BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 48-123, VOLUME 4

5 JUNE 2006

Aerospace Medicine

MEDICAL EXAMINATIONS AND STANDARDS VOLUME 4—SPECIAL STANDARDS AND REQUIREMENTS

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFMOA/SGOP

Certified by: AF/SGO (Maj Gen Charles B Green)

Pages: 27

This instruction implements AFPD 48-1, *Aerospace Medical Program* and Department of Defense Directive (DoDD) 1332.18, *Separation or Retirement for Physical Disability*, and DoDD 6130.3, *Physical Standards for Appointment, Enlistment and Induction*, May 1994, DoDI, 6130.4, *Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces,* Jan 2005, DoDD 5154.24, *Armed Forces Institute of Pathology (AFIP)*. It establishes procedures, requirements, recording, and medical standards for medical examinations given by the Air Force. It prescribes procedures and references the authority for retiring, discharging, or retaining members who, because of physical disability, are unfit to perform their duties. This instruction applies to all applicants for military service, scholarship programs, Air National Guard and the Air Force Reserve. Active duty flight medicine offices will use the AFRC supplement to this instruction when managing units assigned Reserve Members and will maintain a copy of the AFRC Supplement when Reserve units are located on the same base.

This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Authority to collect and maintain records prescribed in this outlined in Title 10, United States Code, Section 8013 and Executive Order, 9397. Privacy Act System Notice F044 AFSG G, Aeromedical Information Management and Waiver Tracking System (AIMWTS), applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123, *Management of Records Disposition Schedule (RDS)* located at **https://afrims.af.mil**. The reporting requirement in this volume are exempt from licensing according to AFI 33-324, paragraph 2.11.10, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*. Send comments and suggested improvements on AF Form 847, *Recommendation for Change of Publication*, through channels, to AFMOA/SGPA, 110 Luke Avenue, Room 405, Bolling AFB, DC 20032-7050. **Attachment 1** is a list of references and supporting information.

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A bar (|) indicates a revision from the previous edition.

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Chapter 1

PERIODIC HEALTH ASSESSMENTS/EXAMINATIONS

1.1. Periodic Health Assessments/Examinations.

1.1.1. Clarification: Report of Physical Examination, SF 88, *Report of Medical Examination*, (or DD Form 2808, *Report of Medical Examination*) and SF 93, *Report of Medical History*, (or DD 2807-1, *Report of Medical History*) are only required for initial physicals, or as indicated in Air Force Instruction (AFI) 48-123V2, Chapter 1. For this AFI, all other references to assessments/examinations are Preventive Health Assessments (PHAs.)

1.1.1.1. Frequency. Accomplish PHAs at the frequency listed in AFI 48-123 Volume 1, *Medical Examinations and Standards – General Provisions*, Attachment 2. Annual examinations are usually scheduled in the three months prior to expiration, but may be scheduled as early as 6 months prior.

1.1.1.2. All flight physicals are still to be performed annually by the end of an individual's birth month.

1.1.1.3. Air Force Reserve members with an expired Reserve Component Periodic Health Assessment (RCPHA) will be restricted from Reserve participation for pay or points IAW AFMAN 36-8001, *Reserve Personnel Participation And Training Procedures*. An AF Form 422, *Physical Profile Serial Report* will be accomplished without changing the member's numerical profile. Reference AFPAM 48-133, *Physical Examination Techniques*, for appropriate AF Form 422 format. **For Air National Guard (ANG) members, an AF Form 422 will be accomplished changing the member's profile to P4T.**

1.1.2. PHA for the Air Reserve Components refer to AFI 48-123 Volume 2, *Medical Examinations and Standards – Accessions, Retention and Administration,* Chapter 5 for specific guidance on these members.

1.1.3. All aviator and special operational duty personnel requiring an annual AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, will have an in-person examination office visit with flight surgeon to complete the PHA.

1.2. Special Evaluation Requirements:

1.2.1. General. This chapter establishes minimum evaluation requirements for cases submitted to certification and waiver authorities. All cases require appropriate follow-up and documentation of potentially disqualifying conditions. The Aircrew Waiver Guide (accessible through aeromedical information management waiver tracking system (AIMWTS)) provides additional guidance in the preparation of cases for flying waivers.

1.2.2. Artificial Dentures. During dental evaluation document the satisfactory restoration of masticatory function, appearance, and clear speech. Complete dental prosthesis is demonstrated by adequate phonetics, retention, stability, interocclusal space, and occlusion. Oral tissues supporting the prosthesis must be in good health.

1.2.3. Head Trauma. Minimum observation periods and evaluation requirements are listed in **Table 1.1.**.

1.2.3.1. The severity of injury is a governing factor. Head injuries more than 10 years old do not require evaluation in the absence of sequelae. Refer to the specific attachments for information on the evaluation and disposition of head injuries with sequelae.

Table 1.1. Evaluation Of Head Injury.

Degree of Head Injury	Minimum Observation Time	Evaluation Requirements
Mild (see AFI 48-123 Volume 3, *Medical Examinations and Standards – Flying and Special Operational Duty*, Attachment 4.23**.** for criteria). Coordinate all actions with MAJCOM/SG to include submission of tests to the Aeromedical Consultation Service (ACS).	**1 month**	**Enlistment, Induction, Appointment:** Complete Neurological Examination by a Physician. **Flying Class I, IA, III, Space and Missile Duty:** Complete Neurological and Mental Status Examination by a Flight Surgeon. **Flying Class II:** 1. Complete Neurological and Mental Status Examination by a Flight Surgeon. 2. Neuropsychological Testing as specified by the Clinical Science Division, Neuropsychiatry Branch, Brooks-City Base, TX, within 30 days of head injury. Send results of testing to the ACS for review prior to Return to Flying Status (RTFS).
Moderate (see AFI 48-123V3, Attachment 4.23. for criteria). Coordinate all actions with MAJCOM/SG to include submission of tests to the ACS.	**2 years** For trained Space and Missile Duty, waiver may be considered after 6 months with concurrence of ACS	**Enlistment, Induction, Appointment:** Comprehensive neuropsychological evaluation performed by a neuropsychologist. **Flying Class I, IA, III, Space and Missile Duty:** 1. Complete Neurological Evaluation by a Neurologist or Internist. 2. CT Scan or MRI. 3. Neuropsychological Testing as Specified by the Clinical Science Division, Neuropsychiatry Branch, Brooks-City Base, TX. **Flying Class II**: 1. Complete Neurological and Mental Status Examination by a Neurologist. 2. CT of the head (within 48 hrs following injury). 3. MRI of head (if possible, within 48 hrs following injury). 4. EEG Routine (with a sleep sample). 5. Neuropsychological Testing as specified by the Clinical Science Division, Neuropsychiatry Branch, Brooks City-Base TX, within 30 days of head injury. Send testing results to the ACS for review prior to RTFS. 6. ACS evaluation 6 months following injury.

Degree of Head Injury	Minimum Observation Time	Evaluation Requirements
Severe (see **AFI 48-123V3, Attachment 4.23. for criteria).** Coordinate all actions with MAJCOM/SG to include submission of tests to the ACS.	**5 years** for closed head trauma **10 years** for penetrating head trauma (TIME PERIOD IS NOT WAIVERABLE) For trained Space and Missile Operations Duty (SMOD), waiver may be considered after 2 years with concurrence of ACS	**Enlistment, Induction, Appointment:** Comprehensive neuropsychological evaluation performed by a neuropsychologist. **Flying Class III, Space and Missile Duty:** 1. Complete Neurological Evaluation by a Neurologist. 2. CT Scan. 3. Neuropsychological Testing as specified by the Clinical Science Division, Neuropsychiatry Branch, Brooks City-Base TX. **Flying Class I, IA:** Not waiverable. Exceptions may be granted after a 10-year period of observation. **Flying Class II:** 1. Complete Neurological and Mental Status Examination by a Neurologist. 2. CT of head (within 48 hrs following injury). 3. MRI of head (if possible, within 48 hrs following injury). 4. EEG Routine (with a sleep sample). 5. Neuropsychological Testing as specified by the Clinical Science Division, Neuropsychiatry Branch, Brooks City-Base TX, within 30 days of head injury. Send results of testing to the ACS for review prior to RTFS. 6. ACS evaluation 6 months following injury.

1.2.4. Elevated serum cholesterol. Members with elevated serum cholesterol should be evaluated by the primary care management (PCM) Provider and treated according to the *National Cholesterol Education Program (NCEP) Guidelines*. Male aircrew members age 40 or greater, or female aircrew members age 50 or greater, meeting either of the criteria below requires further management per the *Aircrew Waiver Guide* for "Hyperlipidemia:"

1.2.4.1. Fasting calculated low density lipoprotein (LDL) greater than 190 mg/dl

1.2.4.2. Fasting calculated low density lipoprotein (LDL) greater than 160 mg/dl with one or more of the following risk factors:

1.2.4.2.1. Positive family history of atherosclerotic heart disease.

1.2.4.2.2. Current smoker.

1.2.4.2.3. Hypertension, treated or not.

1.2.4.2.4. High density lipoprotein (HDL) cholesterol less than 35 mg/dl.

1.2.4.3. Initial applicants for commission, enlistment, Flying Class II and III, who are 40 years of age and older, are required to obtain an Exercise Tolerance Test (ETT) if their cardiac risk index (CRI) is 10,000 or greater.

Formula: CRI= $\left(\frac{cholesterol}{HDL} - 1\right) age^2$

1.2.5. Intraocular Pressure:

1.2.5.1. Routine Determination. Refer examinees with the following intraocular pressures to a qualified optometrist or ophthalmologist for consultation:

1.2.5.1.1. Two or more current determinations of 22 mmHg or higher.

1.2.5.1.2. A difference of 4 mmHg or greater between right and left eyes.

1.2.5.2. Optometrist/Ophthalmology Evaluations. Evaluations include, where appropriate, a dilated examination of the disc with a stereoscopic magnifying lens (Hruby, Goldmann, 90D), visual fields, applanation tonometry, and stereo disc photos (when available).

1.2.6. Malocclusion, Teeth. Report of examination by a dentist with comment as to whether incisal and masticatory functions are adequate for an ordinary diet, plus a comment on the degree of facial deformity with the jaw in natural position and whether there is interference with speech or wear of protective equipment.

1.2.7. Sickle Cell Trait. Positive sickle cell screening tests on personnel performing flying duty or required to meet flying medical standards are confirmed by hemoglobin electrophoresis. A one-time certification, by the proper certification authority in **Attachment 2**, is required for all flying personnel and flying training applicants with sickle cell trait.

1.2.8. Hepatitis, History of. Hepatitis B and C antigen/antibody testing, ALT, and GGPT (in cases of confirmed Hepatitis A, no additional testing is required).

1.2.9. Color Vision. Initial enlistment or commission examinations have no standards for color vision. Color vision tests must be accomplished IAW AFPAM 48-133, and recorded monocularly on all accessions (enlistment and commission) since many Air Force specialties require normal color vision. Failure of the test is defined as five or more incorrect responses (including failure to make responses in the appropriate amount of time) in reading the 14 test plates of the Pseudoisochromatic Plate (PIP) set.

1.2.9.1. No other tests for color vision (see AFI 48-123V3, Attachment 4.11) are authorized except as described for Medical Flight Screening (MFS).

1.2.10. Allergic Disorders, History of. Be cautious of self-imposed diagnoses. Record all historical details such as age of onset, seasonal and geographical variation, severity, frequency and duration, medication used, efficacy of treatment, and date of last occurrence. Nasal smear of eosinophils will be done if acute allergic rhinitis is suspected.

1.2.11. Backache, Severe or Incapacitating, History of. Current orthopedic consultation, which reports strength, stability, mobility, and functional capacity of the back. Report of appropriate x rays. Summary of past treatment from a cognizant physician, if applicable.

1.2.12. Blood Pressure, Elevated, Finding or History of:

1.2.12.1. Record the blood pressure (sitting position) for a minimum of one blood pressure readings for 3 days. Prolonged rest or sedation is not allowed. If the blood pressure is persistently elevated, medical consultation is indicated.

1.2.12.2. Air Force Reserve Officer's Training Corps (AFROTC) and US military academy examinees will, when found to have disqualifying blood pressure on initial examinations, be rechecked for a preponderance based on at least three readings at successive 1-hour intervals during a 1-day period. If the blood pressure is persistently elevated, medical consultation is indicated.

1.2.12.3. When reports of medical examinations are sent to higher headquarters for review and the examinations indicate the presence of hypertension, it is important that the member's response to treatment be documented in order to facilitate proper disposition of the case. A 3-day blood pressure average with AM and PM readings (one or two readings per day at discretion of physician)

should be accomplished. For borderline averages, consideration of the addition of a 24-hour ambulatory blood pressure may be utilized if available. For the 24-hour ambulatory blood pressure results, only diurnal averages should be used and an average exceeding 135/85 suggests hypertension.

1.2.13. Diabetes, Family History of (parent, sibling, or more than one grandparent). Fasting blood sugar will be obtained and recorded on the initial evaluation and subsequent periodic assessments/examinations. State in the report the method of blood sugar determination and the normal values of the laboratory used.

1.2.14. Enuresis, or History of, in Late Childhood or Adolescence. Comment on the examinee's affirmative reply to question of "bed wetting" to include the number or frequency of incidents and age at last episode.

1.2.15. Flatfoot, Symptomatic Finding, or History of. Current orthopedic consultation with a detailed report of strength, stability, mobility, and functional capacity of the foot and the medical need for orthotics. Report of appropriate x rays.

1.2.16. Speech Disorders and Noticeable Communication Problems. These should be investigated during the initial physical for accession, commissioning, air traffic control and combat controllers or when applying for any flying duty, or required to apply for specialty Air Force specialty Codes (AFSCs). At a minimum, a Reading Aloud Test (RAT) is required as specified in this instruction in the applicable attachment(s). Consult AFPAM 48-133 for proper procedure for performing the RAT.

1.2.17. Substandard Standing & Sitting Height. See **Table 1.2.**. Consult AFPAM 48-133 for proper procedures for accomplishing measurements.

Table 1.2. Disqualifying Standing & Sitting Height Standards For Accession, Flying Class I, IA, II, II (Flight Surgeon) & III

TYPE PHYSICAL > greater than < less than	STANDING HEIGHT (MALE)	STANDING HEIGHT (FEMALE)	SITTING HEIGHT (ALL)
Accession	>80” or < 60”	>80” or <58”	-
FLYING CLASS I	>77” or <64”	>77” or <64”	>40” or <34”
FLYING CLASS IA	>77” or <64”	>77” or <64”	>40” or <33”
FLYING CLASS II	>77” or <64”	>77” or <64”	-
FLYING CLASS II (FLT SG)	>77” or <64”	>77 or <64”	>40” or <33”
FLYING CLASS III	>77” or < 64”	>77” or <64”	-

1.2.17.1. Height waivers may be considered for Flying Class (FC) I applicants. This is a special program administered by Air Education and Training Command (AETC)/SGPS in coordination with AETC/DO, AETC/XP and the ACS.

1.2.18. Amsler Grid Test. Due to the advent of laser technology, the Amsler grid test is an efficient way to examine the central 20 degrees of the visual field in a very effective manner without the necessity of high-tech equipment. Baseline is accomplished on all military personnel. Testing will be

accomplished on all Flying Class I and IA examinations, and annually for all flying personnel. Consult AFPAM 48-133 for proper testing procedures and PIMR grid for frequency.

1.2.19. Airsickness. Airsickness is a common problem in new flying personnel, however most students adjust to the flying environment quickly. Airsickness occasionally occurs in more experienced aircrew as they switch aircraft types, particularly in higher physical stress aircraft (heat, low level, limited visibility, etc.). The Airsickness Management Program (AMP) has been demonstrated as effective in assisting undergraduate pilot training (UPT)/undergraduate navigator training (UNT) students to overcome airsickness. Aircrew can be assisted in overcoming airsickness by early intervention with education, and if necessary, pharmacologic and physiologic therapy. Individuals should continue primary training/regular flight duties while participating in any phase of the AMP. Although this program was designed for students, it may be beneficial for an experienced aircrew having difficulty with airsickness. The program consists of four phases.

NOTE: Pilots undergoing any phase of treatment for airsickness will not fly solo.

1.2.19.1. Phase 0. During initial physiological training, the aerospace physiologist educates students on airsickness before they participate in flight or simulator training. The causes of airsickness and strategies to prevent, manage, and treat airsickness are covered. Aircrew will be made aware of the Airsickness Management Program.

1.2.19.2. Phase I (Airsickness Episode #1). If no underlying medical cause is found, the airsickness episode is reviewed with the flying student to determine if the proper preventive measures learned in Phase 0 were followed. In situations where an individual's prior history of airsickness is identified, or where they manifest unusually high anxiety levels not believed to be associated with manifestations of apprehension, pharmacologic intervention should be considered. Pharmacolgic therapy consists of a combination of 0.5 mg Scopolamine and 5.0 mg Dextroamphetamine Sulfate (Scop/Dex) given 1 to 2 hours prior to flight for three consecutive flights, one flight per day. If this combination is unavailable, use Dextroamphetamine Sulfate 7.5 mg and Scopolamine HBr 0.45 mg in 15 ml of elixir and/or syrup combination or other approved medication.

NOTE: Pilots undergoing treatment for airsickness will not fly solo while using pharmacologic medications.

1.2.19.3. Phase II (Airsickness Episode #2). Aircrew entering this phase will receive progressive relaxation training and may receive pharmacologic therapy at the discretion of the flight surgeon. Progressive relaxation will be taught by life skills or available qualified personnel at each base using any combination of personal instruction, videotapes, and audiocassettes to teach breathing techniques, biofeedback, cognitive restructuring and imagery skills.

1.2.19.4. Phase III (Airsickness Episode #3 and higher). With three or more airsickness episodes, the flight surgeon's evaluation should place greater focus on the crewmember's motivation to continue flying. Aircrew continuing to effectively perform their in flight duties during active or passive episodes of airsickness without the need for intervention from an instructor or other crewmember are generally assessed as having high motivation, and generally encouraged to continue primary training and/or flight duties. Anytime during this phase, it is appropriate to consult life skills to evaluate for manifestations of apprehension. Individual should receive physiologic adaptation in the Barany chair by an Aerospace Physiologist/Physiology Technician. If the individual has airsickness while on Scop/Dex, ground test prior to the next flight, to rule out the potential for medication-induced nausea. Following the completion of physiologic adaptation, a

refresher spin in the Barany chair by an Aerospace Physiologist/Physiology Technician is recommended with any additional airsickness episodes.

GEORGE P. TAYLOR, JR, Lt General,
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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Executive Order 9397

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule

Privacy Act of 1974

Title 10, United States Code, Section 8013

Title 10, United States Code, Section 113

DoDD 1332.18, Separation or Retirement for Physical Disability

DoDD 5154.24, Armed Forces Institute of Pathology (AFIP)

DoDD 6130.3, Physical Standards for Appointment, Enlistment and Induction

AFPD 48-1, *Aerospace Medical Program*

AFI 33-324, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*

AFI 44-109, *Mental Health and Military Law*

AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment*

AFI 47-101*, Managing Air Force Dental Services*

AFI 48-123 Vol 1*, Medical Examinations and Standards – General Provisions*

AFI 48-123 Vol 2*, Medical Examinations and Standards – Accessions, Retention and Administration*

AFI 48-123 Vol 3*, Medical Examinations and Standards – Flying and Special Operational Duty*

AFI 48-145, *Occupational Health Program*

AFJI 44-117, *Ophthalmic Services*

AFJI 48-110, *Immunizations and Chemoprophylaxis*

AFMAN 36-2108, *Enlisted Classification*

AFMAN 36-8001, *Reserve Personnel Participation And Training Procedures*

AFMAN 37-123, *Management of Records*

AFPAM 48-133, *Physical Examination Techniques*

AFPAM 90-902, *Operational Risk Management (ORM) Guidelines and Tools*

AFOSH STD 48-20, *Hearing Conservation Program*

Air Force Records Disposition Schedule (RDS)

Aircrew Waiver Guide

AR 40-501, *Standards of Medical Fitness*

DoDD 1315.7 (reference H)

USCG COMDTINST M6000.1B, *Medical Manual*

NAVMED P-117, *The Manual of the Medical Department*

Reserve Component (ANG) Periodic Health Assessment (RCPHA) Implementation Plan

ANSI S3.6, *Specification for Audiometers*

ISO 1964 (See Atch 3, Note 2) or ISO 389:1991, *Acoustics -- Standard reference zero for the calibration of pure-tone air conduction audiometers*

National Cholesterol Education Program (NCEP) Guidelines

Abbreviations and Acronyms

ACS—Aeromedical Consultation Service

AETC—Air Education and Training Command

AFI—Air Force Instruction

AFMOA—Air Force Medical Operation Agency

AFMOA/SGPA—Air Force Medical Operation Agency, Aerospace Medicine Directorate

AFPC—Air Force Personnel Center

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AGR—Active Guard Reserve

AIA—Air Intelligence Agency

AIMWTS—Aeromedical Information Management Waiver Tracking System

AMP—Aerospace Medicine Primary or Airsickness Management Program

ANG—Air National Guard

ANSI—American National Standards Institute

ARC—Air Reserve Components (ANG, Individual Mobilization Augmentee (IMA) and unit reservists)

ARC SURGEON—HQ AFRC/SGP for unit assigned and IMA members of the Air Force Reserve; ANG/SGP for guardsmen

ARPC—Air Reserve Personnel Center

BMTS—Basic Military Training School

dB—Decibel

DDS—Dental Data System

DoD—Department of Defense

DODD—Department of Defense Directive

DODMERB—Department of Defense Medical Examination Review Board

FC—Flying Class

G6PD—Glucose-6-phosphate dehydrogenase

GSU—Geographically Separated Unit

HPSP—Health Professions Scholarship Program

HQ AFRC/SGP—Headquarters Air Force Reserve Command, Aerospace Medicine Division

IMA—Individual Mobilization Augmentee

IMR—Individual Medical Readiness

ISO—International Organization for Standardization

MAJCOM—Major command

MC—Medical Corps

MEB—Medical Evaluation Board

MEPS—Military Entrance Processing Station

mmHg—Millimeters of mercury

PCS—Permanent change of station

PCM—Primary Care Management

PEB—Physical Evaluation Board

PHA—Preventive Health Assessment

PIMR—Preventive Health Assessment and Individual Medical Readiness

RAT—Reading Aloud Test

RCPHA—Reserve Component Periodic Health Assessment

RDS—Records Disposition Schedule

ROTC—Reserve Officer Training Corps

RTFS—Return to Flying Status

SRTS—Spectacle Request Transmission System

TDY—Temporary duty

USAFA—United States Air Force Academy

USUHS—Uniformed Services University of Health Sciences

Attachment 2

Table A2.1. Certification & Waiver Authority

Category	**Certification Authority** (Notes 8, 9, 11, 12, 14, 15, 17)	**Waiver Authority** (Notes, 1, 2, 8, 11, 10, 12, 14, 17, 20, 21, 22)
Flying Class I, IA, Initial II (Note 16)	AETC/SGPS (Note 6)	AETC/SGPS
Periodic Flying Class II (Notes 3, 4, 5, 6, 10, 23)	-	MAJCOM/SG (Note 17)
Flying Class III (Note 7, 23) **- Initial (Active duty)** **- Initial (ARC members)** **- Continued flying**	 MAJCOM/SG Appropriate ARC/SG (Note 12)	 AETC/SGPS Appropriate ARC/SG (Note 12,17) MAJCOM/SG (Note 17)
Special Operational Duty **- Initial** **- Continued Special Operational Duty (Note: 23)**	 MAJCOM/SG Appropriate ARC/SG (Note 17)	 AETC/SGPS MAJCOM/SG Appropriate ARC/SG (Note 17)
Physiological Training/Operational Support Duty (ASC 9C)	Local SGP	Local SGP State Air Surgeons
Space & Missile Operations Duty **- Active Duty** **- ARC**	 AETC/SGPS (Note 14) Appropriate ARC/SG (Note 17)	 AFSPC/SG AFSPC/SG
USAFA cadet incentive flight, cadet parachute, cadet jumpmaster, cadet soaring, and cadet soaring instructor pilot duties	USAFA/SGP	USAFA/SGP
Initial Commission **- Extended Active Duty** **- Air Reserve Components** **- US Air Force Academy**	 AETC/SGPS Appropriate ARC/SG (Note 17) USAFA/SG	 AETC/SGPS Appropriate ARC/SG USAFA/SG
Change in Commission Status Without Break in Service - Active Duty Members	Note 14	AFPC/DPAMM
Change in Commission Status Entry into: **- ANG** **- IMA Program** **- Reserve Unit Program**	 State Air Surgeon (ANG) AFRC/SG Gaining Reserve Medical Squadron Senior Flight Surgeon (Note 13)	 ANG/SG AFRC/SG AFRC/SG

Table A2.1. Certification & Waiver Authority (continued)

Category	Certification Authority (Notes 8, 9, 11, 12, 14, 15, 17)	Waiver Authority (Notes, 1, 2, 8, 11, 10, 12, 14, 17, 20, 21, 22)
Officer Program Applicants		
- USAFA	DODMERB	AFA/SG
- ROTC	DODMERB	AETC/SGPS
- USUHS	DODMERB	SEC DEF /HA
- HPSP	AETC/SGPS	AETC/SGPS
- Special Officer Procurement	AETC/SGPS	AETC/SGPS
AF Initial Enlistment		
- Active Duty	MEPS	AETC/SGPS
- ARC	MEPS/AFRC Medical Squadron ANG State Air Surgeon	Appropriate ARC/SG
Continued military duty		
- Active duty	AFPC/DPAMM	
- ARC	ARC Medical Squadron	Appropriate ARC/SG
Recall to Active Duty ARC	-	AFPC/DPAMM
PALACE CHASE or FRONT	Gaining ARC Medical Squadron	Appropriate ARC/SG
Active Guard Reserve (AGR) Tours		(Note 20)
- Base level AGR Tours (ANG Title 32) **MAJCOM level AGR tours (ANG Title 10)**	ARC Medical Squadron (Note 18) ANG (Note 17) AFRC/SG (Note 19) ANG/SG	ARC/SG (Note 17) Appropriate ARC/SG
Static Line Parachute Duties Only	Local SGP	AETC/SGPS

NOTES:

1. For cases in which AFMOA/SGPA is waiver authority, interim waiver authority by subordinate commands is specifically denied.
2. HQ USAF/SG is the ultimate waiver authority for all medical waivers. USAF/SG has delegated waiver authority to AFMOA/SGPA, specifically to the USAF Consultant for Aerospace Medicine. Other delegation of certification or waiver authority is only as designated in this regulation.
3. Authority to grant categorical Flying Class II with suffixes A, B, or C is retained by AFMOA/SGPA, unless delegated in this AFI or policy letter.
   3.1. Exceptions.
   3.1.1. Flying Class IIA. MAJCOM/SG may grant the following FCIIA waivers:
   3.1.1.2. Initial and renewal for asymptomatic moderate aortic insufficiency (AI) or with otherwise

non-disqualifying ventricular dysrhythmias, which are considered possibly related to AI (no evidence of left ventricular enlargement or dysfunction) for members seen or case, reviewed at the ACS.

3.1.1.3. Initial and renewal for Minimal Coronary Artery Disease (MCAD) for members seen or case reviewed at the ACS.

3.1.1.4. Initial waiver for Aerospace Medicine Primary (AMP) course applicants who possess color vision deficiency is delegated to HQ AETC/SG. FCIIA restriction will include authorization for a T-37 flight to complete the AMP course.

3.1.2. Flying Class IIB. MAJCOM/SG may grant **renewals only** for waivers initially granted by AFMOA/SGPA.

3.1.3. Flying Class IIC. MAJCOM/SG may grant initial waiver (and renewal) **only** for the following:

3.1.3.1. Asymptomatic mild aortic insufficiency (AI) (no evidence of left ventricular enlargement or dysfunction and no significant associated ventricular dysrhythmias) for members seen or case reviewed at the ACS. Members who did not undergo centrifuge evaluation. FCIIC restriction is as follows: "Medically monitored centrifuge evaluation required prior to assignment to Fighter, Attack, Reconnaissance (FAR) or Trainer Aircraft (except T-1)."

3.1.3.2. Mitral valve prolapse (MVP) for members seen, or case reviewed, at the ACS who did not undergo centrifuge evaluation. See above restriction.

3.1.3.3. H-3 Profile (inactive flyers). The following restriction applies: "An occupational cockpit hearing evaluation/assessment is required prior to reassignment to active flying."

3.1.4. Other. MAJCOM/SG may grant initial and renewal waivers for all routine ACS clinical management group evaluations as defined by the ACS. Controversial cases will be forwarded to AFMOA/SGPA. MAJCOM/SG will forward a copy of **all** FCIIA/B/C actions (memorandum cover letter) as follows: FCIIA, B, or C: forward copy to HQ AFPC/DPAOT3, 550 C Street West Ste 31, Randolph AFB, TX 78150. Colonel (0-6) forward copy to: AFSLMO/CA, 2221 S. Clark Street, Crystal Plaza 6, Ste 500, Arlington, VA 22202. All FCIIC waiver actions delegated to MAJCOM/SG require memorandum cover letter by MAJCOM/SG be forwarded to AFMOA/SGPA, 110 Luke Avenue, Room 400, Bolling AFB, DC 20032-7050 and HQ USAF/A3OT, 1480 AF Pentagon Washington, DC 20032-1480, to include FCIIC waiver renewals. Ensure the restrictions are contained in the memorandum.

NOTE: ARC does not have the requirement to forward FCIIA, FCIIB, and FCIIC waivers to AFPC/DPOA.

4. Certification and waiver authority for USAF flying personnel while **assigned** to the National Aeronautics and Space Administration (NASA) is NASA.
5. HQ AFMC/SG has waiver authority on USAF Test Pilot School/Flight Test Engineer applicants, except for conditions listed in AFI 48-123V3, Chapter 2.1.3. May be further delegated at HQ AFMC/SG discretion.
6. ARC/SG is the certification authority for assigned reserve personnel who apply for the AMP course.
7. Non-rated applicants for flying duty (Class III) and Flight Nurse applicants, who are currently medically qualified and performing flying duty, do not require additional review and certification or reexamination prior to retraining unless the individual is applying for Inflight Refueling Duty, Combat Control Duty, Pararescue Duty, Combat Rescue Officer, or the individual is on a medical

waiver.

Note: Enlisted members applying for commissioning may use their most current PHA, in lieu of accomplishing another physical for the specific purpose of commissioning. However, ANG personnel must accomplish a complete physical examination for commissioning. A current AF Form 422 must accompany all cross-training applications.

8. The MAJCOM or appropriate ARC/SG for ANG is ANG/SG; for unit-assigned reservists and IMAs is HQ AFRC/SG.
9. HQ AETC/SGPS is the certification authority for those individuals undergoing Basic Military Training School (BMTS). For ARC members undergoing BMTS, ARC/SG will coordinate medical disposition.
10. HQ USAF/SG (AFMOA/SGPA) no longer serves as MAJCOM for Direct Reporting Units (DRUs). This responsibility has been delegated as follows: Air Force District of Washington (AFDW), Pentagon is delegated to HQ AMC/SGPA: Others: Air Force Element (AFELM), Defense Intelligence Agency (DIA), Air Force Operational Test and Evaluation Center (AFOTEC), and others, if not otherwise specified in **Table A2.1.** (to include **Notes**), will be the medical facility's MAJCOM/SG that submits the aeromedical waiver examination package. Waiver authority for HQ AFIA is delegated to HQ AFIA/SG when that position is filled by a senior flight surgeon. Waiver authority for personnel assigned to HQ USSOCOM is delegated to HQ AFSOC. Waiver authority for personnel assigned to HQ NORTHCOM is delegated to HQ AFSPC.
11. HQ Air Intelligence Agency (AIA)/SG no longer serves as MAJCOM with regards to certification and waiver authority. Authority has been delegated to the MAJCOM to which the member is assigned for duty (e.g., member's MAJCOM is AIA, but they are assigned permanent change of station (PCS) to USAFE, PACAF, etc., for duty, that MAJCOM becomes the certification and waiver authority in accordance with **Table A2.1.**).
12. HQ AETC/SGPS is sole certification and waiver authority for applicants applying for the Combat Control, Combat Rescue Officer or Pararescue Duty career fields.
13. Applicants who previously held a commission for 6 months or more in any service component and who are within 36 months of nonmedical separation, will not require their physical exam to be reviewed or certified by HQ AFRC/SG prior to being commissioned in the unit assigned reserve program, unless the applicant does not meet the medical requirements IAW AFI 48-123V2, Attachment 3.
14. Local Base Certification/Waiver Authority (active duty only). Flight surgeons (AFSC 48X3/4), normally the Aerospace Medicine Squadron/Flight Commander, or the senior squadron medical element (SME) flight surgeon (tenants only), as specifically identified by the parent MAJCOM, retain this authority. This authority will not be delegated further**.** At locations with flight surgeons who do not meet these criteria, the certification/waiver authority reverts to the MAJCOM of assignment. Non-flight surgeons are not authorized to sign, or certify medical examinations. Flight surgeons granted this authority by their MAJCOM may not certify/waiver ARC aircrew members.
15. Active duty non-aircrew members transitioning into ARC flying positions must have their medical examinations certified by the appropriate ARC Surgeon.

16. The final review authority on SF 88 or DD Form 2808 for Flying Training examinations is the SGP. The final review authority on all other examinations requiring this signature is the senior flight surgeon assigned

17. State certification/waiver authority (ANG only). State Air Surgeons who are current, certified, and trained as specifically identified by ANG/SGPA retain this authority. This authority will not be delegated further. At locations where State Air Surgeons are not assigned, or are not trained, the certification/waiver authority reverts to ANG/SGPA.

18. Delegation of this certification authority is extended only to those Reserve Medical units responsible for providing physical exam support.

19. The appropriate ARC/SG is the certification/waiver authority for AGR tour applicants with disqualifying AFI 48-123V2, Attachment 2 medical conditions; disqualifying AFI 48-123V3, Attachment 4 medical conditions; MAJCOM level tours; and AGR tours with no supporting ARC medical unit.

20. HQ AETC/SGPS is the certification and waiver authority for all ARC members entering active duty in the regular Air Force. Before ARC members will be considered for waiver for active duty in the regular Air Force, all disqualifying defects must be noted, reviewed, evaluated and waived by the ARC waiver authority. Waiver by the ARC authority does not guarantee waiver for regular Air Force duty.

21. Verbal waivers are not authorized. If an extension to an existing waiver is warranted, waiver extension must be recorded in AIMWTS and a new waiver renewal initiated at base level.
NOTE: For example, if a local base flight surgeon requests an extension of sixty days to complete required tests, examinations, specialty consultations, etc., then the appropriate waiver authority may grant that waiver with an expiration date of sixty days in AIMWTS. The base level flight surgeon must then initiate a waiver renewal in AIMWTS.

22. Certification and waiver of medical standards may only be accomplished by a credentialed flight surgeon. When a provider doesn't fill the position at the level delegated to in this attachment, the waiver authority will be retained by AFMOA/SGPA unless delegated in writing by AFMOA/SGPA to an appropriate provider, usually an aerospace medicine specialist, at that level. MAJCOM/SGs who are providers may also delegate their authority to an aerospace medicine specialist on their staff.

23. HQ ACC/SGPA and HQ AFSOC/SGPA are the certification and waiver authority for their perspective Remotely Piloted Aircraft (RPA)/MP-UAV and Sensor Operator personnel, with exception to trained FC II personnel requiring categorical (FC IIA -RPA Duty) waiver in which AFMOA/SGPA retains authority.

Attachment 3

HEARING PROFILE

A3.1. H-1 Profile. The H-1 profile qualifies applicants for Flying Classes I and IA, initial Flying Class II and III, AF Academy, special operational duty, and selected career fields as noted in AFMAN 36-2108, *Enlisted Classification.*

A3.1.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	25	25	25	35	45	45

A3.2. H-2 Profile. The H-2 profile qualifies for AF enlistment, commission, initial Space and Missile Operations duty, and continued special operational duty, but requires evaluation for continued flying (See AFI 48-123V3, A4.4).

A3.2.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	35	35	35	45	55	---

A3.3. H-3 Profile. The H-3 profile is disqualifying for enlistment, and civilian commission. It requires evaluation and MAJCOM waiver for continued flying, and Audiology evaluation for fitness for continued active duty.

A3.3.1. Definition: An H-3 profile is any loss that exceeds the values noted above in the definition of an H-2 profile.

A3.4. H-4 Profile. The H-4 profile requires a Medical Evaluation Board.

A3.4.1. Definition: Hearing loss sufficient to preclude safe and effective performance of duty, regardless of level of pure tone hearing loss, and despite use of hearing aids. This degree of hearing loss is disqualifying for all military duty.

NOTES:

1. All personnel working in hazardous noise areas will be enrolled in the Hearing Conservation Program. The Air Force Hearing Conservation Program directive (found in AFOSH Standard 48-20, *Hearing Conservation Program*) should be consulted. Standard threshold shifts should be appropriately recorded and addressed whenever a significant shift in measured hearing threshold is noted. Such a shift may not result in a profile change.
2. Exceeding the definition/standard for H-1 or H-2 automatically places the individual in the next highest category.

Attachment 4

PHYSICAL PROFILE SERIAL CHART

P. Physical Condition.

P-1. Free of any identified organic defect or systemic disease.

P-2. Presence of stable, minimally significant organic defect(s) or systemic diseases(s). Capable of all basic work commensurate with grade and position. May be used to identify minor conditions that might limit some deployments to specific locations (i.e. Glucose-6-Phosphate Dehydrogenase (G6PD) deficiency).

P-3. Significant defect(s) or disease(s) under good control. Capable of all basic work commensurate with grade and position but that may affect worldwide deployability. Deployment or PCS to remote location requires clearance by medical provider. AFRC uses P-3 to designate individuals undergoing evaluation who require restriction to home station or continental United States (CONUS) and may only be issued by AFRC/SG.

P-4. Organic defect(s), systemic and infectious disease(s), all conditions disqualifying AFI 48-123V2, A2, or AFI 48-123V4, A5 (e.g. diabetes, seizure etc.) for World Wide Service. See Chart **Note 1**.

U. Upper Extremities.

U-1. Bones, joints, and muscles normal. Able to do hand-to-hand fighting.

U-2. Slightly limited mobility of joints, mild muscular weakness or other musculoskeletal defects that do not prevent hand-to-hand fighting and are compatible with prolonged effort. Capable of all basic work commensurate with grade and position.

U-3. Defect(s) causing moderate interference with function, yet capable of strong effort for short periods. Capable of all basic work commensurate with grade and position but that may affect worldwide deployability. Deployment or PCS to remote location requires clearance by medical provider.

U-4. Strength, range of motion, and general efficiency of hand, arm, shoulder girdle, and back, includes cervical and thoracic spine severely compromised or disqualifying by AFI 48-123V2, A2.14. or AFI 48-123V2, A2.15. See Chart **Note 1**.

L. Lower Extremities.

L-1. Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.

L-2. Slightly limited mobility of joints, mild muscular weakness, or other musculoskeletal defects that do not prevent moderate marching, climbing, running, digging, or prolonged effort. Capable of all basic work commensurate with grade and position.

L-3. Defect(s) causing moderate interference with function, yet capable of strong effort for short periods. Capable of all basic work commensurate with grade and position but that may affect worldwide deployability. Deployment or PCS to remote location requires clearance by medical provider.

L-4. Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back, and lumbar vertebrae severely compromised or disqualifying by AFI 48-123V2, A2.14, or AFI 48-123V2, A2.15. See Chart **Note 1**.

H. Hearing (Ears). See **Attachment 3** for hearing profile.

E. Vision (Eyes).

E-1. Minimum vision of 20/200 correctable to 20/20 in each eye.

E-2. Vision correctable to 20/40 in one eye and 20/70 in the other, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/400 in the other eye.

E-3. Vision that is worse than E-2 profile but better than E-4.

E-4. Visual defects disqualifying by AFI 48-123V2, A2.6. See **Note 1**.

S. Psychiatric.

S-1. Diagnosis or treatment results in no impairment or potential impairment of duty function, risk to the mission or ability to maintain security clearance.

S-2. World Wide Qualified and diagnosis or treatment result in low risk of impairment or potential impairment that necessitates command consideration of changing or limiting duties.

S-3. World Wide Qualified and diagnosis or treatment result in medium risk due to potential impairment of duty function, risk to the mission or ability to maintain security clearance. Deployment to remote location requires clearance by medical provider in consultation with the Life Skills provider.

S-4/S4T. Not World Wide Qualified and/or diagnosis or treatment result in high to extremely high risk to the AF or patient due to potential impairment of duty function, risk to the mission or ability to maintain security clearance. This includes conditions in which operational risk is yet unclear. (See **Note 1**, **Note 2** and **Note 3**)

A4.1. Psychiatric profiles are a formal means to notify commanders and medical personnel of the impact of a condition on ability to perform military service. When determining a psychiatric profile, consider the airman's current duties and all foreseeable duties. It is the provider's responsibility, with the assistance of the commander, to become reasonably familiar with the demands of the duties of the airman being evaluated. In general, psychiatric profile changes from S-1 should be considered if there is impairment or potential impairment due to illness or medication use, which necessitates command consideration of changing or limiting duties. When impairment or potential impairment is so minor as to have no impact on military service, it is not necessary to change the S profile. In this and similar circumstances, patient privacy should be protected in accordance with AFI 44-109, *Mental Health and Military Law*, sections 2 and 6.

A4.2. Psychiatric profiles are based on an operational risk management model. Profile decisions should be coupled to BOTH "mishap probability" (chance that medication or illness related duty impairment will occur) and the "hazard severity" (the danger to mission, security or safety should the impairment impact the person's function at a critical time).

A4.3. Do not use these medical profiles to code administrative conditions that render a person unsuitable for duty as opposed to unfit for duty. Examples of unsuitable conditions managed administratively are listed in AFI 48-123V2, Attachment 2. In this circumstance, it is important to use AF Form 422 to communicate potential impairment with command but the S profile should remain unchanged. Disorders of substance abuse or dependence are an exception. These are profiled through AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment*.

NOTES:

1. Individuals with a 4 profile are not qualified for worldwide duty. Ensure these members have met an Medical Evaluation Board (MEB) (if required), consult AFI 48-123V2, Attachment 2, Medical Standards for Continued Military Service, and AFI 48-123V2, Chapter 4. Members on temporary 4 profiles (4T) should be followed per AFI 48-123V2, Chapter 4 if an MEB has not been accomplished.
2. S2 and S3 profiles are intended for long-term conditions that impact mission or security clearance. Do not use the S2 or S3 (minor and moderate conditions) unless the condition has or is expected to persist despite treatment for at least 3 months. For an initial treatment period of significantly impairing conditions, consider use of the S4T until the diagnosis, prognosis and medication or treatment status is clarified. Only the S4 profile may be given a T suffix as a temporary profile. S2 and S3 profiles may revert back to S1 after the condition meets criteria for full remission off medication following treatment and is not expected to recur. S4T profiles lasting over 1 year require MEB (with the exception of alcohol rehabilitation profiles, see guidance found in AFI 48-123V2, paragraph 4.8.7) This includes any recurrent duty impairment from the same condition within a year of the first S4T profile.
3. Sample Risk Assessment Matrix as provided in AFPAM 90-902, *Operational Risk Management (ORM) Guidelines and Tools*, paragraph 25, Figure 7:

SEVERITY		Probability				
		A	B	C	D	E
Catastrophic	I	Extremely				
Critical	II	High		High		
Moderate	III		Medium			
Negligible	IV					Low
		Risk Levels				

NOTE: Severity of hazards is determined by the degree of mission impact of psychiatric symptoms as cognitive and sleep impairment, emotional labiality and suicidality. Examples of probability are defined in AFPAM 90-902, paragraph 24, for individual airmen.

Case examples:

An armed security force member is not working well with others due to extreme emotional labiality, impulsivity, and paranoia associated with at least one violent anger outburst a day. Member guards a high value asset at a forward operational airbase. **Probability** of his symptom occurring is “frequent” and **severity** of mission impact is “critical” to “catastrophic” should member fire M16 weapon at another member or the asset itself. The combination of high probability of an adverse event and severity of the mission impact of inappropriately firing the weapon makes the operational risk level of continuing current duties “extremely high” (see matrix). Member should be profiled S4T, not world wide qualified, and not handle weapons. Member may require evacuation to garrison for definitive diagnosis and treatment.

A closely supervised vehicle maintenance technician has symptoms of major depression, including less than normal concentration and memory, lower energy and depressed mood (without suicidality), and was recently started on medication without significant side effects and with early symptom improvement. The member is able to complete normal duties that are routinely crosschecked. The **probability** of making a mistake is “occasional” while the **severity** of mission impact with usual supervision is “negligible”. The operational risk level in this case is “low”. If symptoms continue longer than 3 months an S2 profile should be considered with appropriate vocational recommendations as “requires ongoing supervision”.

Attachment 5

DEPLOYMENT CRITERIA

A5.1. General Considerations. For the purposes of this instruction a deployment is defined as any temporary duty where Contingency, Exercise, and Deployment temporary duty (TDY) orders were issued, the TDY location is outside of the United States and its dependencies, or during which an individual has no ready access to a permanent fixed military medical treatment facility. ANG deployment is greater than 30 days regardless of location. Conditions, which may seriously compromise the near-term well being if an individual were to deploy, are disqualifying for deployment duty. This may involve reliance on certain medications, appliances, severe dietary restrictions, frequent special treatments, or a requirement for frequent clinical monitoring.

A5.1.1. Individuals returned to duty as "fit" by Physical Evaluation Boards (PEB) may not meet deployment standards. Such individuals, if they are retained, must have profiles restricting them from deployment duties. They may be assignable to locations with large, fixed military medical treatment facilities. This may be true even if they are not assigned a specific assignment limitation code (i.e., Assignment Limitation Code C).

A5.1.2. The standards listed in **A5.2.** apply to any deploying active duty or ARC member, including members who have completed either a MEB or a PEB. An individual must have already met an MEB and must have been returned to duty before they can be profiled as not deployable. Any individual, who does not meet the deployment criteria and cannot accept deployment orders, must meet an MEB, if they have not already done so.

NOTE: Pregnancy does not require an MEB and is handled as a code 81 temporary 4T profile. Any mobility (or TDY) restrictions following completion of pregnancy are detailed in DoDD 1315.7 (reference H).

A5.1.3. ARC members should have deployment criteria addressed in the Narrative Summary submitted in the Worldwide Duty Medical Evaluation package for the purpose of enabling the ARC/SG to make a valid deployability determination. The provider submitting the request should consider the standards in **A5.2.** in the narrative summary.

A5.2. Standards. To deploy, an individual must be able to:

A5.2.1. Perform duties for a prolonged period (12 hours or more).

A5.2.2. Subsist on field rations for prolonged periods.

A5.2.3. Be free of medical conditions, including pregnancy, which require special appliances, or periodic treatment or follow up by medical specialists or sub specialists during the period of deployment.

A5.2.4. Wear or use all required items of uniform or personal protective equipment which includes flak vest, helmet, and the Chemical Warfare Defense Ensemble (CWDE).

A5.2.5. Perform heavy physical work over at least short periods of time. This includes the ability to carry all required deployment baggage (at least 40 lbs) and to run at least 100 yards.

A5.2.6. Have sufficient unaided hearing to safely perform duty.

A5.2.7. Have sufficient night vision to travel unassisted at night.

A5.2.8. Have sufficient corrected visual acuity to safely perform duty.

A5.2.9. Have normal tolerance to heat and cold.

A5.2.10. Have no increased predisposition to sudden incapacitation.

A5.2.11. Travel by either air or sea.

Attachment 6

PREVENTIVE HEALTH ASSESSMENT AND INDIVIDUAL MEDICAL READINESS (PIMR)

A6.1. The PIMR Process. The Preventive Health Assessment (PHA) and Individual Medical Readiness (IMR) "PIMR" process was instituted in 2001 as an upgrade to the previous stand-alone PHA program. The PIMR program provides an ongoing look at force health and outlines specific procedures that help keep military members medically ready to deploy year round. Specifically, it optimizes the health of the human weapon system by providing prevention education and intervention at every medical visit. It also provides a process for keeping a member's IMR requirements up to date at all times.

A6.1.1. The primary objectives of the PIMR process are to assess for changes in health status that would impact members' readiness to perform military duties and to identify members' risk factors for disease and injury and recommend applicable interventions.

A6.1.1.1. Responsibility for ensuring a fit and healthy force is shared between commanders, PCM teams and the individual service members. All have a role in ensuring the success of this program.

A6.1.2. PIMR software allows the ability for medical personnel to track currency of recommended clinical preventive services (CPS) and IMR requirements. IMR currency shall be checked at each medical visit.

A6.1.3. Public Health (or Medical Health Tech for ANG or Aerospace Medicine Tech for AFRC) provides IMR due/overdue lists to Unit CCs. Due/overdue lists are tools that help units manage the program and keep their individuals current. Although medical personnel may periodically bring unit IMR rates to the attention of the installation commander, it is the unit commander's responsibility to ensure his/her personnel are current on IMR requirements.

A6.1.4. Members should be current on IMR year-round. The annual PHA will be the "safety net" to ensure currency on required items.

A6.2. PHA Requirements.

A6.2.1. PHA Frequency.

A6.2.1.1. PHAs on flying personnel will be accomplished annually during the birth month and documented in PIMR software. PHA completion date is the date of the "health record review" in the PIMR software. All aviators must have an in-person interview with the flight surgeon annually to complete the PHA.

A6.2.1.2. PHAs on non-flying personnel become due 12 months after the date of the last PHA. It does not need to be linked to the birth month.

A6.2.1.3. In rare cases (*e.g.*, deployment, unexpected TDY, emergency leave, etc.), individuals may exceed 12 months since their last PHA. If a member is scheduled for deployment and it is reasonably expected that the PHA may come due during the deployment, every effort should be made to perform the PHA prior to the deployment.

A6.2.2. Elements of complete PHA.

A6.2.2.1. Review all IMR requirements; accomplish, schedule or order items needed.

A6.2.2.2. Review medical record, interval health history and AFMS-approved Health Risk Assessment (HRA).

A6.2.2.3. Notify member if PCM Team visit is required.

A6.2.2.4. Inform member which clinical preventive services items are recommended (*e.g*. pap smear, mammogram, fecal occult blood test, etc.).

A6.2.2.5. Accomplish or schedule occupational health exam (OHE), if applicable.

A6.2.2.6. Determine fitness for duty and assess deployability (update AF Form 422, if needed).

A6.2.2.7. Ensure PCM final review of all PHA actions.

A6.2.2.8. Update DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*, and PIMR software.

A6.2.2.9. Document assessment/findings in the medical record.

A6.2.2.10. Provide feedback to the member.

A6.3. IMR Requirements: All IMR requirements must be reviewed, evaluated, and accomplished/scheduled/ordered as part of the complete PHA process. Only members that have met these requirements in all six areas are considered "Fully Medically Ready to Deploy" (IMR GREEN). Yellow periods for each item (built-in grace periods) have been incorporated into the PIMR software and are based on the most current AF/SG policy. Members who have IMR deficiencies or have deployment limiting medical conditions are considered not medically ready to deploy (RED STATUS), and their "not ready" status adversely affects their units' IMR rate. Refer to **Attachment 5** for minimal medical standards for deployment.

A6.3.1. Immunizations.

A6.3.1.1. Clinic personnel verify currency, administer immunizations IAW AFJI 48-110, *Immunizations and Chemoprophylaxis*, and record all immunizations in the Air Force Complete Immunization Tracking Application (AFCITA). Member is IMR RED if any required immunization is overdue.

A6.3.2. Dental Clearance.

A6.3.2.1. Dental clearance is managed through the web-based Dental Data System (DDS) using a classification system. The member's dental classification is imported from DDS into PIMR.

A6.3.2.2. A dental classification of 1 or 2 translates to "member is dentally ready for deployment" and is reflected as IMR GREEN in PIMR. A dental classification of 3 or 4 translates to "member is not dentally ready for deployment", and is reflected as IMR RED in PIMR. Dental classification definitions can be found in AFI 47-101, *Managing Air Force Dental Services*.

A6.3.3. Deployment Limiting Medical Conditions.

A6.3.3.1. During each medical visit, the provider will determine if a deployment limiting medical condition exists, and the AF Form 422 will be updated, if needed. During the PHA, the AF Form 422 will be revalidated. If no changes are indicated, the AF Form 422 may reflect the new date without changes to the PULHES or other blocks. Members with a 4T medical profile or an Assignment Limitation Code -- C will are reflected as IMR RED status.

A6.3.3.2. Profiles will be managed in accordance with this AFI and AFPAM 48-133.

A6.3.3.3. Providers will initiate profiles as indicated in AFI48-123V2, Chapter 4 and guidance in AFPAM 48-133.

A6.3.4. Medical Readiness Lab Tests.

A6.3.4.1. The following lab tests will be considered a minimum for all AF personnel:

A6.3.4.1.1. G6PD, DNA, Blood Type and Rh Factor, Sickledex—Once. Member IMR RED, if missing one of these tests.

A6.3.4.1.2. Human immunodeficiency virus (HIV)—Every 2 years for Active Component. Member IMR RED if overdue. Note: AFRC requires testing every 3 years. All ARC members must be current within 2 years if activated for 30 days or more.

A6.3.4.2. Additional lab tests may be warranted based on deployment location requirements, but will not affect one's IMR status.

A6.3.5. Preventive Health Assessment.

A6.3.5.1. The PHA, as outlined in **A.6.2**. will be conducted annually.

A6.3.5.2. The date of the Health Record Review in PIMR records the date the PHA is complete. Member is IMR RED when the PHA is overdue.

A6.3.6. Medical Equipment. One pair of protective mask spectacle insert is required for members whose distant visual acuity meets the spectacle inserts criteria in AFJI 44-117, *Ophthalmic Services*. Member is IMR RED when a deficiency in this requirement exists.

A6.3.6.1. Non-flying personnel with distant visual acuity (DVA) worse than 20/50 and flying personnel with DVA worse than 20/20 must have gas mask inserts issue date in PIMR from Spectacle Request Transmission System (SRTS).

A6.4. Geographically Separated Units (GSU).

A6.4.1. Individuals preparing for a GSU assignment must complete their PHA within 90 days of departure, and annually thereafter/ GSUs without intrinsic medical support or readily available medical support may request a waiver from the MAJCOM/SG to deviate from this requirement for a period not to exceed 36 months from the last PHA. The frequency of occupational health exam cannot be waived. (See AFI 48-123V1, paragraph 1.2.3. and sub-paragraphs for additional guidance.)

A6.4.2. All PHA and IMR requirements must be current prior to assignment to a GSU, including any occupational health requirements.

A6.4.3. Ongoing preventive care will be the responsibility of the member's assigned PCM.

A6.4.4. Host units should assist GSU personnel in accomplishing required IMR items.

A6.5. Air Reserve Component. The RCPHA will be accomplished annually IAW this AFI. The ANG PHA (RCPHA) will be accomplished IAW this AFI and specific ANG and AFR RPHA implementation guidance.