BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 10-203

25 JUNE 2010

Operations

DUTY LIMITING CONDITIONS

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AF/SG3P

Supersedes: AFI10-203, 30 October 2007

Certified by: AF/SG
(Lt Gen Bruce Green)

Pages: 35

This instruction implements AFPD 10-2, Readiness, October 30, 2006; Title 10, United States Code Sections 136(d) and 671. This Instruction describes how to communicate to commanders individual member restrictions due to medical reasons. The application of restrictions is a commander's program with medical recommendations. It also describes the disposition and management of members who have duty limitations and reporting requirements. It interfaces with AFPD 44-1, *Medical Operations*, AFPD 48-1, *Aerospace Medical Program*. This Instruction applies to all Active Duty Air National Guard and the Air Force Reserve members. 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 Instruction are outlined in Executive Order, 9397, *Numbering Systems for Federal Accounts Relating to Individual Persons, November 22, 1943*. Privacy Act System Notice F044 AF SGD, Automated Medical/Dental Records System, applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records* and disposed of in accordance with the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at **https://www.my.af.mil/gessAF161a/afrims/afrims**/ The reporting requirements 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*. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through the appropriate functional's chain of command. **Attachment 1** is a list of references and supporting information.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include identification of the Assignment Limitation Code (ALC-C) Fast Track program. Definition of Optimal Medical Benefit. Addition of the role of the Exercise Physiologist. Proper procedures for management of pregnancy duty limiting conditions. Use of AF Form 469 for dental class 3 and 4.

Chapter 1

GENERAL PROVISIONS

1.1. Purpose. This AFI establishes procedures for the documentation and administrative management of members with duty limitations and occupational restrictions. These procedures have been developed to ensure maximum utilization and readiness of personnel, while preserving their health and preventing further injury or illness. When individuals have medical conditions affecting their continued qualification for retention in the Air Force, as outlined by the standards in AFI 48-123, this AFI and AFI 41-210 describes appropriate courses of action for medical board disposition.

1.1.1. The goal is that appropriate medical recommendations are communicated to commanders so they are able to determine the optimum utilization of members in their charge within the guidelines of the medically imposed restrictions and ensure timely return to duty, Assignment Limitation Code Request (ALC-R) or MEB processing. **Note**: Commanders and other designated military authorities are entitled to health information to the extent necessary to carry out their military mission IAW DoD 6025.18-R, *DoD Health Information Privacy Regulation* and AFI 41-210.

1.1.2. Commanders and supervisors should consult with healthcare providers to maximize use of personnel with duty limiting conditions (DLC)s. An assessment based on operational risk of personnel assigned to a squadron/unit is critical to maintaining unit readiness to the highest degree possible.

1.1.3. Purpose of AF Form 469 *Duty Limiting Condition Report*. The AF Form 469 is used to convey physical limitations to the commander when a member's health, safety and well being, mission safety or abilities to effectively accomplish the mission are at risk.

1.2. Physical Profile System to include Physical Profile Serial Chart (PULHES) . The physical profile system classifies individuals according to physical functional abilities and long term availability for worldwide duty IAW AFI 36-2101, it applies to the following categories of personnel:

1.2.1. Applicants for appointment, enlistment, and induction into military service.

1.2.2. Active , Air Force Reserve and Air National Guard military personnel, cadets, and scholarship participants.

1.3. Profiles. Profiles are descriptions of physical capabilities which are used for establishing suitability for career fields or Air Force Specialty Code (AFSC). A profile can be entered on a SF 88, *Medical Record-Report of Medical Examination*, DD 2808, *Report of Medical Examination*, or an AF Form 422 *Notification of Air Force Member,s Qualification Status*. Once a profile is established on an AF Form 422, it is valid for up to five years unless the member has undergone a MEB, WWD evaluation, or has a current duty or mobility restriction. If a member wishes to retrain and the baseline profile is older than five years, Force Health Management (FHM) will revalidate the member's physical capabilities in coordination with the member's Primary Care Manager (PCM).

1.4. Duty limitations. Duty limitations are occupational or mobility restrictions entered on the AF Form 469. The maximum duration of the AF Form 469 following MEB or Review in Lieu of MEB (RILO) is 15 months. For any other duty restrictions the maximum duration of AF Form 469 is 12 months. Any pending AF Form 469 must be reviewed for appropriateness and accuracy at each encounter, and renewed minimally at each Preventive Health Assessment (PHA) or Reserve Component Periodic Health Assessment (RCPHA) as appropriate.

1.4.1. Any duty limiting condition which limits mobility or may be unfitting for continued military service must undergo a MEB or an ALC-R within one year of the initial AF Form 469 disposition for the condition IAW AFI 48-123 and AFI 41-210. In no case should members on deployment limiting codes (31 and/or 37 –combined time) exceed one year without MEB or ALC-R processing, unless the specific case is discussed with AFPC/DPAMM or the applicable ARC/SGP and documented in the AF Form 469 and medical record.

1.4.2. The Preventative Health Assessment and Individual Medical Readiness (PIMR) application may track up to three duty limiting conditions simultaneously. However, a member may only have one active AF Form 469 at a time. Therefore, if a provider adds a new diagnosis to an existing AF Form 469, he or she must re-accomplish a 469 including any pre-existing duty limitations. **Note**: PIMR maintains a record of all previous AF Form 469s.

1.4.3. Although a mobility restricting condition may only have a cumulative duration of 365 days prior to a mandatory requirement for the member to undergo a MEB or ALC-R, its duration may expire prior to other conditions' expiration. In this case, a new Form 469 will be automatically generated by the PIMR application reflecting the current status of the remaining duty limiting conditions and sent to the member's unit with the expiration date of the remaining condition (s).

1.5. Special Considerations.

1.5.1. ARC Unique Issues. For ARC members, refer to AFI 48-123 and AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*.

1.5.2. AF Form 422. This Form is used for initial qualifications, qualification for retirement or separation, military retraining, permanent change of station (PCS), school clearance, etc. Additionally, this Form will be used by the wing Exercise Physiologist/Fitness Program Manager (FPM) or ARC Fitness Program Medical Liaison Officer (MLO) to make fitness clearance or exemption recommendations. For further instruction please refer to AFI 48-123 and AFI 10-248, *Fitness Program*.

1.5.3. Refusal to obtain medical evaluation or treatment. After evaluation by medical consultants, members who refuse to obtain medical evaluations or treatment as required or recommended will be processed via ALC-R, MEB or WWD evaluation as appropriate. The Deployment Availability Working Group (DAWG) will refer those members with medical conditions which are disqualifying for continued military service to their PCM. The ALC-R, MEB or WWD evaluation will evaluate the member's retainability in the service with the medical condition in its current state and will consider the probability of progression of disease or worsening of medical condition without the recommended medical treatment. The member may not be eligible for military disability payment and may be subject to

disciplinary action under the Uniform Code of Military Justice (UCMJ) and/or involuntary separation under AFI 36-3206; AFI 36-3208, *Administrative Separation of Airmen*; or AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members.*

1.5.3.1. Members will be provided, if desired, with a second opinion from a PCM-selected consultant to explore treatment options. ANG and AFRC members accomplishing a worldwide duty evaluation may chose to seek a second opinion through their private insurance. If both opinions agree, the, MEB or WWD will progress, if they disagree, the member may choose his/her treatment course. Further opinions will only be considered through the administrative appeal process.

Chapter 2

RESPONSIBILITIES

2.1. Chief of Staff of the Air Force. Establishes USAF personnel readiness goals and standards and is responsible for Force Readiness, including medical readiness to ensure the AF can meet national requirements.

2.2. Air Force Surgeon General. Establishes medical standards and procedures for recommending physical duty limitations.

2.3. Major Command Chief of Aerospace Medicine.

2.3.1. Acts as liaison between medical units, medical squadrons, or medical groups and Air Force Medical Support Agency (AFMSA).

2.3.2. Performs MAJCOM fitness for duty (FFD) and restrictions trend analysis and reports to MAJCOM/ CC.

2.4. Wing Communications Group /Squadron. Assists the medical unit, medical squadron, or medical group to ensure the communication requirements for the DLC program are met. This includes ensuring providers/clinical staff, Force Health Management (FHM), Chief of Aerospace Medicine (SGP), Chief of the Medical Staff (SGH), and Exercise Physiologist/ FPM or ARC MLO access to the PIMR and Armed Forces Health Longitudinal Technology Application (AHLTA), as applicable. It also includes assisting with the initiation and maintenance of organizational email accounts for each unit for AF Form 469 reporting via PIMR.

2.5. Medical Treatment Facility (MTF), Medical Group (MDG), Medical Squadron (MDS), or Reserve Medical Unit (RMU) Commander .

2.5.1. Ensures timely scheduling and appropriate completion of required examinations and consultations. For members on mobility status with conditions limiting deployability, examinations (including laboratory/radiology studies and specialty evaluations) shall be completed not more than 30 days after they have begun unless the reasons are adequately explained and documented (90 days for ARC).

2.5.2. Ensures the following actions/timelines are met:

2.5.2.1. Members on deployment limiting mobility restrictions originally anticipated to expire in 30 days or less will be converted to an Assignment Availability code (AAC) 31 if the restrictions need to be extended beyond 30 days.

2.5.2.2. Once the DAWG has decided that a MEB is required, the MTF ensures the submission of the MEB to AFPC/DPAMM IAW AFI 41-210. For AFRC, ensures all non-duty related conditions are submitted to AFRC/SGP IAW AFI 41-210.

2.5.2.3. Authorized to use 72 hour consultations as a means to expedite duty limitation determinations if a patient is in a mobility position and this condition may result in a Code 31 (Medical Deferment) or 37 (Medical and/or Physical Evaluation Board (MEB/PEB).

2.5.3. Will ensure ARC members with a non-duty related issue (Existing Prior to Service (EPTS) – Line of Duty (LOD) N/A) are referred to their civilian providers. The Medical Unit Commander will then track timely receipt of civilian medical records by the member,

reporting delays to the member's commander IAW AFI 10-250, *Individual Medical Readiness*.

2.6. Medical Treatment Facility (MTF), Medical Group (MDG), Medical Squadron (MDS), or Reserve Medical Unit (RMU) Chief of Aerospace Medicine (SGP).

2.6.1. Is appointed in writing by the Wing/CC , MTF/CC, MDG/CC , MDS/CC or RMU/CC, IAW AFI 48-101, *Aerospace Medical Operations*. This individual will be a credentialed flight surgeon and must have active privileges in flight medicine. Unless otherwise allowed by paragraphs 2.7.1.1. or 2.7.2., the SGP will serve as the Senior Profile Officer (SPO).

2.6.2. Will consult with MAJCOM/SGP to liaison with the Combatant Commander (COCOM)/ SG when conflicts between patient interest and commander interest with regard to deployment suitability cannot be resolved locally. If there is a risk to the patient that the SGP believes may not be fully realized by the unit commander, the next higher commander, who is at least a Group/CC, will have the final authority to resolve the issue(s) of both parties. See paragraphs 3.3.1.1.2 and 3.3.1.1.3 for additional guidance.

2.6.3. Serves as chairman of the DAWG. Alternatively, the Chief of Professional Services (SGH) may serve as the DAWG chairman with concurrence of the MAJCOM SGP.

2.6.4. Reports profile, duty limiting conditions, and deployment availability statistics to MAJCOM and as directed.

2.6.5. Responsible for ensuring profiling and duty limitation standards are met.

2.6.6. Responsible for training all providers with the Chief of Medical Staff (SGH) on the appropriate completion of profiles and duty limitations.

2.7. Senior Profile Officer (SPO).

2.7.1. The standards experts in the Air Force Medical Service (AFMS) are graduates of the Residency in Aerospace Medicine (RAM). Where a RAM is assigned, he/she will serve as the senior profiling officer when more than one profile officer is appointed by the MTF Commander.

2.7.1.1. At MTFs where a RAM is not assigned, or the sole RAM is a squadron or group commander, the MTF/CC may appoint the profile officer most knowledgeable in physical standards as the senior profile officer.

2.7.2. Since the SGP is usually the medical officer most knowledgeable in physical standards, the SGP is generally the Senior Profile Officer. In the rare situation where another profile officer is named the Senior Profile Officer, the SPO will be a credentialed flight surgeon. **Note** ARC: If no credentialed flight surgeons are assigned, the senior credentialed physician will serve as the SPO.

2.7.3. Attends the DAWG

2.7.4. If the SPO is not the SGP, he/she will be responsible for the following:

2.7.4.1. Assisting the SGP in resolving AF Form 469 duty limitation conflicts between profile officers, providers, and commanders.

2.7.4.2. Providing profile, duty limiting conditions, and deployment availability statistics reports to the SGP/DAWG Chairman for review.

2.7.4.3. Assisting the SGP in ensuring profiling and duty limitation standards are met.

2.7.4.4. Assisting the SGP and SGH in training all providers on the appropriate completion of profiles and duty limitations.

2.8. SGH.

2.8.1. Responsible for training all providers with the SGP on the clinical aspects of appropriate completion of profiles and duty limitations.

2.8.2. Responsible for the clinical review and quality control of all MEB narrative summaries, and ensure the timely completion of all MEBs.

2.8.2.1. ARC only: Includes WWD narrative summaries. The AD MTF maintains responsibility for quality control and completion of ARC MEBs.

2.8.2.2. Air National Guard (ANG) only: National Guard Bureau (NGB)/SG maintains quality control and completion of WWD evaluations. AD MTF maintains responsibility for quality control and completion of ANG MEBs.

2.8.3. Ensures all clinical standards of care are met at each patient encounter.

2.8.4. Monitors clinical quality of duty limiting determinations through the facility peer review program in conjunction with the SGP.

2.8.4.1. The Profile Peer Review Checklist (Attachment 2) may be utilized as a guide by both the SGH and SGP when conducting this peer review process. Results of the peer review process will be presented at the monthly DAWG in accordance with paragraph 4.1.4.

2.8.5. Attends the DAWG.

2.9. Primary Care Elements (to include Flight Medicine) and Reserve Physical Examination Sections.

2.9.1. All providers (including specialty consultants) must determine if the reason for the current encounter or another identified condition will affect the member's ability to perform his/her job functions or worldwide deployability. The provider will then utilize the duty limitation system via the AF Form 469, to describe any functional limitations.

2.9.1.1. IAW AFI 10-248 (Effective 1 July 2010, AFI 10-248, *Fitness Program*, will be re-designated AFI 36-2905, *Fitness Program*) an aerobic component must be tested. If a member is unable to test in an aerobic component for 12 months or more, then an MEB must be initiated unless the condition precluding this testing is pregnancy.

2.9.2. The patient's assigned provider will complete or coordinate additional clinical follow-ups or consultations needed to finalize physicals and/or assessments for clearance. ARC medical units will coordinate with the AD MTFs or TRICARE to obtain follow-up and/or consultations for service connected issues and any line of duty determination in progress. ARC members with non-duty connected issues will be referred to their civilian providers for additional evaluation with explicit instructions to provide clinical information to the medical unit.

2.9.3. Deploying or TDY physicians who will be unable to complete MEB narrative summaries and case coordination within the time allowed IAW AFI 41-210 are required through the flight commander to transfer responsibility for their duties to another provider.

2.9.4. Providers derelict in their duty to complete narrative summaries and case coordination may be subject to review and adverse clinical or disciplinary action IAW AFI 44-119, *Medical Quality Operations Improvement*, and the UCMJ, as appropriate.

2.9.5. Providers must convey to commanders the necessary information to make informed decisions on the management of people in their charge. Because the member's commander is ultimately responsible for determining how best to utilize their member's capabilities, the DLC report is limited to stating functional limitations. The limitations need to be timely, accurate, and unambiguous to help commanders make the best decisions for their personnel and mission.

2.9.5.1. The AF Form 469 will contain no positive affirmations regarding the member's workplace as this is the responsibility of the commander/supervisor to determine where a member can work and the type of work they can do. Duty limitations will describe functional impairments. (EXAMPLE: SSgt who works in a shop that uses a pressure hose to clean items. He hurts his shoulder and has a functional limitation of "no lifting shoulder above 90 degrees" or has a functional limitation of "no pushing or pulling with right arm against resistance/no pushups". The AF Form 469 WOULD NOT state "Member is able to use pressure hose" (a positive affirmation). This Form is used solely to describe limitations-"No raising shoulder above 90 degrees.)" Explain limitations in simple layman's terms, avoiding medical terminology.

2.9.5.1.1. The AF Form 469 will not contain diagnoses or sensitive medical info.

2.9.5.2. The AF Form 469 may contain positive instructions regarding a member's medical recommendations. (Example: MSgt who has undergone foot surgery. The AF Form 469 may state: "Member requires the use of hard orthopedic shoe and crutches."

2.9.5.3. In order to properly complete the AF Form 469, the provider must check either the Mobility Restriction or Duty Limiting box or both. This step communicates recommended actions to the member's commander. The provider/medical staff must cross-check the member's organization and duty phone with the member prior to submission of the AF Form 469.

2.9.5.4. AF Form 469 functional limitations which impact unit fitness will be processed IAW AFI 10-248, *Fitness Program*. (Effective 1 July 2010, AFI 10-248, *Fitness Program*, will be re-designated AFI 36-2905, *Fitness Program*). The AF Form 469 may be used to remove a member from unit fitness participation for a period less than 30 days. Members with a functional limitation which impacts unit fitness participation greater than 30 days or members with an impending fitness test in less than 30 days will be referred to the Exercise Physiologist/FPM by the provider for testing exemption recommendations and exercise prescription evaluation. The Exercise Physiologist will use AF Form 422 to document exercise program evaluations, fitness prescription instructions, fitness testing exemption recommendations, and clearance for unrestricted fitness participation or fitness testing. (ARC only: For ARC units without an Exercise Physiologist/ FPM, those

fitness exemptions requiring referral to the HAWC/HPF listed above will be referred to the ARC Fitness Program Medical Liaison Officer (MLO).

2.9.5.4.1. The presence of a functional limitation which requires a fitness program excusal for greater than 30 days via AF Form 422 will also require an AF Form 469 to describe any additional duty limitations and document referral to the Exercise Physiologist. (NOTE: Refer to AFI 10-248 (Effective 1 July 2010, AFI 10-248, *Fitness Program*, will be re-designated AFI 36-2905, *Fitness Program*). regarding appropriate referrals for ARC medical units when functional limitations impact unit fitness.)

2.9.6. Providers and PCM team personnel, or the Reserve Physical Examination Section will review existing duty limitations during all standard and special purpose medical examinations, PHAs, or RCPHAs.

2.9.7. Providers will also assist FHM by making assignment or deployment recommendations for their patients with duty limiting conditions, and for retraining profiles. Conditions that may render a member at risk for deployment or reassignment must be fully explored with the concurrence of the Profile Officer (EXAMPLE: direct communication with a patient's commander may reveal additional requirements not previously documented).

2.9.8. Providers will ensure that patient visits are appropriately documented in the medical record and that duty limitation data is entered into the PHA and Individual Medical Readiness (PIMR) software program or equivalent program.

2.9.8.1. Providers are expected to evaluate/re-evaluate duty limitations with each encounter. For chronic conditions, a simple annotation in the member's medical record such as "no change to DLC" or "DLC remains appropriate" will suffice.

2.9.9. Mental Health providers communicate with commanders IAW AFI 44-109, *Mental Health and Military Law.*

2.9.10. Flight Medicine Responsibilities: Complete all clinical components of flying, special operational duty and occupational health exams and/or assessments. Non-special duty occupational health exams and/or assessments may be delegated to the Occupational Health Clinic when present. PCMs will perform initial physical profiling for special duty applicants with consultation from FHM.

2.10. Competent Medical Authorities. 2.10.1 Members not currently on Personnel Reliability Program (PRP) who have been identified for an assignment with PRP duties will undergo an administrative qualification process. IAW DoD 5210.42-R_AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP).* After members are screened for PRP assignability via the administrative qualification process, they will be continuously monitored IAW DODR 5210.42-R_ AFMAN 10-3902

2.10.1.1. Continuous monitoring is the process for ensuring the individual maintains PRP assignment eligibility while in training and enroute for assignment. The losing Competent Medical Authority (CMA) will pass to the losing commander, any medical condition requiring the generation of an AF Form 469.

2.10.1.2. Additionally, the losing CMA will pass all AF Form 469s to the gaining CMA after administrative qualification.

2.10.1.3. This does not relieve the MTF of their responsibility to pass any medical condition that is normally reported to a commander (e.g. alcohol related incident (ARI), alcohol abuse, depression, suicide attempts/threat, prior drug use, etc.). Medical issues that are minor in nature and do not meet the criteria of an AF Form 469 will not be passed to the gaining CO and do not require a CMA review until certification action at the gaining base.

2.10.2. Once the gaining CMA (at Installations with Active PRP Members Assigned) is notified that the incoming member has been administratively qualified and/or receives an AF Form 469 on the member, it is the gaining CMAs responsibility to monitor AHLTA for medical conditions which may preclude the member from assignability to the gaining base and PRP certification.

2.11. Clinical Consultants. Will provide timely, complete, and concise narrative summaries regarding the member's clinical status with specific functional limitations. Consults will be completed and documented within 14 days of patient encounter. This may be delayed if significant studies are pending, but will never exceed 14 days following definitive diagnosis. ARC **Note**: consults must be completed within 90 days.

2.11.1. If a clinical consultant determines that a member requires a duty limitation, the consultant may initiate an AF Form 469, but should communicate this duty limitation to the member's PCM. Clinical consultants may initiate rehabilitation for a specific illness or injury, but the Exercise Physiologist/FPM will make overall fitness prescriptions which account for the functional limitation and rehabilitation program.

2.11.2. If the case involves questions about the member's qualification for continued military service or deployability, the clinical consultant should include specific recommendations in the medical record or narrative summary regarding these issues.

2.11.3. Civilian clinical consultants. Civilian clinical consultants should limit recommendations to functional limitations. Military providers retain final deployment and retainability recommendation authority.

2.11.4. ARC members who are seen by their civilian providers may take up to 90 days to receive a narrative summary.

2.12. Profile Officers.

2.12.1. Profile officers are appointed in writing by the medical unit Commander.

2.12.2. Profile officers will be Flight Surgeons credentialed in Flight Medicine (unless no Flight Surgeons are assigned). They will be familiar with this AFI, AFI 48-123, AFI 44-170, *Preventive Health Assessment* and AFI (Effective 1 July 2010, AFI 10-248, *Fitness Program,* will be re-designated AFI 36-2905, *Fitness Program*). . Formal training on the duties of the profile officer and the aforementioned AFIs may be obtained from the Aerospace Medicine Primary Course.

2.12.3. Profile officers will ensure squadron interests (mission) and the patient's interests (health or restoration of health) are considered to maximize the benefit to both.

2.12.4. Profile Officers perform final review and sign all Duty Limiting Conditions AF Forms 469 which include mobility restrictions.

2.12.5. Profile Officers perform final review of exercise prescriptions and countersign all AF Form 422s completed by the Exercise Physiologist/FPM or ARC MLO.

2.12.6. Profile officers may supersede the recommendations of a healthcare provider and should communicate the reason for superseding the provider's recommendation to the provider, the SGH, and the SPO. In cases where there is disagreement on profiling or duty limitation issues, the senior profile officer will make the final determination after review of the records and, when necessary consulting with the unit commander.

2.13. Public Health Function (FHM). These functions are performed by a 4N in the physical examination section for AFRC and the Full Time Health Technician for the ANG, as they do not have a FHM function (see ARC supplements for further clarification). (Flight Medicine for the ARC; Health Technician for the ANG).

2.13.1. Performs administrative quality reviews of DLCs, physical examinations, profiles, and appropriate clearances before these documents are forwarded/leave the facility (except routine PHAs, MEBs, and WWDs).

2.13.2. Manages the profiling/duty limitation system in accordance with this Instruction. Serves as the communications link between squadron/unit commanders, supervisors, and the health care providers.

2.13.3. Keeps Primary Care Elements, medical facility executive leadership, unit health monitors, unit deployment managers, and unit as well as installation leadership informed of current status for all duty limitations over 30 cumulative days, and mobility availability decisions.

2.13.4. Attends DAWG, produces agenda, metrics, minutes and any required reports. ARC DAWG members are highly encouraged to attend collocated Active Duty DAWG.

2.13.4.1. Performs the required review as indicated in paragraphs 4.1.3.1 and 4.1.3.3 in preparation for the DAWG.

2.13.5. Evaluates new pregnancy duty limitation recommendation from providers. After Public Health evaluates a patient for workplace exposure IAW the Fetal Health Protection Program, forwards pregnancy duty limitations to the clinic providing primary care to the patient for review. Any modification in restrictions by the provider must be referred to Public Health for fetal risk exposure evaluation.

2.13.6. FHM notifies the health care provider to initiate MEB action, FFD or WWD action for ARC members (with non-duty related medical conditions) as soon as the provider determines that the member will not be expected to return to duty within 1 year of the non-mobility start date (or within 1 year of the date a non-mobility profile should have been initiated) unless directed earlier by AFI 48-123.

2.13.6.1. FHM will assist the PCM and Physical Evaluation Board Liaison Officer (PEBLO), via the DAWG, in identifying other members who require MEB action or an ALC-R.

2.13.7. FHM performs quality control review on AF Form 422 and AF Form 469 after MEB/PEB processing as applicable. Particular attention should be paid to members who have been given an Assignment Limitation Code C (ALC-C) by AFPC/DPAMM or AFRC/SGP. When utilized, one of the following ALC-Cs is applied:

2.13.7.1. ALC-C1- Deployable/Assignable to Global DoD fixed installations with intrinsic Medical Treatment Facilities (MTF). Deployable/Assignable to non-permanent installations or installations without intrinsic MTF with approval of gaining installation SGP or SGH (MAJCOM equivalent if none at installation) or COCOM/SG as applicable.

2.13.7.2. ALC-C2 – Deployable/Assignable to CONUS installations with intrinsic fixed MTFs (TRICARE Network availability assumed). Deployable/Assignable to OCONUS installations with approval of gaining COCOM/SG or MAJCOM/SG (or delegate).

2.13.7.3. ALC-C3 – Non-Deployable/Assignment limited to specific installations based on medical need and availability of care.

2.13.8. Ensures AF Form 469 is appropriately accomplished by a medical provider. A minimum quality review must be accomplished utilizing MTF acceptable and approved practices. Public Health is responsible for timely execution, and follow-up. Questions on applicability of standards versus restrictions may be addressed with either the provider, the Profile Officer or the SGP.

2.13.9. FHM will review and sign all AF Form 469s and all AF Form 422s, except those for fitness.

2.13.10. Through AHLTA/PIMR, FHM will distribute AF Form 469 and AF Form 422 as directed in this Instruction to the member's commander. Care should be taken to ensure that distribution of a patient's protected health information (PHI) is limited to the minimum necessary and these disclosures must be tracked using local medical unit procedures

2.13.11. FHM will accomplish an initial medical record and PIMR review for incoming base personnel to ensure any limitations to duty performance, TDY, deployment/mobility and PHA data are appropriately captured. FHM will refer duty limitations suspected to be inappropriate, no longer necessary, or otherwise in need of correction or amendment to the PCM to ensure mission effectiveness and patient safety are maintained. Questionable limitations may also be made available to the Profile Officer to determine in consultation with the individual's commander and senior profile officer or SGP acceptable duty restrictions.

2.13.11.1. During this record review process the PEBLO will be notified of any newly arrived members who have assignment limitation codes in order to facilitate tracking of Review in Lieu of MEB (RILO) requirements by the PEBLO.

2.13.12. FHM will review retraining applications to ensure members are qualified for entry into the AFSC(s) for which the member is applying. Review of each AFSC's physical requirements is found in the Air Force Enlisted Classification Directory (AFECD) and the Air Force Officer Classification Directory (AFOCD) located on the Air Force Personnel Center (AFPC) website. The AF Form 422 will indicate each of the selected AFSCs the member is, and is not qualified to enter. When flying or special operational duty AFSCs are selected, AFI 48-123 will be reviewed for disqualification, the member will be informed and a determination of potential waiver action will be determined by a flight surgeon.

2.14. Member's Commander.

2.14.1. Ensures the unit attains and maintains maximal medical readiness.

2.14.2. Ensures the member is available for and completes examinations including required follow-up studies and final disposition.

2.14.3. Establishes an encrypted organizational email account through the base communications unit by which AHLTA/PIMR may communicate AF Form 469 and AF Form 422 actions. Ensures regular monitoring of this account.

2.14.3.1. Authorizes access only to the commander, unit deployment manager, unit health monitor and unit first sergeant in order to ensure HIPAA compliance by MTF.

2.14.3.2. Ensures contact information for organizational account is current and accurate and provides that information to base communications as well as the local AHLTA/PIMR administrator.

2.14.4. Reviews and concurs/non-concurs with mobility recommendations. The commander will coordinate all non-concur determinations with the SPO.

2.14.4.1. Issues AF Form 469 to member. Counsels and issues written instructions on duties and responsibilities of member when required.

2.14.4.2. For AF Form 469 actions which do not limit mobility, the commander may delegate these requirements to the unit first sergeant and is not required to sign the Form.

2.14.4.3. For AF Form 469 actions limiting mobility, the commander must sign the AF Form 469 prior to issuing it to the member.

2.14.5. Commanders must know the FFD status of the people in their charge. A DoD exemption to the HIPAA Privacy Rule allows for disclosures of Protected Health Information (PHI) to commanders without the patient's authorization, but these disclosures must be tracked. Unit First Sergeants, and Unit Deployment Managers and Unit Health Monitors also fall under this exemption in regard to information contained in the AF Form 469 and AF Form 422. Refer to AFI 41-210 for more information on commander access to medical information.

2.14.6. Commanders must determine how to utilize a member based on the functional limitations and their knowledge of the job. The commander and supervisor know best how to utilize their people.

2.15. Member.

2.15.1. Member must report medical conditions that potentially affect deployability, or any significant change in chronic medical conditions to the appropriate medical provider at the time they become present.

2.15.2. Meets scheduled medical appointments as directed. Informs unit supervisor of required follow-up evaluations and appointments. Reports all medical/dental treatment obtained through civilian sources or any medical condition that hinders duty performance to the appropriate military medical authority. See AFI 48-123 for additional guidance regarding ARC members.

2.15.3. Member must make all attempts to resolve medical condition in a timely manner. This includes but is not limited to attendance at all appointments, active participation in rehabilitation, and using medications as prescribed by their health care provider. Failure to meet this requirement as determined by medical authority and commander may result in

MEB and resultant administrative separation from the AF, without medical disability compensation. See AFI 48-123 for additional guidance regarding ARC members.

2.15.4. Upon receiving an AF Form 469 with restrictions affecting fitness, member will immediately notify his/her unit fitness manager. If the member's restrictions are more than 30 days or member has a fitness test due in the restriction period, the member will make an appointment with the wing Exercise Physiologist/FPM or ARC MLO as soon as practical.

2.15.5. Defer the following actions when a member's failure to comply with medical assessment requirements renders the Air Force Medical Service unable to determine a member's current medical status: clearance actions for deployment, PCS, retraining or attendance at service academies or Professional Military Education (PME), MPA or RPA orders or any orders status of 30 days or more (ARC).

2.15.5.1. When a member declines an invasive procedure recommended for a return to functional status, they will be offered a second opinion. If the second opinion concurs with the first recommendation and the member still declines, they will be processed for MEB or WWD as appropriate with possible separation without disability compensation. For additional guidance, refer to paragraph **1.5.3**.

2.16. Military Personnel Flight (MPF).

2.16.1. Provides a monthly listing of personnel with AACs of 31, 37, and 81 (pregnancy deferment) from Military Personnel Data System (MilPDS) to FHM if PIMR to MiLPDS electronic transfer fails.

2.16.2. Refers members recommended for retraining with available AFSCs and job descriptions to FHM for determination of physical suitability. Assists AFPC in processing retraining requests.

2.16.3. Ensures FHM is part of the process in clearing applicants for special duty assignments, PME, formal schools clearance, medical retraining requests, overseas PCS clearances, or security clearances. See DoD 5210.42-R_AFMAN 10-3902 for specific procedures

2.16.4. Attends the DAWG.

2.16.4.1. Works closely with Force Health Management to ensure all personnel on Assignment Availability Code 31, 37, and 81 are reconciled on a monthly basis.

2.16.4.2. Will not be present at the DAWG during discussion of PHI.

2.17. Exercise Physiologist/Wing Fitness Program Manager or ARC Fitness Program Medical Liaison Officer (MLO).

2.17.1. Provides consultation on duty limiting conditions affecting physical fitness to Wing Commander or equivalent, Group Commanders, Squadron Commanders, Profile Officer, SGP, Providers, and the DAWG.

2.17.2. Provides exercise prescriptions to all members assigned to the wing with duty limiting conditions affecting their ability to participate in unit physical fitness duties for greater than 30 days or member has a fitness test due in the restriction period. In this role, serves as the wing's expert on ensuring members maintain the maximal compliance with physical fitness standards IAW AFI 10-248(Effective 1 July 2010, AFI 10-248, *Fitness*

Program, will be re-designated AFI 36-2905, *Fitness Program*). within the constraints that the duty limiting conditions allow. Records appointments for exercise prescriptions in the medical record.

2.17.2.1. Maintains AHLTA and PIMR access.

2.17.2.2. Documents exercise prescriptions/fitness testing exemption recommendations on AF Form 422.

2.17.2.3. Is not required to see every referred member face-to-face, but will at minimum review the AF Form 469 and AHLTA note associated with the referral.

2.17.2.4. Documents the rationale for each exercise prescription in AHLTA including milestones requiring a face-to-face visit.

2.17.2.5. Signs the AF Form 422 as a provider but not as the profile officer. Final signature on an AF Form 422 for an exercise prescription only will be performed by a profile officer. This requirement ensures that a medical officer has reviewed the prescription for any potential adverse health outcomes. However, if the AF Form 422 also includes an exercise exemption recommendation, the SPO must sign the AF Form 422.

2.17.3. Attends the DAWG. Brings a roster of all members who have a DLC affecting participation in unit physical fitness or fitness assessment for more than 90 days. Provides an in-depth verbal report for all cases lasting more than 9 months at the DAWG.

2.17.4. Utilizes all resources available to engage the member with a duty limiting condition, the treating provider, and the unit leadership to provide a plan to maintain physical conditioning if a DLC affects ability to perform physical fitness for more than 30 days.

2.17.5. Provides feedback to the DAWG on the quality of DLC actions by providers which affect physical fitness for greater than 30 days.

2.17.6. Serves with the SPO as the only authorities to recommend medical exemptions of a member with a DLC to the member's commander from components of physical fitness testing.

2.18. AFPC/DPAMM.

2.18.1. If member is qualified for continued active duty following an MEB or PEB, AFPC/ DPAMM returns medical evaluation report to the medical facility with instructions for disposition of the examinee. The ARC/SGPs perform this function for their respective componet members.

Chapter 3

ESTABLISHING AND DISSEMINATING DUTY RESTRICTIONS

3.1. Duty Limitations and Mobility Restrictions.

3.1.1. Members will be evaluated for potential duty limitations at every medical encounter. If a member is determined to require a duty limitation or mobility restriction, the AF Form 469 will be used. This includes use of the Form 469 for dental classes 3 and 4.

3.1.2. The healthcare provider or his designee will enter the demographic data, specify duty limitations or mobility restrictions, and enter the physical limitations and/or restrictions and a release date into PIMR. Only specific limitations will be entered. Diagnoses will not be recorded on the comment or limitation section of this Form. The provider will then electronically sign the Form.

3.1.2.1. The AF Form 469 may be used to remove a member from unit fitness training for a period less than 30 days. Members with a functional limitation which impacts unit fitness greater than 30 days or for those with an impending fitness test in less than 30 days will report to the Exercise Physiologist/ FPM or ARC MLO at the HAWC or HPF for testing exemption and exercise prescription evaluation. AF Form 422 will be used to document exercise program evaluations performed at the HAWC or HPF by the FPM.

3.2. Duty Limitations Only.

3.2.1. For duty limitations with no mobility or retraining implications, copies will be sent electronically via PIMR to FHM for review and then forwarded to the member's unit.

3.2.2. Duty limitations that could permanently affect a member's ability to perform their specific AFSC duties but are not unfitting for continued military service or mobility should be handled via retraining administratively. Refer to AFI 36-2101 and AFI 48-123 for further guidance regarding medical administrative retraining.

3.3. Mobility Restrictions.

3.3.1. When a medical condition with or without duty limitations also prevents the member from deploying, the PCM will check the Mobility Restriction box on the AF Form 469. After electronic signature, the Form will be automatically forwarded to FHM which will assess the Form, determine if the condition will require a code 31, 37, or 81 (illness expected to last between 31 and 365 days, MEB/ALC-R/WWD, or pregnancy respectively), annotate it appropriately, and forward it to the Profile Officer. The Profile Officer will validate by electronic signature, and it is then forwarded electronically to the member's unit commander via PIMR for concurrence/non-concurrence. The commander or designated representative will issue the Form to the member. The AF Form 469 must be forwarded to the squadron commander within 24 hours of initiation unless reasons for delay are adequately documented. For ARC members, the Form 469 must be forwarded to the commander prior to the member's next duty day.

3.3.1.1. Commander concurrence (member's squadron commander or higher):

3.3.1.1.1. When the commander agrees with the mobility restriction, they sign the AF Form 469 and issue the Form personally to the member or distribute via designated representative.

3.3.1.1.2. If a commander chooses to non-concur, they contact the FHM or profile officer who approved the 469 via reply email. FHM with guidance by the profile officer will collect pertinent medical data and provide it to the SPO. The SPO will contact the PCM and review the medical data. The SPO can override the PCM's recommendation and revise the mobility restriction in order to resubmit to the member's commander. If the SPO agrees with the PCM, the SPO will meet with the member's commander to review the case. If the SPO and unit commander disagree, the member can be placed on mobility status with the concurrence of the commander's next reporting official (normally the member's group commander). The final commander acting on the Form 469 serves a completed copy on the member after SPO notifies FHM of the action and FHM generates a new Form 469. This new Form 469 will include comments indicating that the member's squadron/group commander has non-concurred and the member will remain qualified for mobility/deployment. Rationale for the decision will be documented by the SPO in the member's medical record.

3.3.1.1.3. A specified deployment may have medical requirements determined by the COCOM. Thus, while a commander can place an individual on mobility regardless of medical recommendations, the gaining force commander may not accept the individual for deployment. For a defined deployment, the SPO will coordinate through their MAJCOM to the gaining command regarding waiver of defined medical requirements.

3.3.1.1.4. In the event of a commander's non-concurrence on a profile for a member with a condition which is unfitting for continued military service, an ALC request or MEB will continue to be processed IAW AFI 41-210.

3.3.2. Permanent mobility restrictions (ALC) may only be determined by AFPC/DPAMM (ARC/SGPs for ARC members). These limitations will be displayed on the AF Form 469 permanently at the bottom of the physical limitations/restrictions portion and once assigned, will not be overridden by any local DLC or profile action (Forms 469/422).

3.3.3. Pregnancy Duty Limitations. In addition to duty and mobility restriction, the member's worksite will be evaluated for any physical or chemical hazards that could affect the mother or fetus. Initially, this will require a Form 469 restricting all pregnant members within 5 duty days of notification of a positive pregnancy test from all known physical or chemical hazards to the fetus. This Form 469 will be modified within 15 duty days with restrictions tailored to the hazards of the individual workplace. This may require temporary removal from certain AFSC duties. This will not require retraining.

3.3.3.1. The modified AF Form 469 will be delayed up to 15 days in order for bioenvironmental engineering, public health, and flight medicine (as appropriate) to effectively evaluate the workplace for hazards. For Category 1 shops, surveillance documented should be recent enough to allow individualized restrictions to be formulated for the AF Form 469. Other shops may require more recent surveillance and workplace hazard identification in order to properly complete the Form 469.

3.3.3.2. AFMOA OB/GYN consultants will validate the AF standard duty limitations for pregnancy annually and produce an updated AF Form 469 pregnancy overprint.

3.3.3.3. When an OB/GYN or women's health provider is not assigned, the patient's PCM will perform this function in consultation with Public Health.

3.3.3.4. Fitness clearances will be made by the wing exercise physiologist for pregnant members upon request by the unit Exercise Physiologist/ FPM or ARC MLO, IAW AFI 10-248 (Effective 1 July 2010, AFI 10-248, *Fitness Program*, will be re-designated AFI 36-2905, *Fitness Program*). .

3.3.4. External duty limitations (civilian or sister service). Members must report changes in physical status to their military medical unit. Duty limitations specified by any non-AF provider must be entered onto an AF Form 469 by a AF provider to be considered valid. Military providers retain final deployment recommendation authority.

3.4. ALC-C.

3.4.1. Further detailed guidance is available in AFI 41-210, *Patient Administration Functions*, AFI 41-210, *USCENTAF Supplement*, and AFI 48-123. When AFI 41-210, directs a profiling action, the annotation will be on an AF Form 469 as a mobility limitation.

3.4.2. Authority. AFPC/DPAMM is the authority to assign or remove the ALC-C on active duty members and the appropriate ARC/SGP is the authority to assign or remove the ALC-C for ARC members.

3.4.3. AFPC/DPAMM or ARC/SGP may assign stratified ALC-C codes based on risk and medical requirement. The code may be valid indefinitely but must be reviewed and renewed as mandated by RILO requirements.

3.4.4. The authority to deploy a member with an ALC-C is based on stratification levels, or as specified in the reporting instructions for a defined deployment.

3.4.5. Members who have conditions that render them unfit for continued military service IAW AFI 48-123 or unable to deploy may either undergo a MEB or may undergo an ALC-R under the Assignment Limitation Code Fast Track Process. In addition to those conditions specifically listed in AFI 48-123, members may require MEB or ALC-R due to a duty limiting condition which has resulted (or likely will result) in a mobility restriction for 365 days or longer. Refer to AFI 48-123 and AFI 41-210 for further requirements for MEB/ALC-R.

3.4.5.1. Under the Assignment Limitation Code Fast Track Process, an ALC-R may be made by the DAWG chairman at each MTF directly to AFPC/DPAMM or ARC/SGP. Any condition, regardless of AFSC which is likely to result in the member being returned to duty with an ALC-C in the experience of the DAWG chairman is eligible for an ALC-R.

3.4.5.2. A member enters into the ALC Fast Track Process by a provider identifying a duty limiting condition which is unfitting for continuing military service and initiating a Form 469 with a mobility restriction requiring an MEB or ALC-R (Code 37). The provider, FHM, or profile officer identifies the condition as likely to result in the member returning to duty with ALC-C and requests review by the DAWG chairman. If the

DAWG chairman agrees with the assessment, the Form 469 is modified to reflect a Code 31 and the Assignment Limitation Code Fast Track Process is initiated.

3.4.5.3. The Assignment Limitation Code Fast Track Process is designed to provide an efficient process to maintain overall Air Force end strength. As such, an abbreviated note consistent with a robust AHLTA new patient note is required. This note should provide objective criteria regarding the nature and severity of the unfitting/mobility restricting condition as well as any other condition which may affect the unfitting condition. An abbreviated commander's letter is also required (Atch 3), as well as a current AF Form 469 and AF Form 422 if applicable. Finally, if a checklist is available for the condition, it will be completed and included with the ALC-R.

3.4.5.3.1. Current ALC-R checklists will be maintained on the AFMS Knowledge Exchange under the Aerospace Medicine Junction: **https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=AerospaceMedicine**

3.4.5.4. Upon ALC-R submission, AFPC/DPAMM may request further information from the MTF, require a full MEB/PEB, return the member to full duty, or return the member with an ALC-C.

3.4.5.4.1. AFRC/SGP may make the same requests and requirements for Reserve members using the WWD process.

3.4.5.5. If the member is returned to full duty or returned with an ALC-C, the AF Form 469 and Form 422 will be modified by FHM under the direction of the Senior Profile Officer. If the member is required to undergo an MEB, FHM will change the Form 469 to reflect an AAC 37, and refer the case to the PEBLO for processing. The PEBLO will notify the member and PCM that an MEB is required.

3.4.5.6. An ALC-R is a request to AFPC/DPAMM (AFRC/SGP for the Reserve) to determine the ability for the Air Force to utilize a member with a condition which may not be conducive to worldwide mobility. As such, not all career fields are capable of maintaining members with certain mobility limitations. Depending upon the condition and career field, AFPC/DPAMM (AFRC/SGP for the Reserve) may not entertain an ALC-R. A current list of career fields acceptable for the Assignment Limitation Code Fast Track Program will be maintained on the AFMS Knowledge Exchange under the Aerospace Medicine Junction:.**https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=AerospaceMedicine** Members in those career fields will be required to undergo full MEB to allow AFPC to further determine their utilization.

Chapter 4

CASE MANAGEMENT REVIEW

4.1. DAWG.

4.1.1. Purpose. The DAWG will be established at each wing/base level and will meet monthly (at least quarterly for the ARC) to review all personnel identified as having a deployment-limiting medical condition. The working group will identify all non-deployment eligible personnel (medically mobility limited) and track progress from identification of medical condition through resolution or removal from mobility status. They will further identify cases exceeding the prescribed time limits, review a representative sample of DLCs and provide feedback to PCM teams, including providers, via the SGH. It also produces and provides a report to the MTF executive committee via the Aerospace Medicine Council (AMC). ***Note:*** The DAWG will meet quarterly for ARC.

4.1.2. Membership will consist of the SGP, SGH, SPO, FHM function, PEBLO, a PCM provider, Exercise Physiologist, an OB/GYN or Women's Health Clinic representative (if assigned at the base), MPF representative, and a referral management specialist. Other members may be assigned as required – i.e. military services coordinator at DoD/VA pilot sites. Inclusion of other members from outside the MTF must meet HIPAA compliance standards.

4.1.2.1. PCM providers will all attend the DAWG on a rotating basis, thereby ensuring all PCM's have an opportunity to become familiar with the process.

4.1.2.2. It may be necessary to add a mental health representative to the DAWG depending on the number and complexity of mental health diagnoses on the list to be reviewed.

4.1.2.3. The MPF representative will bring a list of code 31, 37, and 81s for reconciliation with medical data. The MPF representative should bring a list of members on code 37 who also have a pending separation, retirement or PCS.

4.1.3. The DAWG will review and provide oversight of the following processes:

4.1.3.1. For members with DLCs which do not affect mobility, the FHM will review a representative sample (amount determined locally by the SGP) and provide a summary of the trends in quality of DLC actions by providers.

4.1.3.2. For members on Code 31: The PIMR generated list will be reviewed for progress as well as impediments in order to facilitate the rapid resolution of all cases. All AF Form 469 duty restrictions that have recently exceeded 30 days and have converted to code 31 will be reviewed. FHM will review the records of these cases prior to each DAWG. They will come to the meeting having identified problem cases and, along with the PCM, be prepared to discuss potential solutions. Providers will be notified when a code 31 case reaches 10 months cumulative time in preparation for code 37 MEB processing. When it becomes obvious the member will not be returned to full duty prior to one year on a code 31, an MEB should be initiated even if the year has not elapsed. For ARC members with conditions deemed not-LOD, the WWD process will be utilized.

4.1.3.3. The DAWG will determine if a member's condition(s) does/does not meet standards for continuing military service IAW AFI 48-123 and an MEB/WWD is required. The DAWG will document this decision in the minutes. The DAWG will change the member's AAC from 31 to 37 in PIMR when: Diagnoses which may be unfitting for continuing military service are made. Workups for these diagnoses are adequate to determine a fitness for duty prognosis. The unfitting condition(s) have reached optimal medical benefit. Once optimal medical benefit is achieved, and a recommendation regarding retention can be made, a narrative summary will be completed within 30 days. The timeframe from decision to place on code 37 to AFPC/DPAMM or ARC/SGP submission should in most cases be no more than 90 days.

4.1.3.3.1. Optimal Medical Benefit for the purposes of initiating an MEB or Assignment Limitation Code Request is defined as the point in which a member's condition has stabilized enough to allow the narrative summary to be valid for 90 days and no intervention will drastically change the course of the member's condition enough to change the fitness for continuing military service determination by the PEB. Any condition which is unfitting for continued military service IAW AFI 48-123 and meets this definition should be considered for MEB if the condition is not likely to resolve in the opinion of the senior profile officer within 12 months from diagnosis.

4.1.3.4. For members on Code 37: The PEBLO will maintain a spreadsheet of all code 37 cases currently open at the MTF. Cases exceeding 90 days from initiation of the MEB will be reviewed for progress and impediments to completion. Additionally, the PEBLO will review code 37 records prior to each DAWG to identify problems in any other cases which require attention. Some of these cases will require coordination with the involved PCM in order to determine what action, if any, is required. Further, the PEBLO will present any requests for additional information that may be received from AFPC/DPAMM or AFRC/SGP or ANG/SGP.

4.1.3.5. Code 81, pregnancy. The FHM function will query PIMR for all code 81 cases and report this information to the DAWG monthly. The continued pregnancy status will be confirmed by the OB/GYN representative.

4.1.3.6. ALC-C RILO due dates. The PEBLO will maintain a spreadsheet of all ALC-C RILO due dates.

4.1.3.6.1. The FHM function will assist in keeping this list current by advising the PEBLO of any new RILO cases identified during the in-processing medical record review process. Prior to each DAWG the PEBLO will review these records to identify problems which require attention. The entire list will be reviewed at each DAWG with status updates provided by both the PEBLO and the PCM on cases currently being worked.

4.1.4. Peer review. The SGH will present monthly peer review statistics for clinical practice standards for DLCs. The SGP will present administrative peer review statistics for DLCs.

4.1.4.1. The SGP/SGH review will utilize the format in Attachment 2 for peer review.

4.2. Metrics.

4.2.1. The FHM function will develop a report from PIMR data reflecting the current status of their wing and supported units, reporting through the DAWG to the medical unit executive function and wing commander: Components of the report will include:

4.2.1.1. Medically Mobility Ready (MMR) percentage. These members show all status green in PIMR and are capable of deploying with no medical actions required.

4.2.1.2. Medically Mobility Restricted-Actionable (MMRA) percentage. These members have no AAC 31, 37 or 81 and no ALC –C codes. They do have unmet PIMR requirements that could be resolved within 30 days.

4.2.1.3. Medically Mobility Restricted-Non-Actionable (MMRN) percentage. Members who would require greater than 30 days to become MMR, are Codes 31, 37, or 81, or are on a stratified ALC-C.

4.2.2. Diagnosis and Medication Surveillance. FHM will present the findings to the DAWG of selected monthly diagnostic or medication utilization queries as directed by the SGH to ensure military members with certain medical conditions do not remain unidentified to the mobility reporting system. A Composite Health Care System (CHCS)/AHLTA query will be compared to existing code 31, 37 and 81 lists to provide increased visibility on conditions which may impact deployment availability. Personnel identified using this surveillance should be referred to their PCM for initiation of DLC action if indicated. Overall statistics and findings will be presented to the professional staff by the SGH at least every six months for education purposes. This does not apply to AFRC and ANG units.

4.2.2.1. The SGH will develop a list of the ten most frequently seen diagnoses requiring MEB at the MTF, as well as medications associated with treating these conditions. A schedule for monthly review of a different diagnosis and/or medication from the list at the DAWG will be developed. FHM will conduct the reviews and present findings, i.e. cases that may need MEB.

4.2.3. The DAWG will produce the following minimum data and report to the MTF Executive committee via the AMC:

1) MMR, MML, MMC.
2) A report of any other locally derived metrics as required analyzing any adverse MMR, MML, MMC trends.
3) Average duration of MEB completion time from initiation of code 37 in PIMR to submission of case to AFPC/DPAMM.
4) Review in lieu of MEB overdue rates.
5) Peer review and surveillance significant findings.

Chapter 5

MEB AND WWD

5.1. MEB. Whenever a member has a physical limitation or diagnosis that may affect their retainability for continued military service or mobility status which is not likely to resolve within twelve months, the member will have an MEB or ALC-R (also see section 3.4) for his/her conditions which do not meet retention standards IAW AFI 48-123. AFRC and ANG members with non-service connected issues will have a WWD determination. The respective AFRC/SGP or ANG/SGP will specify criteria and processes for WWD determinations. Active duty units supporting AFRC or ANG members should obtain and maintain a copy of applicable guidance.

5.2. The MEB. is the first step in the Air Force disability evaluation process. The primary purpose of the MEB is to determine whether or not a member's medical condition warrants consideration for continued military service (including mobility potential and fitness testing). AFI 48-123 outlines those medical conditions that require a medical board or ALC-R. AFRC or ANG members must be entitled to disability processing to undergo MEB or ALC-R processing by active duty MTFs. AFRC/SGP or ANG/SGP will provide AFRC or ANG specific guidance. For FFD purposes, commanders and their designees, to include personnel offices, must receive medical information. Only the minimum necessary will be provided. If disclosures of this information have not been specifically authorized by the armed forces member, the MTF will account for the disclosures in accordance with DoDD 6025.18, *Privacy of Individually Identifiable Health Information in DOD Health Care Programs* and AFI 41-210.

Note*:* The MEB guidance in AFI 41-210 should be reviewed in addition to this chapter. Additionally, the medical conditions listed in AFI 48-123 are not all inclusive. Other diseases or defects not specifically listed can be cause for MEB based upon the medical judgment of the examining physician and the SPO.

5.2.1. Presumption of Fitness. The existence of a physical defect or condition does not of itself necessarily provide justification for or entitlement to an MEB or ALC-R. For most approaching retirement, a full MEB will not be necessary. An ALC-C regardless of AFSC request to DPAMM or AFRC/SGP for the Reserve will suffice unless the presumption of fitness is in doubt. See DoDI 1332.38, para E3.P#.5.3 and AFI36-3212, para 3.17. for further guidance for presumption of fitness.

5.2.2. Establishing the MEB.

5.2.2.1. The medical unit commander appoints in writing members of MEBs IAW AFI 41-210. The number of appointees should be large enough to convene a three member board without delay. A PEBLO will also be designated.

5.2.2.2. Once the PCM provider determines a member is unfit for continued military service IAW AFI 48-123, an AF Form 469 is accomplished indicating that the member is not mobility qualified (Code 37) and the case is referred via the member's commander to the PEBLO/DAWG Chairman for disposition. If the case appears amenable to requesting an ALC-R under the ALC Fast Track Process, the Form 469 is modified to reflect a code 31 and is sent through the ALC Fast Track Process (section 3.4).

5.2.2.3. If the case requires full MEB as determined by the DAWG Chairman, the PCM provider will accomplish a narrative summary and obtain physician countersignature if not a physician and supporting documentation from applicable medical consultants if available. As an exception, mental health cases will always have a military psychiatrist as a board member.

5.2.2.3.1. For installations subject to the DoD/VA integrated disability evaluation system process, referrals to the VA military services coordinator and VA medical examiner will be required prior to completion of the narrative summary. At these installations, information obtained from the VA medical examination will be an integral part of the narrative summary.

5.2.2.4. For assignment limitation code request (Atch 3).The PEBLO or MEB clerk will coordinate a commander's Member Utilization Questionnaire (Atch 3) with endorsements, ensuring the commander has meaningfully assessed the member's deployability, mobility, and ability to perform normal duties.

5.2.2.5. A full commander's letter is required for cases being referred to the MEB. For an example see AFI 41-210.

5.2.3. MEB Process.

5.2.3.1. The SGP will serve as the senior board member with detailed knowledge of standards relating to medical fitness, disposition of patients and disability separation processing. The SGH will serve as the second board member. The third member of the board will be any physician privileged and appointed to participate in the MEB process as outlined above. If the MEB includes a mental health diagnosis, one of the board members must be a psychiatrist.

5.2.3.2. The SGH will perform a clinical quality and appropriate assessment as part of the medical evaluation board process.

5.2.3.3. The SGP will conduct a fitness for continued military duty assessment with attention to mission and operational needs as part of the MEB.

5.2.3.4. The three-member board will then conduct the MEB according to AFI 41-210.

5.2.3.5. The completed MEB will be forwarded with all supporting documentation to AFPC by the PEBLO or MEB clerk.

5.2.3.6. If the member is returned to duty following an Assignment Limitation Code Request, MEB and/or PEB, the member's PCM will create a new AF Form 469 with current duty limitations. The AF Form 422 will be updated IAW AFI 41-210.

5.2.3.6.1. For AFRC and ANG members who are returned to duty by AFPC, the AFRC/SGP or ANG/SGP for their members will determine these current duty limitations.

5.2.3.7. For further guidance on the MEB process, refer to AFI 41-210.

Chapter 6

LIMITED SCOPE MEDICAL TREATMENT FACILITIES (LSMTF) AND MEDICAL AID STATIONS (MAS)

6.1. Definitions.

6.1.1. LSMTF's are medical elements, flights, or small medical squadrons with a credentialed medical provider that do not provide the scope of services found in a medical group. LSMTFs are typically assigned to a line squadron or group (e.g. Air Base Squadron, Mission Support Group or Air Base Group). In some cases, a LSMTF may report directly to a wing or MAJCOM.

6.1.2. Medical Aid Stations are small medical elements without a credentialed medical provider and are typically located at a geographically separated units (GSU) or Munitions Support Squadron (MUNSS) site.

6.1.3. MUNSS are geographically separated units responsible for receipt, storage, maintenance and control of United States War Reserve Munitions in support of the North Atlantic Treaty Organization and its strike missions. See AFI 21-200, *Munitions and Missile Maintenance Management*.

6.1.4. GSU are units that are not at the same physical location or base as the parent unit.

6.2. Responsibilities.

6.2.1. MAJCOM/SG. Will assign a supporting MTF for each GSU and MUNSS (LSMTF, MAS, and GSU without LSMTF or MAS) within their Area of Responsibility to assist with the documentation and administrative management of members with duty limitations and occupational restrictions.

6.2.2. Supporting MTF/CC

6.2.2.1. Is ultimately responsible for the documentation and administrative management of members with duty limitations and occupational restrictions as defined in AFI 10-203 at the GSU and MUNSS sites and will ensure appropriate support is provided.

6.2.2.2. Will Program Objective Memorandum (POM) for additional MTF personnel to meet the requirements to support assigned GSU and MUNSS sites based on current manpower models and increased workload.

6.2.2.3. Will ensure a credentialed provider, preferably a profile officer, is available to counsel members placed on code 31, code 37, or code 81 at the GSU and MUNSS sites. This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the member's electronic medical record.

6.2.3. MTF/SGP at supporting MTF:

6.2.3.1. Will ensure appropriate documentation and administrative management of members with duty limitations and occupational restrictions at the GSU or MUNSS sites.

6.2.3.2. Profile Officers at the supporting MTF will perform profile officer duties for members assigned to supported GSU or MUNSS sites who require an AF Form 469 or AF Form 422.

6.2.3.3. The DAWG at the supporting MTF will administratively manage the duty limiting condition, Code 31, 37, 81, ALC-C, RILO, and FAST TRACK cases from the GSU and MUNSS sites as outlined in AFI 10-203, chapter 4.

6.2.4. Force Health Management at the supporting MTF will perform the FHM functions as outlined in AFI 10-203 for the supported GSU and MUNSS sites. Video teleconferencing, teleconferencing, or electronic data and communication systems may be utilized to facilitate these functions.

6.2.5. The PEBLO at the supporting MTF will perform the PEBLO functions as outlined in AFI 10-203 for the supported GSU and MUNSS sites. Video teleconferencing, teleconferencing, or electronic data and communication systems may be utilized to facilitate these functions.

6.2.6. LSMTF OIC

6.2.6.1. Will ensure that patients presenting for care are evaluated, treated and/or referred as appropriate by a credentialed provider.

Note*: Credentialed providers at a LSMTF will have the same scope of responsibility as providers at the supporting MTF to include the appropriate evaluation, clinical management, referral, profile disposition, and narrative summary preparation as appropriate for their patients*

6.2.6.2. Will ensure that information for patients with duty limiting conditions is entered into PIMR and sent to the supporting MTF for FHM review and profile officer approval.

6.2.6.3. Will ensure that medical records and provider staff are made available for the supporting MTF DAWG.

6.2.6.4. Will coordinate with GSU and MUNSS site commanders and supervisors to ensure members obtain the required exams and studies.

6.2.6.5. Will ensure that LSMTF credentialed providers prepare an appropriate narrative summary when required within the time specified by policy and provide all supporting documents and information for MEB/RILO/FAST TRACK or other Disability Evaluation System (DES) processing to the supporting MTF.

6.2.6.6. If no LSMTF credentialed provider is available, will ensure members with a duty limiting condition that restricts mobility (code 31, code 37, or code 81) are referred to the supporting MTF to receive counseling by a credentialed provider, preferably a profile officer. This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the member's electronic medical record.

6.2.7. OIC overseeing MAS:

6.2.7.1. Will ensure that patients presenting for care are evaluated, treated and/or referred as appropriate under the supervision of a credentialed provider.

Note*:* MAS medical personnel will provide documentation and management of members with duty limitations and occupational restrictions as defined in AFI 10-203 within the scope of training, manpower, and equipment.

6.2.7.2. Will ensure that information for patients with duty limiting conditions is entered into PIMR and sent to the supporting MTF for FHM review and profile officer approval. If PIMR is not available at the supported site, then will ensure duty limiting condition information is forwarded to the supporting MTF for entry into PIMR.

6.2.7.3. Will ensure that medical records and medical element staff are made available for the supporting MTF DAWG.

6.2.7.4. Will coordinate with GSU or MUNSS site commanders and supervisors to ensure members obtain the required exams and studies.

6.2.7.5. Will ensure members with a duty limiting condition that restricts mobility (code 31, code 37, or code 81) are referred to the supporting MTF to receive counseling by a credentialed provider, preferably a profile officer. This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the member's electronic medical record.

6.3. Prescribed Forms.

AF Form 422, *Notification of Air Force Member's Qualification Status*

AF Form 469, *Duty Limiting Condition Report*

6.4. Adopted Forms.

AF IMT 847, *Recommendation for Change of Publication*

DD Form 2808, *Report of Medical Examination*

SF Form 88, *Medical Record-Report of Medical Examination*

PHILIP M. BREEDLOVE, Lt Gen, USAF
DCS, Operations, Plans and Requirements

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFI 36-3209 *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members,* 14 Apr 2005

AFI 41-210 *Patient Administration Functions*, 22 Mar 2006

AFI 44-109 *Mental Health and Military Law*, 1 Mar 2000

AFI 44-119 *Medical Quality Operations*, 24 Sep 2007

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AFI 48-101 *Aerospace Medicine Operations*, 19 Aug 2005

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AFPD 44-1 *Medical Operations*, 1 Sep 1999

AFPD 48-1 *Aerospace Medicine Program*, 3 Oct 2005

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

Abbreviations and Acronyms

AAC—Assignment Availability Code

AD—Active Duty

AETC—Air Education and Training Command

AFECD—Air Force Enlisted Classification Directory

AFI—Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFOCD—Air Force Officer Classification Directory

AFPC—Air Force Personnel Center

AFPC/DPAMM— Air Force Personnel Center, Medical Standards Department

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AHLTA—Armed Forces Health Longitudinal Technology Application

ALC—C—Assignment Limitation Code-C

ALC—R — Assignment Limitation Code Request

ANG—Air National Guard

CHCS—Composite Health Care System

CMA—Competent Medical Authority

COCOM—Combatant Commander

DAWG—Deployment Availability Working Group

DES—Disability Evaluation System

DLC—Duty Limiting Condition

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

e-Publishing——the e-Publishing website (www.e-publishing.af.mil)

EPTS—Existing Prior to Service

FFD—fitness for duty

FHM—Force Health Management

FPM—Fitness Program Manager

HAWC—Health and Wellness Center

GSU—Geographically Seperated Unit

HIPAA—Health Insurance Portability and Accountability Act

HPF—Health Promotions Flight

AF/SG—Air Force Surgeon General

LOD—Line of Duty

LSMFT—Limited Medical Treatment Facilities

MAJCOM—Major Command

MAS—Medical Aid Stations

MDG—Medical Group

MDS—Medical Squadron

MEB—Medical Evaluation Board

MilPDS—Military Personnel Data System

MLO—Medical Liaison Officer

MMR—Medically Mobility Ready

MMRA—Medically Mobility Restricted-Actionable

MMRN—Medically Mobility Restricted-Non-Actionable

MNMC—Medically Non-Mission Capable

MPF—Military Personnel Flight

MTF—Medical Treatment Facility

MUNSS—Munitions Support Squadron

NGB—National Guard Bureau

OB-GYN—Obstetrics and Gynecology

PCM—Primary Care Manager

PCS—Permanent Change of Station

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PHA—Preventive Health Assessment

PHI—Protected Health Information

PIMR—Preventive Individual Medical Readiness Health Assessment

PME—Professional Military Education

PRP—Personal Reliability Program

RAM—Residency in Aerospace Medicine

RCPHA—Reserve Component Periodic Health Assessment

RDS—Records Disposition Schedule

RILO—Review In Lieu Of

RMU—Reserve Medical Unit

RTD—Return to Duty

SG3PF—Aerospace Medicine Division

SGH—Chief of the Medical Staff

SGP—Chief, Aerospace Medicine SPO—Senior Profile Officer

UCMJ—Uniform Code of Military Justice

USC—United States Code

WWD—World Wide Duty

Attachment 2

PROFILE AND DUTY LIMITING CONDITION

Table A2.1. PROFILE AND DUTY LIMITING CONDITION PEER REVIEW

	PATIENT ID	YES	NO	NOTES
CLINICAL				
Are functional limitations appropriate for diagnosis?				
Is estimated duration appropriate?				
ADMINISTRATIVE				
Was deployability appropriately addressed?				
Are functional limitations written appropriately? (laymen's terms, describes what member can't do, not what he/she can do)				
Was need for MEB identified, if required?				

Attachment 3

COMMANDER'S QUESTIONNAIRE

XXXXXXXXX

From: XXXXXXX
XXXXXXX
XXXXXXX

To: Deployment Availability Working Group (DAWG)

RE: Commander's Input to DAWG regarding XXX XXXXXX XXXXXX

1. Answers to the following five questions will assist the local DAWG and the Air Force Personnel Center (AFPC) to determine an appropriate disposition regarding the continued retainability and deployability of XXXXX XXXXXX who has been diagnosed with a medical condition that is not compatible with continued unrestricted military service. This letter will be included with the medical package to indicate how the medical condition has impacted daily operations and mission support.

2. Please circle Yes or No, adding comments as required (use additional sheet if necessary):

   a. Can the member perform all of the duties required by their current AFSC? Yes / No

   b. Can the member perform their AFSC's duties in a deployed location? Yes / No

   c. Has missed work had an impact on mission completion? Yes / No

   d. How many days of work has the member missed due to medical appointments or illness during the past year?

   e. Should the member be retained in the Air Force? Yes / No

f. Please return this form and direct any questions to the MEB office at 722-1918.

//Signed XXX 8 Aug 08//
Ima Rusty Flybouy, MD, MPH
Major, USAF, MC, SFS
DAWG Chairman