unless deemed necessary by the examining physician.

(c) Commanders will take proper action against obligated Ready Reservists who fail to take their required periodic examinations. Nonobligated Ready Reservists who fail to take the periodic examination will be discharged per AR 135-175 or AR 135-178.

b. *Examinations for Reserve officers appointed from the ROTC Program.*

(1) Officers who have had an examination within 18 months of their scheduled date of entry on ADT need not be given an entry examination. (The examination given them must have been of the scope prescribed by chapter 8.) Orders directing these officers to report for active duty or ADT

will state the date of their most recent qualifying examination. The orders must also include the following statement: "You are medically qualified for entry on (active duty or active duty for training)."

(2) Officers whose last examination was given more than 18 months from their scheduled date of entry on active duty or ADT will have an entry examination within 5 working days after reporting to their first duty station. This examination will be of the scope prescribed by chapter 8. Orders directing these officers to report for active duty or ADT will state the date of their most recent qualifying examination.

c. *Specialty consultations.* Examinations (including specialty consultations) may be given to determine a Reservist's medical fitness for retention in military service under any law or regulation. Such examinations will be given only if the authorizing officer (para 9-7a) judges that such examinations or consultations are needed.

*also see CH 101 2001/01*  
**9-11. Physical profiling**

a. Examiners will determine and record physical profiles for Reservists per chapter 7.

b. Army area commanders, ARCOM commanders, and U.S. Army GOCOM commanders will ensure that medical profiling officers are designated to review and verify physical profiles of Reservists not on active duty. Profiling officers should be available within USAR medical units to provide this support within chosen areas; such officers need to be designated in units approved to do medical examinations.

c. Normally, only the designated profiling officer may verify and change the physical profiles of Reservists not on active duty. The ARCOM or GOCOM command surgeon may review and revise disputed or questionable cases; if needed, he or she may refer unusual cases through the Army area commander to Commander, HSC (HSPA-C), Fort Sam Houston, TX 78234-6000, for final determination of a correct profile.

d. Each Reservist and USAR unit commander will ensure that civilian hospitalizations and any believed marked changes in physical status are reported. They will also ensure that physical profiles are reviewed in such cases. After hospitalization at an MTF, profiles of patients returned to duty are reviewed; however, USAR profiling officers may need to give a followup review to profiles of Reservists not returned to active duty.

### 9-12. Standards of medical fitness

a. *Standards for appointment or enlistment.* Applicants for first appointment or enlistment will meet the standards set in chapter 2.

b. *Standards for retention or reenlistment.* For retention or reenlistment within 6 months of discharge, Reservists must meet the standards set in chapter 3. Unless Reservists or their commander question their fitness, they are considered to meet these

standards and need not be examined. The commander may direct an examination, however, if the Reservist's fitness is in doubt.

c. *Standards for periodic medical examinations.* Reservists must meet the standards set in chapter 3. These standards may be waived for Reservists who have a medical condition but who are continued on active status per paragraph 9-15b. ~~The standards may not be waived, however, for officers who are being considered for promotion to general officer.~~

d. *Standards for active duty and ADT.* In examinations before active duty and ADT, the standards set in chapter 3 will be applied. Special care will be given to record any defects or conditions that are present before such tours and that may form a basis for a claim against the government.

e. *Other standards.*

(1) For other duties, such as Airborne, marine diving, and Ranger or Special Forces, chapter 5 prescribes standards for the selection and retention of both officers and enlisted personnel.

(2) Reservists will meet the standards of physical fitness and maintain proper body weight set in AR 600-9.

### 9-13. Examination reviews

a. To increase the use of headquarters staff surgeons in command activities, Army area commanders and ARCOM or GOCOM commanders should select USAR hospitals to review examinations. However, reviews may be made by any USAR unit that has—

(1) A lieutenant colonel or higher Medical Corps officer position in its TOE or TDA.

(2) A major or higher Medical Corps officer assigned or attached and working in that position.

b. Most periodic examinations and enlistment and reenlistment examinations done at Active Army MTFs and MEPS need not be reviewed. Those that do are described in d(1) through (3) below.

c. Disputed or questionable cases may be referred for final determination directly to Commander, HSC (HSPA-C), Fort Sam Houston, TX 78234-6000.

d. Special reviews are required as follows:

(1) All reports of examinations given personnel for Class 1, 1A, and 2 aviation duty will be sent to Commander, USAAMC; ~~ATTN: ATZQ-AAAMC-AA-ERHSXY-AER~~, Fort Rucker, AL 36362-5333 for review. In his or her review, the Commander, USAAMC, will determine the medical fitness of the examined personnel for aviation duty. Only upon his or her written recommendation may the waivers described in paragraph 9-14 be granted. After review, the reports of those found medically qualified will be returned to their commanders for filing in their health records. Reports of aviators found medically disqualified will be returned to their commanders through HQDA (DAPC-OPP-V), Alexandria, VA 22332-0400; reports of enlisted ATCs found

medically disqualified will be returned to their commander through HQDA (DAPC-EPL-T), Alexandria, VA 22332-0400. Reports on flight surgeons and APAs will be reviewed by Commander, USAAMC. After this review, the reports on flight surgeons and APAs found medically qualified will be returned to their commanders for filing in their health records. Reports on flight surgeons and APCs found medically unqualified will be returned to their commanders through HQDA (DAPC-OPH-MC), WASH DC 20324-2000.

(See para 8-24i and j for information on waivers.)

(2) A flight surgeon must review the reports of examinations given all Class 3 aviation personnel. The fitness of Class 3 personnel other than flight surgeons will be determined locally and waivers for such personnel will be recommended locally. (See para 8-24i(4).) After review, the records of Class 3 personnel other than flight surgeons will be returned to their commanders for filing in their health records. Reports on flight surgeons will be reviewed by Cdr, USAAMC per (1) above. After this review, the reports on flight surgeons found medically qualified will be returned to their commanders for filing in their health records. Reports on flight surgeons found medically unqualified will be returned to their commanders through HQDA (DAPC-OPH-MC), WASH DC 20324-2000.

(3) The DODMERB, U.S. Air Force Academy, CO 80840-6518 will review reports of examinations given applicants for entrance into the ROTC Four-Year Scholarship Program. Only DODMERB may determine the medical fitness of applicants entering this program. (See AR 40-29/AFR 160-13/ BUMEDINST 6120.3/CG COMDTINST N6120.8.)

(4) The commanders of MEDDACs or MEDCENs that give examinations will review the examinations and determine the medical fitness of personnel—

(a) In the ROTC Four-Year Scholarship program, MEDDAC or MEDCEN commanders will determine if scholarship cadets are medically fit to stay in the Program.

(b) In all other ROTC programs, MEDDAC or MEDCEN commanders will determine medical fitness for both entrance and retention in these programs.

(c) In ROTC programs, whose personnel are examined by other Government medical facilities or by civilian facilities, Reviews will be made by the MEDDAC or MEDCEN commander in the area where the examined person's college or university is located.

(d) Being appointed as commissioned officers from the ROTC programs and given combat arms assignments.

(e) Entering on active duty or ADT.

(5) MEDDAC or MEDCEN commanders will review examinations given in AMEDD personnel procurement programs.

If an AMEDD personnel procurement office is given administrative and logistical support by a MEDDAC or MEDCEN, the MEDDAC or MEDCEN commander will make the review. If an AMEDD personnel procurement office is not supported by a MEDDAC or MEDCEN, the commander of the nearest MEDDAC or MEDCEN will make the review.

#### 9-14. Waivers

Only the following authorities may waive the fitness standards described in paragraph 9-2:

a. The Commanding General, USAREC may grant waivers for original enlistment.

b. The Commanding General, MHLPERCENPERSCOM may grant waivers for all USAR aviator and air traffic control personnel. Waivers may be granted only upon the written recommendation of the Commander, USAAMC.

(1) HQDA (DAPC-OPP-V), Alexandria, VA 22332-0400 may waive conditions that are medically unsuitable for entrance into flight training (Classes 1 and 1A). For Active Army and Reserve Component aviators, HQDA (DAPC-OPP-V) may also waive conditions unsuitable for remaining on Class 2 flight status.

(2) HQDA (DAPC-EPL-T), Alexandria, VA 22332-0400 may waive conditions that are medically unsuitable for entrance into and staying on Class 2 Active Army and USAR air traffic control duty. Waivers may be granted only upon favorable written recommendation of the Commander, USAAMC.

c. HQDA (DAPC-OPH-MC), WASH DC 20324-2000 may waive conditions that are medically unsuitable for entrance into and staying on flight surgeon duty. Waivers may be granted only upon the written recommendation of the Commander, USAAMC.

d. The Commanding General, TRADOC may grant waivers for the ROTC program. When delegated by Commanding General, TRADOC, ROTC regional commanders may also grant waivers.

e. The Commanding General, ARPERCEN may grant waivers in all other cases.

#### 9-15. Disposition of medically unfit Reservists

a. Normally, Reservists who do not meet the fitness standards set by chapter 3 will be transferred to the Retired Reserve per AR 140-10 or discharged from the USAR per AR 135-175 or AR 135-178. They will be transferred to the Retired Reserve only if eligible and if they apply for it.

b. Reservists who are found unfit may request continuance in an active USAR status. In such cases, physical disability incurred in either military or civilian status will be granted for any disease or injury caused by the person's own misconduct acceptable; it need not have been incurred only in the line of duty. However, no waiver

will be granted for any disease or injury caused by the person's own misconduct.

(1) Requests for continuance will include—

(a) A report of an examination of the scope prescribed by chapter 8.

(b) A summary of the Reservist's experience and qualifications.

(c) An evaluation by his or her unit commander of his or her potential value to the military service.

(2) Requests will be sent to the Commanding General, ARPERCEN for review and final determination. The Commanding General, ARPERCEN will consider each request and determine if the Reservist's experience and qualifications are needed in the service. Each request will also be reviewed by the Surgeon, ARPERCEN; he or she will determine if—

(2.1) Waivers requested for officers being considered for assignment/selection to and within the General Officer grades will be sent to the Chief, Army Reserve for review and final determination. The Chief, Army Reserve will consider each request and determine if the reservist's experience and qualifications are needed in the service. Each request will be reviewed by The Surgeon General, who will determine whether—

(a) The disability may adversely affect the reservist's performance of active duty. The reservist's grade, experience, and qualifications must be considered when determining this.

(b) The rigors of active service would aggravate the condition so that further hospitalization, time loss from duty, or a claim against the Government would result. The Chief, Army Reserve must consider The Surgeon General's review when making a final determination.

(a) The disability may adversely affect the Reservist's performance of active duty. The Reservist's grade, experience, and qualifications must be considered when determining this.

(b) The rigors of active service would aggravate the condition so that further hospitalization, time lost from duty, or a claim against the Government might result.

(3) Separation of Reservists who are continued in USAR then later found disqualified for active duty, ADT, retention, or further continuance in the USAR will be deferred pending review by the Commanding General, ARPERCEN.

(4) Disputed or questionable cases may be referred by the Commanding General, ARPERCEN to the Commanding General, HSC (HSPA-C), Fort Sam Houston, TX 78234-6000 for recommendations.

(5) Cases where the opinions of The Surgeon General and Chief, Army Reserve differ concerning officer(s) being considered for assignment/promotion to and within general officer grades will be forwarded to the Deputy Chief of Staff for Personnel (DAPE), WASH DC 20310-0300 for final determination.

## 9-16. Disposition of Reservists temporarily disqualified because of medical defects

a. Normally, ready or standby Reservists temporarily disqualified because of a medical defect will be transferred to the Standby Reserve inactive list (AR 140-10). Transfer will be made if—

(1) The person is not required by law to remain a member of the Ready Reserve.

(2) The person is currently disqualified for retention in an active USAR status.

(3) The condition is considered to be remediable within 1 year from the date disqualification was finally determined.

b. When determined by the Commanding General, ARPERCEN to be in the best interest of the service, temporarily disqualified Reservists may be transferred to or kept in the Standby Reserve for 1 year (AR 140-10). This will not be done if the Reservist requests discharge from the USAR or transfers to the Retired Reserve.

c. Reservists who by law must remain members of a Reserve Component and whose medical defects are considered to be remediable within 1 year from the date of disqualification will be kept in an active status for 1 year. These Reservists will be reassigned to the USAR Control Group (Standby).

d. Reservists described in *a* and *b* above will be given another medical examination no later than 1 year from the date disqualification was last determined. Those found qualified when reexamined will be transferred to the USAR status they held before they were disqualified. Those found still to be disqualified will be transferred, if eligible, to the Retired Reserve per AR 140-10. If not eligible, they will be discharged per AR 135-175 or AR 135-178.

## 9-17. Disposition of ROTC program officers with medical defects

a. When ROTC Program officers are given examinations after entrance on active duty or ADT (para 9-10b), commanders of installations where the officers are serving are given review and waiver authority for minor medical defects. Such defects are those that are static in nature and will not interfere with the officer's performance of assigned general or special duties. Officers who meet the fitness standards listed in chapter 3 are medically acceptable for active duty.

b. In questionable cases involving a disqualifying defect, the installation commander will send SF 88 and allied papers by the quickest means to the Commander, ARPERCEN. Commanding General, ARPERCEN will, in turn, send the reports to the Commander, HSC (HSPA-C), Fort Sam Houston, TX 78234-6000 for review.

(1) The Commanding General, ARPERCEN will electrically transmit to the installation commander the results of the final review by the Commanding General, HSC. This will permit, as needed, either the payment of uniform allowances or the opening of separation proceedings. At the

same time, the reports of examination and allied papers will be returned to the installation commander by the quickest means.

(2) Pending receipt of the final review results, the ROTC graduate officer may continue, with assignment limitations, to attend the basic course. If deemed advisable, however, he or she may be carried in a patient status.

(3) Officers found to be disqualified for retention because of a condition that existed before their entry into service will be processed per AR 635-40. Their records will be disposed of per AR 635-10 and AR 614-10; after they return home, they will be processed per AR 135-175.

## 9-18. Dental examinations

a. A dental record will be prepared for each USAR member. (See AR 40-66.) As a minimum, the dental record will contain either of the following:

(1) An SF 603 (Health Record-Dental) with section I, paragraphs 1 through 4 completed.

(2) A panographic radiograph of the teeth.

b. To meet the requirements of the dental record, an examination should be performed by dental officers of the Armed Forces Reserve Component who are not on active duty. Active Component, government, or civilian dentists will not be used to meet this requirement. The need for an examination will be satisfied if, during periods of duty, the USAR member—

(1) Becomes eligible for and receives care from Active Component facilities at the time of—

(a) Reception station processing.

(b) Initial entry training or other active duty.

(2) Receives care that leads to completion of SF 603 or a panographic radiograph.

c. The dental examination is not a prerequisite for deployment; nor will it be used to justify either of the following:

(1) A panographic radiograph.

(2) Demands on resources outside the USAR to perform the examination.

d. The Commanding General, FORSCOM may assign the dental examination support mission to USAR dental units and sections. The Commanding General, ARPERCEN may use IRR dental officers to perform examinations on a points-only basis.

## Chapter 10 Medical Examination Techniques

### 10-1. General

This chapter is a guide to medical examination techniques to be used in the medical evaluation of an individual. Health Risk Appraisals are required for all periodic medical examinations; however, they are not a substitute for a complete history and physical.

### 10-2. Application

These techniques are applicable for type "A" or "B" medical examinations, (chap 8).

### 10-3. Head, face, neck, and scalp

a. Record all swollen glands, deformities, or imperfections of the head and face. In the event of detection of a defect, such as moderate or severe acne, cyst, or scarring, a statement will be made as to whether this defect will interfere with the wearing of military clothing and equipment.

b. The neck will be examined by palpation of the parotid and submaxillary regions, palpation of the larynx for mobility and position, palpation of the thyroid gland for nodularity and size, and palpation of the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected they will be described in detail and a clinical opinion of the etiology will be recorded.

c. The scalp will be examined for deformities of the skull in the nature of depression and exostoses of a degree which would prevent the individual from wearing a military helmet.

### 10-4. Nose, sinuses, mouth, and throat

a. If there are no complaints referable to the nose or sinuses, simple anterior rhinoscopy will suffice, provided that in this examination the nasal mucous membrane, the septum, and the turbinates have a normal appearance. If the individual under consideration has complaints referable to the nose and sinuses, a more detailed examination will be done and recorded. Most commonly, these complaints are external nasal deformity; nasal obstruction, partial or complete on one or both sides; nasal discharge; postnasal discharge; sneezing; nasal bleeding; facial pain; and headaches.

b. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretion may provide the examiner valuable information regarding the type and location of the sinus infection. Tenderness over the sinuses should be evaluated carefully. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine also if there is any tenderness to percussion beyond the boundaries (as determined by x-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves which may indicate the presence of a neoplasm. Note any external swelling of the region of the forehead, orbit, cheek, and alveolar ridge.

c. Many systemic diseases manifest themselves as lesions of the mouth and tongue: namely, leukemia, syphilis, agranulocytosis, pemphigus, erythema multiforme, and dermatitis medicamentosa. Thus, an individual with lesions of this type should have the benefit of a complete systemic history and general medical examination, including serological tests for syphilis, urinalysis, and

complete blood counts. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of teeth. Particular attention should be paid to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.

d. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence and position of residual or recurrent lymphoid tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate and note its type, whether mucous, frank pus, or crusts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall or in the lateral angles of the pharynx. Note any swelling or ulceration of the posterior pharyngeal wall. Examine the peritonsillar region and the lateral angle of the pharynx and note if there is evidence of swelling which displaces the tonsil, indicating possible neoplasm or abscess. Mirror examination of the larynx should be performed if the individual complains of hoarseness.

#### 10-5. Ears

a. Careful, specific, and detailed information concerning any complaint referable to the external ear, the middle ear, or the internal ear, such as earache, discharge, hearing impairment, dizziness, or tinnitus, should be recorded.

b. An inspection should include the auricle, the external canal, and the tympanic membrane. Abnormalities (congenital or acquired) in size, shape, or form of the structure must be noted, evaluated, and recorded.

(1) *Auricle.* Note deformities, lacerations, ulcerations, and skin disease.

(2) *External canal.* Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal note whether it is normal cerumen, foreign body, or exudate. Purulent exudate in the canal must have its source determined. If this exudate has its origin in the middle ear, record whether it is profuse or scanty and whether it is pulsating.

(3) *Drum membrane.* All exudate and debris must be removed from the canal and tympanic membrane before a satisfactory examination can be made. Unless the canal is of abnormal shape, the entire drum membrane should be visualized and the following points noted and recorded.

(a) Any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.

(b) Use a Siegal speculum to determine if the tympanum is air-containing.

(c) Note and describe any perforations, giving size and position, indicating whether they are marginal or central, which quadrant is involved, and whether it is the flaccid

or the tense portion of the membrane that is included.

(4) *The tympanum.* In the case of a perforation of the drum membrane, attempt to determine the state of the middle ear contents, particularly with reference to hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. Do the Determine if visible pathological changes indicate an acute or a chronic process. This clinical objective examination should permit the examiner to evaluate the infectious process in the middle ear and to make a reasonably accurate statement regarding the chronicity of the infection, the extent and type of involvement of the mastoid, the prognosis regarding the hearing, and the type of treatment (medical or surgical) that is required.

#### 10-6. Hearing

a. The external auditory canal should be carefully cleaned of any obstructive material. Some tests are qualitative. These tests have as their goal the classification of auditory responses into general categories rather than the precise measurement of amount of impairment. The examiner should be familiar with the standard tuning fork tests; for example, the Weber for lateralization of sound; the Schwabach for determining bone conduction; and the Rinne for determining the ratio of bone-to-air condition. These tests provide a check on audiometric results and should be used whenever possible.

b. In cases of vestibular dysfunction the individual usually complains of dizziness. With this complaint of "dizziness," an attempt should be made to ascertain by careful history taking whether the so-called dizziness is a true vertigo. If the vertigo comes in attacks, record detailed information describing a typical attack, including such things as premonitory signs, associated symptoms, changes in sensorium, direction of falling, duration of attack, and after effects. If the "dizziness" is not characterized by true vertiginous attacks, describe the symptoms exactly and note the time of day the symptoms are worse and any possible association of symptoms with fatigue, excitement, the use of drugs, alcohol, or tobacco, dietary indiscretion, occupation, change of posture, abuse of the eyes, headache, or hearing impairment. These individuals should have a complete general medical examination and should have an ophthalmology and a neurological consultation. The examination of the vestibular apparatus should include—

(1) Determination of presence of spontaneous nystagmus or past pointing.

(2) Tests for postural vertigo and positional nystagmus.

(3) Turning tests.

(4) Caloric stimulation of the labyrinth.

#### 10-7. Dental

a. The dental examination will include complete, thorough visual and digital inspection of all soft tissues of the oral region,

visual and exploratory inspection of supporting tissues and all surfaces of the remaining natural teeth, and determination of the serviceability of fixed and removable prostheses if present. Diagnostic aids such as roentgenograms, percussion, thermal, electrical, transillumination, and study casts will be utilized as required by the examining dentist as required to achieve the purpose of the examination.

b. See AR 40-29/AFR 160-13/BUMEDINST 6120.3/CG CONDTINST N6120.8 for additional instructions pertaining to USMA applicant examinations.

#### 10-8. Eyes

a. A history of any ocular disease, injury, surgery, medication, loss of vision, diplopia, and the use of glasses or contact lenses will be obtained. An attempt will be made to elicit any pertinent family history, such as a history of glaucoma, retinitis pigmentosa, cataracts, and maternal lues.

b. Individual applicants for entrance in the military service, including those scheduled by the DODMERB for medical examination to enter service academies or ROTC scholarship programs, who wear contact lenses regularly will be advised that they are not required to remove their contact lenses for any period preceding the examination. A written report of refractive error, to include contact lens and spectacle lens prescription data, must be obtained by the examinee from his or her attending ophthalmologist or optometrist. The report, indicating examination was accomplished within 1 year of the military medical examination, will be attached to SF 88. The strength of contact lenses which the examinee may possess will not be accepted as refractive error; nor will it be entered as such in item 60, SF 88. Item 73, SF 88 will be annotated to indicate which ocular findings were obtained upon removal of contact lenses.

c. The general examination will include the following points:

(1) Examination of the orbits to determine any bony abnormality of facial asymmetry should be made; the position of the eyes should be determined. Note any exophthalmos, enophthalmos, or manifest deviation of the visual axes.

(2) Observation of gross ocular motility to determine the presence or absence of nystagmus or nystagmoid movements and the concomitant movement of the eyes in the six cardinal directions: right, left, up and to the right, up and to the left, down and to the right, down and to the left.

(3) Note the presence of epiphora or discharge and position of the puncta; apply pressure over the lacrimal sac to determine if this produces any discharge from the puncta.

(4) Note the presence of ptosis, the position of the lashes, inversion or eversion of the lids, the presence of any evidence of inflammation at the lid margins, and the presence of any cysts or tumors.

(5) Ocular tension by digital palpation will be recorded as normal, increased, or

low. If other than normal, the tension will be taken with tonometer and the actual readings recorded. Tonometry will be performed on all examinees after their 40th birthday.

(6) Size, shape, and equality of this pupils, direct consensual, and accommodative pupillary reflexes will be measured. Abnormalities of pupillary reactions will be recorded and investigated.

(7) Palpebral and bullar conjunctiva will be examined by eversion of the upper lid, depression and eversion of the lower lid, and by direct examination with the lids separated manually as widely as possible.

(8) The cornea, anterior chamber, iris, and crystalline lens will be examined by both direct and oblique examination. The cornea will be examined for clarity, discrete opacities, superficial or deep scarring, vascularization, and the integrity of the epithelium. The anterior chamber will be examined for depth, alteration of the normal character of the aqueous humor, and retained foreign bodies. The irides will be examined for evidence of abnormalities, anterior or posterior synechiae, or other pathologic changes. The crystalline lens will be examined for evidence of clouding opacities.

(9) The media will be examined first with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Any opacity appearing in the red reflex on direct examination or on movement of the eye will be localized and described. The fundus will be examined with the strongest plus or weakest minus lens necessary to bring the optic nerve into sharp focus. Particular attention will be paid to the color, surface, and margin of the optic nerve, to the presence of any hemorrhages, exudates, or scars throughout the retina, to any abnormal pigmentation or retinal atrophy, to any elevation of the retina, and to the condition of the retinal vascular bed. The macula will be specially examined for any changes. Any abnormalities observed will be noted.

#### 10-9. Chest and lungs

~~a. All medical examinations accomplished for entrance into active duty or Reserve Component service must include a chest x-ray. (Rescinded.)~~

~~b. Medical examinations, when accomplished for separation, discharge, or retirement from active duty, must include a chest x-ray.~~

~~c. A chest x-ray is not required as a part of periodic or other medical examinations accomplished for active duty and Reserve Component members. Such x-rays will only be accomplished when, as a result of the medical history or physical findings, the medical examiner deems that an x-ray of the chest is clinically indicated. Chest x-rays are not required for initial examination for appointment, enlistment, or induction into the Active Army or Reserve Components or for pre-contracting examinations for ROTC or USMA when examinations are accomplished in CONUS, Alaska, or Puerto Rico.~~

They are required for the above examinations if accomplished in other OCONUS areas. Such x-rays will only be initiated when, as a result of medical history or physical findings, the medical examiner deems then clinically indicated.

(1) Medical examination should be carried out in a thorough, systematic fashion as described in any standard textbook on physical diagnosis. Particular care should be taken to detect pectus abnormalities, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis since any of these findings require additional intensive inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated.

(2) There should be no hesitancy in expanding the history if abnormalities are detected during medical examination or in repeating the medical examination if chest-film abnormalities are detected.

~~d. The standard posterior anterior (PA) chest film, if included in any medical examination, is sufficient in most instances, provided it is interpreted carefully. Particular attention must be given to the hila and the areas above the second anterior ribs since these areas may be abnormal in the presence of normal spirometry. For flying personnel on whom thoracic surgery is performed, it is essential that both preoperative and postoperative pulmonary function studies be accomplished to determine subsequent eligibility for return to flying duties. In addition, flying personnel will be evaluated in a low pressure chamber (to include rapid decompression), with a flight surgeon in attendance, prior to return to flying duties after thoracotomy, and in cases of a history of spontaneous pneumothorax.~~

~~e. Of the several conditions that are disqualifying for initial induction, there are three which are most often inadequately evaluated and which result in unnecessary and avoidable expense and time loss following induction. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis. Specific comment in amplification of previous paragraphs follows:~~

(1) ~~Asthma.~~ In evaluation of asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the ~~evaluate examinee's~~ physician, this should result in rejection even though physical examination is normal. (See para 2-24d.)

(2) ~~Bronchiectasis.~~ Individuals who report a history of frequent respiratory infections (colds) accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported or suspected by a finding of posttussive rales at one or both bases posteriorly or by a finding

of lacy densities at the lung base on the chest film: If bronchiectasis is considered on the basis of history, medical findings, or chest film abnormalities, confirmatory opinions should be sought from the examinee's personal physician, or the examinee should be referred to the appropriate chest consultant for evaluation and recommendations.

(3) ~~Tuberculosis.~~ Active tuberculosis is often asymptomatic and often not accompanied by abnormal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of tuberculosis will be missed. The most sensitive tool for detection of early pulmonary tuberculosis is the chest film. Any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe should be suspected strongly of being tuberculosis. It is thus imperative that all routine chest films be completely scrutinized by an experienced radiologist. Many tuberculous lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical lordotic view must be obtained for clarification. It is neither practical nor possible in most instances to determine whether or not a tuberculous lesion is inactive on the basis of single radiologic examination. For all these reasons, any patient suspected of tuberculosis should be referred to a qualified chest consultant or to an appropriate public health clinic for evaluation. It is not feasible to carry out diagnostic skin tests and sputum studies in a medical examination station. (Rescinded.)

#### 10-10. 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 mmHg. Thus, concern with blood pressure is to detect significant hypertension. It is mandatory that personnel entrusted to record blood pressure on examinees be familiar with situations that result in spurious elevation. It is only reasonable that a physician repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used. Artificially high blood pressure may be observed as follows:

(1) If the compressive cuff is loosely applied.

(2) If the compressive cuff is too small for the arm size. (Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual this may require an "oversize" cuff.)

(3) If the blood pressure is repetitively taken before complete cuff deflation occurs (trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure).

(4) Prolonged bed rest will not precede the blood pressure recording; however, due regard must be given to physiologic effects such as excitement and recent exercise. Limits of normal for military applicants are defined in appropriate sections of this regulation. 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) The blood pressure determination will be made in accordance with the recommendation of the American Heart Association. The systolic reading will be taken as either the palpatory or auscultatory reading depending on which is the higher. (In most normal subjects, the auscultatory reading is slightly higher.) Diastolic pressure will be recorded as the level at which the cardiac tones disappear by auscultation. In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. If the technique can be ascertained to be correct, and there is no underlying valvular defect, a diastolic reading will be taken in these instances at the change in tone. Variations of blood pressures with the position change should be noted if there is a history of syncope or symptoms to suggest postural hypertension. Blood pressure in the legs should be obtained when simultaneous palpation of the pulses in upper and lower extremities reveal a discrepancy in pulse volume or amplitude.

*b. Cardiac auscultation.* Careful auscultation of the heart is essential so that significant cardiac murmur or abnormal heart sound will not be missed. Experience has shown that significant auscultatory findings may not be appreciated unless both the bell and diaphragm portions of the stethoscope are used in examination. As a minimum, attention should be directed to the second right interspace, second left interspace, lower left sternal border, and cardiac apex. Patients should be examined in the supine position, while lying on the left side, and in the sitting position leaning slightly forward. In the latter position, auscultation should be performed at the end of a full expiration, remaining attuned for a high-pitched diastolic murmur of aortic valve insufficiency.

*c. Cardiac murmurs.* There are no absolute rules which will allow the physician to easily distinguish significant and innocent heart murmurs. For practical purposes, all systolic murmurs which occupy all or nearly all of systole are due to organic cardiac problems. Similarly, any diastolic murmur should be regarded as evidence of organic heart disease. Experience has taught that

the diastolic murmur of aortic valve insufficiency and mitral valve stenosis are those most frequently missed. Innocent murmurs are frequently heard in perfectly normal individuals. In an otherwise normal heart, a slight to moderate ejection type pulmonary systolic murmur is the most common of all murmurs. When accompanied by normal splitting and normal intensity of the components of the second heart sound, such a murmur should be considered innocent. A particularly pernicious trap for the attentive physician is the thin-chested young individual in whom such a pulmonary ejection murmur is heard and who, in recumbency, demonstrates persistent splitting of the second heart sound. Such a combination suggests the possibility of an atrial septal defect. In such a situation a change from persistent splitting to normal splitting of the second heart sound as the patient sits or stands for practical purposes denies the possibility of atrial communications. Awareness of this minor point will prevent an overdiagnosis of such lesions. Other innocent murmurs which are commonly misinterpreted as evidence of organic heart disease include extra cardiac cardiorespiratory noises, surface contact friction noises in the thin-chested individual, venous hums, and isolated supraclavicular arterial bruits of blood flow in the subclavian arteries. Final interpretation of a murmur must be based on cumulative evidence of history, examination, chest x-rays, and ECG. In doubtful cases, additional opinions should be solicited by appropriate consultation request.

*d. Chest x-ray.* In most cases a simple PA chest x-ray will suffice to adequately assess cardiac size and pulmonary vascularity. A misdiagnosis of cardiac enlargement is commonly encountered in the thin-chested individual whose heart, although normal, is limited in PA extent and appears broad in lateral dimension. Thus, a final indictment of cardiac enlargement cannot be made on the basis of a PA chest x-ray alone. In such cases, and in cases requiring additional consultation for unresolved areas of concern, x-ray views should be obtained in PA, lateral, and both right and left anterior oblique views with barium in the esophagus. Such x-rays allow a more critical evaluation and definitive interpretation. At times it may be necessary to assess cardiac size and the amplitude and vigor of cardiac pulsations by fluoroscopic examination.

#### 10-11. Electrocardiogram

*a.* ECGs should be accomplished routinely on all the following individuals:

(1) Those in whom medical history or clinical findings are suggestive of cardiac abnormalities.

(2) Examinees with a sitting pulse rate of 50 per minute or less.

(3) Examinees who have reached their 40th birthday or are older.

(4) Applicants for flying training and all flying personnel.

(5) Applicants for service academies.

(6) Personnel who are being examined for retirement.

*b.* In these individuals, the ECGs obtained serve not only to diagnose and screen for possible heart disease but as a base line for future comparison. It is imperative then that a proper technique of recording the ECG be followed.

(1) The routine ECG will consist of 12 leads; namely standard leads 1, 2, 3, a VR, a VL, a VF, and the standard precordial leads V<sub>1</sub> through V<sub>6</sub> recorded at 25 mm per second. All artifacts and machine problems must be eliminated.

(2) Care must be taken in the proper placement of the precordial electrodes. It is important that the precordial electrodes across the left precordium are not carried along the curve of the rib but maintained in a straight line. Special care must be taken in the placement of the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Electrode paste must not be smeared from one precordial position to another. A standardization mark should be included in each lead recorded.

#### 10-12. Skin

*a. Examination.* The skin will be examined with the patient completely nude in a well-lighted room, except that female examinees will be properly draped and the presence of a female attendant is required. Particular attention will be paid to the cutaneous manifestations of systemic disease.

*d. Description.* All lesions will be fully described. Lesions may be classed as primary or secondary and their size, shape, color, location, and distribution will be recorded. Primary lesions are macules, papules, pustules, vesicles, and wheals. Secondary lesions are scales, crusts, excoriations, fissures, ulcers, erosions, scars, pigmentation, and depigmentation. Tattoos and identifying body marks will be fully described. Pilonidal defects (cyst or tract) will also be fully described.

#### 10-13. Height, weight, and body build

*a.* A thorough, general inspection of the entire body will be made, noting the proportion and symmetry of the various parts of the body, the chest development, the condition and tone of the muscles and the general nutrition. The build will be recorded as slender, medium, heavy, or obese.

*b.* Procedures for measuring height and weight are—

(1) *Height.* Recorded in inches and fractions of an inch to the quarter. Shoes will be removed when the height is taken.

(2) *Weight.* Taken with the clothing removed. The examinee will be weighed on a standard set of scales that is known to be correct. Record weight to the nearest pound; do not record fractions of a pound.

#### 10-14. Hematology and serology

*a. Hematology.*

(1) Examinees will be questioned carefully to elicit a history of unexplained anemia,

splenomegaly, splenectomy, lymphadenopathy or lymph node biopsy, purpura, and abnormal bleeding following trauma or surgery. The skin will be inspected for pallor, icterus, cyanosis, petechiae, purpura, or abdominal, axillary, or cervical scars. The mucous membranes will be inspected for pallor, cyanosis, or icterus. Palpation will be done to detect the presence or adenopathy or splenomegaly.

(2) Other hematologic studies will be accomplished as deemed necessary by the examining physician.

**b. Serology.** A serological test for syphilis, using standard serologic technique, will be performed on all initial examinations and subsequently when clinically indicated or required by other directives. Positive serologies will be rechecked. Sufficient tests and examinations will be performed to clarify the status of any person who presents a positive blood serology (TB MED 230/NAVMED P-5052-11A/AFP 161-39).

### 10-15. Temperature

Abnormal temperatures will be rechecked and adequately explained prior to completion of a medical examination. When the body temperature is not actually determined, a dash will be entered in item 56, SF 88.

### 10-16. Abdomen and gastrointestinal system

**a.** A careful history is of special importance in evaluating the integrity and function of the digestive system. All symptoms of dysphagia, heartburn, regurgitation, nausea, and vomiting, flatulence, abdominal pain, diarrhea, changes in bowel habits, and blood in stool or rectal bleeding must be thoroughly explored.

**b.** A thorough examination of the abdomen must be performed with the patient in the supine position as well as an examination in the standing position for detection of hernia.

**c.** The appropriate radiologic and endoscopic examinations should be used when necessary to confirm a diagnosis.

**d.** When indicated, gastric secretory studies, chemical tests of liver function and stool examinations for blood, eggs, and parasites should be done.

### 10-17. Anus and rectum

**a.** When a suspicion of anorectal disease exists, a complete examination of this area should be done, including proctoscopy.

**b.** Digital rectal will be accomplished for all examinations for individuals 40 years of age or over.

### 10-18. 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.

### 10-19. Genitourinary system

**a. Venereal disease and malformations.** A search will be made for evidence of venereal disease and malformations. The glans penis and corona will be exposed and urethra stripped. The testes and scrotal contents will be palpated, and the inguinal lymph nodes will be examined for abnormalities. When indicated, x-ray, other laboratory examinations, and instrumentation will be conducted.

**b. Female examination.** A pelvic examination will be performed on all female examinees. The presence of a female attendant is required and the examinee will be properly draped. The examination will include bimanual palpation, visual inspection of the cervix and vaginal canal by speculum and, when possible, a Papanicolaou smear. When there is an imperforate hymen or other contraindication to vaginal examination, a rectal examination will be performed and the method of examination will be noted on SF 88.

#### **c. Urinalysis.**

(1) Routine urinalysis, to include determination of specific gravity, protein and sugar, and microscopic study, will be performed for all examinees. Examining physicians may require examinees to void the urine in their presence. Prior to voiding, the examinee must be examined for the presence of venereal disease. When either albumin, casts, white blood cells, or red blood cells are found in the urine, urinalysis should be repeated not less than twice a day on 3 consecutive days. If cellular elements 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 para 10-18.)

### 10-20. Spine and other musculoskeletal

**a. Orthopedic evaluation.** The examinee will perform a series of movements designed to bring into action the various joints and muscles of the body. This purpose is best accomplished by requiring the examinee to follow movements made by the examiner. Gait and posture will be specifically noted.

**b. Examination of range of motion.** Extend the arms and forearms fully to the front and rotate them at the shoulders. Extend the arms at right angles with the body; place the thumbs on the points of the shoulder; raise and lower the arms, bringing them sharply to the sides at each motion. Extend the arms fully to the front, keeping the palms of the hands together and the thumbs up; carry the arms quickly back as far as possible, keeping the thumbs up, and at the

same time raise the body on the toes. (Question the examinee regarding any previous dislocations of the shoulder.) Extend the arms above the head, locking the thumbs, and bend over to touch the ground with the hands, keeping the knees straight. (Question the examinee as to wrist injury for possible scaphoid fracture.) Extend one leg, lifting the heel from the floor, and move all the toes freely; move the foot up and down and from side to side; bending the ankle joint, the knee being kept rigid; bend the knee freely; kick forcibly backward and forward; stand upon the toes of both feet; squat sharply several times; kneel upon both knees at the same time. (If the individual comes down on one knee after the other there is reason to suspect infirmity, such as injury to menisci. Question the examinee as to previous injury.) Lack of ability to perform any of these exercises indicates some defect or deformity that should be investigated further.

#### **c. Examination of major joints.**

(1) **The shoulder.** With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry or abnormal configuration or muscle atrophy. From the back, with the examinee standing, observe the scapulohumeral rhythm as the examinee elevates the arms from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is caused for particularly 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 dorsalkyphosis, or excessive lumbar lordosis. Have the examinee flex and extend the spine and bend to each side; noting the 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 the legs, particularly the thigh musculature. Have the 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. Observe for the ability to balance as well as for possible weakness of hip muscles or instability of the joint. This is indicated by the dropping downward of the buttock and pelvis of the flexed (that is, 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 his or her toes.

#### 10-21. 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 93. During the interview, the examinee's behavior will be observed and an estimate made of his or her current mental status. Any evidence of 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.

Note: Diagnostic concepts and terms used in paragraph 10-21 are in consonance with the DSM-III-R Manual, American Psychiatric Association, 1987. The minimum psychiatric evaluation will include Axis I, II, and III.

## Appendix A References

### Section I Required Publications

#### AR 25-400-2

The Modern Army Recordkeeping System (MARKS). (Cited in para 8-5.)

#### AR 40-3

Medical, Dental, and Veterinary Care. (Cited in paras 3-4a and c; 7-10b(2); 8-4a; 8-8; 8-21a(6) and c(1)(b); 8-24d(4), j(5), and k(1); and 9-9d; and table 8-1, item 75.)

#### AR 40-8

Temporary Flying Restrictions Due to Exogenous Factors. (Cited in para 8-24l and table 8-1, item 73.)

#### AR 40-29/AFR 160-13/BUMEDINST 6120.3/CG COMDTINST N6120.8

Medical Examination of U.S. Service Academy and ROTC Four-Year Scholarship Applicants. (Cited in paras 9-13d(3) and 10-7b; and table 8-1, items 44 and 72.)

#### AR 40-66

Medical Record and Quality Assurance Administration. (Cited in paras 8-5, 8-13b, 8-19a, 8-24l(2) (a), 8-26b(3), and 9-18a.)

#### AR 40-330

Rate Codes and General Policies for Army Medical Department Activities. (Cited in para 9-7c(4).)

#### AR 40-562/BUMEDINST 6230.1/AFR 161-13/CG COMDTINST 6230.4

Immunization Requirements and Procedures. (Cited in paras 8-21c(1)(c) and 9-9a.)

#### AR 55-46

Travel of Dependents and Accompanied Military and Civilian Personnel To, From, or Between Oversea Areas. (Cited in para 5-13c.)

#### AR 135-100

Appointment of Officers and Warrant Officers of the Army. (Cited in para 9-8a(1).)

#### AR 135-175

Separation of Officers. (Cited in paras 3-2a(1), 3-5, 3-7h, 9-10a(5)(c), 9-15a, 9-16d, and 9-17b(3).)

#### AR 135-178

Separation of Enlisted Personnel. (Cited in paras 3-2a(2), 3-5, 3-7h, 9-10a(5)(c), 9-15a, and 9-16d.)

#### AR 135-200

Active Duty for Training and Annual Training of Individual Members. (Cited in paras 9-5a(2) and 9-8a(6).)

#### AR 135-210

Order to Active Duty as Individuals During Peacetime. (Cited in paras 9-5a(2) and 9-8a(7).)

#### AR 140-10

Assignments, Attachments, Details, and Transfers. (Cited in paras 3-5, 3-7h, 9-15a, and 9-16.)

#### AR 140-111

U.S. Army Reserve Enlistment and Reenlistment Program. (Cited in para 9-8a(4).)

#### AR 145-1

Senior ROTC Program: Organization, Administration, and Training. (Cited in paras 8-17 and 9-2a(1).)

#### AR 145-2

Junior Reserve Officer Training Program. (Cited in para 9-2a(1).)

#### AR 175-178

Separation of Enlisted Personnel. (Cited in paras 3-2a(2), 3-4e, 3-7h, 9-10a(5)(c), 9-15a, and 9-16d.)

#### AR 310-10

Military Orders. (Cited in para 9-5b.)

#### AR 600-9

The Army Weight Control Program. (Cited in paras 2-22, 4-17, 4-18, 5-8l and m, 8-11, and 9-12e(2).)

#### AR 600-20

Army Command Policies and Procedures. (Cited in para 8-12.)

#### AR 600-85

Alcohol and Drug Abuse Prevention and Control Program. (Cited in paras 4-24h(2) and 8-24j(1)(d).)

#### AR 600-105

Aviation Service of Rated Army Officers. (Cited in paras 4-3b(1), 4-24h(2), and 8-24c, d, g, and h(4); and table 8-1, item 73.)

#### AR 600-106

Flying Status for Nonrated Army Aviation Personnel. (Cited in paras 8-24c and h(4), and table 8-1, item 73.)

#### AR 600-200

Enlisted Personnel Management System. (Cited in para 5-13c.)

#### AR 601-270/AFR 33-7/OPNAVINST 1100.4/MCO P-1100.75

Military Entrance Processing Stations. (Cited in paras 8-4a, 8-14d(2), and 8-16d.)

#### AR 611-85

Selection of Enlisted Volunteers for Training as Aviation Warrant Officers. (Cited in paras 4-2a, 8-21c(3)(a) and 8-24e(1).)

#### AR 611-110

Selection and Training of Army Aviation Officers. (Cited in paras 4-2a, 8-7c(1), 8-21c(3)(a), and 8-24e(1).)

#### AR 611-201

Enlisted Career Management Fields and Military Occupational Specialties. (Cited in paras 5-12a and 8-26a.)

#### AR 612-2

Preparation of Replacements for Oversea Movement (POR). (Cited in para 5-13c.)

#### AR 614-30

Oversea Service. (Cited in para 7-9c(2)(c).)

#### AR 630-5

Leave and Passes. (Cited in para 7-9f.)

#### AR 635-40

Physical Evaluation for Retention, Retirement, or Separation. (Cited in paras 3-2a(1) and (4); 3-3d; 3-4a; b, and c; 3-7h; 7-3c(4); 7-8d and h; 7-8h; 8-7d; 9-5a(3); 9-17b(3); and tables 7-2 (item 4) and 8-3.)

#### AR 635-100

Officer Personnel. (Cited in paras 3-2a(1), 7-9b(3), and table 8-3.)

#### AR 635-120

Officer Resignations and Discharges. (Cited in para 3-4e.)

#### AR 635-200

Enlisted Personnel. (Cited in paras 3-2a(2), 3-4d and e, 7-9b(3), and 8-15b(7) and table 8-3.)

#### DA PAM 351-4

U.S. Army Formal Schools Catalog. (Cited in para 5-7.)

#### DSM-III-R

Diagnostic and Statistical Manual, Third Edition, Revised, American Psychiatric Association, 1987. (Cited in paras 2-30, 3-31, 4-24, and 6-27.) (This manual may be obtained from the American Psychiatric Association, 1400 K St., N.W., Washington DC 20005-2492.)

#### FAA Guide

FAA Guide to Aviation Medical Examiners. (Cited in paras 4-2c(1), and 8-24k(3)(d) and (e) and (2)(c).) (Available from the FAA Mike Monroney Aeromedical Center (Code ACC-141), P.O. Box 25082, Oklahoma City, OK 25082-0082.)

#### FAR

Federal Aviation Regulation, Parts 65 and 67. (Cited in paras 4-2c, 8-16a(3), and 8-24l(1).) (Available from the FAA Mike Monroney Aeromedical Center (Code ACC-141), P.O. Box 25082, Oklahoma, OK 25082-0082.)

**JTR**

Joint Travel Regulations. (Cited in para 9-5a.)

**NGR 40-501**

Medical Examination for Members of the Army National Guard. (Cited in paras 3-3d, 3-4c, 7-8g, 8-7f, 8-11, 8-17, 8-20, and 8-22b.)

**NGR 600-105**

Aviation Service for Rated Army Officers. (Cited in para 8-24e(1).)

**NGR 600-200**

Enlisted Personnel Management. (Cited in paras 3-4c, 3-5, 3-7h, and 3-26a(3).)

**NGR 635-100**

Termination of Appointment and Withdrawal of Federal Recognition. (Cited in paras 3-2a(1), 3-7h, and 3-26a(3).)

**TB MED 81**

Cold Injury. (Cited in para 3-41b.)

**TB MED 267**

Guidelines for Medical Evaluation of Applicants and Personnel in Army Nuclear Power Program. (Cited in para 5-19.)

**TB MED 501**

Hearing Conservation. (Cited in table 8-1.)

**TM 8-640/AFP 160-14**

Joint Motion Measurement. (Cited in paras 2-9a, 2-10a, 3-12b, 3-13d, 6-10c, and 6-11e.)

**Unnumbered Publication**

Medical Capabilities Study (country-by-country). (Cited in para 8-26b.) (This publication may be obtained from Commander, Armed Forces Medical Intelligence Center, Fort Detrick, Frederick, MD 21701-5000.)

**Section II****Related Publications**

A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

**AR 37-106**

Finance and Accounting for Installations: Travel and Transportation Allowances

**AR 40-5**

Preventive Medicine

**AR 95-1**

General Provisions and Flight Regulations

**AR 135-91**

Service Obligations, Methods of Fulfillment, Participation Requirements, and Enforcement Procedures

**AR 135-133**

Ready Reserve Screening, Qualification Records System and Change of Address Reports

**AR 140-1**

Army Reserve Mission, Organization, and Training

**AR 140-185**

Training and Retirement Point Credits and Unit Level Strength Accounting Records

**AR 600-6**

Individual Sick Slip

**AR 600-20**

Army Command Policies and Procedures

**AR 611-75**

Selection, Qualification, Rating and Disrating of Marine Divers

**AR 611-85**

Selection of Enlisted Volunteers for Training as Aviation Warrant Officers

**AR 614-10**

U.S. Army Exchange Program With Armies of Other Nations: Short Title: Personnel Exchange Program

**AR 635-10**

Processing Personnel for Separation

**Civil Service Handbook X-118**

Qualification Standards. (This publication is available at local civilian personnel offices.)

**DA PAM 600-5**

Handbook on Retirement Services for Army Personnel and Their Families

**DA PAM 600-8**

Military Personnel Management and Administrative Procedures

**DOD Directive 6130.3**

Physical Standards for Enlistment, Appointment and Induction. (This publication may be obtained from the Naval Publications and Forms Center, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120-5099 using DD Form 1425 (Specifications and Standards Requisition).)

**FM 21-20**

Physical Training Program

**NGR 40-3**

Medical Care for Army National Guard Members

**Publication 70-003-A**

Coronary Risk Handbook. (American Heart Association.) (This publication is available at all medical examining facilities.)

**Publication 70-008-A**

Exercise Testing and Training of Apparently Healthy Individuals. (American Heart Association.) (See 70-003-A above for publication source.)

**Publication 70-008-B**

Exercise Testing and Training of Individuals with Heart Disease or at High Risk for

Its Development. (American Heart Association.) (See 70-003-A above for publication source.)

**Publication 70-041**

The Exercise Standards Book. (American Heart Association.) (See 70-003-A above for publication source.)

**TB MED 230/NAVMED P-5052-11A/AFP 161-39**

Treatment and Management of Venereal Disease

**TB MED 295**

Medical Officers Guide for Management of Pregnant Servicewomen

**TB MED 523**

Control of Hazards to Health From Microwave and Radio Frequency Radiation and Ultrasound

**TB MED 524**

Control of Hazards to Health From Laser Radiation

**Section III****Prescribed Forms****DA Form 3081-R**

Periodic Medical Examination (Statement of Exemption). (Prescribed in para 8-16a(4).)

**DA Form 3083-R**

Medical Examination for Certain Geographical Areas. (Prescribed in para 8-26b(3).)

**DA Form 3349**

Physical Profile. (Prescribed in para 7-3d.)

**DA Form 4186**

Medical Recommendation for Flying Duty. (Prescribed in para 8-24j.)

**DA Form 4497-R**

Interim Medical Examination—Flying Personnel. (Prescribed in para 8-21c(2)(b).)

**DA Form 4970**

Medical Screening Summary—Over-40 Physical Fitness Program. (Prescribed in para 8-27.)

**SF 88**

Report of Medical Examination. (Prescribed in para 8-13.)

**SF 93**

Report of Medical History. (Prescribed in para 8-14.)

**Section IV****Referenced Forms****DA Form 1811**

Physical Data and Aptitude Test Scores Upon Release From Active Duty

**DA Form 3475-R**  
Diving Duty Summary Sheet. (AR 611-75.)

**DA Form 3947**  
Medical Evaluation Proceedings

**DA Form 4186**  
Medical Recommendation for Flying Duty

**DA Form 1425**  
Specifications and Standards Requisition

**DD Form 689**  
Individual Sick Slip

**DD Form 1966/1 through 6**  
Record of Military Processing Armed  
Forces of the United States

**FAA Form 8420-2**  
Airman Medical and Student Pilot Certifi-  
cate, Second Class

**FAA Form 8500-8**  
FAA Report of Medical Examination  
(Available from the FAA Mike Monroney  
Aeromedical Center (Code ACC-141), P.O.  
Box 25082, Oklahoma City, OK  
25082-0082.)

**FAA Form 8500-9**  
Airman Medical Certificate (Available from  
the FAA Mike Monroney Aeromedical  
Center (Code ACC-141), P.O. Box 25082,  
Oklahoma City, OK 25082-0082.)

**SF 507**  
Clinical Record—Report on or Continua-  
tion of SF 507

**SF 513**  
Medical Record—Consultation Sheet

**SF 520**  
Clinical Record—Electrocardiographic  
Record

**SF 600**  
Health Record—Chronological Record of  
Medical Care

**SF 603**  
Health Record—Dental

## Appendix B Reading Aloud Test

**B-1.** The Reading Aloud Test (RAT) will be administered to all applicants. The test will be conducted as follows:

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

b. If he or she 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.

c. Have the applicant read aloud as follows: "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."

**B-2.** 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.

**Table 2-1**  
**Militarily acceptable weight (in pounds) as related to age and height for males—initial Army procurement**

Height (inches)	Minimum weight (any age)	Maximum weight by years of age				
		16-20	21-30	31-35	36-40	41 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

**Table 2-2**  
**Militarily acceptable weight (in pounds) as related to age and height for females—initial Army procurement**

Height (inches)	Minimum weight (any age)	Maximum weight by years of age					
		18-20	21-24	25-30	31-35	36-40	41 and over
58	90	120	124	126	129	132	135
59	92	122	126	128	131	134	137
60	94	124	128	130	133	136	139
61	96	127	130	132	135	139	141
62	98	128	132	134	137	140	144
63	100	132	134	136	139	143	145
64	102	135	136	139	143	145	149
65	104	138	140	144	148	150	153
66	106	141	145	148	151	154	157
67	109	145	149	152	156	158	162
68	112	150	153	156	160	162	166
69	115	154	157	161	164	167	170
70	118	158	162	165	168	171	174
71	122	162	166	169	173	175	179
72	125	167	171	174	178	181	184
73	128	171	177	179	183	186	190
74	130	175	182	185	188	191	195
75	133	179	187	190	194	196	200
76	136	184	192	196	199	202	205
77	139	188	197	201	204	207	211
78	141	192	203	206	209	213	216
79	144	196	208	211	215	218	220
80	147	201	213	216	219	223	225

**Table 3-1**

**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, such 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.

**Revised classification (prognosis)**

Class I—Good.

Class II—Good with therapy.

Class III—Fair with therapy.

Class IV—Guarded despite therapy.

**Table 4-1**  
**Acceptable audiometric hearing level for Army aviation, including air traffic controllers**

		ISO 1964—ANSI 1969 (unaided sensitivity)					
Frequency (Hz)		500	1000	2000	3000	4000	6000
Classes 1 & 1A	Each ear (in dB)	25	25	25	35	45	45
Class 2 (aviators)	Better ear (in dB)	25	25	25	35	65	75
	Poorer ear (in dB)	25	35	35	45	65	75
Class 2 (air traffic controllers)	Each ear (in dB)	25	25	25	35	65	75
Class 3	Better ear (in dB)	25	25	25	35	65	75
	Poorer ear (in dB)	25	35	35	45	65	75

**Table 4-3**  
**Neurology**

Complaint	Permanent disqual.	Class 1, 1A			Permanent disqual.	Class 2, 3		
		2-yr wait	6-mo wait			2-yr disqual.	3-mo disqual.	4-wk disqual.
Syncope	Unexplained				Until Reviewed			
Seizure	Any				Same			
Vascular Headache	Any				Same			
New Growth	Any				Same			
Craniotomy	Any				Same			
Bony Defect	Any				Same			
Encephalitis	6 yrs				Until Reviewed			
Meningitis	1 yr				Until Reviewed			
Metabolic Disorder	Until Reviewed				Same			
CNS Bends	Until Reviewed				Same			
EEG Abnormality	Until Reviewed				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 Reviewed			

**Table 7-1**  
**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; able to perform long marches, stand 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 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 musculo-skeletal 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 musculo-skeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.	Audiometer average level for each 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 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 alcohol 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 significant restriction of use.	Defects or impairments which interfere with full function requiring significant 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 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).
4	<u>Functional level below P3.</u>	<u>Functional level below U3.</u>	<u>Functional level below L3.</u>	<u>Hearing level below H3.</u>	<u>Visual acuity below E3.</u>	<u>Does not meet S3 above.</u>
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 physical capacity.

**Table 7-2  
Profile codes**

Serial/code	Description/assignment limitation	Medical criteria
(1) Profile Serial 111111. CODE A	No assignment limitation. 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 table 7-1.
(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 table 7-1.
(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. <u>The codes listed below are for military personnel administrative purposes. Corresponding limitations are general guidelines and are not to be taken as verbatim limitations (e.g., a soldier with a code C may not be able to run but may have no restrictions on marching or standing). Item 3 of DA Form 3349 will contain the specific limitations.</u>	Vascular insufficiency; symptomatic flat feet; low back pathology; arthritis of low back or lower extremities.
CODE D	No mandatory strenuous physical activity. (State time in item 8.)	Organic cardiac disease; pulmonary insufficiency; hypertension, more than mild.
CODE E	No assignment to units requiring continued consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.
CODE F	No assignment to isolated areas where definitive medical care (U.S. Armed Forces hospital) is not available.	Individuals who require continued medical supervision or periodic followup. Cases of established pathology likely to require frequent outpatient care or hospitalization.
CODE G	No assignment requiring handling of heavy materials including weapons (except individual weapon: for example, 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, or near moving machinery.	Epileptic disorders (cerebral dysrhythmia) of any type; other disorders producing syncopal attacks of severe vertigo, such as Meniere's syndrome.
CODE J	<p>1. No exposure to noise in excess of 85 dBA or weapon firing without use of properly fitted hearing protection. Annual hearing test required.</p> <p>2. Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for POR qualification or annual weapons qualification with proper ear protection). Annual hearing test required.</p> <p>3. No exposure to noise in excess of 85 dBA or weapon firing without use of properly fitted hearing protection. This individual is "deaf" in one ear. Any permanent hearing loss in the good ear will cause a serious handicap. Annual hearing test is required.</p> <p>4. Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA 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.</p>	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 temperature.

**Table 7-2**  
**Profile codes—Continued**

Serial/code	Description/assignment limitation	Medical criteria
CODE N	No continuous wearing of combat boots. (State the length of time in item 8.)	Any vascular or skin condition of the feet or legs which, when aggravated by continuous wear of combat boots, tends to develop unfitting skin lesions.
CODE P	No continuous wearing of woolen clothes. (State the length of time in item 8.)	Established allergy to wool, moderate.
CODE U	Limitation not otherwise described, to be considered individually. (Briefly define limitation in item 8.)	Any significant functional assignment limitation not specifically identified elsewhere. Includes conditions described under Profile S-3.

(4) Profile serial numerical designator is determined by the functional capacity guide (table 7-1).

**CODE V** Department of the Army Flag. This code identifies the case of a soldier with a disease, injury, or medical defect which is below the prescribed medical criteria for retention but who is continued in the military service pursuant to chapter 9, this regulation, AR 635-40, or predecessor directives. 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.

**CODE W** Waiver. This code identifies the case of an individual with disease, injury, or medical defect which is below the prescribed medical criteria for retention who was accepted under the previously applicable standards for physicians, dentists, and allied medical specialists or who is granted a waiver by direction of the Secretary of the Army. Such soldiers generally have rigid and strict limitations as to duty, geographical, or climatic area utilization. In some instances the soldier may have to be utilized only within close proximity to a medical facility capable of handling such cases.

**CODE Y** Fit for duty. This code identifies the case of a soldier who has been determined to be fit for duty (not entitled to separation or retirement because of physical disability) after complete processing under AR 635-40, and has had his or her physical profile and appropriate assignment limitations determined by the medical board or The Surgeon General.

**Table 8-1**  
**Scope and recording of medical examinations**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
1 (Name)	X	X	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. (IO).
2 (Grade)	X	X	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 the 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 (SSN)	X	X	Examinee's social security number. If none, enter a dash.	396-38-0699;—
4 (Home address)	X	X	Examinee's current civilian mailing address. Do not confuse with military organization or present temporary mailing address.	
5 (Purpose of exam)	X	X	Enter the purpose of the 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 (Date)	X	X	Enter the 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 87; 3 Mar 87.
7 (Sex)	X	X	Do not use an abbreviation.	Male.
8 (Race)	X	X	Enter the appropriate race or ethnicity: American Indian/Alaskan Native, Asian, Black, White, or Unknown.	
9 (Years of Government service)	X	X	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 (Agency)	X	X	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 (Unit)	X	X	The examinee's current military unit of assignment, Active or Reserve. If no current military affiliation, enter a dash.	B Company, 2D BN, 325th Inf, 82nd Airborne Division, Fort Bragg, NC 28307-5100;—
12 (Date of birth)	X	X	Record in military style; that is, day, month and year, followed by age, in parenthesis, to the nearest birthday.	14 Jan 43 (21); 26 Mar 20 (45).
13 (Place of birth)	X	X	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 (Next of kin)	X	X	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; None.
15 (Place of exam)	X	X	Name of the examining facility or examiner and address. If an 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 (Other information)	X	X	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 it as such. Identifying or administrative data for the convenience of the examining facility should be entered either in item 16, if space allows, or 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.	

**Table 8-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
17 (Rating specialty)	X	X	The individual's current military job or specialty by title and SSI or 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 (Head, face, neck, scalp)	X	X	Record all swollen glands, deformities, or imperfections of the head or face. If a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face is detected, 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 (Nose)	X	X	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 (Sinuses)	X	X	Record all abnormal findings.	Marked tenderness over left maxillary sinus.
21 (Mouth, throat)	X	X	Record any abnormal findings. Eucleated tonsils are considered abnormal.	Tonsils enucleated.
22 (Ears)	X	X	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 (Eardrums)	X	X	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 is required for all diving, free fall parachuting, and flying duty examinations except ATCs.	Valsalva normal bilaterally, 2 mm oval perforation, left posterosuperior quadrant. No motion on valsalva maneuver, completely dry. No evidence of inflammation at present.
24 (Eyes)	X	X	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, 3. Vasculature.	Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye. Does not encroach on cornea; nonprogressive, avascular.
25 (Ophthalmoscope)	X	X	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 (Pupils)	X	X	Record all abnormal findings.	
27 (Ocular motility)	X	X	Record all abnormal findings.	
28 (Lungs and chest)	X	X	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 (Heart)	X	X	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 (Vascular system)	X	X	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 (Abdomen, viscera)	X	X	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.

**Table 8-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
32 (Anus, rectum)	X	X	Digital rectal required for all examinations for all soldiers 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 (Endocrine)	X	X	Record all abnormal findings.	
34 (G-U system)	X	X	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 (Upper extremities)	X	X	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 the 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 (Feet)	X	X	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 (Lower extremities)	X	X	Record as for item 35.	
38 (Spine, other musculoskeletal)	X	X	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, 1/2 in. from midline at level of T-8.
39 (Body marks)	X	X	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-in. vertical linear scar, dorsum left forearm. 3-in. heart-shaped tattoo, nonobscene, lateral aspect middle 1/3 left arm.
40 (Skin)	X	X	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 (Neurologic)	X	X	Record complete description of any abnormality.	
42 (Psychiatric)	X	X	Record all abnormalities. Before a psychiatric diagnosis is made, a minimum psychiatric evaluation will include Axis I, II, and III. This is not to be confused with ARMA (item 72).	
43 (Pelvic)	(*)	(*)	*See paragraph 8-21a 9 and 10-19b for requirements for pelvic examination and Papanicolaou test. Check vaginal or rectal. Record any abnormal findings. Pelvic required for initial examination for commissioning, enlistment, or induction.	Normal.

**Table 8-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
44 (Dental)	X	X	Dental examination accomplished by a dentist is required for applicants for a service academy, Uniformed Services University of the Health Sciences, the Four-Year ROTC Scholarship Program, aviation training and duty, and diving training and duty (see also AR 40-29/AFR 160-13/BUMEDINST 6120.3/CG COMDINST N6120.8 and chap 5 of this regulation). Examinations accomplished for appointment as commissioned or warrant officers, enlistment or induction in the Army, ARNG, and USAR, entrance on active duty or ADT periodic (Active Army, ARNG, and USAR), discharge, relief from active duty, or retirement do not require dental examinations accomplished by a dentist; however, a dentist will be utilized when reasonably available. Examining physicians or dentists will apply the appropriate standards prescribed by chapters 2, 3, 4, or 6, and indicate "acceptable" or "nonacceptable." Examining physicians or dentists will also indicate the appropriate dental classification as defined by AR 40-3, paragraph 10-5.	Acceptable Dental Class 2.
45A B C D (Urine)	X	X	Identify tests used and record results. Items A and D are 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 soldiers.	
46 (Chest x-ray)			Not required for initial examination for appointment, enlistment, or induction into the Active Army or Reserve Components or for precontracting examinations for ROTC or USMA when examinations are accomplished in CONUS, Alaska, or Puerto Rico unless clinically indicated. Required for the above examinations if accomplished in any other OCONUS areas. Required 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. Required for separation/retirement examinations.	Womack Army Community Hospital, Ft Bragg, NC 28307-5000, 11 July 1985, negative.
47 (Serology)			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 or other medical examinations, unless clinically indicated. Required for initial examination for appointment, enlistment, or induction.	Nonreactive. Reactive.
48 (EKG)	(*)	X	*Required for retirement or if age 40 or over; 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 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 (Blood type)			None.	
50 (Other tests)	X	X	Mammography—Baseline age 35 and annually at and after age 40 for women on active duty or ADT tours in excess of 1 year. 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 Army soldiers age 40 and over, and on all initial flying and diving duty examinations regardless of age. Cholesterol—Periodic and separation examinations commencing at age 20. All flying duty examinations. Required for initial examination for appointment, enlistment, or induction into Armed Forces of all applicants age 40 and over. New entrants' Drug and Alcohol Testing—Academy applicants must be tested during pre-appointment physical. ROTC cadets must be tested during precommissioning physical (and precontracting physical as determined by HQDA). All others must be tested within 72 hours after initial entry on active duty.	Identify test(s) and record results.

**Table 8-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
			<p><b>Fasting Blood Glucose</b>—Periodic examination for individuals age 40 and over. Also required for initial examination for appointment, enlistment, or induction into the Armed Forces of all applicants age 40 and over and all FDME (all components).</p> <p><b>Sickle Cell screen</b>—Required on all initial flying, HALO, diving duty, examinations regardless of race. If positive, electrophoresis is required. If sickle tests have been done previously, results may be transcribed from official records.</p> <p><b>Immunoassay (ELISA) Serologic Test and Immuno-electrophoresis (Western Blot Test)</b>—Record as HIV Antibody Positive (Western Blot Confirmed), HIV Antibody Positive (Western Blot Not Confirmed), or HIV Antibody Negative. These tests must be accomplished on all periodical medical examinations and on all medical examinations administered for initial entrance into Active Army and Reserve Component military service including enlistment or induction, entrance into a service academy, Four-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. HIV testing must be accomplished prior to accession. If more than 6 months elapse between the test and accession, the test must be repeated. (See AR 600-40, para 3-3.)</p>	
51 (Height)	X	X	Record in inches to the nearest quarter inch (without shoes). For Class 1 and 1A aviation personnel, record the time of day if near height limits. For initial Classes 1 and 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.	71½.
52 (Weight)	X	X	Record in pounds to the nearest whole pound (without clothing and shoes).	164.
53 (Color hair)	X	X	Record as black, blond, brown, gray, or red.	Brown.
54 (Color eyes)	X	X	Record as blue, brown, gray, or green.	Blue.
55 (Build)	X	X	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For the definition of obesity see the glossary.	
56 (Temperature)	(*)	X	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6.
57A (Sitting BP)	X	X	Record for all examinees.	110/76.
B (Recumbent BP)	(*)	X	*Required for initial flying and diving duty.	
C (Standing BP)			*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: for example, sitting blood pressure (BP) exceeds limits prescribed by standards of medical fitness applicable to the purpose of the examination. Abnormal readings should be rechecked as prescribed by paragraph 10-10 or by Commander, USAAMC, for flying duty examinations.	
58A (Sitting pulse)	X	X	Record for all examinees.	
B, C, D (Post exercise pulse)	(*)	X	Required for initial flying and diving duty.	
E (Standing pulse)	X	X	*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, for example, if A is 100 or more, or below 50. If either D or E is 100 or more, or less than 50, record the pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73.	

**Table 3-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
59 (Distant vision)	X	X	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)	(*)	X	*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 percent).  The word "manifest" or "cycloplegic," whichever is applicable, will be entered after "refraction." "Manifest" required for Class 2 flying duty if uncorrected vision less than 20/20.  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 (Near vision)	X	X	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20), enter 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 (Heterophoria)	—	X	Identify the test used; for example, either Maddox Rod or Steroscope, Vision Testing (SVT), 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 the SVT.  For flying duty Class 1 and 1A and initial entrance 2 and 2A, the following are required: A Cover Test (CT) at near and distance, with a light 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, a light target will be used. An accommodative (Prince) rule will not be used.	ES: 4 EX 0 R.H. 0 L.H. 0.  Prism Div. . . . CT Ortho. PC 35 mm.
63 (Accommodation)	—	X	Record values without using the word "diopters" or symbols.	Right 10.0; Left 9.5.
64 (Color vision)	X	X	Required for all flying duty Class 1, 1A and initial/entrance 2, 2A, and 3. 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 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 para 4-12).	Pseudoisochromatic plate; or PIP Pass 3/14. Fail 9/14.
65 (Depth perception)	—	X	Identify the test used. Record the results as "Corrected" or "Uncorrected," as applicable. Enter the 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. RANDOT circles 0/8.
66 (Field of vision)	—	X	Identify the test used and the results. If a vision 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 a visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.
67 (Night vision)	—	(*)	*Only if indicated by history, and/or record review. If not indicated, enter "not indicated by history (NIBH)."	NIBH.
68 (Red lens test)	—	X	Record test results and describe all abnormalities.	Normal.
69 (Intraocular tension)	(*)	(*)	*Only if indicated. Tonometry required on all personnel age 40 and over and on all initial flying duty medical examinations. Tonometry required 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 (Hearing)	—	—	Not required. Enter dash in each space.	
71 (Audiometer)	X	X	Test and record results at 500, 1000, 2000, 3000, 4000, and 6000 Hertz using procedures prescribed in TB MED 501.	

**Table 8-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
72 (Psychological psychomotor)	(*)	X	<p>*Only if indicated. ARMA and RAT (app B; also AR 40-29/AFR 160-13/BUMEDINST 6120.3/CG COMDTINST N6120.8) required for initial entry of aviation personnel, Classes 1, 1A, 2, and 3, and ATCs, Class 2A. Enter as "ARMA sat." or "ARMA unsat." Unsatisfactory ARMA requires a summary of defects responsible for failure in item 73. ARMA and RAT required for service academies and preparatory schools. Results of other psychological testing, when accomplished, will be attached to SF 88.</p> <p>MDAR required for initial entry for diving duty. This rating will include consideration of requirements of paragraph 5-10. If the chamber required for paragraph 5-10d(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 5-10g(3), whether he or she has fear of depths, enclosed places or of the dark.</p>	<p>ARMA sat. ARMA unsat.—s item 73. RAT sat.</p> <p>MDAR sat. MDAR unsat.</p>
73 (Notes)	X	X	<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 used, will not be transferred or commented on except as necessary in connection with the examination. All aviation personnel will include and sign 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. Traumatic cataract, left eye, removed 29 July 1984, no comp. see items 59 and 60 for vision correction. Item 72 cont. History of multiple idiopathic syncopal attacks.</p>
74 (Summary of defects)	X	X	<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 a short, concise diagnosis; do not repeat the full description of a defect which has already been described under the appropriate item. Do not summarize minor, nonsignificant findings.</p>	
75 (Recommendations)	X	X	<p>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 given in AR 40-3.</p>	
76 (Physical profile)	X	X	<p>The physical profile as prescribed in chapter 7 will be recorded.</p>	1 1 1 1 2 1
77 (Examinee qualified/not qualified)	X	(*)	<p>*Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5. Though not required, this item may be completed as a recommendation of the examining physician in the case of applicants or nominees for the USMA or the USNA. No entry will be made for USAFA applicants or nominees.</p>	
78 (Disqualifying defects)	X	X	<p>List all disqualifying defects by item number. This listing is required even though the defects are stated in item 74. If qualified, enter a dash.</p>	
79-81 (Physician, dentist names)	X	X	<p>Enter the typed or printed names of examiners.</p> <p>If the examination is accomplished for entrance into service academies (USMA, USNA, USAFA, USCGA, USMMA), signatures of a physician and a dentist are required.</p>	

**Table 8-1**  
**Scope and recording of medical examinations—Continued**

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
			<p>If the 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.</p> <p>Examinations accomplished for enlistment or induction, entrance on active duty of Reserve Component soldiers, and all periodic, discharge, relief from active duty, and retirement examinations must be signed by a physician.</p> <p>Dentists, optometrists, podiatrists, audiologists, nurse practitioners, and physician assistants may also sign attesting to that portion of the examination actually accomplished by them.</p>	
82	(*)	(*)	*See paragraph 8-14d.	
(Reviewing officer name)				

**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 or 1A examination will be identical to the initial examination except that—
2. 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.
3. 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.
4. Anthropometric measurements, if required, may be transcribed from the original SF 88 without being repeated.
5. All other portions of the flying duty examination, including the cycloplegic refraction, must be repeated.
6. A new SF 93 is required in all cases.
7. When flying duty medical examinations are performed on Army personnel at USAF and USN facilities, certain tests may not be available (for example, RAT) or tests other than those used by the Army may be the only ones available (for example, FALANT rather than PIP). In such cases, the Commander, USAAMC, is authorized to waive the requirement or accept the substitute test.

**Table 8-2**  
**Number of months for which a flying duty medical examination (FDME) 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 the left column to the examinee's birth month; read across to month of last FDME; intersection number is the maximum validity period. When last FDME was within the 3-month period preceding the end of the birth month, the validity period will normally not exceed 15 months. When the last FDME was for entry into aviation training, for FEB, post-accident, post-hospitalization, pre-appointment (WOC), etc., the validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with paragraph 8-26 j, by 1 month only for completion of an examination begun before the end of the birth month.

**Table 8-3**  
**Schedule of separation medical examinations**

Action	Required	Not required	Can be requested by soldier (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** at servicing MTF determines that, because of medical care received during active service, medical examination will serve the best interests of soldier and Government: for example, hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		
Individual is member of the ARNG on active duty or ADT in excess of 30 days.		X	X
Individual is member of the ARNG 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 soldiers previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (AR 635-40, chap 6, and predecessor regulations).	X (Plus MEBD and PEB)		
Officers, WOs, and enlisted soldiers 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 soldiers 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 and/or mental status evaluation.	X*		
Officers and WOs being processed for separation under provisions of AR 635-100, when medical examination and/or mental status evaluation is not a requirement.		X	X
Enlisted soldiers being processed for separation under the provisions of chapters 8 and 9, and AR 635-200, paragraphs 5-3 and 16-4.	X		
Enlisted soldiers being processed for separation under provisions of AR 635-200, chapter 13 (both mental evaluation and medical examination required).	X		
Enlisted soldiers being processed for separation under provisions of AR 635-200, chapters 14 and 15. (Mental status evaluation only is required. Medical examination may be requested by the soldier 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 soldiers being processed for separation under provisions of AR 635-200, chapter 10. (If a medical examination is requested by the soldier, then mental status evaluation is required.)			X
Discharge in absentia (officers and enlisted soldiers):			
Civil confinement.		X	
When a Bad Conduct Discharge or a Dishonorable Discharge is upheld by appellate review and the individual is on excess leave.		X	
Deserters who do not return to military control.		X	
Enlisted soldiers being processed for separation under all other provisions of AR 635-200 not listed above.		X	X

\*Examination will be accomplished not earlier than 4 months, nor later than 1 month prior to scheduled date of retirement discharge, relief from active duty, or ADT.  
\*\*Physician assistants may review health records of officers, WOs, and enlisted soldiers upon expiration of term of service (separation or discharge) if such authority has been granted by the supervising physician or approved by the MTF commander or unit staff surgeon.

# PHYSICAL PROFILE

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

1. MEDICAL CONDITION Knee Pain	2.	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td>P</td><td>U</td><td>L</td><td>H</td><td>E</td><td>S</td> </tr> <tr> <td>1</td><td>1</td><td>T3</td><td>1</td><td>1</td><td>1</td> </tr> </table>	P	U	L	H	E	S	1	1	T3	1	1	1
P	U	L	H	E	S									
1	1	T3	1	1	1									

3. ASSIGNMENT LIMITATIONS ARE AS FOLLOWS No running over one mile. No deep knee bend activities.	CODES
---	-------

4. THIS PROFILE IS  PERMANENT  TEMPORARY EXPIRATION DATE

5. THE ABOVE STATED MEDICAL CONDITION SHOULD NOT PREVENT THE INDIVIDUAL FROM DOING THE FOLLOWING ACTIVITIES

<input type="checkbox"/> Groin Stretch	<input type="checkbox"/> Thigh Stretch	<input type="checkbox"/> Lower Back Stretch	<input type="checkbox"/> Neck & Shoulder Stretch	<input type="checkbox"/> Neck Stretch
<input type="checkbox"/> Hip Raise	<input type="checkbox"/> Quads Stretch & Bat.	<input type="checkbox"/> Single Knee to Chest	<input type="checkbox"/> Upper Back Stretch	<input type="checkbox"/> Ankle Stretch
<input type="checkbox"/> Knee Bender	<input type="checkbox"/> Calf Stretch	<input type="checkbox"/> Straight Leg Raise	<input type="checkbox"/> Chest Stretch	<input type="checkbox"/> Hip Stretch
<input type="checkbox"/> Side-Straddle Hop	<input type="checkbox"/> Long Sit	<input type="checkbox"/> Elongation Stretch	<input type="checkbox"/> One-Arm Side Stretch	<input type="checkbox"/> Upper Body Wt Tng
<input type="checkbox"/> High Jumper	<input type="checkbox"/> Hamstring Stretch	<input type="checkbox"/> Turn and Bounce	<input type="checkbox"/> Two-Arm Side Stretch	<input type="checkbox"/> Lower Body Wt Tng
<input type="checkbox"/> Jogging in Place	<input type="checkbox"/> Hams. & Calf Stretch	<input type="checkbox"/> Turn and Bend	<input type="checkbox"/> Side Bender	<input type="checkbox"/> All

<p>6. AEROBIC CONDITIONING EXERCISES</p> <input checked="" type="checkbox"/> Walk at Own Pace and Distance <input type="checkbox"/> Run at Own Pace and Distance <input type="checkbox"/> Bicycle at Own Pace and Distance <input type="checkbox"/> Swim at Own Pace and Distance <input type="checkbox"/> Walk or Run in Pool at Own Pace  <input type="checkbox"/> Unlimited Walking <input type="checkbox"/> Unlimited Running <input type="checkbox"/> Unlimited Bicycling <input checked="" type="checkbox"/> Unlimited Swimming  <input type="checkbox"/> Run at Training Heart Rate for ___ Min. <input type="checkbox"/> Bicycle at Training Heart Rate for ___ Min. <input type="checkbox"/> Swim at Training Heart Rate for ___ Min.	<p>7. FUNCTIONAL ACTIVITIES</p> <input type="checkbox"/> Wear Backpack (40 Lbs.) <input type="checkbox"/> Wear Helmet <input type="checkbox"/> Carry Rifle <input type="checkbox"/> Fire Rifle With Hearing Protection <input type="checkbox"/> KP/Mopping/Mowing Grass <input type="checkbox"/> Marching Up to ___ Miles <input type="checkbox"/> Lift Up to ___ Pounds <input checked="" type="checkbox"/> All  <p>PHYSICAL FITNESS TEST</p> <input type="checkbox"/> Two Mile Run <input type="checkbox"/> Walk <input checked="" type="checkbox"/> Push-Ups <input type="checkbox"/> Swim <input checked="" type="checkbox"/> Sit-Ups <input type="checkbox"/> Bicycle	<p>8. TRAINING HEART RATE FORMULA</p> <p style="text-align: center;">MALES 220                  FEMALES 225</p> <p style="text-align: center;">MINUS (-) AGE                  MINUS (-) RESTING HEART RATE                  TIMES (x) % INTENSITY                  PLUS (+) RESTING HEART RATE</p> <hr/> <p>50% EXTREMELY POOR CONDITION                  60% HEALTHY, SEDENTARY INDIVIDUAL                  70% MODERATELY ACTIVE, MAINTENANCE                  80% WELL TRAINED INDIVIDUAL</p>
---	--	--

9. OTHER

TYPED NAME AND GRADE OF PROFILING OFFICER John X. Smith, CPT, MC	SIGNATURE 	DATE 10 May 1986
TYPED NAME AND GRADE OF PROFILING OFFICER	SIGNATURE	DATE

**ACTION BY APPROVING AUTHORITY**

PERMANENT CHANGE OF PROFILE  APPROVED  NOT APPROVED

TYPED NAME, GRADE & TITLE OF APPROVING AUTHORITY	SIGNATURE	DATE
--	-----------	------

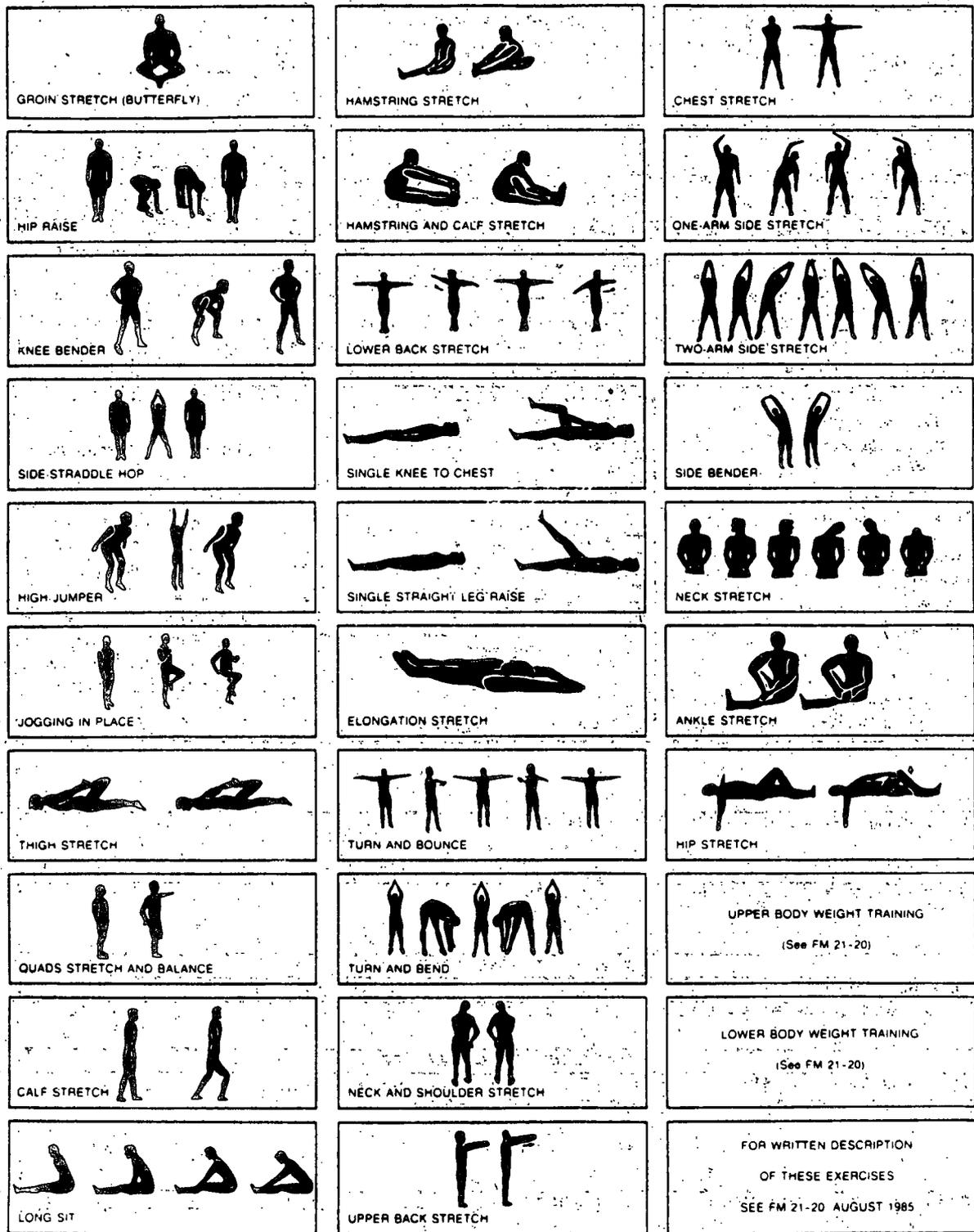
**ACTION BY UNIT COMMANDER**

THIS PERMANENT CHANGE IN PROFILE SERIAL  DOES  DOES NOT REQUIRE A CHANGE IN MEMBER'S  MILITARY OCCUPATIONAL SPECIALTY  DUTY ASSIGNMENT BECAUSE:

TYPED NAME AND GRADE OF UNIT COMMANDER	SIGNATURE	DATE
--	-----------	------

PATIENT'S IDENTIFICATION (For typed or written entries give: Name (last, first, middle); grade; SSN; hospital or medical facility) Jones, James Q. PFC 10 May 86 US Army Health Clinic, Ft. Ord	UNIT ISSUING CLINIC AND PHONE NUMBER Orthopedic Clinic 999-9999 DISTRIBUTION: UNIT COMMANDER - ORIGINAL & 1 COPY HEALTH RECORD JACKET - 1 COPY CLINIC FILE - 1 COPY MILPO - 1 COPY
---	---

Figure 7-1. Sample of a completed DA Form 3349



REVERSE OF DA FORM 3349, MAY 86

Figure 7-1. Sample of a completed DA Form 3349—Continued

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

**MEDICAL SCREENING SUMMARY - OVER-40 PHYSICAL FITNESS PROGRAM**

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

1. DATE OF EXAM (MM/DD/YY) 27 FEB 81	2. MYP CODE 1001	3. PATIENT'S NAME (Last, First, MI) Harrison, Benjamin F.	4. SSN 23456789
5. SEX (M=Male, F=Female) M	6. AGE (Current Birthday) 42	7. SMOKING HISTORY (Average num. per day) 40	8. BLOOD PRESSURE (COCK/COCK mm Hg) 120/100
9. ELECTROCARDIOGRAM (NL=Normal, LVH=Left Ventricle Hypertrophy Only, ABN=Abnormalities other than LVH, LVH+LVH=LVH plus other abnormalities) LVH + ABN			10. SERUM CHOLESTEROL (COCK mg/dl) 102
11. FASTING BLOOD SUGAR (mg/dl) 103	12. CARDIOVASCULAR HISTORY AND PHYSICAL (NL=Normal, ABN=Abnormal) ABN		

FOR AFIP USE ONLY

**CODING INSTRUCTIONS**

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

Figure 8-1. Sample DA Form 4970

## Glossary

### Section I Abbreviations

**ABN**  
abnormal (abnormalities other than hypertrophy)

**AC**  
Active Component

**ACAP**  
aeromedical consultant advisory panel

**ADAPCP**  
Alcohol and Drug Abuse Prevention and Control Program

**ADP**  
automatic data processing

**ADR**  
Aeromedical Data Repository

**ADT**  
active duty for training

**AFIP**  
Armed Forces Institute of Pathology

**AGR**  
Active Guard—Reserve

**AMCS**  
Army Aviation Medicine Consultation Service

**AME**  
aviation medical examiner

**AMEDD**  
Army Medical Department (U.S.)

**APFT**  
Army Physical Fitness Test

**APO**  
Army Post Office

**AR**  
Army Regulation

**ARCOM**  
USAR Command

**ARMA**  
Adaptability Rating for Military Aeronautics

**ARNG**  
Army National Guard (of the United States)

**ARNGUS**  
Army National Guard of the United States

**ARPERCEN**  
Army Reserve Personnel Center

**ASD (HA)**  
Assistant Secretary of Defense (Health Affairs)

**AT**  
annual training

**ATC**  
air traffic controller

**AUS**  
Army of the United States

**AV**  
atrioventricular

**BN**  
battalion

**BP**  
blood pressure

**CAD**  
coronary artery disease

**CAPOC**  
computerized assisted practice of cardiology

**cc**  
cubic centimeter(s)

**Cdr**  
commander

**CG**  
commanding general

**CIA**  
Central Intelligence Agency

**cm**  
centimeter

**comp.**  
complications

**cont.**  
continued

**CONUS**  
continental United States

**corr**  
corrected

**CREST**  
calcinosis, Raynaud's phenomenon, esophageal dysfunction, sclerodactyly, and telangiectasis

**CT**  
Cover Test

**CV**  
cardiovascular

**CVSP**  
Cardiovascular Screening Program

**DA**  
Department of the Army

**DAC**  
Department of the Army civilian

**DAF**  
Department of the Air Force

**dB**  
decibel(s)

**dBa**  
dB measured on the A scale

**Div**  
divergence

**DN**  
Department of the Navy

**DOD**  
Department of Defense

**DODMERB**  
Department of Defense Medical Examination Review Board

**DSM-III-R**  
Diagnostic and Statistical Manual, Third Edition, American Psychiatric Association, 1987

**E**  
eyes (profile)

**ECG**  
electrocardiogram

**EKG**  
electrocardiogram

**ELISA**  
Enzyme-Linked Immunoassay (serological test)

**ENT**  
ear-nose-throat

**EPTS**  
existed prior to service

**ES**  
esophoria

**EX**  
exophoria

**FAA**  
Federal Aviation Administration

**FALANT**  
Farnsworth Lantern Test (USN)

**FAR**  
Federal Aviation Regulations

**FBI**  
Federal Bureau of Investigation

**FDME**  
flying duty medical examination

**FEB**  
flying evaluation board

**FORSCOM**  
Forces Command (U.S. Army)

**FTA-ABS**  
fluorescent treponemal antibody absorption (test)

**GOCOM**  
United States Army Reserve General Officer Command

**G6PD**  
glucose-6-phosphate dehydrogenase

**G-U**  
genitourinary

**H**  
hearing and ear (profile)

**HALO**  
high altitude low opening

**Hgb A**  
hemoglobin type A

**Hgb S**  
hemoglobin type S

**HDL**  
high-density lipoprotein

**HIV**  
human immunodeficiency virus (see HTLV-III)

**HSC**  
Health Services Command (U.S. Army)

**HTLV-III**  
human T-lymphotrophic virus type III (see HIV)

**HQDA**  
Headquarters, Department of the Army

**HRAA**  
Health Risk Appraisal Assessment

**IDT**  
inactive duty training

**in.**  
inch(es)

**IO**  
initial-only

**IRR**  
Individual Ready Reserve

**kg**  
kilogram(s)

**L**  
lower extremities (profile)

**L.H.**  
left hyperphoria

**LVH**  
left ventricular hypertrophy

**MAAG**  
Military Assistance Advisory Group

**MDAR**  
Military Diving Adaptability Rating

**MEBD**  
medical evaluation board

**MEDCEN**  
medical center (U.S. Army)

**MEDDAC**  
medical activity (U.S. Army)

**MEPCOM**  
Military Entrance Processing Command

**MEP(s)**  
military entrance processing stations

**mg**  
milligram

**mg/dl**  
milligrams per deciliter

**MILPO**  
military personnel office

**mm**  
millimeter(s)

**mmHg**  
millimeters of mercury

**MTF**  
medical treatment facility

**MOS**  
military occupational specialty

**NBC**  
nuclear, biological, chemical

**NGB**  
National Guard Bureau

**NGR**  
National Guard Regulation

**NIBH**  
not indicated by history

**NI**  
normal

**NPC**  
near point of convergence

**OASD(HA)**  
Office of the Assistant Secretary of Defense (Health Affairs)

**OCS**  
Officer Candidate School

**OD**  
right eye

**OIC**  
officer-in-charge

**OMPF**  
official military personnel file

**OS**  
left eye

**P**  
permanent (profile) and physical capacity or stamina (profile)

**PA**  
posterior anterior (chest x-ray)

**Pap smear (test)**  
Papanicolaou's test

**PC**  
prism convergence

**PCS**  
permanent change of station

**PD**  
pupillary distance

**PEB**  
physical evaluation board

**PERSCOM**  
Total Army Personnel Command

**PIP**  
pseudochromic plates

**POR**  
preparation of replacements for overseas movement

**PPBD**  
physical profile board

**P-R interval**  
interval between the P and R waves on an ECG

**PT**  
physical training

**PULHES**  
(see separate letters for profile codes)

**QRS interval**  
interval between the Q and R and S waves on an ECG

**RAT**  
Reading Aloud Test

**RBC**  
red blood cell or corpuscle

**R.H.**  
right hyperphoria

**ROTC**  
Reserve Officers' Training Corps

**RPR**  
rapid plasma reagin (test)

**rt**  
right

**s**  
psychiatric (profile)

**sat.**  
satisfactory

**SCUBA**  
self-contained underwater breathing apparatus

**SSI**  
specialty skill identifier

**STS**  
serologic test for syphilis

**SVT**  
Stereoscope. Vision Testing

**T**  
temporary (profile)

**TB MED**  
Technical Bulletin Medical

**TDA**  
table(s) of distribution and allowances

**TDRL**  
Temporary Disability Retired List

**TOE**  
table(s) of organization and equipment

**TPI**  
treponema pallidum immobilization

**TRADOC**  
Training and Doctrine Command (U.S. Army)

**U**  
upper extremities (profile)

**unsat.**  
unsatisfactory

**USA**  
United States Army

**USAAMC**  
United States Army Aeromedical Center

**USAR**  
United States Army Reserve

**USAREC**  
United States Army Recruiting Command

**USAF**  
U.S. Air Force

**USAFA**  
United States Air Force Academy

**USCGA**  
United States Coast Guard Academy

**USMA**  
United States Military Academy

**USMC**  
United States Marine Corps

**USMMA**  
United States Marine Military Academy

**USN**  
U.S. Navy

**USNA**  
United States Naval Academy

**USUHS**  
Uniformed Services University of the Health Sciences

**VDRL**  
venereal disease research laboratory (test)

**VTA**  
vision testing apparatus

**WO**  
warrant officer

**WOC**  
warrant officer candidate

## **Section II** **Terms**

**Accepted medical principles**  
Fundamental deduction consistent with medical facts and based upon the observation of a large number of cases. To constitute accepted medical principles, the deduction must be based upon the observation of a large number of cases over a significant period of time and be so reasonable and logical as to create a moral certainty that they are correct.

**Applicant**  
A person not in a military status who applies for appointment, enlistment, or reenlistment in the USAR.

**Candidate**  
Any individual under consideration for military status or for a military service program whether voluntary (appointment; enlistment, ROTC) or involuntary (induction).

**Civilian physician**  
Any individual who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures in the geographical area concerned.

**Enlistment**  
The voluntary enrollment for a specific term of service in one of the Armed Forces as contrasted with induction under the Military Selective Service Act.

**Impairment of function**  
Any anatomic or functional loss, lessening, or weakening of the capacity of the body, or

any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in the body economy.

**Latent impairment**  
Impairment of function which is not accompanied by signs and/or symptoms but which is of such a nature that there is reasonable and moral certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time or upon change of environment.

**Manifest impairment**  
Impairment of function which is accompanied by signs and/or symptoms.

**Medical capability**  
General ability, fitness, or efficiency (to perform military duty) based on accepted medical principles.

**Obesity**  
Excessive accumulation of fat in the body manifested by poor muscle tone, flabbiness and folds, bulk out of proportion to body build, dyspnea and fatigue upon mild exertion, and frequently accompanied by flat feet and weakness of the legs and lower back.

**Physical disability**  
Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment, which reduces or precludes an individual's actual or presumed ability to perform military duty. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term "physical disability" includes mental diseases other than such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

**Physician**  
A doctor of medicine or doctor of osteopathy legally qualified to prescribe and administer all drugs and to perform all surgical procedures.

**Retirement**  
Release from active military services because of age, length of service, disability, or other causes, in accordance with Army regulations and applicable laws with or without entitlement to receive retired pay. For purposes of this regulation this includes both temporary and permanent disability retirement.

**Sedentary duties**  
Tasks to which military personnel are assigned that are primarily sitting in nature, do not involve any strenuous physical efforts, and permit the individual to have relatively regular eating and sleeping habits.

**Separation (except for retirement)**  
Release from the military service by relief from active duty, transfer to a Reserve

Component, dismissal, resignation, dropped from the rolls of the Army, vacation of commission, removal from office, and discharge with or without disability severance pay.

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M

TAB

TAB TAB

TAB

**PERIODIC MEDICAL EXAMINATION**

**(Statement of Exemption)**

DATE

(For use of this form, see AR 40-501; the proponent is the Office of The Surgeon General)

LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE & SSN. (Type or print)

ORGANIZATION

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.

\_\_\_\_\_  
(Signature)

**MEDICAL EXAMINATION FOR CERTAIN GEOGRAPHICAL AREAS**

(For use of this form, see AR 40-501; the proponent is the Office of The Surgeon General)

DATE

SOLDIER'S LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE & SSN (Type or print)

ORGANIZATION

COUNTRY ASSIGNED

**DEPENDENTS**

NAME	RELATIONSHIP	AGE

Based upon a review of available medical records and the results of examination as necessary, the following recommendations are submitted:

- Soldier is medically qualified to undertake proposed assignment.
- Soldier is not medically qualified to undertake proposed assignment.
- Dependents listed above  are  are not medically qualified to accompany soldier.

REMARKS:

(Continue on reverse side if necessary)

MEDICAL TREATMENT FACILITY

TYPED OR PRINTED NAME OF EXAMINING PHYSICIAN

SIGNATURE OF EXAMINING PHYSICIAN

## INTERIM MEDICAL EXAMINATION — AVIATION, FREE FALL PARACHUTING, AND 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
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11. FLIGHT DUTY PERFORMED

12. TOTAL FLIGHT HOURS	13. FLIGHT HOURS IN LAST 6 MONTHS
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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 blank)     ISO     ASA     ANSI     OTHER

EAR	250	500	1000	2000	3000	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 OF REVIEWING MEDICAL OFFICER
--	--

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 PATIENT	DATE