

Army Regulation 40–501

Medical Services

Standards of Medical Fitness

**Headquarters
Department of the Army
Washington, DC
27 June 2019**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–501
Standards of Medical Fitness

This major revision, dated 27 June 2019—

- o Incorporates Army Directive 2016–28, Sharing U.S. Department of Veterans Affairs Disability Rating for Members of the Ready Reserve (paras 1–4*c*(1) and 1–4*c*(2)).
- o Clarifies various waiver authorities for Officer Candidate School in-Service applicants and Warrant Officer Candidate School direct accessions (paras 1–6*j* and 1–6*k*).
- o Includes the waiver authority for Army divers (para 1–6*o*).
- o Adds Health Insurance Portability and Accountability Act information (para 1–7).
- o Implements DODI 6130.03 by updating and realigning physical standards for enlistment, appointment, and induction (chap 2).
- o Supersedes Army Directive 2012–23, Body Fat Standards for U.S. Army Enlisted Accessions, by changing the maximum body fat standards for males and females in the 17 – 20 years of age categories (tables 2–1 and 2–2).
- o Updates retention standards (chap 3).
- o Realigns chapters into similar order as to anatomical sites and body systems (chaps 3, 4, and 5).
- o Updates the stinging insect profiling language and policy (paras 3–3*e*(1) and 3–35*a*).
- o Updates cancer profiling language and policy (paras 3–3*e*(2)).
- o Clarifies the retention standard for hearing and the Military Operational Hearing Test, such as the Speech Recognition in Noise Test (para 3–9*a*).
- o Adds a new retention standard for rheumatologic conditions (para 3–30).
- o Adds a new retention standard for sleep disorders (para 3–32).
- o Updates the psychiatric retention standards to reflect the most recent diagnoses changes in the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (para 3–33*e*).
- o Supersedes Army Directive 2013–12, Implementation of Department of Defense Policy Change Concerning Chronic Adjustment Disorder (para 3–33*e*).
- o Removes a section on personality and other disorders that previously rendered an individual administratively unfit (formerly para 3–35).
- o Adds a new section on conditions and circumstances not constituting a physical disability (para 3–36).
- o Implements Section 1177, Title 10, United States Code by requiring medical examinations in certain instances prior to administrative separations under conditions other than honorable (para 3–37*a*).

- o Removes the Farnsworth Lantern as a valid flight color vision test and adds the Service approved computer based color vision tests for aviation personnel as a valid color vision test (para 4–5a(4)(b)).
- o Adds medical standards for aircrew for unmanned aircraft systems (para 4–34).
- o Adds medical fitness standards for civil affairs and psychological operations initial training and retention in the military occupational specialty (paras 5–4 and 5–5).
- o Adds initial selection and retention medical fitness standards for divers (para 5–11 and 5–12).
- o Adds initial selection and retention medical fitness standards for Army maritime sea duty (para 5–13).
- o Adds initial selection and retention medical fitness standards for small unmanned aircraft system operators (para 5–14).
- o Moves aeromedical administration guidance to DA Pam 40–502 (formerly chap 6).
- o Moves physical profiling to AR 40–502 (formerly chap 7).
- o Moves administrative procedures for medical examinations to DA Pam 40–502 (formerly chap 8).
- o Moves individual medical readiness standards to AR 40–502 (formerly chap 11).
- o Removes chapters 9 and 10 regarding U.S. Army Reserve and Army National Guard specific issues and incorporates material in a reorganized format (throughout).

Effective 27 July 2019

Medical Services
Standards of Medical Fitness

By Order of the Secretary of the Army:

MARK A. MILLEY
General, United States Army
Chief of Staff

Official:


KATHLEEN S. MILLER
Administrative Assistant
to the Secretary of the Army

Army Directive 2013–12 and Army Directive 2016–28; and supersedes Army Directive 2012–23.

Applicability. This regulation applies to the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It also applies to candidates for military service. During mobilization, the proponent may modify chapters and policies contained in this regulation.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to change, approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander

or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions in accordance with AR 11–2 and identifies key internal controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from The Surgeon General (DASG–HSZ), 7700 Arlington Boulevard, Falls Church, VA 22042–5140.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to The Surgeon General (DASG–HSZ), 7700 Arlington Boulevard, Falls Church, VA 22042–5140.

Distribution. This publication is available in electronic media only and is intended for the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

History. This publication is a major revision. The portions affected by this major revision are listed in the summary of change.

Summary. This publication provides information on individual medical readiness elements; medical fitness standards for induction, enlistment, appointment, and retention; deployment-limiting medical conditions; and related policies and procedures. It implements DODI 6025.19, DODI 6130.03, and DODI 6490.07; incorporates

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*This regulation supersedes AR 40-501, dated 14 June 2017; AD 2012-23, dated 18 September 2012; and AD 2013-12, dated 17 June 2013.

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Glossary

Chapter 1 General Provisions

1–1. Purpose

This regulation governs medical fitness standards for enlistment, induction, and appointment, including officer procurement programs; medical fitness standards for retention and separation, including retirement; medical standards and policies for aviation; and medical fitness standards for diving, Special Forces, airborne, Ranger, free fall parachute training and duty, small unmanned aircraft system (SUAS) operators, and certain enlisted military occupational specialties (MOSs) and officer assignments such as civil affairs, psychological operations, and Army maritime sea duty.

1–2. References and forms

See appendix A.

1–3. Explanation of abbreviations and terms

See the glossary.

1–4. Responsibilities

a. The Surgeon General (TSG) will develop, revise, interpret, and disseminate current Army medical fitness standards and ensure Army compliance with DOD directives and instructions pertaining to those standards. TSG has the authority to issue exceptions to policies that are contained in this regulation.

b. Chief, U.S. Army Reserve (USAR); Director, Army National Guard (ARNG); Superintendent, U.S. Military Academy (USMA); President, Uniformed Services University of the Health Sciences (USUHS); commanders of the U.S. Military Entrance Processing Command (USMEPCOM); Chief, Department of Defense Medical Examination Review Board, U.S. Army Recruiting Command (USAREC); U.S. Training and Doctrine Command; U.S. Army Medical Command (MEDCOM); U.S. Army Cadet Command (USACC); U.S. Army Human Resources Command (HRC); Surgeon's Office, State Adjutants General; and all Army military treatment facilities (MTFs) worldwide will implement policies prescribed in this regulation applicable to all Regular Army (RA) and Reserve Component (RC) personnel and applicants for appointment (including all officer procurement programs), enlistment, and induction.

c. It is the responsibility of each Soldier to maintain his/her individual medical and dental readiness requirements, and report health issues that may affect their readiness to deploy or be retained to continue serving.

(1) Each Soldier in the RA or RC will, as a condition of continued participation in military service, report significant health information to their chain of command. Soldiers will verify documentation of this information during the DOD periodic health assessment (PHA) and/or deployment health assessment processes. In addition, each Soldier will provide all related health information by any non-DOD healthcare provider(s) to the Military Health System and to their respective RC health system. (See Army Directive 2016–28.)

(2) Members of the RC will report any Department of Veterans Affairs disability rating awarded and changes in their health or Department of Veterans Affairs-rated conditions. Members of the RC will provide medical documentation relating to such conditions to their unit commander and the profiling provider designated to assess duty limiting conditions to review for retention standards, deployment status, and to review and issue an appropriate profile for such conditions. A disability rating has no correlation to retention or fitness for duty standards. Appropriate medical authorities will assess the medical conditions related to the disability rating to determine if referral to the Disability Evaluation System (DES) is required in accordance with the profile standards and chapter 3 of this regulation.

(3) The maintenance of good strength and aerobic conditioning is of prime importance to the Army Soldier. Many retention standards reference a Soldier's ability to perform duty. Evaluation of performance of duty should consider the completion of the Army physical fitness test (APFT) and the ability to perform the basic Soldiering tasks and, if applicable, the ability to perform the Soldier's MOS duties at the minimum level of fitness expected from the Soldier and the occupational physical assessment test.

d. Medical examiners will use the medical standards in this policy to complete the assessments described in AR 40–502 and DA Pam 40–502. The examiners will apply the medical standards for the stated purpose and find the examinees described as follows:

(1) *Medically qualified.* Medical examiners will report as “medically qualified” all individuals who meet the medical standards of medical fitness established for the particular purpose for which examined. No individual will be accepted on a provisional basis subject to the successful treatment or correction of a disqualifying defect.

(2) *Medically not qualified.*

(a) Profiling providers will report as “medically not qualified” all individuals who possess any one or more of the medical conditions or physical defects listed in this regulation as a cause for rejection for the specific purpose for which examined, except as noted in paragraph 1–4d(2)(b).

(b) Profiling providers will report as “medically not qualified—prior administrative waiver granted” all individuals who do not meet the standards of medical fitness established for the particular purpose for which examined when a waiver has been previously granted and the applicable provisions of paragraph 1–6 apply.

1–5. Records management (recordkeeping) requirements

The records management requirement for all record numbers, associated forms, and reports required by this regulation are addressed in the Army Records Retention Schedule-Army (RRS–A). Detailed information for all related record numbers, forms, and reports are located in ARIMS/RRS–A at <https://www.arims.army.mil>. If any record numbers, forms, and reports are not current, addressed, and/or published correctly in ARIMS/RRS–A, see DA Pam 25–403 for guidance.

1–6. Review authorities and waivers

a. Medical fitness standards for accession, retention, or special training cannot be waived by medical examiners or by the examinee.

b. Examinees initially reported as medically not qualified by reason of a medical condition or defect when the standards of medical fitness in chapters 2, 4, or 5 apply, may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action. Upon such request, the designated administrative authority or their designees for the purpose may grant such a waiver in accordance with current directives. The Office of the Surgeon General provides guidance when necessary to the review and waiver authorities on the interpretation of the medical standards and appropriateness of medical waivers. The Secretary of the Army is the waiver authority for accession. The medical waiver authority is delegated through the Deputy Chief of Staff (DCS), G–1 to the authorities listed in paragraphs 1–6c through 1–6n.

c. The Department of Defense Medical Examination Review Board, U.S. Air Force Academy, Colorado Springs, CO 80840–6518 is the sole review authority for reports of examinations given applicants for contracting into the Reserve Officers' Training Corps (ROTC) Programs.

d. Military Entrance Processing Stations (MEPS), under the purview of USMEPCOM, are the medical review authorities for original enlistment and non-scholarship ROTC program examinations accomplished in their facilities.

e. Non-scholarship applicants who desire to contract into the ROTC program must have a qualifying Department of Defense Medical Examination Review Board exam.

f. The medical waiver authority for entry into ROTC programs, continuation in advanced course and commissioning of ROTC participants to include the Green to Gold Program is the Commanding General (CG), USACC. The CG, USACC may delegate this medical waiver authority to the USACC brigade commanders but no further delegation is authorized. If such authority is delegated, USACC brigade commanders will conduct a thorough review of all waivers and consult with the USACC Command Surgeon before approving any medical waivers. In those cases where the brigade commander nonconcurs with the USACC Command Surgeon's recommendation, the approval authority will revert back to the CG, USACC for final decision. The approval authority for any medical disqualification of a scholarship cadet resides solely with the CG, USACC and cannot be further delegated.

g. The medical waiver authority for applicants to USMA is the Superintendent, USMA. The waiver authority for commissioning USMA cadets is the Superintendent, USMA, following consultation with the Surgeon, USMA.

h. The CG, USAREC, is the medical waiver authority for original enlistment for RA and USAR.

i. The Director, ARNG is the medical waiver authority for all accessions for ARNG and the Army National Guard of the United States (ARNGUS). For ARNG state Officer Candidate School (OCS) applicants, the medical waiver authority is the Director, ARNG.

j. The medical waiver authority for direct accessions to OCS and Warrant Officer Candidate School is the CG, USAREC.

k. The medical waiver authority for currently serving enlisted Soldiers (in-Service) applicants, as well as ARNG applicants applying to federal/active duty (AD) OCS, is CG, HRC. The application for a medical waiver to OCS will include a recommendation on the medical waiver from a military physician or MTF physician regarding any potential physical limitations, injuries, or medical conditions and their possible impact upon an OCS applicant's ability to function as a military officer.

l. The medical waiver authority for applicants for U.S. Army Medical Department (AMEDD) personnel procurement programs (except USUHS) is CG, USAREC. This waiver authority may be changed by TSG after appropriate coordination with DCS, G–1. The medical waiver authority for students already enrolled in the AMEDD Health Professions Scholarship

Program (HPSP) is TSG (DASG–HSZ). The medical waiver authority for applicants for USUHS is the Assistant Secretary of Defense (Health Affairs).

m. Review and medical waiver authority for direct appointment to the Judge Advocate General Corps is the The Judge Advocate General. Review and medical waiver authority for other direct appointment programs (for example, Chaplain Corps) is the CG, USAREC.

n. The medical waiver authority for Special Forces training; Special Forces assessment and selection, survival, evasion, resistance, and escape (SERE) training; military free fall (MFF); and Special Forces combat diving qualification course is the Commandant, John F. Kennedy Special Warfare Center and School. Waiver authority for the Airborne School is the Commandant, U.S. Army Infantry School, in coordination with HRC.

o. Medical waiver requests for Army divers will be processed through the Chief, Hyperbaric Medicine, Dwight David Eisenhower Army Medical Center, 300 Hospital Road, Fort Gordon, GA 30905–5650 for approval and forwarded to the Director, Engineer Personnel Development Office, 464 Maneuver Support Center Loop, Suite 1661–B, Fort Leonard Wood, MO 65473–9084 for concurrence and final approval in accordance with AR 611–75. Requests for medical waivers for divers should include the Servicemember’s health record and a copy of their medical examination.

p. Medical waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be granted if the applicant does not meet the retention standards of chapter 3. Requests from waiver authorities for exception to this policy will only be made under extraordinary circumstances and only with the approval of TSG (DASG–HSZ).

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

(1) The duration of the waiver was not limited at the time it was granted and the medical condition or physical defect has not interfered with the individual's successful performance of military duty.

(2) The medical condition or physical defect waived was not below the standards of medical fitness applicable to the particular program involved and the medical condition or physical defect has remained essentially unchanged.

(3) The medical condition or physical defect waived was below procurement standards of medical fitness applicable to the particular program involved at the time granted, and the medical condition or physical defect, although worse, is within the retention medical fitness standards prescribed for the program or purpose now at issue.

r. For waivers of hearing standards as measured with diagnostic audiometry, if hearing, as measured with diagnostic audiometry, is worse than initially evaluated and will interfere with the individual's successful performance of military duty, the Soldier may be separated from military Service within the first 180 days for an existing prior-to-Service medical condition, provided an audiologist and an entrance physical standards board (EPSBD) determines that no Service-related cause or aggravation made the hearing worse than when initially evaluated.

1–7. Privacy

AR 40–66 implements DOD 6025.18–R, which is based on the requirements of the Health Insurance Portability and Accountability Act and establishes the limits of a Soldier’s right to the privacy of his/her protected health information. The confidentiality of a Soldier's protected health information will be ensured to the fullest extent possible and protected health information will be disclosed only if authorized by law and regulation.

Chapter 2

Physical Standards for Enlistment, Appointment, and Induction

2–1. General

This chapter implements, and incorporates by reference, DODI 6130.03. Check for the latest published DODI 6130.03 at <http://www.esd.whs.mil/dd/>. DODI 6130.03 establishes the basic medical standards for enlistment, appointment, and induction into the Armed Forces of the United States according to the authority contained in Section 113, Title 10, United States Code (10 USC 113). These standards are not all inclusive and other diseases or defects can be a cause for rejection based upon the medical judgment of the examining healthcare provider where such conditions may reasonably be expected to interfere with the successful performance of military duty or training, or limit geographical assignment.

2–2. Application and responsibilities

a. Purpose. The purpose of the standards contained in the most current DODI 6130.03 and this chapter is to ensure that individuals are medically qualified and are:

- (1) Free of contagious diseases that may endanger the health of other personnel.

(2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or would likely result in administrative separation from the Army under applicable regulation or referral to the DES under AR 635–40.

(3) Medically capable of satisfactorily completing required Army training.

(4) Medically adaptable to the military environment without the necessity of geographical area limitations.

(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

b. Application. This chapter prescribes the medical conditions, physical defects, and procedures that are causes for rejection for appointment, enlistment, and induction into the U.S Army. Unless otherwise stipulated, the conditions listed in this chapter are those that would be disqualifying by virtue of current diagnosis or for which the candidate has a verified past medical history. Other standards may be prescribed by DOD in the event of mobilization or a national emergency. Those individuals found medically qualified based on the medical standards of chapter 2 that were in effect prior to this publication will not be disqualified solely on the basis of the new standards. The designated waiver authorities listed in paragraph 1–6 may grant waivers for selection or continuation in the programs described in paragraph 2–2c, provided the individual meets the retention standards of chapter 3. However, the standards regarding the immune mechanism including immunodeficiencies will not be waived.

c. Scope. The standards of chapter 2 apply to:

(1) Applicants for appointment as commissioned or warrant officers in the RA and RCs, including appointment as a Soldier in the USAR or the ARNG/ARNGUS. This includes enlisted Soldier applicants for appointment as commissioned or warrant officers. (However, for officers of the ARNG/ARNGUS or USAR who apply for appointment in the RA, the standards of chapter 3 are applicable.)

(2) Applicants for enlistment in the RA, including the Delayed Entry Program/Future Soldier Training Program. For medical conditions or physical defects predating original enlistment regardless of component (COMPO), these standards apply for enlistees' first 6 months of AD. Within this 6 months of AD the applicant is subject to evaluation by an EPSBD, conducted in accordance with AR 40–400 and the requirements of AR 635–200.

(3) Applicants for enlistment in the RC and federally recognized units or organizations of the ARNG/ARNGUS. For medical conditions or defects predating original enlistment, these standards apply during the enlistees' initial period of active duty for training (ADT) until their return to Reserve or National Guard units. Such applicants may still be separated following an evaluation by an EPSBD conducted in accordance with AR 40–400. If medical conditions or physical defects fail chapter 3 retention standards, refer the case to DES in accordance with AR 635–200 and AR 635–40. (However, for enlisted Soldiers of the ARNG/ARNGUS or USAR who apply for enlistment in the RA, the standards of chapter 3 are applicable.)

(4) An applicant for reenlistment in the RA, RC, and ARNG/ARNGUS, after a period of more than 12 months has elapsed since discharge.

(5) Applicants (civilian applicants or enlisted Soldier applicants) for the USMA scholarship or advanced course ROTC, USUHS, HPSP, OCS, Warrant Officer Candidate School, and all other Army special officer personnel procurement programs. (See chap 3 for retention of students in HPSP and USUHS programs.)

(6) Retention of cadets at the USMA and students enrolled in ROTC. (However, the Commander, ROTC Cadet Command or the Superintendent, USMA has the authority to grant medical waivers for continuation in these programs, provided the cadet meets the retention and accession standards of chap 3.) If cadets at the USMA are unable to commission due to the standards of DODI 6130.03, they may still be able to be retained as enlisted.

(7) Individuals on the temporary disability retired list (TDRL) who have been found fit on reevaluation by the DES and who elect to return to AD or to active status in the RCs within the time standards prescribed by AR 635–40. These individuals are exempt from this chapter for the condition(s) for which they were found fit on re-evaluation by the DES. However, these Soldiers have to meet medical retention standards for the conditions incurred while on the TDRL. (These conditions are included in the final TDRL examination if it appears the member will be fit for the TDRL condition.)

(8) All individuals being inducted into the Army.

2–3. Height and weight

a. For both men and women, height below 58 inches or over 80 inches does not meet the standard. The height is measured and then rounded to the nearest inch as follows and in AR 600–9:

(1) If the height fraction is less than half an inch, round down to the nearest whole number in inches.

(2) If the height fraction is half an inch or greater, round up to the next whole number in inches.

(3) If the height standard is not met after rounding up or down to the next whole number in inches, the applicant will be rejected for service.

b. Army applicants for initial appointment as commissioned officers (to include appointment as commissioned warrant officers) must meet the standards of AR 600–9. Estimated body composition is used as the final determinant in evaluating an applicant’s acceptability when the weight exceeds that listed in the weight tables.

c. All other applicants must meet the standards of tables 2–1 and 2–2 of this chapter unless formally participating in Headquarters, Department of the Army (HQDA) sponsored pilot testing. Estimated body composition is used as the final determinant in evaluating an applicant’s acceptability when the weight exceeds that listed in the weight tables.

d. USMA, ROTC, and USUHS candidates for admission to the USMA, ROTC, and USUHS who are over the maximum height or below the minimum height in tables 2–1 and 2–2 of this regulation will automatically be recommended by Department of Defense Medical Examination Review Board for consideration for an administrative waiver by HQDA during the processing of their cases.

2–4. Mental health screening

The MEPS physical exam’s mental health screening does not meet the standard for a person-to-person mental health assessment established by DODI 6200.03 in compliance with 10 USC 1074n. This requirement is met on the occasion of the Soldier’s first PHA, 12 months from the accessions physical.

Table 2–1
Military acceptable weight (in pounds) as related to age and height for males (initial Army procurement)

Height (inches)	Minimum weight any age yielding a body mass index (BMI) of 19	Maximum weight by years of age ¹			
		17 – 20	21 – 27	28 – 39	40 and over
58	91	129	128	135	138
59	94	134	132	139	142
60	97	139	141	143	146
61	100	144	146	148	151
62	104	148	150	153	156
63	107	153	155	158	161
64	110	158	160	163	166
65	114	163	165	168	171
66	117	168	170	173	177
67	121	174	176	179	182
68	125	179	181	184	187
69	128	184	186	189	193
70	132	189	192	195	199
71	136	194	197	201	204
72	140	200	203	206	210
73	144	205	208	212	216
74	148	211	214	218	222
75	152	217	220	224	228
76	156	223	226	230	234
77	160	229	232	236	240
78	164	235	238	242	247
79	168	241	244	248	253
80	173	247	250	255	259

Table 2-1
Military acceptable weight (in pounds) as related to age and height for males (initial Army procurement)—Continued

Height (inches)	Minimum weight any age yielding a body mass index (BMI) of 19	Maximum weight by years of age ¹			
		17 – 20	21 – 27	28 – 39	40 and over
		Maximum body fat by years of age ²			
		17 – 20	21 – 27	28 – 39	40 and over
		24 percent	26 percent	28 percent	30 percent

Note:

¹ If a male exceeds these weights, percent body fat will be measured by the method described in AR 600-9.

² If a male also exceeds this body fat, he will be rejected for service.

Table 2-2
Military acceptable weight (in pounds) as related to age and height for females (initial Army procurement)

Height (inches)	Minimum weight any age yielding a BMI of 19	Maximum weight by years of age ¹			
		17 – 20	21 – 27	28 – 39	40 and over
58	91	122	124	126	127
59	94	127	128	130	131
60	97	132	134	135	136
61	100	136	137	139	141
62	104	140	141	144	145
63	107	145	147	148	149
64	110	149	151	153	154
65	114	154	156	158	160
66	117	160	160	162	165
67	121	163	166	168	169
68	125	168	171	173	174
69	128	173	176	178	180
70	132	178	181	183	185
71	136	183	186	188	191
72	140	189	191	194	196
73	144	194	196	200	202
74	148	199	203	204	206
75	152	205	208	210	212
76	156	210	213	215	216
77	160	216	219	221	223
78	164	222	224	227	229
79	168	227	230	234	236
80	173	233	236	240	241

**Table 2–2
Military acceptable weight (in pounds) as related to age and height for females (initial Army procurement)—Continued**

Height (inches)	Minimum weight any age yielding a BMI of 19	Maximum weight by years of age ¹			
		17 – 20	21 – 27	28 – 39	40 and over
		Maximum body fat by years of age ²			
		17 – 20	21 – 27	28 – 39	40 and over
		30 percent	32 percent	34 percent	36 percent

Note:

¹ If a female exceeds these weights, percent body fat will be measured by the method described in AR 600–9.

² If a female also exceeds this body fat, she will be rejected for service.

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

3–1. General

This chapter lists the various disqualifying medical conditions and/or physical defects which may render a Soldier unfit for further military service and which fall below the standards required for the individuals listed in paragraph 3–2. To be deployable, Soldiers should be ready to deploy within 72 hours of receipt of an assigned mission as defined in Army and DOD policy. These medical conditions and/or physical defects, individually or in combination, are those that have met the clinical or administrative medical retention decision point—

- a. Significantly limit or interfere with the Soldier’s performance of their duties (either basic Soldier skills or MOS specific) as substantiated by the Soldier’s commander or supervisor.
- b. Require medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects, medical care, or hospitalization with such frequency as to interfere with the satisfactory performance of duty.
- c. Restrict performance of any of the profile functional activities listed in Section 4 of DA Form 3349 (Physical Profile); prevent the performance of all aerobic events of the APFT (see AR 40–502 for descriptions and instructions on physical profiles); have met a clinical medical retention determination point (MRDP); or have been temporarily profiled for more than 365 days, meeting the administrative MRDP.
- d. May compromise or aggravate the Soldier’s health or well-being if they were to remain in the military Service. This may involve dependence on certain medications, appliances, severe dietary restrictions, frequent special treatments, or a requirement for frequent clinical monitoring.
- e. May compromise the health or well-being of other Soldiers (for example, a carrier of communicable disease who poses a health threat to others).
- f. May prejudice the best interests of the U.S. Government if the individual were to remain in the military Service.

3–2. Application

These retention standards are for continued military service and apply to the following individuals (see chapters 4 and 5 for additional medical standards that are required for continued service in designated specialties):

- a. All commissioned and warrant officers of the RA, ARNG/ARNGUS, and USAR.
- b. All enlisted Soldiers of the RA, ARNG/ARNGUS, and USAR.

Note. For medical conditions or physical defects predating original enlistment, the accession standards apply for enlistees’ first 6 months of AD. The member may only be separated following an evaluation by an EPSBD in accordance with AR 40–400 and AR 635–200. After 6 months, if the physical defect that predates enlistment meets retention standards, the Soldier is retained. If the pre-existing condition is disqualifying under chapter 3, then the member is to be referred to the DES (see AR 635–40, AR 635–200, and DA Pam 635–40).

- c. Students already enrolled in the HPSP and USUHS programs.
- d. Enlisted Soldiers of the ARNG/ARNGUS or USAR who apply for enlistment in the RA.
- e. Commissioned and warrant officers of the ARNG/ARNGUS or USAR who apply for appointment in the RA.
- f. Retired Soldiers recalled to AD.
- g. USAR retirees who have not reached age 60 and apply for transfer to the Ready Reserves.

3-3. Disposition

Soldiers with disqualifying conditions listed in this chapter who do not meet the required medical standards will be referred to the DES in accordance with AR 635-40 with the following caveats:

a. USAR or ARNG/ARNGUS Soldiers not on AD, whose medical condition was not incurred or aggravated during a period of AD, inactive duty training, or while otherwise in a duty status, will be processed in accordance with AR 635-40 and pertinent command-specific guidance.

b. Soldiers pending separation in accordance with the provisions of AR 635-200, AR 600-8-24, AR 135-178, or AR 135-175 authorizing separation under other than honorable conditions who do not meet medical retention standards will be referred to a DES. In the case of enlisted Soldiers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 635-200 or AR 135-178 and AR 635-40. In the case of commissioned or warrant officers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 600-8-24, AR 135-175, and AR 635-40.

c. A Soldier will not be referred to the DES because of impairments that were known to exist at the time of acceptance into the Army, after appropriate waiver was obtained, that have remained essentially the same in degree of severity, and do not meet the definition of a disqualifying medical condition or physical defect as in paragraph 3-1.

d. Profiling healthcare providers who identify a Soldier with a medical condition(s) listed in this chapter should initiate a permanent profile at the time of identification, which will prompt a DES referral. Profiling healthcare providers should not defer initiating a DES referral until the Soldier is being processed for non-disability retirement. Many of the conditions listed in this chapter (for example, arthritis in para 3-23) fall below retention standards only if the condition has precluded or prevented successful performance of duty as described in paragraph 3-1.

e. The requirements for referral to the DES in accordance with AR 635-40 are incorporated in the definition of a disqualifying medical condition or physical defect as in paragraph 3-1.

(1) Stinging insect allergy of Soldiers who receive elective immunotherapy treatment have special instructions on profiling in DA Pam 40-502.

(2) Cancer in remission without residuals may meet retention standards while in surveillance. Oncology should make a recommendation regarding suitability for deployment for consideration in profiling. See DA Pam 40-502 for instructions on profiling.

f. For Soldiers who have previously been found unfit for duty by a Physical Evaluation Board (PEB) but continued on AD or continued on active Reserve service under the provisions of AR 635-40, refer to AR 635-40 for disposition guidance.

g. Soldiers previously found fit for duty but who have a deployment-limiting condition may be referred to the Military Occupational Specialty Administrative Retention Review (MAR2) for a second review. (See AR 635-40.)

3-4. General policy

Possession of one or more of the disqualifying conditions listed in this chapter does not mean automatic retirement or separation from the Service. Soldiers with any medical condition, injury, or defect (individually or in combination) that meets the definition of a disqualifying medical condition or physical defect as stated in paragraph 3-1 will be referred to DES. The profiling officer and approval authority are responsible for referring Soldiers with conditions listed in this chapter to the DES by submitting a permanent profile with a 3 or 4 designation for conditions that have met an MRDP, annotated in e-Profile (the electronic profiling system of record). The limitations must be assessed and described by the profiling provider as prescribed in AR 40-502 and DA Pam 40-502.

3-5. Head

A skull, face, or mandible defect that poses a danger to the Soldier or interferes with the wearing of protective headgear is cause for referral to the DES.

3-6. Eyes

The causes for referral to the DES are as follows:

a. *Active eye disease or any progressive organic disease or degeneration.* Regardless of the stage of activity, when resistant to treatment and affects the distant visual acuity or visual fields so that distant visual acuity does not meet the standard stated in paragraph 3-7e or the diameter of the field of vision in the better eye is less than 20 degrees.

b. *Aphakia.* Bilateral.

c. *Atrophy of the optic nerve.* Due to disease when vision does not meet the standards of paragraphs 3-7e or 3-7f.

d. Glaucoma. If resistant to treatment or affecting visual fields as in paragraph 3–6a, or if side effects of required medication are functionally incapacitating.

e. Degenerations. When vision does not meet the standards of paragraph 3–7, or when vision is correctable only by the use of contact lenses or other special corrective devices (telescopic lenses and so forth.).

f. Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period. This includes intractable allergic conjunctivitis inadequately controlled by medications and immunotherapy or dry eye inadequately controlled with medical or surgical intervention.

g. Residuals or complications of injury, disease, or surgery. Postoperatively uncomplicated photorefractive keratectomy (PRK), laser epithelial keratomileusis (LASEK), or laser-assisted in situ keratomileusis (LASIK) when progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3–7 (see DA Pam 40–502 for profiling instructions).

h. Unilateral detachment of retina. If any of the following exists:

- (1) Visual acuity does not meet the standard stated in paragraph 3–7e.
- (2) The visual field in the better eye is constricted to less than 20 degrees.
- (3) Uncorrectable diplopia exists.
- (4) Detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

i. Bilateral detachment of retina. Regardless of etiology or results of corrective surgery.

j. An eye has been enucleated.

3–7. Vision

The causes for referral to the DES are as follows:

a. Aniseikonia. With subjective eye discomfort, neurologic symptoms, sensations of motion sickness or other gastrointestinal disturbances, functional disturbances or difficulties in form sense, that cannot be corrected by ordinary spectacle lenses.

b. Binocular diplopia. Not correctable by surgery, that is severe, constant, and in a zone less than 20 degrees from the primary position.

c. Hemianopsia or other visual field defects. Of any type if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to fall below required standards.

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

e. Distance visual acuity. That cannot be corrected with ordinary spectacle lenses (contact lenses or other special corrective devices (telescopic lenses, and so forth) are unacceptable) to at least 20/40 in one eye and 20/100 in the other eye, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/800 in the other eye.

f. Visual field with bilateral concentric constriction to less than 20 degrees.

3–8. Ears

The causes for referral to the DES are as follows:

a. Chronic otitis externa. Resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical care or hospitalization.

b. Acoustic nerve dysfunction. (Evaluate functional impairment of hearing under para 3–9.)

c. Chronic mastoiditis. With drainage from the mastoid cavity, requiring frequent and prolonged medical care.

d. Ménière's syndrome or recurrent vertigo. Of sufficient frequency and severity as to interfere with the satisfactory performance of duty or requiring frequent or prolonged medical care or hospitalization.

e. Chronic otitis media. Necessitating frequent and prolonged medical care or hospitalization.

3–9. Hearing

The causes for referral to the DES are as follows:

a. A failing score on a military operational hearing test such as a speech recognition in noise test (SPRINT) score in category E of the SPRINT scoring matrix.

b. Required use of assistive hearing technology that is not compatible with military service.

3–10. Nose, sinuses, mouth, and larynx

The causes for referral to the DES are as follows:

a. Larynx.

- (1) Vocal cord paralysis interfering with speech or breathing.

- (2) Stenosis of the larynx interfering with speech or causing respiratory interference or impairment of any kind.
- (3) Inducible laryngeal obstructions to include vocal cord dysfunction (paradoxical closure of the vocal cords) and laryngomalacia causing significant respiratory symptoms that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
 - b. Glottis.* Chronic obstructive edema of the glottis causing respiratory interference or impairment of any kind or interfering with speech or swallowing.
 - c. Rhinitis.* Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and foul, fetid odor.
 - d. Sinusitis.* Severe, chronic sinusitis that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
 - e. Anosmia.* Permanent.
 - f. Trachea.* Stenosis of the trachea causing respiratory interference or impairment of any kind with exertion.
 - g. Allergic rhinitis.* Chronic, severe, and not responsive to treatment.

3–11. Dental

The causes for referral to the DES are conditions of the jaws, periodontium, or associated tissues that cause the Soldier to be classified as Dental Readiness Classification (DRC) 3 or that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 and cannot be corrected. If the Soldier refuses treatment to correct the condition, the Soldier may be administratively separated from the Army.

3–12. Neck

The causes for referral to the DES are recurring or permanent torticollis; severe fixed deformity with cervical scoliosis, and loss of cervical mobility that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 (see also paras 3–25 and 3–35).

3–13. Lungs, chest wall, pleura, and mediastinum

The causes for referral to the DES are as follows:

- a. Tuberculosis and pulmonary.*
 - (1) If an expiration of service will occur before completion of the period of hospitalization or appropriate outpatient therapy. (Career Soldiers who express a desire to reenlist after treatment may extend their enlistment to cover the period of hospitalization.)
 - (2) When a member of the USAR or ARNG/ARNGUS not on AD has active disease that will most likely require treatment for more than 15 months including an appropriate period of convalescence (3 months) before they can perform full-time military duty. Individuals who are retained in the USAR or ARNG/ARNGUS while undergoing treatment may not be called or ordered to ADT (including mobilization), or inactive duty training during the period of treatment and convalescence.
 - (3) Latent tuberculosis infection (LTBI) warrants antimicrobial therapy and should be temporarily profiled while treated. For further guidance on LTBI surveillance and control, see MEDCOM Regulation 40–64.
- b. Asthma.* This includes reactive airway disease, exercise-induced bronchospasm, asthmatic bronchospasm, or asthmatic bronchitis within the criteria outlined in paragraphs 3–13*b*(1) through 3–13*b*(5). The clinical record must indicate that an asthmatic condition exists by virtue of a positive test with clinically verified asthma. Additional clinical documentation includes whether the asthmatic symptoms occurred on or off medication; the type of treatment used to terminate asthmatic symptoms; the number of attacks per day, week, or month in comparison to the frequency of attacks when the Soldier is taking daily prophylactic medication; and any precipitating factors other than normal activity and environment. Soldiers who are diagnosed as having asthma when medically advisable may be placed on a temporary profile for a 6 to 12 month trial of duty. If at the end of the trial, the Soldier’s clinical condition or duty limitations are described in paragraphs 3–13(2)(a) through 3–13(2)(d), the Soldier will be referred to the DES.
 - (1) Definitions/diagnostic criteria are as follows:
 - (a)* Asthma is a clinical syndrome characterized by cough, wheeze, or dyspnea and physiologic evidence of reversible airflow obstruction or airway hyperactivity that persists over a prolonged period of time (generally more than 6 months).
 - (b)* A baseline, reversible airflow obstruction of greater than or equal to a 12 percent increase and 200 milliliters (mL) increase in forced expiratory volume in 1 second (FEV1) and/or forced vital capacity following the administration of an inhaled bronchodilator (for example, 4 puffs of 90 micrograms of albuterol or 1 nebulizer treatment).
 - (c)* Increased bronchial responsiveness is the presence of an exaggerated decrease in airflow induced by a direct bronchoprovocation challenge such as methacholine inhalation (PC20 FEV1 less than or equal to 4 milligrams (mg)/mL).

Alternatively, indirect challenge testing such as inhaled mannitol (PD15 FEV1 less than or equal to 635 mg, or 10 percent decreasing in FEV1 to a single dose) or capnic voluntary hyperventilation (greater than or equal to a 15 percent decline in FEV1 following eucapnic voluntary hyperventilation testing) may also be used. Demonstration of exercise-induced bronchospasm (greater than or equal to a 15 percent decline in FEV1) following standardized exercised challenge) is also diagnostic of increased bronchial responsiveness; however, failure to induce bronchospasm with exercise does not rule out the diagnosis of asthma and another bronchoprovocation test (for example, methacholine) should be administered. Bronchoprovocation or exercise testing must be performed by a certified technician and interpreted by a provider privileged to perform these procedures.

(d) Acute, self-limited, reversible airflow obstruction and airway hyperactivity can be caused by upper respiratory infections and inhalation of irritant gases or pollutants. This should not be permanently diagnosed as asthma unless significant symptoms or airflow abnormalities persist for at least 6 months and up to 12 months despite appropriate therapy.

(2) Chronic asthma that has an FEV1 less than or equal to 50 percent of predicted despite appropriate therapy is cause for a permanent P-3 or P-4 profile and DES referral if it meets the definition of a disqualifying medical condition or physical defect as in paragraph 3-1, specifically—

(a) Results in required hospitalizations in less than 12 months (greater than one hospitalization or two emergency room visits per year), and/or excessive time lost from duty.

(b) Requires repetitive or ongoing use of any medication other than inhaled agents or leukotriene inhibitors, for example, chronic use of oral corticosteroids or omalizumab (anti-immunoglobulin E) to enable the Soldier to perform all military training and duties.

(c) Results in inability to pass the run event of the APFT despite medications. (The P-3 for the inability to perform the run refers to the inability due to asthma and should not be confused with giving an L2 or L3 based on an underlying orthopedic condition that requires an alternate aerobic APFT event.)

(d) Prevents the Soldier from wearing a protective mask.

(e) Limits Soldier for geographic assignment.

(3) All Soldiers referred to the DES for asthma must receive a consultation from an internist, pulmonologist, or allergist, and must have the following tests: spirometry, spirometry pre and post bronchodilator, and methacholine challenge test (or other acceptable bronchoprovocation test), demonstrating evidence of significantly reversible obstructive airway defect. If negative testing for bronchoprovocation, Soldier should be referred to a pulmonologist for further evaluation to consider evaluation for vocal cord dysfunction or other conditions known to mimic symptoms of asthma.

(4) Chronic asthma meets retention standards, but is a cause for a permanent P-2 profile if it requires regular medications including low dose inhaled corticosteroids and/or oral or inhaled bronchodilators, but does not meet the definition of a disqualifying medical condition or physical defect as in paragraph 3-1.

(5) No profiling action (via DA Form 3349) is required for Soldiers with a diagnosis of mild intermittent asthma that requires no medications or activity limitations. These Soldiers do not meet the definition of a disqualifying medical condition or physical defect as in paragraph 3-1 and do not require a profile nor referral to DES.

c. Non-reversible atelectasis or massive collapse of the lung. Symptoms of the condition limit duty performance or the atelectasis results in complications that require repeated medical intervention. Requires consultation with pulmonary, general surgery, or cardiothoracic surgery provider if referred to the DES.

d. Chronic obstructive pulmonary disease. Chronic (greater than 6 months) dyspnea at rest or with exertion that despite medications meet the definition of a disqualifying medical condition or physical defect as in paragraph 3-1. Soldiers who need systemic steroids or other systemic medications or have chronic respiratory failure, nocturnal hypoventilation, or a supplemental oxygen requirement meet definition of a disqualifying medical condition or physical defect as in paragraph 3-1. Recurrent exacerbations (more than two in a 12-month period, or three total) that result in absence from work or hospitalizations meet the definition of a disqualifying medical condition or physical defect as in paragraph 3-1. While chronic obstructive pulmonary disease (COPD) might be broken down into chronic bronchitis, emphysema, and COPD complicated by bronchiectasis, in many Soldiers these subtypes overlap. All diagnosis of COPD or subtypes of COPD require a chest x-ray, spirometry with bronchodilation, and ideally full lung volumes and a carbon monoxide diffusion capacity test performed by a certified technician and interpreted by a credentialed provider. Prior to referral to DES, a consultation with pulmonary or internal medicine is required.

e. Chronic bronchitis. Chronic, severe, persistent cough (greater than 6 months) with considerable sputum expectoration or with dyspnea at rest or complications that require repeated medical intervention.

f. Emphysema. Chronic dyspnea at rest or with exertion that meets criteria laid out in COPD definition. Diagnosis confirmed with spirometry demonstrating moderate reduction in pulmonary function, dyspnea on mild exertion, hypoxemia, and/or hypercarbia not responsive to a trial (6 to 12 months) of medical therapy and smoking cessation.

g. Chronic obstructive pulmonary disease complicated by bronchiectasis. Permanent abnormal widening or damage to the bronchi (airways) that is moderately symptomatic, with paroxysmal cough at frequent intervals throughout the day, or

with moderate airway obstruction, or a moderate amount of bronchiectatic sputum, or with recurrent pneumonia, or with residuals or complications that require repeated medical intervention.

h. Cystic or congenital disease. Cystic disease of the lung, congenital disease involving more than one lobe of a lung. Requires consultation with pulmonary specialist to confirm comprehensive evaluation, diagnosis, and standard of care treatment and assess residual symptoms prior to DES referral. Soldiers should be referred to DES if they have recurrent respiratory tract infections or meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

i. Diaphragm, congenital defect, symptomatic. Requires consultation with pulmonary specialist to confirm comprehensive evaluation, diagnosis, and standard of care treatment and assess residual symptoms prior to DES referral.

j. Fibrothorax, hydrothorax, empyema, pleural fistula. Persistent and symptomatic that results in persistent symptoms or functional limitations preventing the execution of military duties or physical fitness standards despite medical or surgical treatment.

k. Histoplasmosis, coccidiomycosis, blastomycosis. Chronic and not responsive to treatment resulting in chronic interstitial infections or fibrosing mediastinitis that persists despite therapy meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. Requires consultation with pulmonary specialist prior to DES referral.

l. Interstitial lung diseases and small airway diseases. This category includes hypersensitivity pneumonitis, severe pneumoconiosis, eosinophilic granuloma, pulmonary fibrosis, non-specific interstitial lung diseases, respiratory bronchiolitis, smoker's bronchiolitis, constrictive bronchiolitis, diffuse alveolar damage, and other miscellaneous lung diseases. Chronic (more than 6 months) dyspnea at rest or with exertion, persistent cough, wheezing/chest tightness with abnormal pulmonary function tests and/or abnormal chest x-rays and computed tomography (CT) that results in persistent limitations despite appropriate therapy for more than 12 months; or results in progression of disease, loss of lung function, and/or the need for supplemental oxygen therapy despite treatment, including tobacco cessation, observation, or change in environmental exposures. In addition to full pulmonary function testing (performed by a certified technician and interpreted by credentialed provider), formal exercise testing, inspiratory/expiratory high-resolution CT scans, and a tissue diagnosis (surgical or bronchoscopic) that is read by a pulmonary pathologist should be obtained to assist in definitive diagnosis and prognosis. Requires consultation with a pulmonologist prior to DES referral.

m. Pleurisy, chronic, or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function that persists despite therapy.

n. Pneumothorax, spontaneous. Second episode of spontaneous pneumothorax following surgical correction, those with persistent risk who are considered unsuitable for surgical correction, or those individuals with persistent anatomic defects considered high risk for recurrence despite surgical correction should be referred to DES.

o. Pulmonary sarcoidosis. Chronic (greater than 6 months) dyspnea at rest or with exertion, or cough, or chest pain that, despite a 12-month course of medical therapy, meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. Any diagnosis of symptomatic cardiac or central nervous system sarcoid, and any persistent extra-pulmonary sarcoid meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 should be referred to DES. All Soldiers with this diagnosis require full pulmonary function tests and referral to a pulmonologist prior to DES referral as well as consultations from specialties if there is evidence of other organ involvement (for example, eyes, cardiac, neurologic).

p. Stenosis, bronchus. Bronchial stenosis that is associated with repeated bronchopulmonary infections meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. Treatment that requires the placement of permanent endobronchial stents should be referred to DES.

q. Surgery of the lungs. A complete lobectomy, or pneumonectomy with spirometry demonstrating a moderate restrictive lung defect, persistent post-operative pain or otherwise meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

3–14. Heart

The causes for referral to the DES are as follows (see table 3–1 for functional classifications and for metabolic equivalents (METS) ratings to be included in the DES) and that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1:

a. Coronary heart disease. Associated with:

(1) Myocardial infarction, angina pectoris, or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm. The policies for trial of duty, profiling, and referral to the DES apply (as outlined in para 3–14p). The trial of duty will be for 120 days.

(2) Myocardial infarction with normal coronary artery anatomy. The policies for trial of duty, profiling, and referral to the DES apply (as outlined in para 3–14p). The trial of duty will be for 120 days.

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

(4) Fixed obstructive coronary artery disease, asymptomatic but with objective evidence of myocardial ischemia. The policies for trial of duty, profiling, and referral to the DES apply (as outlined in para 3–14p). The trial of duty will be for 120 days.

(5) Service members over 40 must have a cardiovascular disease risk evaluation per the United States Preventive Services Task Force Guidelines during their PHA (website available at <https://www.uspreventiveservicestaskforce.org/>). If labs are available at the time of the PHA screening assessment, elevated cardiac risk (identified by an index of 7.5 percent if labs are using the American Heart Association/American College of Cardiology pooled cohort risk assessment tool) must be referred to cardiology for further evaluation.

b. Supraventricular tachyarrhythmias. When life threatening or symptomatic enough to interfere with performance of duty. This includes atrial fibrillation, atrial flutter, paroxysmal supraventricular tachycardia, and others.

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

d. Heart block. High degree atrioventricular (AV) block and symptomatic bradyarrhythmias, even in the absence of organic heart disease or syncope. None of these conditions is cause for referral to the DES when associated with recognizable temporary precipitating conditions; for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or acute illness.

e. Primary or secondary myocardial disease. To include all forms of chronic myocarditis.

f. Ventricular flutter and fibrillation, ventricular tachycardia. When potentially life threatening (for example, when associated with forms of heart disease that are recognized to predispose to increased risk of death and when there is no definitive therapy available to reduce this risk) or meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. None of these ventricular arrhythmias are a cause for medical board referral to the DES when associated with recognizable temporary precipitating conditions; for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or acute illness.

g. Sudden cardiac arrest. When an individual survives sudden cardiac arrest that is not associated with a temporary or treatable cause.

h. Pericarditis.

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

(2) Chronic idiopathic pericarditis.

i. Valvular heart disease. With cardiac insufficiency at functional capacity of Class II or worse as defined by the New York Heart Association. (See table 3–1.)

j. Premature ventricular contractions with frequent or continuous attacks. Whether or not associated with organic heart disease, accompanied by discomfort or fear to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

k. Syncope. Recurrent syncope or near syncope that is not controlled or meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

l. Cardiovascular disorders. Any cardiovascular disorder requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

m. Congenital heart disease that has long term risks, complications, or impact on duty performance. The exception would be those congenital heart disease conditions that can be repaired with resolution of long term risks, complications.

n. Miscellaneous cardiovascular conditions. Such as Rheumatic fever, active, with heart damage. Recurrent attacks.

o. Surgery and other invasive procedures involving the heart, pericardium, or vascular system. These procedures include newly developed techniques or prostheses not otherwise covered in this paragraph.

(1) Permanent prosthetic valve implantation.

(2) Implantation of permanent pacemakers, anti-tachycardia and defibrillator devices, and similar newly developed and evolving implanted devices.

(3) Reconstructive cardiovascular surgery employing exogenous grafting material to include coronary angioplasty (including bypass grafting and stenting).

(4) Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, and meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. The policies for trial of duty, profiling, and referral to the DES apply (see paras 3–14b through 3–14j).

(5) Coronary artery revascularization, with the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual

undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pull-ups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349. The policies for trial of duty, profiling, and referral to the DES apply (see paras 3–14*b* through 3–14*j*).

(6) Heart or heart-lung transplantation.

(7) Coronary or valvular angioplasty procedures, with the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. The policies for trial of duty, profiling, and referral to the DES apply (see paras 3–14*b* through 3–14*j*).

(8) Cardiac arrhythmia ablation procedures, with the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia as noted in paragraph 3–14. The policies for trial of duty, DES referral, and physical profile apply (see paras 3–14*b* through 3–14*j*).

(9) Congenital heart disease with surgical or percutaneous repair procedures, with the option of a 180-day trial of duty based upon physician recommendations when the individual is asymptomatic and when other functional assessment procedures indicate it is advisable. The policies for trial of duty and referral to the DES are outlined in paragraph 3–14*p*.

p. Trial of duty and profiling for cardiovascular conditions.

(1) Trial of duty will be based upon a cardiologist's recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessments (such as coronary angiography, exercise testing, and newly developed techniques) indicate it is medically advisable.

(2) Prior to commencing the trial of duty period, an evaluation will be accomplished in all cases and a physical activity prescription on DA Form 3349 in the e-Profile will be provided by the cardiologist. The results of the trial of duty will include the individual's interim history, present condition, prognosis, and the final recommendations. If the Soldier successfully completes the trial of duty, is considered a New York Heart Association Functional Class I, and there are no physical or assignment restrictions, the Soldier may be returned to duty without referral to the DES. If the Soldier has any duty limiting physical restrictions after the trial of duty; he/she should be referred to the DES. In addition to the documented results of the trial of duty, a detailed report from the commander or supervisor clearly describing the individual's ability to accomplish assigned duties and to perform physical activity will be incorporated into the DES record. The results of the medical evaluation board (MEB) and an updated DA Form 3349 in e-Profile will then be forwarded to the PEB if the Soldier does not meet medical retention standards. For RC Soldiers not on AD, the trial of duty may consider performance in the Soldier's civilian position, as well as any military duty that may have been performed in the interim.

(3) The following profile guidelines supplement the general policy of AR 40–502 and DA Pam 40–502. Individuals recommended for a trial of duty will be given a temporary profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349 in e-Profile. If the Soldier later is referred to DES, the completed DES will include a profile with a permanent numerical designator in the "P" factor of the physical profile that is based on functional assessment as follows:

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

(b) Numerical designator "2." Individuals with minor physical activity limitations or who require frequent medical follow up.

(c) Numerical Designator "3." Individuals who are asymptomatic but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality. Those requiring assignment limitations.

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

3–15. Vascular system

The causes for referral to the DES are as follows:

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

(1) Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or more on level ground at 112 steps per minute without a rest, meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain, gangrenous, or chronic ulcerative skin changes in the distal extremities or meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

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

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

c. Aneurysm. Aneurysm of any vessel not correctable by surgery and aneurysm corrected by surgery after a period of up to 90 days trial of duty meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. The policies for trial of duty, profiling, and referral to the DES apply (see para 3–14p).

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

e. Chronic venous insufficiency (postphlebotic syndrome). When more than mild and symptomatic despite elastic support.

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

(1) Thromboangiitis obliterans with intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, produces other complications, or meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(2) Thrombophlebitis when repeated attacks requiring treatment are of such frequency that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

g. Varicose veins. Severe and symptomatic despite therapy.

h. Cold injury. (See para 3–28.)

3–16. Abdominal organs and gastrointestinal system

The causes for referral to the DES are as follows:

a. Esophagus.

(1) Achalasia (cardiospasm) with dysphagia not controlled by medical therapy, dilatation, surgery, continuous discomfort, or inability to maintain weight.

(2) Eosinophilic esophagitis, with frequent recurrent dysphagia or foreign body obstruction after adequate trial of medical therapy or if treatment requires swallowed steroids.

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

(4) Stricture of the esophagus of such a degree as to restrict diet to liquids, require repeated dilatation (more than two) and hospitalization, or cause difficulty in maintaining weight and nutrition.

b. Stomach and duodenum.

(1) Gastritis, if severe, with recurring symptoms not relieved by medication, surgery, or endoscopic intervention and meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(2) Second ulcer bleed in the absence of a risk factor such as nonsteroidal anti-inflammatory drug use or *h pylori* infection (duodenal or gastric), that is not relieved by medication, surgery, or endoscopic intervention and meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(3) Gastrectomy, total.

(4) Gastrectomy, subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite of good medical management, the individual develops “dumping syndrome” which persists for 6 months postoperatively; or develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively or continues to demonstrate appreciable weight loss 6 months postoperatively.

c. Small and large intestines.

(1) Inflammatory bowel disease, to include Crohn's disease, ulcerative colitis, indeterminate (chronic, recurrent), and microscopic (collagenous or lymphocytic) colitis that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 to include treatment with assignment limiting medications (immune modulator medication or steroids) or requires medications for control that requires frequent (every 1 to 2 months) monitoring by a physician. If receiving intravenous medication for greater than 6 months, must be referred to the DES.

(2) Peritoneal adhesions with recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, or intractable constipation requiring frequent admissions to the hospital.

(3) Intestinal stricture (large or small intestine) with repeated symptoms of pain or obstruction not relieved by medication, surgery, or endoscopic intervention meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(4) Irritable bowel syndrome or other functional gastrointestinal disorder meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 when they cause 6 months of symptoms resulting in prolonged absences from work despite optimal medical therapy or requires geographic assignment limitations.

(5) Gluten-sensitive enteropathy (celiac disease or sprue). All Soldiers with a geographic limitation and who require permanent P3, code V, to describe the deployment restrictions on the DA Form 3349 in e-Profile will be referred to the

DES. The diagnosis of celiac sprue may be made with either positive antibodies to tissue transglutaminase (known as TTG IgA positive) or duodenal biopsy with pathology consistent with celiac disease.

- (6) Colectomy, partial or total, when more than mild symptoms of diarrhea remain or if complicated by colostomy.
- (7) Colostomy, when permanent.
- (8) Enterostomy, when permanent.
- (9) Ileostomy, when permanent.

d. Hepatic-biliary tract.

(1) Ameobic abscess with persistent abnormal liver function tests and failure to maintain weight and vigor after appropriate treatment.

(2) Biliary dyskinesia or Sphincter of Oddi dysfunction with frequent abdominal pain that is not relieved by simple medication and/or presents with periodic jaundice meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(3) Cirrhosis of the liver.

(4) Hepatitis B and C. Hepatitis B or C, chronic, when following the acute stage, symptoms persist, and/or there is objective evidence of positive hepatitis B surface or E antigen or detectable hepatitis B deoxyribonucleic acid viral load in serum. Chronic hepatitis C virus (HCV) as documented by detectable HCV ribonucleic acid viral load in serum.

(5) Liver transplant recipient. If found fit for duty by a PEB, Soldiers will be restricted to assignment locations where adequate medical care is available and will not deploy to an austere environment. Soldiers must have ready access to tertiary medical care, laboratory facilities, and pharmacy.

e. Pancreas.

(1) Chronic pancreatitis.

(2) Pancreas (whole organ or islet cell) transplant recipient. If found fit for duty by a PEB, Soldiers will be restricted to assignment locations where adequate medical care is available and will not deploy to an austere environment. Such Soldiers should not be exposed to potentially infectious or noxious environments to include prolonged wear of individual chemical equipment for training. Soldiers must have ready access to tertiary medical care, laboratory facilities, and pharmacy.

(3) Pancreatectomy.

(4) Pancreaticoduodenostomy, pancreaticogastrostomy, or pancreaticojejunostomy, followed by more than mild symptoms of digestive.

f. Anorectal.

(1) Proctitis, chronic, with moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(2) Proctectomy.

(3) Proctopexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after an appropriate treatment period.

g. Abdominal wall. Hernia, including inguinal, and other abdominal hernias, except for small asymptomatic umbilical hernias, with severe symptoms not relieved by dietary or medical therapy, or other hernias if symptomatic and if operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

3–17. Female genital system

The causes for referral to the DES are as follows if symptoms of the condition are meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1:

a. Dysmenorrhea.

b. Endometriosis.

c. Menopausal syndrome. Physiologic or artificial.

d. Chronic pelvic pain. With or without demonstrative pathology that has not responded to medical or surgical treatment.

e. Hysterectomy. When complications or residual symptoms.

f. Oophorectomy. When complications or residual symptoms.

3–18. Male genital system

The causes for referral to the DES are as follows if symptoms of the condition are of such severity as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1:

a. Hypospadias. When accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings.

b. Orchiectomy. When complications or residual symptoms.

c. *Chronic or recurrent conditions.* Prostatitis, orchitis, epididymitis, or scrotal pain or unspecified symptoms associated with male genital organs.

3–19. Urinary system

The causes for referral to the DES are as follows:

a. *Cystitis.* When complications or residuals of treatment themselves meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

b. *Incontinence of urine.* Due to disease or defect not amenable to treatment and meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

c. *Kidney.*

(1) Chronic kidney disease, as defined in the Kidney Disease: Improving Global Outcomes classification system, when the glomerulofiltration rate (GFR) stage is G3a or worse (estimated GFR less than 60 cc/min/1.73 m² by the modification of diet in renal disease or chronic kidney disease-Epidemiology Collaboration equations (CKD–EPI)).

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

(3) Cystic kidney (polycystic kidney), when symptomatic or the focus of frequent infection.

(4) Glomerulonephritis or nephrotic syndrome, when chronic or recurring.

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

(6) Calculus in kidney, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(7) Hypoplasia of the kidney, when symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(8) Perirenal abscess, with residuals of a degree meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(9) Pyelonephritis or pyelitis, when the condition is chronic, and has not responded to medical or surgical treatment, and with evidence of hypertension, or eye-ground changes, or cardiac abnormalities.

(10) Pyonephrosis, when not responding to treatment.

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

e. *Urethritis.* Chronic, when not responsive to treatment meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

f. *Cystectomy.*

g. *Cystoplasty.* If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cubic centimeters or if refractory symptomatic infection persists.

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

i. *Nephrostomy.* With chronic drainage residual.

j. *Pyelostomy.* With chronic drainage residual.

k. *Ureterocolostomy.*

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

m. *Ureteroileostomy cutaneous.*

n. *Ureteroplasty.*

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

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

o. *Ureterosigmoidostomy.*

p. *Ureterostomy.* External or cutaneous.

q. *Urethrostomy.* If there is complete amputation of the penis or when a satisfactory urethra cannot be restored.

r. *Kidney transplant recipient.* If found fit for duty by a PEB, Soldiers will be restricted to assignment locations where adequate medical care is available and will not deploy to an austere environment. Such Soldiers should not be exposed to potentially infectious or noxious environments to include prolonged wear of individual chemical equipment for training. Must have ready access to tertiary medical care, laboratory facilities, and pharmacy.

3–20. Spine and sacroiliac joints

The causes for referral to the DES are as follows (see also para 3–23):

a. *Dislocation of the hip, congenital.*

b. *Spina bifida.* Demonstrable signs and moderate symptoms of root or cord involvement.

c. Spondylolysis or spondylolisthesis. More than one episode of symptoms resulting in repeated outpatient visits, or repeated hospitalization as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

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

e. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective findings to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

f. Kyphosis. More than moderate, meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

g. Scoliosis. Severe deformity with over 2 inches deviation of tips of spinous process from the midline, or of lesser degree if recurrently symptomatic meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

h. Nonradicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine. Whether idiopathic or secondary to degenerative disc or joint disease that fails to respond to adequate conservative treatment and necessitates significant limitation of physical activity. Controlled substances are not “adequate conservative treatment” if given chronically.

3–21. Upper extremities

The causes for referral to the DES are as follows (see also para 3–23):

a. Amputation.

(1) For purposes of this regulation, upper extremity amputation is defined as the loss of part or parts of an upper extremity equal to or greater than—

(a) A thumb proximal to the interphalangeal joint.

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

(c) One finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

(2) Soldiers with amputations will (assuming no other conditions not meeting retention standards) be provided a temporary profile not less than 4 months (but not to exceed 1 year) to enable the Soldier to attain maximum medical benefit.

b. Joint range of motion. Range of motion (ROM) which do not equal or exceed the following measurements. Measurements should be made with a goniometer and conform to the methods illustrated and described in the Veterans Administration Schedule for Rating Disabilities (VASRD). SF Form 527 (Medical Record—Group Muscle Strength, Joint R.O.M. Girth and Length Measurements) should be used to document the ROM and the method of measurement.

(1) *Shoulder.* Forward elevation to 90 degrees, or abduction to 90 degrees.

(2) *Elbow.* Flexion to 100 degrees, or extension to 60 degrees.

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

(4) *Hand.* (For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints in the VASRD.) An active flexor value of combined joint motions of 135 degrees in each of two or more fingers of the same hand, or an active extensor value of combined joint motions of 75 degrees in each of the same two or more fingers, or limitation of motion of the thumb that precludes opposition to at least two finger tips.

c. Recurrent dislocations of the shoulder. When not repairable or surgery is contradicted.

3–22. Lower extremities

The causes for referral to the DES are as follows (see also para 3–23):

a. Amputations.

(1) Lower extremity amputations are defined, for purposes of this regulation, as follows:

(a) Loss of toes that precludes the abilities to run or walk without a perceptible limp as to meet the rdefinition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(b) Any loss greater than that specified above, to include foot, ankle, below the knee, above the knee, femur, and hip.

(2) Soldiers with amputations will (assuming there are no other conditions that do not meet retention standards) be provided a temporary profile not less than 4 months (but not to exceed 1 year) to enable the Soldier to attain maximum medical benefit.

b. Feet.

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

(2) Pes planus, when symptomatic, moderately severe, with pronation on weight bearing which prevents the wearing of military footwear, or when associated with vascular changes.

(3) Pes cavus when moderately severe, with moderately severe discomfort on prolonged standing and walking, metatarsalgia, and which prevents the wearing of military footwear.

(4) Neuroma that is refractory to medical treatment, refractory to surgical treatment, and meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(5) Plantar fasciitis or heel spur syndrome that is refractory to medical or surgical treatment, or prevents the wearing of military footwear, meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(6) Hammertoes, severe, that precludes the wearing of appropriate military footwear or are refractory to surgery, meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(7) Hallux limitus, hallux rigidus.

c. Internal derangement of the knee.

(1) Residual instability following conservative or surgical measures, if more than moderate in degree.

(2) If complicated by arthritis (see paras 3–23a through 3–23c).

d. Joint ranges of motion. ROM that does not equal or exceed the following measurements. Measurements should be made with a goniometer and conform to the methods illustrated and described in the VASRD.

(1) Hip. Flexion to 90 degrees or extension to 0 degree.

(2) Knee. Flexion to 90 degrees or extension to 15 degrees.

(3) Ankle. Dorsiflexion to 10 degrees or planter flexion to 10 degrees.

e. Shortening of an extremity that exceeds two inches.

f. Recurrent dislocations of the patella.

3–23. Miscellaneous conditions of the extremities

The causes for referral to the DES are as follows (see also paras 3–26 and 3–27):

a. Arthritis. Due to infection, associated with persistent pain and marked loss of function with objective x-ray evidence and documented history of recurrent incapacity defined as multiple episodes of inability to perform MOS-specific duties related to a single acute or chronic condition, that does not meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1. For arthritis due to gonococcal or tuberculous infection (see para 3–31).

b. Arthritis. Due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

c. Osteoarthritis. With severe symptoms associated with impairment of function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

d. Avascular necrosis of bone. When severe enough as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

e. Chondromalacia or osteochondritis dissecans. Severe, manifested by frequent joint effusion (more frequent than once every 3 months or more than 3 times in 1 calendar year), more than moderate interference with function, or with severe residuals from surgery.

f. Fractures.

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

(2) Nonunion of fractures, when, after an appropriate healing period, the nonunion meet the rdefinition of a disqualifying medical condition or physical defect asin paragraph 3–1.

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

(4) Callus, excessive, following fracture, when functional impairment meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 and the callus does not respond to adequate treatment.

g. Joints.

(1) Arthroplasty with severe pain, limitation of motion, and of function.

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

(3) Contracture of joint, with marked loss of function and the condition is not remediable by surgery.

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

(5) Prosthetic replacement of major joints if there is resultant loss of function or pain meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

h. Muscles.

(1) Flaccid paralysis of one or more muscles with loss of function following surgical correction or if not remediable by surgery will meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(2) Spastic paralysis of one or more muscles with loss of function will meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

i. *Myotonia congenita*.

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

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

l. *Osteomyelitis*. Chronic, with recurrent episodes not responsive to treatment and involving the bone to a degree that interferes with stability and function.

m. *Tendon transplant*. With fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

n. *Tendinopathy*. Any tendinopathy persistent tenosynovitis (more than 60 days per year), or tendinopathy that after 60 days period of treatment/rest meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

3–24. Skin and soft tissues

The causes for referral to the DES are as follows:

a. *Acne*. Severe, unresponsive to treatment, wearing of the uniform or other military equipment as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

b. *Atopic dermatitis (eczema)*. Severe, and which meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

c. *Amyloidosis*. Generalized.

d. *Cysts and tumors*. (See para 3–34.)

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

f. *Dermatomyositis*.

g. *Dermographism*. When symptoms meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

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

i. *Epidermolysis bullosa*.

j. *Erythema multiforme*. More than moderate and recurrent or chronic.

k. *Fungal infections*. Superficial/deep, if not responsive to therapy meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

l. *Hidradenitis suppurativa*. If unresponsive to treatment and meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

m. *Scarring scalp disorders*. To include folliculitis decalvans, lichen planopilaris, central centrifugal cicatricial alopecia, and dissecting cellulitis of the scalp if unresponsive to treatment and meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

n. *Hyperhidrosis on the hands or feet*. When severe or complicated by a dermatitis or infection, either fungal or bacterial and not amenable to treatment.

o. *Leukemia cutis or mycosis fungoides or cutaneous T-Cell lymphoma*. (See also para 3–34.)

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

q. *Lupus erythematosus*. Cutaneous or mucous membranes involvement that is unresponsive to therapy and meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

r. *Neurofibromatosis*. When it meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

s. *Panniculitis*. Relapsing, febrile, nodular.

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

u. *Pemphigus*. Not responsive to treatment and with moderate constitutional or systemic symptoms or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

v. *Psoriasis*. Extensive and not controllable by treatment or treatment requires frequent monitoring by a healthcare provider.

w. *Radio dermatitis*. If resulting in malignant degeneration at a site not amenable to treatment.

x. *Scars and keloids*. So extensive or adherent that they seriously interfere with the function of an extremity or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

y. *Scleroderma*. Generalized or of the linear type that seriously interferes with the function of an extremity.

z. *Urticarial/Angioedema*. Chronic, severe, and not responsive to treatment.

aa. Xanthoma. Regardless of type, but only when meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

bb. Intractable plantar keratosis. Chronic, requiring frequent medical/surgical care or that meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

cc. Allergic dermatoses.

3–25. Blood and blood-forming tissues

The causes for referral to the DES are as follows:

a. Anemia. Acquired, aplastic, or unspecified, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, frequent visits by a healthcare provider.

b. Hemolytic crisis. Chronic and symptomatic.

c. Leukopenia. Chronic, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, frequent visits by a healthcare provider.

d. Hypogammaglobulinemia. With objective evidence of function deficiency and severe symptoms not controlled with treatment.

e. Purpura and other bleeding diseases. When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, frequent visits by a healthcare provider.

f. Thromboembolic disease. When response to therapy is unsatisfactory, or requiring prolonged/indefinite systemic anticoagulation. If found fit for duty by a PEB, Soldiers will be restricted to assignment locations where adequate medical care is available and will not deploy to an environment where there is high risk for traumatic injury (for example, combat zone).

g. Splenomegaly. Chronic.

h. Porphyria, cutanea tarda, or other types of porphyria.

i. Splenectomy.

3–26. Systemic conditions

The causes for referral to the DES are as follows:

a. Brucellosis. Chronic with substantiated, recurring febrile episodes, severe fatigue, lassitude, depression, or general malaise.

b. Exertional rhabdomyolysis. The diagnosis of exertional rhabdomyolysis, defined as severe exercise-induced muscle pain resulting from repetitive exercise with an elevation of serum creatine kinase generally at least five times the upper limit of the lab normal range or urine myoglobin, will be referred to DES for the following:

(1) The Soldier has recurrent episodes of exertional rhabdomyolysis.

(2) The Soldier has a single episode with severe systemic complications (for example, compartment syndrome).

(3) The Soldier has a single episode which results in physical complications that meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

(4) Soldiers with any of the following symptoms 2 weeks after experiencing an episode of exertional rhabdomyolysis should be referred to the appropriate specialist for consideration of referral to DES:

(a) Persistent residual kidney injury.

(b) Persistent elevation of serum creatine kinase five times the upper limit of the lab normal range or delayed clinical recovery.

(c) A history of sickle cell trait.

(5) The Uniformed Services University Consortium for Health and Military Performance (CHAMP) (online at <https://www.usuhs.edu/champ-provider>) is available via email to assist in clinical consultation at champ@usuhs.edu. In addition, a Clinical Practice Guideline in the Management of Exertional Rhabdomyolysis in Soldiers is available at <https://www.usuhs.edu/champ-clinical-tools>.

c. Leprosy. Any type that is not completely responsive to appropriate treatment or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

d. Malignant hyperthermia.

e. Myasthenia gravis.

f. Mycosis, blastomycosis, coccidioidomycosis, and histoplasmosis. Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals that themselves are unfitting.

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

h. Amyloidosis.

i. Tuberculosis.

(1) Meningitis, tuberculous.

- (2) Pulmonary tuberculosis, tuberculous empyema, and tuberculous pleurisy (see para 3–13).
- (3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.
- (4) Tuberculosis of the female genitalia.
- (5) Tuberculosis of the kidney.
- (6) Tuberculosis of the larynx.
- (7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery. These will be evaluated on an individual basis, considering the associated involvement, residuals, and complications.
- j. Human immunodeficiency virus.* Human immunodeficiency virus (HIV) confirmed antibody positivity, with the presence of progressive clinical illness or immunological deficiency.
 - (1) For Regular Army and RC Soldiers on an order to AD specifying a period of more than 30 days (excluding 10 USC 10148), refer to the DES.
 - (2) For RC Soldiers not on an order to AD specifying a period of more than 30 days, or who are performing ADT under 10 USC 10148, a line of duty determination is required to determine their eligibility to be referred to the DES under the duty-related process. Records of official diagnoses concerning the presence of progressive clinical illness or immunological deficiency in RC Soldiers may be used as a basis for determining progression of clinical illness or immunological deficiency. (See AR 600–110 for the most current HIV policies, including testing requirements.)
 - (3) HIV-infected ARNG Soldiers who demonstrate progressive clinical illness or immunological deficiency, will be processed under AR 635–40 and NGR 600–200 or NGR 635–101, as appropriate, as determined by medical authorities.
 - (4) HIV-infected USAR Soldiers who demonstrate progressive clinical illness or immunological deficiency, will be processed under AR 635–40 and AR 135–178 (enlisted) or AR 135–175 (officer), as appropriate, as determined by medical authorities.
- k. Symptomatic neurosyphilis.* Any form.
- l. Sexually transmitted disease.* Complications or residuals of such chronicity or degree that meets the r definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

3–27. Exertional heat illness

Exertional heat illness represents a continuum in severity, and includes heat exhaustion (HE), heat injury (HI), and heat stroke (HS). HS should be the working diagnosis for any Soldier with profound altered mental status. Final diagnosis should be delayed until the entire clinical picture is evident. The Uniformed Services University CHAMP (<https://www.usuhs.edu/champ-provider>) is available by e-mail to assist in clinical consultation at champ@usuhs.mil. The U.S. Army Research Institute of Environmental Medicine (USARIEM) (<http://www.usariem.army.mil/index.cfm/about/divisions/tmmd>) and U.S. Army Public Health Center (<http://phc.amedd.army.mil>) are subject matter experts in heat physiology, acclimation, related operational issues, to offer valuable clinical and educational resources such as TB MED 507. The causes for referral to the DES are as follows:

- a.* HE is defined as a syndrome of hyperthermia (core temperature at time of event usually 40 degrees centigrade or 104 degrees Fahrenheit) with physical collapse or debilitation occurring during or immediately following exertion in the heat, with no more than minor central nervous system dysfunction (such as headache, dizziness). HE resolves rapidly with minimal cooling intervention.
 - (1) Individual episodes of HE are not cause for referral to the DES. However, Soldiers who experience three episodes of HE in less than 24 months require referral to the DES.
 - (2) Soldiers diagnosed with HE are individually profiled as determined by the treating credentialed provider. Soldiers with HE pending referral to the DES will be profiled using guidance provided in table 3–2.
- b.* HI is defined as HE with clinical evidence of organ (for example, liver, renal, stomach) and/or muscle (for example, rhabdomyolysis) damage without sufficient neurological symptoms to be diagnosed as HS.
 - (1) Single episodes of HI are not cause for an immediate referral to the DES. However, Soldiers who experience three episodes of HI in less than 24 months or a single episode with severe complications (for example, compartment syndrome) of such a nature that the complications meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1, require referral to the DES. Soldiers demonstrating any of the following complications, despite 2 weeks of rest, should be referred to the appropriate medical specialist for consideration of referral to the DES:
 - (a) Persistent residual kidney injury.
 - (b) Persistent elevation of serum creatine kinase more than five times the upper limit of the lab normal range.
 - (c) Persistent elevation of transaminases more than three times the upper limit of the lab normal range.
 - (2) All Soldiers diagnosed with HI will be placed on a temporary profile, numerical designator 4 in the physical, upper, lower, hearing, eyes, psychiatric (PULHES) physical capacity factor P, (T4-(P)), for a period of 1 week. After the 1-week

period, the Soldier will be reevaluated and individually profiled as determined by the treating credentialed provider. Soldiers diagnosed with HI and pending referral to the DES will be profiled using guidance provided in table 3–2.

c. HS is defined as a syndrome of hyperthermia (core temperature at time of event usually 40 degrees centigrade or 104 degrees Fahrenheit), physical collapse or debilitation, and encephalopathy as evidenced by delirium, stupor, or coma, occurring during or immediately following exertion or significant heat exposure. HS can be complicated by organ and/or tissue damage, systemic inflammatory activation, and disseminated intravascular coagulation.

(1) Following an episode of HS, the Soldier will be placed on a T4-(P) profile for a period of 2 weeks. After the 2-week period, the Soldier will be reevaluated weekly for the need of a continuing profile and/or referral to the DES. This reevaluation will include an assessment for the presence or absence of physical damage and/or complications and any contributing risk factor(s) that may have increased the Soldier's inability to tolerate the heat exposure. For profile guidance, see table 3–2.

(2) During the reevaluation period, the Soldier will be classified into one of the following three categories:

(a) HS without sequelae demonstrated by all clinical signs and symptoms resolved by 2 weeks following the heat exposure event.

(b) HS with sequelae to include any evidence of cognitive or behavioral dysfunction, renal impairment, hepatic dysfunction, rhabdomyolysis, or other related pathology that does not completely resolve by 2 weeks following the heat exposure event.

(c) Complex HS that is recurrent or occurring in the presence of a non-modifiable risk factor, either known (for example, a chronic skin condition such as eczema or burn skin graft) or suspected (for example, sickle cell trait or malignant hyperthermia susceptibility).

(3) Soldiers with complex HS require referral to the DES. The Soldier's provider should consider referring the Soldier to a center with clinical expertise in heat illness for further evaluation.

d. Initial entry training Soldiers will not be separated based upon the diagnosis of one episode of HS with or without complications but will be placed into a Warrior Training and Rehabilitation Program (formerly the Physical Training and Rehabilitation Program) for the duration of their profile.

3–28. Cold injury

The USARIEM (<http://www.usariem.army.mil/index.cfm/about/divisions/tmmd>) and U.S. Army Public Health Center (<http://phc.amedd.army.mil>) are subject matter experts in cold physiology, acclimation, and related operational issues, and offer valuable clinical and educational resources. The causes for referral to the DES are as follows:

a. *Frostbite (freezing cold injury).*

(1) The definition of frostbite is the consequence of freezing of tissue. First degree frostbite is manifested by superficial injury without blistering. Second degree frostbite is manifested by superficial injury with clear blisters with only epidermal tissue loss. Third-degree and fourth-degree frostbite are manifested by significant sub epidermal tissue loss.

(2) Soldiers with first degree frostbite after clinical healing will be given a P–2 profile permitting the use of extra cold weather protective clothing, including non-regulation items, to be worn under authorized outer garments.

(3) Soldiers with frostbite more than first degree will be given a temporary profile, renewed as appropriate, for the duration of the cold season restricting them from any exposure to temperatures below 0 degrees centigrade (32 degrees Fahrenheit) and from any cold weather training activities limited for the remainder of the cold season. After the cold season, Soldiers will be reevaluated and, if appropriate, given the P–2 profile described in paragraph 3–28a(2), or a P–3 for persistent cold sensitivity, vascular or neuropathic symptoms, or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1, and referred to the DES.

(4) Soldiers will require referral to the DES for recurrent cold injury, recurrent or persistent cold sensitivity, vascular or neuropathic symptoms, disability due to tissue loss from cold injury, or any geographic limitations.

b. *Immersion foot/trench foot (nonfreezing cold injury).*

(1) The definition of trench foot is the consequence of prolonged cold immersion of an extremity. It is manifested by maceration of tissue and neurovascular injury.

(2) Soldiers with residual symptoms or significant tissue loss after healing will be referred to the DES.

c. *Accidental hypothermia.*

(1) The definition of accidental hypothermia is clinically significant reduction of body temperature due to environmental cold exposure.

(2) Soldiers with significant symptoms of cold intolerance or a recurrence of hypothermia after an episode of accidental hypothermia will be referred to the DES.

3–29. Endocrine and metabolic

The causes for referral to the DES are as follows:

- a. *Acromegaly*.
- b. *Adrenal insufficiency*. Requiring replacement therapy.
- c. *Diabetes insipidus*. Requiring the use of medication for control.
- d. *Diabetes mellitus*.
 - (1) All cases of type 1 disease.
 - (2) All cases of type 2 disease requiring medications for glycemic lowering.
 - (3) All cases of diabetes mellitus with microvascular or macrovascular complications.
 - (4) All cases with HbA1C greater than 7.0 percent despite lifestyle modification for 6 months, intolerance, or declination of medical therapy.
 - (5) If a Servicemember who has been previously found fit for duty while taking oral diabetic information and has a change requiring insulin should be referred back to the DES as this requires refrigeration of medication.
- e. *Goiter*. Causing breathing obstruction.
- f. *Fasting hypoglycemia*. (As documented during a 72-hour fast.) When caused by an insulinoma or other hypoglycemia-inducing tumor.
- g. *Hyperparathyroidism*. When residuals or complications of surgical correction such as renal disease or bony deformities meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
- h. *Cushing’s syndrome*.
- i. *Osteomalacia or osteoporosis*. Resulting in fracture with residuals after therapy of such nature or degree meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
- j. *Primary hyperaldosteronism*. When resulting in uncontrolled hypertension and/or hypokalemia.
- k. *Multiple endocrine neoplasia*. Any type.
- l. *Pituitary macroadenomas*. When resulting in hypothalamic/pituitary dysfunction or symptoms of mass effect.
- m. *Pheochromocytoma*.
- n. *Thyroid carcinoma*. Any type, if persistent despite usual therapy (surgery, radioactive iodine, and treatment with suppressive doses of levothyroxine).
- o. *Hypoparathyroidism*. When severe, persistent, and difficult to manage.
- p. *Salt-wasting congenital adrenal hyperplasia*.
- q. *Carcinoid syndrome*.
- r. *Endocrine tumors of the gastrointestinal tract*. When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision. Such tumors include gastrinoma, glucagonoma, vasoactive intestinal peptide secreting tumor, neurotensinoma, pancreatic polypeptide-secreting tumor, and somatostatinoma.
- s. *Graves’ eye disease*. With moderate ocular dysfunction including severe proptosis or decrease in visual acuity or persistent diplopia.
- t. *Hypopituitarism*. From any cause.
- u. *Persistent hyponatremia*. Due to the syndrome of inappropriate antidiuretic hormone.
- v. *Endocrine conditions*. Requiring replacement or adjustment therapies must be stable on oral or transdermal medication preparations.

3–30. Rheumatologic

The causes for referral to the DES are as follows:

- a. *Behcet’s syndrome*. That requires geographic assignment limitations, or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
- b. *Fibromyalgia*. As defined by the American College of Rheumatology; diagnosis made by or with the consultation of a rheumatologist and when the symptoms meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
- c. *Hypersensitivity angitis*. When chronic or having recurring episodes that are more than mildly symptomatic or show definite evidence of functional impairment which is resistant to treatment after a reasonable period of time (no longer than 12 months).
- d. *Inflammatory myopathy*. Including polymyositis, dermatomyositis, myositis associated with other connective tissue disease, and inclusion body myositis that requires geographic assignment limitations, or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.
- e. *Progressive systemic sclerosis*. Diffuse and limited disease that requires geographic assignment limitations, or meets the definition of a disqualifying medical condition or physical defect as d in paragraph 3–1.
- f. *Rheumatoid arthritis*. When condition requires geographic assignment limitations, or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

g. Spondyloarthropathies. With chronic or recurring episodes of arthritis causing functional supported by objective, subjective, and radiographic findings, or requires medication for control that requires frequent monitoring by a physician as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

- (1) Ankylosing spondylitis.
- (2) Reiter's syndrome.
- (3) Psoriatic arthritis.
- (4) Arthritis associated with inflammatory bowel disease.
- (5) Whipple's disease.

h. Sjogren's syndrome. When chronic, more than mildly symptomatic, and resistant to treatment for up to 12 months.

i. Systemic lupus erythematosus. When condition requires geographic assignment limitations or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

j. Adult onset Still's disease. When condition requires geographic assignment limitations or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

k. Systemic vasculitis involving major organ systems. Chronic, requires geographic assignment limitations, or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

l. Mixed connective tissue disease and other overlap syndromes. When condition requires geographic assignment limitations, or meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

m. Gout. In advanced cases with frequent acute exacerbations or severe bone, joint, or kidney damage meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

3–31. Neurological

The causes for referral to the DES are as follows:

- a. Amyotrophic lateral sclerosis and all other forms of progressive neurogenic muscular atrophy.*
- b. All primary muscle disorders.* Including facioscapulohumeral dystrophy, limb girdle dystrophy, and myotonic dystrophy characterized by progressive weakness and atrophy.
- c. Myasthenia gravis.* Unless clinically restricted to extraocular muscles.
- d. Progressive degenerative disorders of the basal ganglia and cerebellum.* Including Parkinson's disease, Huntington's chorea, hepatolenticular degeneration, and variants of Friedreich's ataxia.
- e. Multiple sclerosis, optic neuritis, transverse myelitis, and similar demyelinating disorders.*
- f. Stroke.* Including both the effects of ischemia and hemorrhage, when residuals affect performance.
- g. Migraine, tension, or cluster headaches.* When manifested by incapacitating attacks that interfere with duty or social activities three or more days per month. All such Soldiers will be referred to a neurologist, who will ascertain the cause of the headaches. The neurologist will determine whether prophylactic therapy (up to 6 months) or referral to the DES is warranted. If the headaches are not adequately controlled at the end of the 6 months, the Soldier will be referred to the DES. If the neurologist feels the Soldier is unlikely to respond to therapy, the Soldier can be referred directly to the DES.
- h. Narcolepsy or similar sleep disorders.* (See para 3–32c.) The evaluation and treatment of these diagnoses by a neurologist or other sleep specialist is required to determine treatment and disposition.
- i. Seizure disorders and epilepsy.* Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. However, they may be considered along with other disabilities in judging fitness. In general, epilepsy is disqualifying unless the Soldier can be maintained free of clinical seizures of all types by nontoxic doses of medications. The following guidance applies when determining whether a Soldier will be referred to the DES:

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

- (2) If a trial of duty on treatment is elected by the neurologist, the Soldier will be given a temporary profile with restrictions appropriate to protect the health and safety of the Soldier.

- (3) Once the Soldier has been seizure-free for 12 months with a non-toxic medication regimen, the profile may be downgraded to a P–2 profile that documents the history of epilepsy and includes the treating neurologist's recommendation regarding suitability for deployment. If the Soldier remains seizure-free for 36 months, profile restrictions may be removed.

- (4) If seizures recur beyond 6 months after the initiation of treatment, the Soldier will be placed on a P–3 profile and referred to the DES. However, should seizures recur during a later attempt to withdraw medications or during transient illness, referral to the DES is at the discretion of the treating neurologist.

(5) If the Soldier has remained seizure-free (off medications) for 12 months, they may be removed from profile restrictions.

(6) Recurrent pseudoseizures are causes for referral to DES under the same rules as epilepsy. Routine neurologist evaluation should be obtained for these Soldiers.

j. Traumatic brain injury. If, after adequate treatment, there remain residual symptoms and impairment to such a degree as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1, referral to the DES is required.

k. Other neurologic conditions. Any other neurologic conditions when, after adequate treatment, there remain residual symptoms and impairments such as persistent severe headaches, uncontrolled seizures, weakness, paralysis or atrophy of important muscle groups, deformity, lack of coordination, tremor, pain, sensory disturbance, alteration of consciousness, speech, personality, or cognitive and mental function as to meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

3–32. Sleep disorders

The causes for referral to the DES are as follows:

a. Chronic insomnia disorder. Insomnia is defined as difficulty initiating sleep, maintaining sleep, or waking earlier than desired which occurs at least 3 nights per week for at least 3 months with associated daytime impairment that can include symptoms of fatigue, mood disturbance/irritability, daytime sleepiness, decreased motivation, or increased propensity for errors/accidents. Insomnia which does not respond to cognitive behavioral therapy and/or requires medications to promote sleep (defined as using any medication with sedative properties specifically for sleep up to or more than three times a week) over 6 consecutive months and despite or due to therapy meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 and requires a referral to the DES.

b. Sleep-related breathing disorders.

(1) Central sleep apnea that causes hypersomnolence (sleepiness) and does not resolve with removing or reducing an offending medication or by treatment of a known medical etiology. If central sleep apnea is due to congestive heart failure, cardiology evaluation is required to determine need for referral to the DES.

(2) Obstructive sleep apnea (OSA) that causes daytime hypersomnolence or snoring that interferes with the sleep of others and cannot be corrected with weight loss, positive airway pressure (PAP), surgery, or an oral appliance. The diagnosis of OSA must be based on a polysomnogram. Minimum adherence to PAP therapy, for mild, moderate, or severe OSA, is defined as 4 hours of therapy per day for at least 70 percent of days over a period of 30 days. Optimal adherence to PAP therapy is defined as 6 hours or more of therapy per day for at least 90 percent of days.

(a) Individuals that require PAP modes other than auto-adjusting pressure, bi-level pressure or continuous pressure for control of OSA will be referred to the DES.

(b) A 12-month trial of PAP therapy may be attempted to assist with other therapeutic interventions, during which time the individual will be issued a temporary profile. If PAP therapy is required for longer than 12 months and the Soldier is adherent to PAP (meets the minimum adherence criteria as defined in paragraph 3–32b(2)) with adequate treatment of daytime sleepiness, the Soldier should be profiled as a permanent P–2 and are required to deploy with a PAP battery.

(c) If symptoms of hypersomnolence or snoring cannot be controlled with weight loss, PAP therapy, surgery, or an oral appliance, or the Soldier is unable to achieve the minimum adherence to PAP defined in paragraph 3–32b(2), then the Soldier will be referred to the DES. If the use of PAP or other therapies for sleep apnea meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1, the Soldier should be referred to the DES.

(d) If prescribed stimulant therapy is required to treat hypersomnolence despite adequate treatment of OSA, refer to the DES.

(3) Nocturnal hypoxemia due to a medical condition. Soldiers that require supplemental oxygen treatment for longer than 6 months while sleeping should be referred to the DES.

c. Hypersomnia of central origin. Hypersomnia of central origin is a category of sleep disorders characterized by excessive daytime sleepiness which is not from disturbed sleep or a misaligned circadian rhythm. Diagnosis requires an evaluation by a provider with expertise in sleep medicine.

(1) As part of the diagnostic testing, actigraphy for a minimum of 1 week that reveals an average sleep period of 7 or more hours without circadian variability before an attended in-lab polysomnogram that adheres to the American Academy of Sleep Medicine Practice Parameters for the multiple sleep latency test is required. Lack of response to therapy and/or treatments and residuals that meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1 requires referral to the DES. Evaluation of adequacy of response will include a maintenance of wakefulness test with mean sleep onset latency greater than or equal to 35 minutes.

(2) Disorders of hypersomnia of central origin that require the evaluation in paragraph 3–32c(1) include, but are not limited to:

- (a) Narcolepsy without cataplexy.
 - (b) Recurrent hypersomnia.
 - (c) Idiopathic hypersomnia.
 - (d) Hypersomnia due to a medical condition.
 - (e) Hypersomnia due to drugs or substances.
- (3) Narcolepsy with cataplexy requires referral to the DES.

d. Circadian rhythm sleep disorders. These disorders only require a referral to the DES if the condition meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

e. Parasomnias. These disorders are characterized by unwanted movements occurring while the Soldier is asleep and may result in physical injury. If the parasomnia is secondary to a precipitating factor such as a medication side effect, undiagnosed/untreated obstructive sleep apnea or insufficient sleep, and does not reoccur once the medication is stopped, OSA is treated, or adequate sleep is obtained, it does NOT require a referral to DES. All other parasomnias that pose a potential danger to the Soldier require referral to the DES. Parasomnias that require the above evaluation include but are not limited to rapid eye movement sleep behavior disorder.

3–33. Learning, psychiatric, and behavioral health

Diagnostic concepts and terms used in this section are in consonance with the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). The minimum behavioral health evaluation will include evaluation for primary behavioral health disorders and medical conditions by a behavioral health provider which can result in significant symptoms. The causes for referral to the DES are as follows:

a. Disorders with psychotic features. For example, delusions, hallucinations, disorganized thinking or speech, grossly disorganized or abnormal motor behavior, or negative symptoms, not secondary to intoxication, infections, toxic, or other identifiable medical causes resulting in interference with social adjustment or with duty performance.

b. Bipolar and depressive disorders.

- (1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
- (2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

(3) Any history of a manic episode, not secondary to intoxication, infections, toxic, or other identifiable medical causes.

c. Anxiety, obsessive-compulsive, dissociative, somatic symptom and related disorders (excluding factitious disorder), and trauma and stressor related disorders.

- (1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
- (2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

d. Neurocognitive disorders. The causes for referral to the DES include persistence of symptoms or associated personality change sufficient to interfere with the performance of duty or social adjustment.

e. Chronic adjustment disorder. Referral to a DES will occur when the Soldier exhibits persistent or recurring symptoms meeting the criteria detailed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders. These symptoms must be directly caused by exposure to an enduring stressor and must last longer than 6 months. The causes for referral to DES for chronic adjustment disorder are:

- (1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
- (2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

f. Feeding and eating disorders.

- (1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
- (2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

3–34. Tumors and malignancies

The causes for referral to the DES are as follows:

a. Malignant neoplasms that are unresponsive to therapy. Or when therapy is such as to require prolonged, intensive medical supervision, or when the residuals of treatment themselves meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

b. Neoplastic conditions of the lymphoid and blood-forming tissues that are unresponsive to therapy. Or when therapy is such as to require prolonged, intensive medical supervision, or when the residuals of treatment themselves meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

- c. *Malignant neoplasms.* When on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.
- d. *History of benign or malignant neoplasms of the brain, spinal cord, or their coverings.*
- e. *Benign tumors.* If their condition meets the definition of a disqualifying medical condition or physical defect as in paragraph 3-1.
- f. *Pigmented villonodular synovitis.* When meets the definition of a disqualifying medical condition or physical defect as in paragraph 3-1.

3-35. General and miscellaneous conditions and defects

The causes for referral to the DES are as follows:

- a. *Stinging insect allergy.* A Soldier, who has been determined by an allergist to have a stinging insect allergy to fire ant, wasp, honeybee, yellow jacket, or hornets, but who would not benefit from venom immunotherapy (VIT) will be referred to the DES. When a Soldier elects to receive recommended VIT, the Soldier may be exempt from the DES referral by an allergist. See DA Pam 40-502 for instructions on profiling. Allergists will annually review the Soldier for progress to resolution or worsening of conditioning and adjust profiling action consistent with annual review. If the Soldier is unable to maintain appropriate VIT injection intervals, the allergist will refer the Soldier to the DES.
- b. *Miscellaneous conditions and defects.* Conditions and defects not mentioned elsewhere are causes for referral to the DES, if—
 - (1) The medical condition(s) (individually or in combination) identified is chronic or of a nature that meets the definition of a disqualifying medical condition or physical defect as in paragraph 3-1.
 - (2) The individual's health or well-being would be compromised if they were to remain in the military service.
 - (3) In view of the Soldier's condition, their retention in the military service would prejudice the best interests of the U.S. Government (for example, a carrier of communicable disease who poses a health threat to others). Questionable cases, including those involving latent impairment, will be referred to the DES.

3-36. Conditions and circumstances not constituting a physical disability

- a. If the Soldier has a condition, circumstance, or defect of a developmental nature, not constituting a physical disability that interferes with assignment to or satisfactory performance of duty, and that was not service aggravated and is not compensable under the VASRD, the Secretaries of the Military Departments may authorize separation. These Service-members will not be referred to the DES. These conditions will be addressed through administrative channels, including AR 135-175, AR 135-178 (for ARNG and USAR), AR 635-200, or AR 600-8-24 (for RA), as appropriate.
- b. Additional conditions include:
 - (1) Allergy to material(s) used in military uniformed clothing.
 - (2) Formaldehyde allergies.
 - (3) Formaldehyde releasers allergies.
 - (4) Permethrin allergies.

3-37. Medical examinations

- a. 10 USC 1177 requires a medical examination in certain instances prior to administrative separation of Soldiers under conditions other than honorable. Separation authorities will ensure medical examinations are completed for any Soldier, officer or enlisted, pending administrative separation under conditions other than honorable who has been deployed overseas in support of a contingency operation or sexually assaulted during the previous 24 months, and who is diagnosed with post-traumatic stress disorder (PTSD) and/or traumatic brain injury, or who otherwise reasonably alleges the influence of such condition based on their service while deployed or based on such sexual assault.
- b. As required by DODI 6040.46, all RA and RC Soldiers separating from AD after serving for 180 days or more, or over 30 days in support of contingency operations, are required to complete a separation history and physical examination (SHPE). Soldiers who qualify for the SHPE because of non-disability retirement or separation are presumed fit for retention. When the examination identifies a medical condition that fails medical retention standards under the standards of this chapter, the Soldier will be referred to a PEB. The PEB will determine fitness for purposes of the Soldier's retention, separation or retirement for disability, or separation for disability without entitlement to disability benefits. It will apply the standards found in Chapter 5, AR 635-40.

**Table 3–1
Methods of assessing cardiovascular disability—Continued**

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

**Table 3–1
Methods of assessing cardiovascular disability—Continued**

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
	rest. If any physical activity is undertaken, discomfort is increased.			

New York Heart Association Therapeutic Classification

Therapeutic Classification		Revised classification (prognosis)
Class A	Patients with cardiac disease whose physical activity need not be restricted.	Class I—Good
Class B	Patients with cardiac disease whose ordinary activity need not be restricted, but who should be advised against severe or competitive physical efforts.	Class II—Good with therapy
Class C	Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.	Class III—Fair with therapy
Class D	Patients with cardiac disease who should be at complete rest, confined to bed or chair.	Class IV—Guarded despite therapy

METS (Required for PEB adjudication)

Class I = 8 METS or greater; Class II = 5–8 METS; Class III = 3–5 METS; Class IV = Less than 3 METS

**Table 3–2
Profile progression recommendations for the Soldier with heat stroke, with or without sequelae; complex heat stroke; heat exhaustion; or heat injury, pending a medical evaluation board**

Profile ¹	Restrictions ²	HS without Sequelae	HS with Sequelae	Complex HS or HE/HI pending MEB
T template	Complete duty restrictions.	2 weeks	2 weeks minimum, advance when clinically resolved	2 weeks minimum, advance when clinically resolved
T template	Physical training and running, walking, swimming, or bicycling at own pace and distance not to exceed 60 minutes per day. No maximal effort; no APFT; no wear of Interceptor Multi-Threat Body Armor (IBA); no mission oriented protective posture (MOPP) gear; no ruck marching. No airborne operations (AO).	1 month minimum	2 months minimum	Pending MEB
T template	Gradual acclimatization (see TB MED 507). No maximal effort; no APFT; no MOPP IV gear. IBA limited to static range participation. May ruck march at own pace and distance with no more than 30 pounds. Non-tactical AO permitted.	1 month minimum	2 months minimum ³	Not applicable
T template	Continue gradual acclimatization. May participate in unit physical training; chemical, biological, radiological, and nuclear training with MOPP gear for up to 30 minutes; IBA on static and dynamic ranges for up to 45 minutes; no record APFT. Ruck	Not applicable	Pending completion of 30-day heat exposure requirement, if not accomplished during prior profile ³	Not applicable

Table 3–2**Profile progression recommendations for the Soldier with heat stroke, with or without sequelae; complex heat stroke; heat exhaustion; or heat injury, pending a medical evaluation board—Continued**

Profile ¹	Restrictions ²	HS without Sequelae	HS with Sequelae	Complex HS or HE/HI pending MEB
	march at own pace and distance with no more than 30 pounds up to 2 hours. Non-tactical AO permitted.			

Notes:

¹ Temporary Profile; templates.² Soldiers manifesting no heat illness symptomatology or work intolerance after completion of profile restrictions can advance and return to duty without a MEB. Any evidence/manifestation of heat illness symptomatology during the period of the profile requires a MEB referral.³ HS with sequelae return to full duty requires a minimum period of heat exposure during environmental stress (Heat Category 2 during the majority of included days).

Chapter 4 Medical Fitness Standards for Flying Duty

4–1. General

a. This chapter discusses medical conditions and physical defects that are causes for rejection in selection, training, and retention of Army aircrew. Aeromedical administration, including waiver procedures for specific conditions, is detailed in DA Pam 40–502.

b. In this regulation, the term “flying duty” is synonymous with “flight status” and “aviation service.” The term “aircrew” or “aircrew member” applies to rated and non-rated personnel in aviation service, unmanned aircraft system (UAS) operators, and air traffic controllers (ATCs). All provisions apply to Regular Army, USAR, and ARNG.

c. The U.S. Army Aeromedical Activity (USAAMA) reviews cases and makes recommendations to applicable aeromedical waiver authorities regarding the qualification of aircrew. These recommendations include qualified, qualified with waiver, or medical suspension from aviation service. The USAAMA issues aeromedical policy letters (APLs) and technical bulletins to articulate detailed aeromedical policy regarding the evaluation and disposition of specific aeromedically disqualifying conditions. These are located at <https://vfo.rucker.amedd.army.mil>. All conditions resulting in PULHES codes greater than 1 require complete work-up in accordance with APLs because the condition may be disqualifying for aviation service.

d. All permanent PULHES codes of 3 or 4 require referral to a MAR2 if the Soldier meets the medical retention standards of chapter 3. If the Soldier has a permanent PULHES code of 3 or 4 and does not meet the medical retention standards of chapter 3, then the Soldier will be referred to the DES.

4–2. Applicability and classes of medical standards for flying

This chapter lists medical conditions and physical defects that are causes for rejection in selection, training, and retention of Army aircrew members. Chapter 2 of this regulation implements DODI 6130.03. Check for the latest published DODI 6130.03 at <https://www.esd.whs.mil/dd/> to ensure the correct accession medical standards are applied. Chapter 3 of this regulation lists medical conditions and physical defects (retention standards) that are cause for referral to the DES for any Soldier. Civilian crew members are further discussed in paragraph 4–35. Aircrew are divided into the following classes:

a. Class 1 (warrant officer candidate, commissioned officer or cadet) standards apply to all initial applicants until the beginning of training at aircraft controls, to include:

- (1) Applicants for aviator training (see AR 611–110).
- (2) Applicants for special flight training programs directed by Department of the Army (DA) or National Guard Bureau (NGB), such as Army ROTC or USMA flight training programs.
- (3) Other non-U.S. Army personnel selected for training, or as determined by Chief, Army Aviation Branch.

b. Class 2 standards apply to:

- (1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch.
- (2) Rated Army aviators (see AR 600–105).
- (3) Department of the Army Civilian (DAC) pilots.
- (4) Contract pilots employed by contractors of the U.S. Army if required by the contract.
- (5) Army aviators considered for return to aviation Service.
- (6) Selected senior career officers of the Army who are medically qualified under Army Class 2 medical standards, when directed by DA or NGB under special procurement programs for initial Army aviation flight training.

- (7) Applicants to DA or NGB civilian-acquired aeronautical skills programs.
- (8) Other non-U.S. Army personnel in categories similar to those listed above.
- c. Class 2F and 2P standards apply to physicians, medical students, nurse practitioners, and physician assistants applying for or enrolled in the Army flight surgeon (FS) Primary Course (see AR 600–105 and AR 600–106).
- d. Class 3 standards apply to non-rated uniformed and DAC crewmembers ordered by a competent authority to participate in regular flights in Army aircraft, but who do not operate aircraft flight controls. This includes all personnel listed in AR 600–106 or not otherwise covered under the other classes of medical standards for flying.
- e. Class 4 standards apply to uniformed ATCs and UAS operators. DACs and contractor ATCs are Class 4, but follow Office of Personnel Management (OPM) standards (see para 4–34).

4–3. Head

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards, plus the following:

- a. Any defect in the bony substance of the skull, regardless of cause.
- b. Head trauma discussed in paragraph 4–27.

4–4. Eyes

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards, plus the following:

- a. *Lids and conjunctiva.*
 - (1) Epiphora (chronic tearing).
 - (2) Trachoma, unless healed without cicatrices.
 - (3) Pterygium that encroaches on the cornea more than 1 millimeter or is progressive, or for Class 1, history of surgical removal of a pterygium within the last 12 months.
- b. *Cornea.*
 - (1) Any condition requiring contact lenses for adequate correction of vision, such as corneal scars and opacities, or complications secondary to use of contact lenses. Contact lens use requires annual follow up.
 - (2) History of herpetic corneal ulcer or keratitis; acute, chronic, or recurrent.
 - (3) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy, astigmatic keratotomy, or corneal implants (Intacs).
 - (4) Current or history of corneal dystrophy of any type; including, but not limited to, keratoconus of any degree does not meet the standard.
 - (5) History of ocular surgery; including, but not limited to, extraocular muscle surgery.
 - (6) Corneal refractive surgery is generally acceptable for aviation duties, but cases must be reviewed for final approval. PRK, LASIK, and LASEK are approved corneal refractive surgery procedures. Implantable collamer lens (ICL) is disqualifying and not waived for Class 1 or Class 2 (pilots). ICLs will be considered on a case by case basis for Class 2F, 2P, 3, and 4, and all cases will require a waiver. Corneal refractive surgery is disqualifying if any of the following conditions are met:
 - (a) Pre-surgical refractive error in either eye exceeds a spherical equivalent of -6 diopters or +4 diopters. Waivers are considered up to -8 diopters to +4 diopters spherical equivalent.
 - (b) Pre-surgical astigmatism (cylinder) exceeds +3.00 or -3.00 diopters. Any astigmatism greater than this is not waivable.
 - (c) A recovery period of at least 3 months for initial applicants already in the military or 6 weeks for current aviation personnel has not occurred from the date of the last refractive surgery or augmenting procedure. New accessions to the military must have at least 180 days recovery period from the last refractive surgery or augmenting procedure and accession medical examination.
 - (d) There have been complications and/or medication or ophthalmic solutions or any other therapeutic interventions such as sunglasses, are required.
 - (e) Post-surgical refraction in each eye is not stable as demonstrated by at least 2 separate refractions at least 1 month apart. New accessions must wait at least 90 days post procedure to complete the initial refraction. The most recent refraction demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.50 diopters for cylinder vision.
 - (f) Slit lamp examination shows residual haze.
 - (g) Low contrast sensitivity testing exceeds 20/60 in either eye.
 - (7) Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision below the standard as described in paragraph 4–5 does not meet the standard.

(8) Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision below the standards.

(9) Current or history of uveitis or iridocyclitis.

c. Uveal tract.

(1) Coloboma of the choroid or iris.

(2) History of inflammation of the uveal tract, acute, chronic, or recurrent; including anterior uveitis, peripheral uveitis or pars planitis, posterior uveitis, or traumatic iritis.

d. Retina.

(1) History of central serous retinopathy.

(2) History of chorioretinitis, including evidence of presumed ocular histoplasmosis syndrome.

(3) History of retinal holes, tears, or detachments. History of surgeries or procedures for the same, or peripheral retinal injury, defect, or degeneration that may cause retinal detachment.

(4) History of retinal defects or dystrophies, angiomas, retinoschisis and retinal cysts, phakomas, and other congenito-retinal hereditary conditions that impair visual function or are progressive.

(5) History of degenerative changes of any part of the retina.

e. Optic nerve.

(1) Optic nerve drusen or hyaline bodies of the optic nerve.

(2) History of optic or retrobulbar neuritis.

f. Lens.

(1) Current aphakia, history of lens implant or current or history of dislocation of a lens.

(2) Current or history of opacities of the lens that interfere with vision or that are considered to be progressive, including cataract.

g. Ocular motility.

(1) History of extraocular muscle surgery after age 4, or history of extraocular muscle surgery before age 4 with other residual ocular abnormalities.

(2) Monofixation syndrome (microtropias).

(3) Any degree of tropia detected in ocular motion on the cover-uncover test (unilateral cover test or tropia test).

(4) Esophoria greater than 8 prism diopters.

(5) Exophoria greater than 8 prism diopters.

(6) Hyperphoria greater than 1 prism diopter.

h. Miscellaneous defects and diseases.

(1) Glaucoma as evidenced by applanation tension 30 millimeters of mercury (mmHg) or higher or secondary changes in the optic disc or visual field associated with glaucoma.

(2) Intraocular hypertension as evidenced by two or more determinations of 22 mmHg or higher, or a persistent difference of 4 or more mmHg tension between the two eyes, when confirmed by applanation tonometry.

(3) History of penetrating trauma to the eye or hyphema.

4–5. Vision

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the following:

a. Class 1. Any disqualifying condition must be referred to optometry or ophthalmology for verification.

(1) Uncorrected distant visual acuity worse than 20/50 in either eye. Each eye must be correctable to 20/20 with no more than one error per five presentations of 20/20 letters, in any combination, on either the Armed Forces vision tester (AFVT) or any projected Snellen chart set at 20 feet.

(2) Uncorrected near visual acuity worse than 20/20 in each eye; with no more than one error per five presentations of 20/20 letters, in any combination, on the AFVT or any Snellen near visual acuity card.

(3) Cycloplegic refractive error using the method in aeromedical technical bulletins under cycloplegic refraction.

(a) Hyperopia greater than +3.00 diopters of sphere in any meridian by transposition in either eye. (Spherical equivalent method does not apply.)

(b) Myopia greater than -1.50 diopters of sphere in any meridian by transposition in either eye. (Spherical equivalent method does not apply.)

(c) Astigmatism greater than +/-1.00 diopter of cylinder in either eye.

(4) Color vision, as follows:

(a) Three or more errors in reading the 14 test plates of the pseudoisochromatic plate (PIP) set.

(b) Computerized color vision tests, as follows:

1. Rabin cone contrast test with any score of less than 55 in the red, blue, or green cones in either eye.

2. Wagonner computerized color vision test with a score of moderate or severe deficiency for red, green, or blue. A score of mild is not disqualifying.

(5) Binocular depth perception (stereo acuity) worse than 40 seconds of arc.

(a) Any error in Group B of the AFVT.

(b) Any error in levels 1 through 7 of the 10 levels of three circles each in the random dot circles test.

(c) Any error in levels 1 through 9 of the 9 levels of four circles each in the titmus graded circles stereoacuity test.

(6) Field of vision, any scotoma, other than physiologic blind spot.

(7) Night vision as noted by history. (There is currently no definitive test or score.) Any ocular abnormalities resulting in decreased night vision must be referred to ophthalmology for confirmation.

(8) Near point of convergence greater than 100 mm.

b. *Classes 2, 2F, 2P, 3, and 4.* Same as Class 1, except as listed below:

(1) Distant and near visual acuity. Uncorrected acuity worse than 20/400 in either eye at distance or near, or vision not correctable to 20/20 with no more than 1 error per 5 presentations of 20/20 letters, in any combination, on either the AFVT or any projected Snellen chart set at 20 feet.

(2) Manifest refractive error. Refractive error of such magnitude that the individual cannot be fit with aviation spectacles. For new accessions to the military see the accession standards for allowable refractive error.

(3) Near point of convergence greater than 100 millimeters is not disqualifying unless symptomatic, but requires an ophthalmology or optometry for evaluation.

4–6. Ears

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

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

b. *External ear.*

(1) Deformities of the pinna that cause distractions or hearing loss while wearing protective headgear.

(2) History of post auricular fistula.

c. *Middle ear.*

(1) Barotitis media, until resolved.

(2) Current or history of cholesteatoma.

(3) History of chronic or recurrent Eustachian tube dysfunction, to include patulous Eustachian tube.

(4) Otosclerosis.

(5) History of simple, radical, or modified radical mastoidectomy.

(6) Any surgical procedure in the middle ear that includes fenestration of the oval window or horizontal semicircular canal, any endolymphatic shunting procedure, stapedectomy, the use of any prosthesis or graft, or reconstruction of the stapes.

(7) Chronic tympanic membrane perforation, until completely healed with acceptable hearing and motility, as documented by current otolaryngology evaluation.

d. *Inner ear.*

(1) Abnormal labyrinthine function to include any disease affecting balance (for example; Ménière's disease).

(2) History of perilymph fistula.

(3) Tinnitus, except when associated with high frequency hearing loss.

(4) History of vertigo, except physiologic vertigo induced by gravity forces, aircraft spins, or Bárány chair.

4–7. Hearing

Conditions that do not meet medical standards for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are hearing loss in decibels (dB) greater than shown in table 4–1.

4–8. Nose, sinuses, mouth, and larynx

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

a. Any infectious lesion until recovery is complete and the part is functionally normal. This includes recurrent sinusitis or chronic sinusitis and/or surgery to treat chronic sinusitis.

b. Recurrent calculi of any salivary gland or duct.

c. Any congenital or acquired lesion that interferes with the function of the mouth or throat.

d. Any defect in speech that would prevent or interfere with clear and effective communication in the English language over a radio communication system. For initial applicants, this is determined by administration of the reading aloud test. In questionable cases, the aviation unit commander, ATC supervisor, or other appropriate aviation official will provide a written recommendation to the FS.

e. History of allergic rhinitis or vasomotor rhinitis requiring immunotherapy.

f. Current anosmia or parosmia.

g. Deviation of the nasal septum, nasal polyps, retention cysts, or septal spurs that results in symptomatic obstruction of airflow, chronic rhinitis, chronic sinusitis, or interference of sinus drainage.

h. History of tracheostomy.

4–9. Dental

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

a. Orthodontic appliances, if they interfere with effective oral communication, or pose a hazard to personal or flight safety.

b. DRC 3 or 4 conditions, until the abnormalities or deficiencies have been corrected.

4–10. Neck

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in accession standards. Cervical disorders are discussed under paragraph 4–17.

4–11. Lungs, chest wall, pleura, and mediastinum

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

a. *Spontaneous pneumothorax.*

(1) Class 1, initial Class 2 and 3. A history of spontaneous pneumothorax.

(2) Classes 2, 2F, 2P, and 3.

(a) Single instance of spontaneous pneumothorax within the last 2 months with or without surgical intervention is disqualifying unless clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and with no additional lung pathology, or other contraindication to flying.

(b) Recurrent spontaneous pneumothorax; waiver may be considered if effectively treated by pleuridesis and/or pleurectomy with complete recovery.

b. *Traumatic pneumothorax.* Disqualifying unless clinical evaluation shows complete recovery with full expansion of the lung, and normal pulmonary function.

c. *Pulmonary tuberculosis or tuberculous pleurisy.* LTBI warrants antimicrobial therapy, but is not, itself, justification for disqualification.

d. *Pulmonary bullous lesion.* To include bullae, blebs, or other congenital or structural defects posing an increased risk for pneumothorax; disqualifying regardless of surgical resection.

e. *Any treatment with chemotherapeutic agents (such as bleomycin).* Causes disqualification from ever being exposed to greater than 40 percent FIO₂ which precludes altitude chamber training or operations in aircraft requiring oxygen use. It is disqualifying for all classes except Class 4 UAS operators and ATC.

f. *Airway hyper responsiveness.* Including asthma, reactive airway disease, and exercise-induced bronchospasm or asthmatic bronchitis, reliably diagnosed and symptomatic after the 13th birthday.

g. *Chronic obstructive pulmonary disease.*

(1) Current or history of bullous or generalized pulmonary emphysema.

(2) Current bronchitis, acute or chronic symptoms over 3 months occurring at least twice a year.

h. *Congenital or acquired defects.* Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation-perfusion, results in recurrent infections, or exercise limitations.

4–12. Heart

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

a. *History of any cardiac surgical procedure.* To include pacemaker insertion, defibrillator implantation, valve replacement, bypass tract ablation by any method, coronary angioplasty (including bypass grafting and stenting).

b. *History of any abnormal electrocardiographic findings.* Including, but not limited to:

- (1) Left axis deviation greater than minus 45 degrees.
- (2) Acquired right axis deviation greater than 120 degrees.
- (3) Mobitz Type II second degree AV block, and third-degree AV block.
- (4) Acquired left anterior or posterior hemiblock with no symptoms and a normal evaluation is not disqualifying.
- (5) Acquired complete right bundle branch block with no symptoms and a normal evaluation is not disqualifying.
- (6) Complete left bundle branch block.
- (7) Pre-excitation as manifested by Wolff-Parkinson-White pattern or short PR interval (beginning of the P wave to the beginning of the QRS complex) of less than 120 milliseconds in all 12 leads.
- (8) Sinus pause or asystole accompanied by symptoms and/or greater than 2.2 seconds in duration.
- (9) Bradycardias accompanied by symptoms and/or hypotension.
- (10) Supraventricular tachycardia (3 or more beats at a rate greater than 100) to include atrial fibrillation/flutter, multifocal atrial tachycardia, junctional tachycardia, and persistent sinus tachycardia.
- (11) Frequent uniform or multiform ventricular premature beats, or ventricular premature beats, or ventricular premature beat pairs.
- (12) Ventricular tachycardia (3 or more beats at a rate greater than 100), to include ventricular fibrillation/flutter and accelerated idioventricular rhythm.
- (13) Acquired ST interval and T wave abnormalities consistent with myocardial dysfunction of any etiology.
- (14) Aeromedically abnormal exercise treadmill test until reviewed by the USAAMA. This is not disqualifying if further testing is normal and there is no atherosclerotic coronary artery disease.
 - c. *History of hypertrophic, dilated, or obstructive cardiomyopathy.* To include left ventricular hypertrophy, as documented by clinical or electrocardiogram evidence. Hypertrophy due to athletic heart syndrome is not disqualifying.
 - d. *History of valvular heart disease.* As defined by the current American College of Cardiology and American Heart Association guidelines.
 - (1) The following are disqualifying:
 - (a) Moderate and severe pulmonary, tricuspid, or mitral regurgitation.
 - (b) Trace aortic insufficiency with a bicuspid aortic valve or mild, moderate, or severe aortic insufficiency with a tricuspid or bicuspid aortic valve.
 - (c) Bicuspid aortic valve.
 - (d) Moderate and severe mitral regurgitation.
 - (e) Mitral valve prolapse.
 - (f) Stenosis of any valve.
 - (2) The following meet the standard and are not disqualifying:
 - (a) Trace or mild pulmonary, tricuspid, or mitral regurgitation.
 - (b) Trace aortic insufficiency with a normal trileaflet aortic valve.
 - e. *History of myocarditis or endocarditis.* To include subacute bacterial endocarditis. History of pericarditis until reviewed by the USAAMA.
 - f. *Any evidence of atherosclerotic coronary artery disease.*
 - g. *History of congenital anomalies of the heart or great vessels, or surgery to correct these anomalies.*
 - h. *History of cor pulmonale or congestive heart failure.*
 - i. *Suspected coronary artery disease.* As indicated by an elevated cardiac risk index, elevated total cholesterol or cholesterol/high-density lipoprotein cholesterol ratio in conjunction with an abnormal aeromedical graded exercise treadmill stress test, or abnormal electron beam coronary tomography. Further testing with a thallium or sestamibi exercise treadmill stress test or stress echocardiogram is required and if normal this is not disqualifying. If these are abnormal, a cardiac catheterization is required, and if normal this is not disqualifying.

4–13. Vascular system

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

- a. *History of diseases of the lymphatic system and blood vessels.* Including, but not limited to, aortic aneurysm, arteriosclerotic occlusive disorders, fistulas, vasculitis, vasospastic disorders (for example: Raynaud's syndrome), thromboembolic disorders (including stroke), and lymphedema.
- b. *Thrombophlebitis.*
 - (1) Acute, superficial thrombophlebitis until resolved.
 - (2) History of deep vein thrombophlebitis, thrombosis of any deep vessel, or thromboembolism.
 - (3) Use of blood thinning agents except aspirin.

c. Hypertension. History of hypertension with a systolic pressure of 140 mmHg or greater, and/or diastolic pressure of 90 mmHg or greater, with or without systemic complications confirmed by average reading of a 3-day blood pressure check.

d. Hypotension. Orthostatic hypotension, orthostatic intolerance, or symptomatic hypotension.

4–14. Abdominal organs and gastrointestinal system

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes listed in the accession standards plus the following:

a. Esophageal disease.

(1) Current or history of esophageal disease; including, but not limited to, ulcerations, varices, fistula, or achalasia.

(2) Gastro-esophageal reflux disease with complications.

(a) Stricture or B-ring.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagitis.

(e) Extraesophageal complications, reactive airway disease, recurrent sinusitis, or dental complications.

(3) Current or history of dysmotility disorders to include diffuse esophageal spasm, nutcracker esophagus, non-specific motility disorder, and achalasia.

(4) Eosinophilic esophagitis.

(5) Other esophageal stricture; for example, lye or other caustic ingestion.

b. Stomach and duodenum.

(1) Gastric or duodenal ulcers.

(2) History of surgery for peptic ulceration or perforation.

(3) History of gastroparesis.

(4) History of bariatric surgery of any type.

(5) Gastric varices.

c. Small and large intestine.

(1) History of bowel resection for any cause, with the exception of appendectomy.

(2) History of any procedures for the relief of intestinal obstruction, adhesions, or intussusception, with the exception of uncomplicated pylorotomy or intussusception in childhood.

(3) History of functional bowel syndrome (irritable bowel syndrome) if of sufficient severity to require frequent intervention or prescription medication, megacolon, diverticulitis, diverticulosis with complications, regional enteritis (Crohn's disease), ulcerative colitis, or proctitis.

d. Hepato-pancreato-biliary tract.

(1) Enlargement of the liver, except when the liver function tests are normal and the condition does not appear to be caused by active disease.

(2) Cholelithiasis.

(3) Cholecystectomy once recovery is complete and asymptomatic is not disqualifying.

e. History of gastrointestinal bleeding. Excluding minor bleeding from hemorrhoids or acute rectal fissure. (See aeromedical guidance located at https://vfso.rucker.amedd.army.mil/public/downloads/army_apls_may2015.pdf under Gastroesophageal Reflux Disease, Peptic Ulcer Disease, and Irritable Bowel Syndrome.)

f. Abdominal wall.

(1) Current hernia (except for small or asymptomatic umbilical hernias); including, but not limited to, uncorrected inguinal and other abdominal wall hernias.

(2) Abdominal fistula or sinus.

g. Current or history of intestinal malabsorption syndromes. Including, but not limited to, celiac sprue, pancreatic insufficiency, post-surgical and idiopathic. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.

h. Gluten-sensitive enteropathy (celiac disease or sprue). All Soldiers with this condition are unable to live in an austere environment and require permanent P3 code V to describe the deployment restrictions on the DA Form 3349 in e-Profile requiring referral to the DES.

4–15. Female genital system

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

a. Pregnancy. Uncomplicated pregnancy is not disqualifying, but results in flying duty restrictions. Applicants already in the military are disqualified until fully recovered and at least 6 weeks postpartum. New accessions to the military are disqualified until 6 months after the completion of the pregnancy. Unresolved complications of pregnancy may be disqualifying and are evaluated on a case by case basis. In uncomplicated pregnancies, flying is restricted to synthetic flight simulator training during the entire pregnancy; or multi-crew, multi-engine, non-ejection seat fixed wing aircraft during weeks 13 through 24 of gestation. The requirement for physiological training is waived during pregnancy.

b. Menstruation. Abnormal menstruation requiring medication, resulting in anemia, or unresponsive to medical management; including, but not limited to, menorrhagia, metrorrhagia, or polymenorrhea.

c. Dysmenorrhea. Requiring medication, unresponsive to medical therapy, or incapacitating to a degree recurrently requiring absences from routine activities.

d. Endometriosis. Requiring medication or unresponsive to medical therapy.

e. Estrogen/progesterone preparations. When used solely for contraception or replacement following menopause or hysterectomy are not disqualifying.

f. Polycystic ovarian syndrome with metabolic complications.

4–16. Male genital system

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the accession standards plus the following:

a. Benign prostatic hypertrophy requiring chronic medication.

b. Chronic or recurrent prostatitis, orchitis, epididymitis, or scrotal pain, or unspecified symptoms associated with male genital organs.

4–17. Urinary system

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes listed in the accession standards plus the following:

a. History of urinary tract stone formation or retention of urinary tract stone within the collecting system.

b. Chronic renal disease of any severity.

c. History of persistent hematuria with greater than three or more red blood cells per high-power field on two of three properly collected urinalyses.

d. History of any metabolic abnormality of the urine, to include proteinuria, glycosuria, and hypercalcinuria.

e. Bladder hyperactivity requiring medication.

4–18. Spine and sacroiliac joints

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes listed in the accession standards plus the following:

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. Back pain. History of chronic or recurrent disabling episodes of back pain, especially when associated with significant objective findings.

c. Vertebrae. History of any fracture or dislocation of the vertebrae, to include insertion of spinal orthopedic hardware.

(1) A compression fracture involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 12 months ago and is asymptomatic.

(2) Any degree of compression fracture of the cervical vertebrae, twelfth thoracic vertebrae, or first lumbar vertebra is disqualifying.

(3) A history of fracture of the transverse or spinous process is not disqualifying if asymptomatic.

d. Current herniated nucleus pulposus.

e. Spinal surgery. Including, but not limited to, fusion or disc replacement at any level is disqualifying. This is not disqualifying for Class 4 unless there are residual symptoms. Waivers are not considered for Class 1. Disc replacement is limited to two levels for waiver consideration. Fusion at more than two levels is not considered for waiver in Class 2 or 3, except fixed wing pilots with fusion will be considered on a case by case basis.

f. Scoliosis.

(1) *Class 1.* Any degree of scoliosis. Scoliosis may be qualified if the angulation is found to be stable by two standing scoliosis x-ray series done 12 months apart, and the scoliosis angle in the thoracic or lumbar spine is 20 degrees or less by the Cobb method.

(2) *Classes 2, 2F, 2P, or 3.* Standing scoliosis x-ray series demonstrating an angle in the thoracic or lumbar spine that exceeds 20 degrees by the Cobb method.

- (3) *Any surgery to correct spinal curvature.* This is not disqualifying for Class 4.
- g. *Current or history of spondylolysis or spondylolisthesis congenital or acquired.*

4–19. Upper extremities

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards.

4–20. Lower extremities

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards.

4–21. Miscellaneous conditions of the extremities

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

- a. *Loss of strength or endurance, amputations, or limitations in motion that compromise flying safety.* These disqualifying limitations include those resulting from injury or chronic disease (for example, gout, osteoarthritis, rheumatologic diseases, and so on).
- b. *Current or history of osteoarthritis or traumatic arthritis of isolated joints.* When condition has interfered with a physically active lifestyle or that prevents the satisfactory performance of aviation duties.
- c. *Current retained hardware (including plates, pins, rods, wires, or screws).* If symptomatic, interferes with proper wearing of equipment or military uniform, limits ROM, or interferes with the performance of aviation duties.
- d. *Current osteoporosis.* As demonstrated by a reliable test such as a dual energy x-ray absorptiometry scan.

4–22. Skin and soft tissues

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes listed in the accession standards plus the following:

- a. Any skin condition that interferes with joint flexibility or the use of aviation clothing or life support equipment.
- b. Disorders with primarily dermatological manifestations but with systemic implications, such as psoriasis or neurofibromatosis Type 1 are disqualifying. Waiver will depend on comprehensive evaluation.

4–23. Blood and blood-forming tissues

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

- a. *Chronic anemia, of any etiology.*
 - (1) Males with a hematocrit (HCT) less than 40 percent, or females with an HCT less than 37 percent.
 - (2) If a complete hematologic evaluation results in the diagnosis of physiologic anemia, or anemia due to sickle cell trait or beta thalassemia minor; males with a HCT less than 38 percent; or females with a HCT less than 35 percent.
- b. *History of coagulation defects.* Including, but not limited to, von Willebrand's Disease, idiopathic thrombocytopenia, or Henoch-Schönlein Purpura.
- c. *History of splenectomy.* For any reason.

4–24. Systemic conditions

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 include those conditions listed in the accession standards, as well as diseases and conditions that, based upon sound aeromedical principles, may in any way affect or compromise the individual's health or well-being, flying safety, or mission completion.

- a. Many therapeutic interventions and medications are also disqualifying as well. See the medications APLs.
- b. Documented history of heat and cold injuries that would require referral to DES (see paras 3–33 and 3–34).
- c. History of anaphylaxis to stinging animals. A cutaneous only reaction to a stinging insect under the age of 16 is not disqualifying. Applicants who have been successfully treated with immunotherapy are not disqualified.
- d. Current history of disorders involving the immune mechanism, including immunodeficiencies.
- e. Presence of human immunodeficiency virus or serologic evidence of infection or false positive screening test(s) with ambiguous results on confirmatory immunologic testing.
- f. Current or history of muscular dystrophies or myopathies.
- g. Current or history of polymyositis or dermatomyositis complex with skin involvement.
- h. Current or history of sarcoidosis.

4–25. Endocrine and metabolic

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes listed in the accession standards plus the following:

- a. History of symptomatic hypoglycemia.
- b. Diabetes mellitus, even if controlled with medication or diet.
- c. Hypogonadism requiring chronic medication.
- d. Hypothyroidism requiring medication.
- e. Current or history of hyperthyroidism.
- f. Metabolic bone disease.

4–26. Rheumatologic

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following:

- a. Current or history of lupus erythematosus or mixed connective tissue disease variant.
- b. Current or history of gout.
- c. Current or history of inflammatory myopathy including polymyositis or dermatomyositis.
- d. Current or history of spondyloarthritis including ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.

4–27. Neurological

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards plus the following (see table 4–2):

- a. *Current or history of cerebrovascular conditions.* Including, but not limited to, subarachnoid or intracerebral hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack, or arteriovenous malformations.
- b. *History of electroencephalographic abnormalities of any kind.* Includes spike-wave complexes, spikes, or sharp waves.
- c. *History of chronic, recurrent, or incapacitating headaches.* Including history of ocular or acephalic migraine with visual disturbance.
- d. *History of neuritis, neuralgia, neuropathy, or radiculopathy.* Until reviewed by the USAAMA.
- e. *History of decompression sickness (Type II) or an air embolism.* With neurologic involvement.
- f. *History of disturbances in consciousness, single episode or recurrent.* To include nontraumatic loss of consciousness (LOC), narcolepsy, cataplexy, all forms of paroxysmal convulsive disorders, or single convulsive seizures of any type, except—
 - (1) Single episode of documented vasovagal syncope such as syncope with venipuncture or immunizations.
 - (2) Single episode of documented postural or parade-rest syncope, not otherwise disqualifying.
 - (3) Febrile seizures before the age of 5 with a normal EEG.
- g. *Central nervous system infections.*
 - (1) *Class 1.* Within 1 year prior to examination, except 6 years for encephalitis, or if there are residual neurological deficits or other sequelae.
 - (2) *Classes 2, 2F, 2P, 3, and 4.* Until complete recovery without residual neurological deficits or other sequelae.
- h. *History of organic mental syndromes; developmental, learning, or sensory processing disorders; or toxic or metabolic central nervous system disorders.* Until reviewed by the USAAMA.
- i. *History of degenerative or demyelinating process.* Such as multiple sclerosis, dementia, Alzheimer's disease, Parkinson's disease, or basal ganglia disease.
- j. *History of diseases with neurologic sequelae.* Such as hepatolenticular degeneration, neurofibromatosis, acute intermittent porphyria, or familial periodic paralysis.
- k. *History of benign or malignant neoplasms of the brain, pituitary gland, spinal cord, or their coverings.*
- l. *History of diagnostic or therapeutic craniotomy, or any procedure involving penetration of the dura mater or the brain substance.* Including ventriculo-peritoneal shunts, evacuation of hematomas, and brain biopsy.
- m. *Head injury, disqualification for all Classes.* History of any head injury associated with the following will be cause for permanent disqualification for aviation duty for all Classes. (See table 4–2.)
 - (1) Intracranial hemorrhage or hematoma, to include epidural, subdural, intracerebral, or subarachnoid hemorrhage.
 - (2) Any penetration of the dura mater or brain substance.
 - (3) Radiographic or other evidence of retained intracranial foreign bodies or bony fragments.
 - (4) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis or cranial neuropathy.

- (5) Persistent focal or diffuse abnormalities of the EEG reasonably assumed to be a result of an accident.
- (6) Depressed skull fracture with or without dural penetration.
- (7) Linear or basilar skull fracture with or without dural penetration and LOC greater than 2 hours.
- (8) Post-traumatic syndrome as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium that does not resolve within 6 weeks after injury.
- (9) Unconsciousness exceeding 24 hours.
- (10) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

n. Head injury, permanent disqualification and 2-year termination of aviation service. History of head injury associated with any of the following will be cause for permanent disqualification for flying duties for Class 1; and termination of aviation service for a minimum of 2 years for Classes 2, 2F, 2P, 3, and 4 (see table 4–2):

- (1) Linear or basilar skull fracture with LOC for more than 15 minutes but less than 2 hours.
- (2) Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that persists for more than 2 weeks, but resolves within 6 weeks of the injury.
- (3) Amnesia (post-traumatic and retrograde, patchy or complete), delirium, disorientation, or impairment of judgment that exceeds 24 hours.
- (4) Unconsciousness for a period of greater than 2 hours, but less than 24 hours.

o. Head injury, 2-year disqualification or 3-month temporary medical suspension. History of head injury associated with any of the following will be cause for a 2-year disqualification for Class 1; and temporary medical suspension from aviation duty for 3 months for Classes 2, 2F, 2P, 3, and 4 (see table 4–2):

- (1) Linear or basilar skull fracture with LOC for less than 15 minutes.
- (2) Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that persists for more than 48 hours but resolves within 14 days of the injury.
- (3) Post-traumatic headaches alone that persist more than 14 days after injury, but resolve within 1 month.
- (4) Amnesia (post-traumatic and retrograde, patchy and complete), delirium, or disorientation that lasts less than 24 hours, but more than 12 hours after injury.
- (5) Unconsciousness for more than 15 minutes but less than 2 hours.
- (6) Cerebrospinal fluid rhinorrhea or otorrhea that clears within 7 days of injury provided there is no evidence of cranial nerve palsy.

p. Head injury, 3-month disqualification or 1-month aviation duty suspension. History of head injury associated with any of the following will be cause for a 3-month disqualification for Class 1, and temporary medical suspension from aviation duty for 1 month for Classes 2, 2F, 2P, and 3.

- (1) Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that resolves within 48 hours of the injury.
- (2) Post-traumatic headaches alone that resolves within 14 days after injury.
- (3) Amnesia (post-traumatic and retrograde, patchy and complete), delirium, or disorientation that lasts less than 12 hours after injury.
- (4) Unconsciousness less than 15 minutes.

4–28. Sleep disorders

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards, plus the following:

- a. History of obstructive sleep apnea.* As defined by apnea-hypopnea index of 5 or greater during a standard polysomnogram.
- b. Sleep disorders such as chronic insomnia.* Disorders result in excessive daytime sleepiness or require chronic treatment in any form.
- c. Current or history of parasomnia.* Including, but not limited to, sleep walking, enuresis, or night terrors after the age of 15.
- d. Other sleep disorders.* Sleep disorders due to a general medical condition, related to another mental disorder, or induced by substances may be disqualifying.

4–29. Learning, psychiatric, and behavioral health

The minimum psychiatric evaluation will include diagnostic criteria and terms found in the most recent edition of the DSM–5. Waiver considerations will be submitted to the USAAMA as fully detailed in DA Pam 40–502. The causes of

medical unfitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in current accession standards, except as modified by the following:

a. Psychotic episode. Current or history of any psychotic episode evidenced by impairment in reality testing, to include transient disorders, from any cause except transient delirium secondary to toxic or infectious processes before age 12.

b. Bipolar or depressive disorders. Current or history of bipolar or depressive disorders.

c. Anxiety disorder of obsessive-compulsive disorder. Current or history of anxiety disorder or obsessive-compulsive disorder; including, but not limited to, generalized anxiety disorder, panic disorders, or unspecified anxiety disorder. Current or history of any phobias or severe or prolonged anxiety episodes after age 12 even if they do not meet the diagnostic criteria of the DSM-5.

d. Post-traumatic stress syndrome. Current or history of PTSD.

e. Dissociative disorder. Current or history of dissociative disorder.

f. Impulse control disorder. Current or history of any impulse control disorder.

g. Somatic symptom. Current or history of any somatic symptom and related disorders.

h. Neurodevelopmental disorders. Current or history of autism spectrum disorders, communication disorders or other neurodevelopmental disorders if occurring after the 14th birthday. History of visual perceptual disorder or other learning disorders.

i. Personality disorder. Current or history of personality disorder or other unspecified personality disorder. Other unspecified personality disorder includes personality traits insufficient to meet criteria for personality disorder diagnosis, and maybe cause for an unsatisfactory aeromedical adaptability rating.

j. Adjustment disorder. Current or history of any adjustment disorder.

k. Substance-related disorders.

(1) Current diagnosis of alcohol use disorder with risk to safety, judgment, and occupational impairment is disqualifying for all classes.

(2) Current or history of alcohol use disorder including unspecified alcohol-related disorders without risk to safety, judgment, or occupational impairment may be disqualifying for all classes.

(3) Current or history of drug abuse (including illegal drugs, other illicit substances, and prescribed medication) is disqualifying for all classes. Experimental use of drugs during adolescences may be found fit after review by the USAAMA.

l. Substance-induced mental disorder. Illicit drug use or other substance-induced mental disorder is disqualifying. History of misuse, abuse, or dependence of any controlled substance, and/or use of any illicit drugs, including marijuana and psychoactive substances is disqualifying for all classes. Experimental use of drugs during adolescence, minor traffic violations, or clearly provoked impulsive episodes may be found fit after review by the USAAMA.

m. Suicide attempt or ideation. Current or history of suicide attempt or ideation at any time.

n. Fear of flying that impairs functioning. Refer aircrew with a conscious fear of flying, that is, those who have made a conscious choice not to fly, to the aviation unit commander for a nonmedical disqualification and flying evaluation board. (See AR 600–105.)

o. Emotional responses to situations of stress, either combat or noncombat. When such a reaction may interfere with the efficient and safe performance of an individual's flying duties as determined by USAAMA review.

p. Psychoactive medication. Current or history of current use of psychoactive medication.

q. Attention deficit hyperactivity disorder. Current or history of attention deficit hyperactivity disorder.

4–30. Tumors and malignancies

Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the causes in the accession standards and as listed below:

a. Benign tumors. Same as the causes listed in the accession standards and paragraph 4–27k.

b. History of any malignant tumor. Except for squamous cell carcinoma of the skin that has been removed.

4–31. Miscellaneous

a. Linear anthropometric dimensions. Conditions that do not meet the standards of medical fitness for flying duty Classes 1, 2, 2F, 2P, 3, and 4 are the following:

(1) *Class 1.* Failure to meet linear anthropometric standards. The following are qualifying:

(a) Total arm reach equal to or greater than 164.0 centimeters.

(b) Sitting height equal to or less than 102.0 centimeters.

(c) Crotch height equal to or greater than 75.0 centimeters.

(2) *Class 3.* Linear anthropometric measurements and body composition not compatible with aviation or crew member safety, or operational effectiveness at the Class 3 aircrew member's workstation.

b. Weight and body build. Aircrew members are medically unfit for flying duty Classes 1, 2, 2F, 2P, 3, and 4 when the body weight or build prevents normal functions required for safe and effective aircraft flight such as interference with aircraft instruments, controls, and aviation life support equipment, to include proper function of crash worthy seats, and other mechanisms of egress. (Military aircrew members may be subject to administrative restriction from flying duty by their commander when body weight or composition exceeds the limits prescribed by AR 600–9.)

4–32. Medical standards for Class 3 personnel

Aeromedical Class 3 is a large category that includes a broad spectrum of jobs. The physical standards articulated in chapter 4 apply to this class as well. Class 3 physicals are now processed using the same procedures as the other classes. Class 3 physicals are no longer dispositioned at the local level. Local waivers are no longer acceptable and waivers must be requested using an aeromedical summary and final determinations are made by the applicable waiver authority. USAAMA’s function, as with other classes, is interpretation of the standards in light of an individual’s specific duties and fitness requirements and making a recommendation to the waiver authority.

4–33. Aeromedical adaptability

a. Conditions that do not meet the standards of medical fitness for flying duty for all Classes, excluding civilian ATCs, is an unsatisfactory aeronautical adaptability (AA) due to socio-behavioral factors that are considered unsuitable for or unadoptable to Army aviation. The unsatisfactory AA may be a manifestation of underlying psychiatric disease or may be accompanied by non-medical disqualifications (see AR 600–105). Unsatisfactory AA is not a medical diagnosis, but is a determination by the FS and aviation commander or supervisor of suitability or adaptability.

b. Until reviewed by the USAAMA, an unsatisfactory AA may be given for lower levels (signs and symptoms) than those mentioned in paragraph 4–33c if, in the opinion of the aeromedical provider and aviation commander or civilian supervisor, mental or physical factors might be exacerbated under the stresses of Army aviation or the person might not be able to carry out their duties in a mature and responsible fashion. An individual may be disqualified for any of a combination of factors listed in paragraph 4–33c and/or due to personal habits or appearance indicative of attitudes of carelessness, poor motivation, or other characteristics that may be unsafe or undesirable in the aviation environment.

c. The causes for an unsatisfactory aeronautical adaptability include:

(1) Deliberate or willful concealment of significant and/or disqualifying medical conditions on medical history forms or during an aeromedical provider interview.

(2) An attitude toward flying that is clearly less than optimal. For example, the person appears to be motivated overwhelmingly by prestige, pay, or other secondary gains rather than skill, achievement, and professionalism of flying.

(3) Clearly noticeable personality traits such as immaturity, self-isolation, difficulty with authority, poor interpersonal relationships, impaired impulse control, or other traits that may interfere with functioning as a team member in an operational aviation setting, even though there are insufficient criteria for a personality disorder diagnosis.

(4) Review of the history or service treatment records reveals multiple or recurring physical complaints that strongly suggest either somatization disorder or a propensity for physical symptoms during times of stress.

(5) A history of arrests, illicit drug use, or social “acting out” that may indicate immaturity, impulsiveness, or antisocial traits. Experimental use of drugs during adolescence, minor traffic violations, or clearly provoked impulsive episodes may be found fit after review by the USAAMA. (See para 4–29I.)

(6) Significant prolonged or currently unresolved interpersonal or family problems, marital dysfunction, or significant family opposition or conflict concerning the Soldier’s aviation career.

4–34. Medical standards for air traffic controller and unmanned aircraft system personnel

a. Military air traffic controllers and UAS operators are considered aircrew, though the physical standards articulated elsewhere in this chapter are applied with an understanding of the differences in the working environment between Class 4 and the other classes of aircrew. Class 4 personnel are not subjected to the physiologic stresses of flight (for example, altitude, g forces, vestibular stimulation). However, their mission requires intense concentration for prolonged periods. They are not located within the platforms they control, so their situational awareness must often be understood through the perception of subtle changes in symbology and color coding. The platform’s situation and status is represented completely on two dimensional screens devoid of three dimensional cues; understanding the platform’s dynamic environment requires well developed cognitive agility. Additionally, ATC and UAS operators deploy as part of units and are expected to fully participate in field activities to include set-up and teardown of their sites as well as other Soldier tasks.

b. Threats of subtle incapacitation are of special concern for Class 4 personnel, and include but are not limited to:

(1) Vision issues such as diplopia and color perception.

(2) Learning, psychiatric, and behavioral disorders, especially those that would impair judgment and attention.

- (3) Endocrine disorders that would affect alertness.
- (4) Sleep disorders.
- (5) Neurological disorders affecting cognition and concentration such as chronic headache.
- (6) Conditions adversely affecting speech recognition and articulation or the use of headphone apparatus.
- (7) Orthopedic conditions affecting the ability to stand or sit for prolonged periods or amputations that may interfere with safe performance of duty.
- (8) Many prescription and over-the-counter medications are inappropriate for Class 4 duties and require a waiver. (See aeromedical guidance (https://vfso.rucker.amedd.army.mil/public/downloads/army_apls_may2015.pdf) under Medications.)

4–35. Department of the Army Civilian and civilian contract aircrew members

Both contract and federal employees perform similar aircrew functions to uniformed personnel. However, different physical standards and procedures often apply to DAC personnel. DAC and contract aircrew members receiving flight duty examinations at MTFs must complete and sign DD Form 2870 (Authorization for Disclosure of Medical or Dental Information) to release examination results to their air field commander, supervisor, or other official who requires medical recommendations for flying duties.

a. Use of Aeromedical Electronic Resource Office. All Army flight physicals done applying Army aeromedical standards or OPM standards will be entered into the Aeromedical Electronic Resource Office (AERO) for review and disposition by the USAAMA and are issued a DD Form 2992 (Medical Recommendation for Flying or Special Operational Duty). (See para 4–35f(1).)

b. Federal Aviation Administration. All contract personnel using the Federal Aviation Administration (FAA) for medical certification will not be entered into AERO and will not be issued a DD Form 2992. These personnel will maintain a current and appropriate Class FAA medical certification and tracking for compliance will be a local responsibility.

c. Class 1. Class 1 physicals include applicants for flight training. The Army does not presently train civilian pilots, either DAC or contract. The Army accepts new civilian pilots who have already been trained and who qualify under Class 2 physical standards.

d. Class 2.

(1) DAC pilots must qualify under the same Army Class 2 standards and procedures as uniformed pilots.

(2) Civilian pilots employed by contractors of the U.S. Army will maintain a current annual second-class FAA medical certificate unless the contract requires the individual to complete an Army flight physical using Army Class 2 standards. For all others who want to complete an Army Class 2 flight physical, this will depend on the availability of aviation medicine services at a supporting MTF and contract allowances.

e. Class 3.

(1) DAC Class 3 personnel must qualify under the same Army Class 3 standards and procedures as uniformed personnel.

(2) Army contract civilian non-rated crewmembers will maintain a current annual third-class FAA medical certificate unless the contract requires the individual to complete an Army flight physical using Army Class 3 standards. For all others who want to complete an Army Class 3 flight physical, this will depend on the availability of aviation medicine services at a supporting MTF and contract allowances.

f. Class 4.

(1) DAC and contract ATCs will maintain an Army flight duty medical examination utilizing the medical qualification requirements specified in OPM's Position Classification Standard for ATC Series GS–2152 (available at <https://www.opm.gov/>). The physical is given by an Army aeromedical provider, and qualification is communicated to the aircrew's commander using a DD Form 2992. All physicals use DD Form 2807–1 (Report of Medical History) and DD Form 2808 (Report of Medical Examination).

(2) Contract ATCs may be required to maintain a second-class FAA medical certificate, but it is not required by HQDA.

(3) DAC UAS operators fall under the same standards as uniformed UAS operators.

(4) Army contract UAS operators, as a group, must be able to fly systems in the continental United States (CONUS) as well as outside the continental United States (OCONUS). The FAA has determined that in order to control a UAS within federal airspace, an operator must have an FAA Class 2 medical certificate. The FAA allows the DOD to define their physical standards so long as they are not less restrictive than the second-class FAA medical standards. If required by the contract, an Army Class 4 flight physical will be completed. For all others who want to complete an Army Class 4 flight physical, this option depends on the availability of aviation medicine services at a supporting MTF and contract allowances.

Table 4–1
Acceptable audiometric hearing level for Army aviation and air traffic control—Continued
ISO 1964–ANSI 1996 (unaided sensitivity (see DA Pam 40–501))

Frequency in hertz (Hz)	500	1000	2000	3000	4000	6000
Class 1	25	25	25	35	45	45
Classes 2/2F/2P/3/4	25	25	25	35	55	65

Table 4–2
Head injury guidelines for Army aviation

Disposition by Class (Refer to the glossary for acronyms and abbreviations used)

Head Injury Classification	Permanent Aeromedical Disqualification (DQ)	Severe Head Injury	Moderate Head Injury	Mild Head Injury
Class 1	Perm DQ	Perm DQ	2-year DQ	3-month DQ
Classes 2/2F/2P/3/4	Perm DQ	2-year DQ	3-month DQ	4-week DQ
Problem:				
- Intracranial bleeding	Any	—	—	—
- Penetration of dura or brain	Any	—	—	—
- Intracranial bone fragment or foreign bodies	Any	—	—	—
- Central nervous system deficits indicating parenchymal injury	Any	—	—	—
- EEG abnormality due to injury	Any	—	—	—
- Depressed skull fracture	Any	—	—	—
- Basilar or linear skull fracture with—	LOC > 2h	LOC 15m - 2h	LOC <15m	—
- Post-trauma syndrome lasting—	>6wk	2wk - 6wk	48h - 14d	<48h
- LOC lasting—	>24h	2 - 24h	15m - 2h	<15m
- Cerebrospinal fluid leaking—	>7d	—	<7d	—
- Amnesia, delirium, or disorientation lasting—	—	>24h	12 - 24h	<12h

Chapter 5

Medical Fitness Standards for Miscellaneous Purposes

5–1. General

This chapter sets forth medical conditions and physical defects that are causes for disqualification for—

- a. Airborne training and duty, Ranger training and duty, Special Forces training and duty, and Reconnaissance and Surveillance Leaders Course (RSLC) training.
- b. SERE training.
- c. MFF training and duty.
- d. Civil affairs training and duty.
- e. Psychological operations training and duty.
- f. Engineer diving training and duty.
- g. Small UAS operators.
- h. Army service schools.
- i. Geographical area assignments.
- j. USMA, ROTC, and USUHS height requirements.

5–2. Application

The standards apply to applicants or individuals from all COMPOs (RA, ARNGUS, ARNG, and USAR) under consideration for selection or retention in these programs, assignments, or duties.

5–3. Medical fitness standards for initial selection for airborne training, Ranger training, Special Forces training, Reconnaissance and Surveillance Leaders Course training, civil affairs, and psychological operations

The causes of medical disqualification for initial selection for airborne training, Ranger training, Special Forces, and RSLC training are all the causes listed in the accession standards, plus all the causes listed in this paragraph and paragraph 5–4. Waiver considerations will be submitted to and considered by the John F. Kennedy Special Warfare Center and School. Contact Special Operations Forces Recruiting to submit a waiver consideration to attend training.

a. Head and neck.

- (1) Current accession standards.
- (2) Loss of bony substance of the skull.
- (3) Persistent neuralgia; tic douloureux; facial paralysis.
- (4) A history of subarachnoid hemorrhage or intracranial hemorrhage.

b. Eyes and vision.

- (1) Current accession standards with exceptions noted in paragraphs 5–3b(2) through 5–3b(4).
- (2) For airborne and Ranger training, distant visual acuity of any degree that does not correct to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.
- (3) For Special Forces training, distant visual acuity of any degree that does not correct to 20/20 in each eye within 8 diopters of plus or minus refractive error, with spectacle lenses.
- (4) For airborne and Special Forces training, failure to pass the PIP set for color vision unless the applicant is able to identify vivid red and/or vivid green as projected by the ophthalmological projector or the stereoscope vision testing (SVT) (see para 4–5a(7)).

c. Ears and hearing.

- (1) Current accession standards.
- (2) Radical mastoidectomy.
- (3) Any infectious process of the ear until completely healed.
- (4) Recurrent or persistent tinnitus that impairs hearing or ability to perform duty.
- (5) History of attacks of vertigo, with or without nausea, emesis, deafness, or tinnitus.

d. Nose, sinuses, mouth, and larynx. Current accession standards.

e. Dental. Current accession standards and personnel in DRC 3 or 4.

f. Lungs and chest wall.

- (1) Current accession standards.
- (2) Spontaneous pneumothorax, except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 years.

g. Heart and vascular system. Current accession standards, except for Special Forces training and duty as follows: blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. Blood pressure management that meets standards with medication is not disqualifying. Unsatisfactory orthostatic tolerance test is also disqualifying.

h. Abdomen and gastrointestinal system.

- (1) Current accession standards.
- (2) Unrepaired hernia of any variety (including inguinal or other abdominal) or repaired hernia within a 6-month period.
- (3) Operation for relief of intestinal adhesions at any time.
- (4) Laparotomy within a 6-month period.
- (5) For Special Forces initial training, asplenia (absence of the spleen) for any reason.

i. Genitourinary system. Current accession standards.

j. Spine, scapulae, and sacroiliac joints. Current accession standards.

k. Extremities.

- (1) Current accession standards.
- (2) Less than full strength and ROM of all joints.
- (3) Loss of any digit from either hand.
- (4) Deformity or pain from an old fracture.

- (5) Instability of any degree of major joints.
- (6) Decreased or poor grasping power in either hand.
- (7) Pain in a weight-bearing joint.
- l. Hardware.* Retained hardware placed within 6 months, that requires a profile or impairs function does not meet standard.
- m. Skin and cellular tissues.* Current accession standards.
- n. Blood and blood-forming tissue diseases.*
 - (1) Current accession standards.
 - (2) Sickle cell disease. Sickle cell trait with hematocrit greater than 35 for females and 38 for males and no prior vaso-occlusive crisis is not disqualifying.
- o. Systemic disease.* General and miscellaneous conditions and defects.
 - (1) Current accession standards.
 - (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 12 weeks after the drug has been discontinued.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual.
- p. Sexually transmitted diseases.* Current accession standards.
- q. Endocrine and metabolic diseases.* Current accession standards.
- r. Neurological and sleep disorders.*
 - (1) Current accession standards.
 - (2) Active disease of the nervous system of any type.
 - (3) Abnormal emotional responses to situations of stress (both combat and noncombat), when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the Soldier's duties.
- s. Learning, psychiatric, and behavioral disorders.*
 - (1) Current accession standards.
 - (2) Individuals who are under treatment with any mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, and so on, and for a period of 12 weeks after the drug has been discontinued.
 - (3) Evidence of excessive anxiety or emotional instability. Fear of dark, enclosed spaces, and/or heights that impairs functioning in those environments.
 - (4) Fear of flying when a manifestation of a psychiatric illness.
 - (5) History of psychosis or attempted suicide at any time.
 - (6) Phobias that materially influence behavior.
 - (7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.
- t. Tumors and malignant disease.* Current accession standards.
- u. Height.* No special requirement.
- v. Weight.* No special requirement.
- w. Body build.*
 - (1) Current accession standards.
 - (2) Marfanoid body habitus.

5–4. Medical fitness standards for retention for airborne duty, Ranger duty, Special Forces duty, civil affairs, and psychological operations

Retention of an individual in airborne duty, Ranger duty, and Special Forces duty, civil affairs, or psychological operations will be based on—

- a.* Their continued demonstrated ability to satisfactorily perform their duties as an airborne officer or enlisted Soldier, Ranger, or Special Forces member.
- b.* The effect upon the individual's health and well-being by remaining on airborne, Ranger, Special Forces duty, civil affairs, or psychological operations.

5–5. Medical fitness standards for selection for survival, evasion, resistance and escape, and other training

The causes of medical disqualification for SERE, civil affairs, psychological operations, and cultural support training are all the causes listed in the accession standards, plus all the causes listed in this paragraph. Waiver considerations will be

submitted to and considered by the John F. Kennedy Special Warfare Center and School. Contact Special Operations Forces Recruiting to submit a waiver consideration to attend training.

- a. *Head and neck.* (See para 5–3a.)
- b. *Ears and hearing.* Current accession standards.
- c. *Nose, sinuses, mouth, and larynx.* Current accession standards.
- d. *Dental.* Current accession standards and personnel in DRC 3 or 4.
- e. *Lungs and chest wall.* Current accession standards.
- f. *Heart and vascular system.* Current accession standards.
- g. *Abdomen and gastrointestinal system.* Current accession standards.
- h. *Genitourinary system.* Current accession standards.
- i. *Spine, scapulae, and sacroiliac joints.* Current accession standards.
- j. *Extremities.* Current accession standards.
- k. *Skin and cellular tissues.* Current accession standards.
- l. *Systemic disease and miscellaneous conditions and defects.*
 - (1) Current accession standards.
 - (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 12 weeks after the drug has been discontinued.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of recent occurrence as to constitute an undue hazard to the individual.
- m. *Sexually transmitted diseases.* Current accession standards.
- n. *Endocrine and metabolic diseases.* Current accession standards.
- o. *Neurologic and sleep disorders.*
 - (1) Current accession standards.
 - (2) Active disease of the nervous system of any type.
- p. *Learning, psychiatric, and behavioral disorders.*
 - (1) Current accession standards.
 - (2) Evidence of excessive anxiety, emotional responses to situations of stress (both combat and noncombat), and when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the Soldier's duties.
- q. *Tumors and malignant diseases.* Current accession standards.
- r. *Height.* No special requirements.
- s. *Weight.* No special requirements.
- t. *Body build.*
 - (1) Current accession standards.
 - (2) Marfanoid body habitus.

5–6. Medical fitness standards for initial selection for military free fall parachute training

The causes of medical disqualification for initial selection for MFF parachute training are the causes listed in the accession standards, plus the causes listed in paragraph 5–3, plus all the causes listed in this paragraph. Waiver considerations will be submitted to and considered by the John F. Kennedy Special Warfare Center and School. Contact Special Operations Forces Recruiting to submit a waiver consideration to attend training.

- a. *Head and neck.*
 - (1) Current accession standards.
 - (2) Loss of bony substance of the skull if retention of personal protective equipment is affected or creates a safety risk during MFF operations.
 - (3) A history of subarachnoid hemorrhage or intracranial hemorrhage.
- b. *Eyes and vision.*
 - (1) Current accession standards, with exceptions noted in paragraphs 5–6b(2) through 5–6b(4).
 - (2) Uncorrected near visual acuity (14 inches) of worse than 20/50 in the better eye. Uncorrected distant visual acuity of worse than 20/100 in either eye. Distant vision that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error worse than plus or minus 8 diopters.
 - (3) Failure to pass the PIP for color vision unless the applicant is able to identify vivid red and vivid green as projected by the ophthalmological projector or the SVT.
 - (4) History of refractive surgery (PRK, LASIK, LASEK, or ICL) is not disqualifying if accession standards are met.
- c. *Ears and hearing.*
 - (1) Current accession standards.

- (2) Persistent or recurrent abnormal labyrinthine function, as determined by appropriate tests.
 - (3) Any infectious process of the ear, including external otitis, until completely healed.
 - (4) History of attacks of vertigo with or without nausea, emesis, deafness, or tinnitus.
 - (5) Tympanic membrane or Eustachian tube dysfunction, resulting in the inability to equilibrate pressure in the middle ear cavity.
 - (6) Perforation marked scarring or thickening of the ear drum resulting in the inability to equilibrate pressure in the middle ear cavity.
- d. Nose, sinuses, mouth, and larynx.* Current accession standards.
- e. Dental.* Current accession standards, and personnel in DRC 3 or 4.
- f. Lungs and chest wall.*
- (1) Current accession standards.
 - (2) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation-perfusion or results in recurrent infection or exercise limitations.
 - (3) Spontaneous pneumothorax, except a single occurrence at least 2 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function.
 - (4) History of any clinically significant air gas embolism (AGE), or pulmonary over inflation injury; including, but not limited to, subcutaneous emphysema, mediastinal emphysema, dysbaric pneumothorax (without appropriate post-hoc ancillary studies proving absence of anatomic or physiologic abnormalities that would suggest the candidate is at increased risk for pulmonary dysbarism or paradoxical AGE).
- g. Heart and vascular system.*
- (1) Current accession standards, to include blood pressures with an average systolic of less than 90 mmHg or greater than 140 mmHg or an average diastolic of less than 60 mmHg or greater than 90 mmHg regardless of age. Blood pressure management that meets standards with medication is not disqualifying. An unsatisfactory orthostatic tolerance test is also disqualifying.
 - (2) Family history of sudden cardiac death, hypertrophic obstructive cardiomyopathy, or idiopathic hypertrophic subaortic stenosis (without appropriate ancillary studies, such as echocardiography, proving absence of anatomic or physiologic abnormalities that would suggest candidate is at increased risk for Sudden Cardiac Death, or exercised or stress-induced cardiopulmonary dysfunction).
- h. Abdomen and gastrointestinal system.* Current accession standards.
- i. Genitourinary system.* Current accession standards.
- j. Spine, scapulae, ribs, and sacroiliac joints.*
- (1) Current accession standards.
 - (2) Spondylolysis that is symptomatic and likely to interfere with MFF duty.
 - (3) Lumbosacral or sacroiliac strain when associated with significant objective findings.
- k. Extremities.*
- (1) Current accession standards.
 - (2) More than two shoulder dislocations, or increased laxity of the shoulder joint.
 - (3) Any limitation of motion of any joint that might compromise safety.
 - (4) Any loss of strength that might compromise safety.
 - (5) Instability of any degree or pain in a weight-bearing joint.
 - (6) Retained hardware placed within 6 months that requires a profile or impairs function does not meet the standard.
- l. Skin and cellular tissues.* Current accession standards.
- m. Blood and blood-forming tissue diseases.*
- (1) Current accession standards.
 - (2) Significant anemia (hematocrit less than 37 in females and 40 in males) or history of hemolytic disease due to variant hemoglobin state.
 - (3) Sickle cell disease. Sickle cell trait with hematocrit greater than 35 for females and 38 for males and no prior vaso-occlusive crisis is not disqualifying.
 - (4) Significant anemia or history of hemolytic event, secondary to glucose-6 phosphate dehydrogenase (G6PD) deficiency.
- n. Systemic disease.* General and miscellaneous conditions and defects.
- (1) Current accession standards.
 - (2) History of motion sickness, other than isolated instances without emotional involvement.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.
- o. Sexually transmitted diseases.* Current accession standards.

p. Endocrine and metabolic diseases. Current accession standards.

q. Neurologic and sleep disorders.

(1) Current accession standards.

(2) The criteria outlined in paragraph 4–27 for Classes 2 and 3 flying duty apply.

r. Learning, psychiatric, and behavioral disorders.

(1) Current accession standards.

(2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, and so on, and for a period of 12 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias that materially influence behavior.

(7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

s. Tumors and malignant diseases. Current accession standards.

t. Height. Current accession standards.

u. Weight. Current accession standards.

v. Body build. Current accession standards.

(1) Current accession standards.

(2) Marfanoid body habitus.

w. Obesity. To any degree, if it compromises the candidate's ability to perform continuous, strenuous combat MFF operations across the operational spectrum. Must meet body fat standards of AR 600–9.

5–7. Medical fitness standards for retention for free fall parachute duty

Retention of an individual in free fall parachute duty will be based on—

a. The Soldier's demonstrated ability to satisfactorily perform free fall parachute duty.

b. The effect upon the individual's health and well-being by remaining on free fall parachute duty.

c. Determination of whether any severe illness, operation, injury, or defect is of such a nature or of such recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

5–8. Medical fitness standards for Army service schools

Except as provided elsewhere in this regulation, medical fitness standards for Army service schools are covered in course-specific Army Regulations and the Army Training Requirements and Resources System Course Catalog (<https://atrrs.army.mil/atrrscc/>) under course prerequisites.

5–9. Medical fitness standards for initial selection for Special Forces and Ranger combat diving qualification course

The causes of medical disqualification for initial selection for marine self-contained underwater breathing apparatus diving training are the causes listed in the accession standards, plus the following causes listed in this paragraph. Waiver considerations will be submitted to and considered by the John F. Kennedy Special Warfare Center and School. Contact Special Operations Forces Recruiting to submit a waiver consideration to attend training. (See AR 611–75 for more information).

a. Head and neck.

(1) Current accession standards.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected or creates a safety risk in maritime operations.

(3) History of subarachnoid hemorrhage or intracranial hemorrhage.

b. Eyes and vision.

(1) Current accession standards, with exceptions noted in paragraph 5–9b(2) and 5–9b(3) below.

(2) Distant visual acuity that does not correct to 20/20 in each eye with spectacle lenses. Any refractive error in spherical equivalent of worse than plus or minus 8 diopters.

(3) Failure to pass the PIP set for color vision unless the applicant is able to identify vivid red and vivid green as projected by the ophthalmological projector or the SVT.

(4) History of refractive surgery (PRK, LASIK, LASEK, or ICL) is not disqualifying if accession standards are met.

c. Ears and hearing.

- (1) Current accession standards.
- (2) Persistent or recurrent abnormal labyrinthine function as determined by appropriate tests.
- (3) Any infectious process of the ear, including external otitis, until completely healed.
- (4) History of attacks of vertigo with or without nausea, emesis, deafness, or tinnitus.
- (5) Tympanic membrane, eardrum, or Eustachian tube dysfunction resulting in the inability to equilibrate pressure in the middle ear cavity.

d. Nose, sinuses, mouth, and larynx. Current accession standards.

e. Dental.

- (1) Current accession standards and personnel in DRC 3 or 4.
- (2) Any infectious process and any conditions that contribute to recurrence until eradicated.
- (3) Malocclusion, or extensive restoration or replacement by bridges or dentures that interfere with the use of a self-contained underwater breathing apparatus. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a self-contained underwater breathing apparatus mouthpiece.

f. Lungs and chest wall.

- (1) Current accession standards.
- (2) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation or perfusion.
- (3) Spontaneous pneumothorax, except a single occurrence at least 2 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function. Traumatic and iatrogenic pneumothorax is disqualifying for a year. Any underlying congenital or structural defect (blebs, bullae, and so on) are disqualifying regardless of pneumothorax history.

(4) History of any clinically significant AGE, or pulmonary over inflation injury; including, but not limited to, subcutaneous emphysema, mediastinal emphysema, or dysbaric pneumothorax (without appropriate post-hoc ancillary studies, such as chest computerized tomography, echocardiography, and/or pulmonary functions testing, proving absence of anatomical or physiologic abnormalities that would suggest candidate is at increased risk for pulmonary dysbarism or paradoxical AGE).

(5) Any history of persistent COPD, obstructive, restrictive, or interstitial lung disease is disqualifying.

g. Heart and vascular system. Current accession standards, to include blood pressures with an average systolic of less than 90 mmHg or greater than 140 mmHg or an average diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. Blood pressure management that meets standards with medication is not disqualifying. An unsatisfactory orthostatic tolerance test is disqualifying.

(1) Electrocardiographic evidence of QTc>430 msec is disqualifying and requires further evaluation for waiver consideration.

(2) Radiographic evidence (on screening chest x-ray) of cardiomegaly (without appropriate ancillary studies, such as echocardiography, proving absence of anatomic or physiologic abnormalities that would suggest candidate is at increased risk for Sudden Cardiac Death, or exercised or stress-induced cardiopulmonary dysfunction).

(3) Family history of sudden cardiac death, hypertrophic obstructive cardiomyopathy, or idiopathic hypertrophic subaortic stenosis without appropriate ancillary studies, such as echocardiography, proving absence of anatomic or physiologic abnormalities that would suggest candidate is at increased risk for sudden cardiac death, or exercised or stress-induced cardiopulmonary dysfunction.

(4) Corrected atrial septal defect or patent foramen ovale when associated with a history of decompression syndrome or arterial gas embolism.

h. Abdomen and gastrointestinal system. Current accession standards.

i. Genitourinary system. Current accession standards.

j. Spine, scapulae, ribs, and sacroiliac joints.

- (1) Current accession standards.
- (2) Spondylolisthesis that is symptomatic or likely to interfere with diving duty.
- (3) Healed fracture or dislocation of the vertebrae except a mild, asymptomatic compression fracture.
- (4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

k. Extremities.

- (1) Current accession standards.
- (2) Any limitation of motion of any joint that might compromise safety.
- (3) Any loss of strength that might compromise safety.
- (4) Instability of any degree or pain in a weight-bearing joint.
- (5) Retained hardware placed within 6 months that requires a profile or impairs function does not meet the standard.

l. Skin and cellular tissues. Current accession standards.

m. Blood and blood-forming tissue diseases.

- (1) Current accession standards.
- (2) Significant anemia (hematocrit less than 37 in females and 40 in males) or history of hemolytic disease due to variant hemoglobin state or G6PD deficiency.
- (3) Sickle cell disease. Sickle cell trait with hematocrit greater than 35 for females and 38 for males and no prior vaso-occlusive crisis is not disqualifying.
 - n. Systemic disease.* General and miscellaneous conditions and defects.
 - (1) Current accession standards.
 - (2) Chronic motion sickness.
 - (3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.
 - o. Sexually transmitted diseases.* Current accession standards.
 - p. Endocrine and metabolic diseases.* Current accession standards.
 - q. Neurological and sleep disorders.*
 - (1) Current accession standards.
 - (2) The criteria outlined in paragraph 4–27 for Classes 2 and 3 flying duty apply.
 - r. Learning, psychiatric, and behavioral disorders.* Disorders with psychotic features, affective disorders (mood disorders), anxiety, somatoform, or dissociative disorders (neurotic disorders).
 - (1) Current accession standards.
 - (2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, and so forth, and for a period of 12 weeks after the drug has been discontinued.
 - (3) Evidence of excessive anxiety or emotional instability.
 - (4) Fear of flying when a manifestation of a psychiatric illness.
 - (5) History of psychosis or attempted suicide at any time.
 - (6) Phobias that materially influence behavior.
 - (7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.
 - (8) Fear of depths, enclosed places, or of the dark.
 - s. Tumors and malignant diseases.* Current accession standards.
 - t. Height.* (See para 2–3.)
 - u. Weight.* The individual must meet the weight standards prescribed by AR 600–9. AR 600–9 is a commander’s program with very fixed body fat measurement processes. To assess this standard, the medical examiner may impose body fat measurements not otherwise requested by the commander.
 - v. Body build.*
 - (1) Current accession standards.
 - (2) Marfanoid body habitus.
 - (3) Obesity of any degree, if it compromises the candidate’s ability to perform continuous, strenuous combat diving operations across the operational spectrum (including all maritime, subsurface maritime, coastal, and land-based missions). Must meet body fat standards of AR 600–9.

5–10. Medical fitness standards for retention for Special Forces and Ranger combat diving duty

Retention of a Soldier in marine diving duty self-contained underwater breathing apparatus will be based on—

- a.* The Soldier’s demonstrated ability to satisfactorily perform marine self-contained underwater breathing apparatus diving duty.
- b.* The effect upon the Soldier’s health and well-being by remaining on marine self-contained underwater breathing apparatus diving duty.
- c.* Determination of whether any severe illness, operation, injury, or defect is of such a nature or of such recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

5–11. Medical fitness standards for initial selection for divers (military occupational specialty 12D)

The causes of medical disqualification for initial selection for diving training are all of the current accession standards. Waiver considerations will be submitted to and considered by the John F. Kennedy Special Warfare Center and School. Contact Special Operations Forces Recruiting to submit a waiver consideration to attend training. (See AR 611–75 for more information.) Specific Army dive standards also include the following:

- a. Head and neck.*
 - (1) Any defect in the bony substance of the skull, regardless of cause.

(2) Any acute or chronic condition of the neck that is not compatible with wear and use of diving equipment to include helmets, tanks, or diving apparatus.

b. Eyes and vision.

(1) Uncorrected distance visual acuity worse than 20/200 and not correctable to 20/20 in each eye.

(2) Uncorrected near visual acuity worse than 20/50 and not correctable to 20/20 in each eye.

c. Ears and hearing.

(1) Perforation marked scarring or thickening of the eardrum.

(2) Inability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver.

(3) Acute or chronic disease of the auditory canal, tympanic membrane, middle, or internal ear.

(4) Audiometric average level for each ear not more than 25 dB at 500, 1000, and 2000 Hz with no individual level greater than 30 dB. Not over 45 dB at 4000 Hz.

(5) History of otitis media or otitis externa with any residual effects that might interfere with or be aggravated by diving duty.

d. Nose, sinuses, mouth, and larynx.

(1) History of chronic or recurrent sinusitis at any time.

(2) Speech impediments of any origin; any condition that interferes with the ability to communicate clearly in the English language.

e. Dental.

(1) Personnel in DRC 3 or 4.

(2) Any defect of the oral cavity or associated structures that interferes with the effective use of an underwater breathing apparatus is disqualifying. Maxillofacial or craniofacial abnormalities precluding the comfortable use of diving gear including headgear, mouthpiece, or regulator is disqualifying.

f. Lungs and chest wall.

(1) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation-perfusion ratio.

(2) Spontaneous pneumothorax, except a single occurrence at least 2 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function. Traumatic and iatrogenic pneumothorax is disqualifying for a year. Any underlying congenital or structural defect (blebs, bullae, and so on) are disqualifying regardless of pneumothorax history. Clinical evaluation should include the following:

(a) Normal pulmonary function testing.

(b) Standard, non-contrast chest computer tomography scan.

(c) Favorable recommendation from a pulmonologist.

(d) Final evaluation and approval by attending diving medical officer (DMO)/undersea medical officer (UMO).

(3) Chronic obstructive or restrictive pulmonary disease.

(4) LTBI patients must be taking therapeutic medications prior to the start of diver training or reinstatement of diving duty. For further guidance on latent tuberculosis infection surveillance and control, see MEDCOM Regulation 40–64.

(5) Diving related pulmonary barotrauma, as follows:

(a) Designated divers who experience mediastinal or subcutaneous emphysema are temporarily disqualified from diving duty for 30 days. They may be returned to diving duty following completion of the waiver process via the Chief, Hyperbaric Medicine, Dwight David Eisenhower Army Medical Center, 300 Hospital Road, Fort Gordon, GA 30905–5650, if the diver is asymptomatic and is determined to have a normal, standard, non-contrast chest CT.

(b) A history of pulmonary barotrauma in a diver candidate is disqualifying. Designated divers who experience a pulmonary barotrauma following a dive with no procedural violations or a second episode of pulmonary barotrauma, are considered disqualified for diving duty. A waiver request will be considered if the diver is asymptomatic after 30 days and must include:

1. Pulmonary function testing.

2. Standard, non-contrast chest CT.

3. Favorable recommendation from a pulmonologist.

4. Evaluation by a DMO/UMO.

g. Heart and vascular system.

(1) Varicose veins that are symptomatic or may become symptomatic as a result of diving duty; deep vein thrombophlebitis; gross venous insufficiency.

(2) Any circulatory defect (shunts, stasis, and others) resulting in increased risk of decompression sickness.

h. Abdomen and gastrointestinal system.

(1) Current hernia of any variety.

(2) Operation for relief of intestinal adhesions at any time.

(3) Chronic or recurrent gastrointestinal disorder that may interfere with or be aggravated by diving duty. Severe colitis, peptic ulcer disease, pancreatitis, and chronic diarrhea do not meet the standard unless asymptomatic on an unrestricted diet for 24 months with no radiographic or endoscopic evidence of active disease or severe scarring or deformity. Gastroesophageal reflux disease that does not interfere with or is not aggravated by diving duty is not considered physically disqualifying.

(4) Laparotomy or celiotomy within the preceding 6 months.

i. Genitourinary system.

(1) Designated divers with full recovery from acute infections of genitourinary organs may be reinstated at the discretion of the DMO/UMO.

(2) Pregnancy is disqualifying for diving duty upon diagnosis. Return to diving duty prior to 6 months post spontaneous vaginal delivery or caesarian section requires waiver request. Return to diving duty 6 months or more post spontaneous vaginal delivery or caesarian section requires evaluation and approval by a DMO/UMO or FS trained in diving medicine.

j. Spine, scapulae, ribs, and sacroiliac joints.

(1) Healed fractures or dislocations of the vertebrae until reviewed by a DMO/UMO.

(2) Any condition that limits the diver's ability to perform diving duties to include carrying and wearing of various diving apparatus, weight belts, diving helmets, and dive tanks.

k. Extremities.

(1) Any condition of the extremities that limits an individual's ability to satisfactorily complete diving duties is disqualifying. Any condition that is exacerbated by continued diving duties is disqualifying.

(2) Any fracture (including stress fractures) is disqualifying for diving if it is less than 3 months post injury, and if there are any residual symptoms. Designated divers with full recovery from uncomplicated fractures with no residual pain may be reinstated at the discretion of the DMO/UMO.

(3) Any musculoskeletal condition that is chronic or recurrent which predisposes to diving injury, limits the performance of diving duties, or may confuse the diagnosis of a diving injury is disqualifying.

l. Skin and cellular tissues. Any active or chronic disease of the skin.

m. Blood and blood-forming tissue diseases. Significant anemia or history of hemolytic event secondary to G6PD deficiency.

n. Systemic diseases and miscellaneous conditions and defects.

(1) Chronic motion sickness is disqualifying for diving duty upon diagnosis. Return to diving duty requires waiver approval.

(2) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe diving.

(3) Chronic viral infections and communicable diseases which can be transmitted to fellow divers are disqualifying for diving.

(4) Active sexually transmitted disease until adequately treated. Serological test for syphilis is required.

o. Endocrine and metabolic disease. In addition to current accession standards, any condition that compromises the performance and safety of the diver is disqualifying. Any condition that is exacerbated by continued diving service is also disqualifying.

p. Neurologic and sleep disorders.

(1) The special criteria that are outlined in paragraphs 4–27 and 4–28 for Class 1 flying duty are applicable to diving duty.

(2) Any condition that could be exacerbated or manifest itself as a result of the stressors of diving duty and obscure a diving related injury is disqualifying.

q. Learning, psychiatric, and behavioral disorders.

(1) The special criteria that are outlined in paragraph 4–29 for Class 1 flying duty are applicable to diving duty.

(2) The military diving adaptability rating (MDAR) may be considered MDAR satisfactory if the applicant meets the standards of paragraph 4–29 with the addition of having no fear of depths, enclosed places, or of the dark.

r. Tumors and malignant diseases. In addition to current accession standards, any condition that compromises the performance and safety of the diver is disqualifying. Any condition that is exacerbated by continued diving service is also considered disqualifying.

s. Height. Even though the Soldier's weight or body composition is within the limits prescribed by AR 600–9, they will be found medically disqualified if the examiner considers that their height, weight, or associated conditions in relationship to the bony structure, musculature, and/or total body fat content would adversely affect diving safety or endanger the Soldier's well-being if permitted to continue in diving status.

t. Pressure intolerance. If a hyperbaric chamber is available, examinees will be tested for the inability to equalize pressure. Each candidate will be subjected, in a hyperbaric compression chamber, to a pressure of 60 feet sea water (41.4

pounds per square inch absolute) to determine their ability to withstand the effects of pressure (including the ability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver). This test should not be performed in the presence of a respiratory infection that may temporarily impair the ability to equalize or ventilate.

u. Decompression sickness/arterial gas embolism.

(1) In diving duty candidates, any prior history of decompression sickness or arterial gas embolism is considered disqualifying and requires a waiver.

(2) Designated divers diagnosed with any decompression sickness (including symptoms of joint pain or skin changes) will:

(a) Have an entry made in their service treatment record and signed by the attending DMO/UMO describing the events and treatment of the injury.

(b) Be evaluated by a cardiologist for the presence of a patent foramen ovale with the results documented in the service treatment record.

(3) Designated divers diagnosed with AGE or DCS Type II presenting with neurological, pulmonary, or shock symptoms will be disqualified for diving duty pending command approval of evaluation and waiver by Chief, Hyperbaric Medicine, Dwight David Eisenhower Army Medical Center, 300 Hospital Road, Fort Gordon, GA 30905–5650.

(a) Obtain a brain with or without spine magnetic resonance imaging (MRI) (whichever is indicated) once the diver's condition is stabilized within 1 week from the time of the injury.

(b) If initial MRI is negative, and the diver had complete relief of symptoms following treatment, the diver can be returned to duty in 30 days following documentation in the Soldier's record details of the clinical presentation, subsequent resolution of the injury, and interim waiver for return to duty by Chief, Hyperbaric Medicine, Dwight David Eisenhower Army Medical Center, 300 Hospital Road, Fort Gordon, GA 30905–5650.

(c) If initial MRI shows acute findings, or the diver has residual symptoms following treatment, the diver will remain disqualified for diving duty until a waiver is obtained from the engineer dive proponent in accordance with paragraph 1–6m for resumption of diving duty. The work-up should include, at a minimum:

1. Initial MRI (within 1 week).
2. Follow-up MRI at 30 days.
3. Neurology consult.

v. Initial physical examination. The initial physical examination for divers (MOS 12D) must be performed or reviewed by a DMO/UMO or a FS who has completed the Recognition and Treatment of Diving Casualties course (course identification number A–4N–0018) at the Naval Diving and Salvage Training Center, Panama City, FL.

w. Frequency of medical examinations.

(1) Divers (MOS 12D) must have an initial diving medical examination within 2 years prior to the start of Diver Phase Two training at the Naval Diving and Salvage Training Center in Panama City, FL.

(2) Divers (MOS 12D) must have a full diving medical examination every 5 years. The medical examination for divers must be performed by or reviewed by a DMO, UMO, or FS who has completed the Recognition and Treatment of Diving Casualties course (course identification number A–4N–0018) at the Naval Diving and Salvage Training Center, Panama City, FL.

5–12. Medical fitness standards for retention for diver duty (military occupational specialty 12D)

The medical fitness standards contained in paragraph 5–11 and DODI 6130.03 will be used to guide clinical decision making when evaluating current divers. The DMO/UMO should exercise clinical judgment to ensure:

a. The diver is free of any disease or condition that would endanger themselves, their dive team members, or compromise successful completion of the mission.

b. The diver is free of any acute or chronic disease or condition that will be exacerbated by continuation of diving duty and pose undue risk on the health and wellbeing of the diver.

5–13. Medical fitness standards for initial selection and retention for Army maritime sea duty

The following permanent profile standard of PULHES 222221 must be met in accordance with DA Pam 611–21 for entry level and continued service in MOS 88K, 88L, 880A, and 881A (see AR 56–9 for more information):

a. Vision standards. Distance visual acuity must be correctable to at least 20/20 in one eye and 20/40 in the other eye.

b. Color vision. Individual must pass one of the currently used color vision tests, without the use of color sensing lenses.

5–14. Medical fitness standards for initial selection and retention for small unmanned aircraft system operators

The causes of medical disqualification for SUAS training are all the medical conditions listed in DODI 6130.03, plus the following:

Note. These standards are separate from UAS operators in chapter 4 and as applied in DA Pam 40–502.

- a. Head and neck.* (See para 5–3a.)
- b. Eyes and vision.*
 - (1) Distant and near visual acuity must be correctable to 20/20 in each eye, no visual field deficits and no diplopia.
 - (2) Ability to identify/distinguish vivid red and green.
 - (3) After receiving SUAS training, individuals who perform duties of a SUAS operator must have an annual vision screening and meet the following visual acuity requirements:
 - (a)* Distant and near visual acuity must be correctable to 20/20 in each eye, no visual field deficits and no diplopia.
 - (b)* Ability to identify/distinguish vivid red and green.
- c. Ears and hearing.* Current accession standards.
- d. Nose, sinuses, mouth, and larynx.* Current accession standards.
- e. Dental.* Current accession standards.
- f. Lungs and chest wall.* Current accession standards.
- g. Heart and vascular system.* Current accession standards.
- h. Abdomen and gastrointestinal system.* Current accession standards.
- i. Genitourinary system.* Current accession standards.
- j. Spine, scapulae, and sacroiliac joints.* Current accession standards.
- k. Extremities.* SUAS operators require excellent manual dexterity while meeting the current accession standards.
- l. Skin and cellular tissues.* Current accession standards.
- m. Blood and blood-forming tissue diseases.* Current accession standards.
- n. Systemic disease and miscellaneous conditions and defects.*
 - (1) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 12 weeks after the drug has been discontinued.
 - (2) Any severe illness, operation, injury, or defect of such a nature or of recent occurrence as to constitute an undue hazard to the individual.
- o. Endocrine and metabolic diseases.* Current accession standards.
- p. Neurologic and sleep disorders.* Active disease of the nervous system of any type.
- q. Learning, psychiatric, and behavioral disorders.* Evidence of excessive anxiety, tenseness, or emotional responses to situations of stress (both combat and noncombat), when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the Soldier's duties.
- r. Tumors and malignant diseases.* Current accession standards.
- s. Height.* No special requirements.
- t. Weight.* No special requirements.
- u. Body build.* No special requirements.

5–15. Asplenic Soldiers

Asplenic Soldiers are disqualified from initial training and duty in military specialties involving significant occupational exposure to dogs or cats if found fit for duty after PEB.

5–16. Medical fitness standards for certain geographical areas

- a.* Some Soldiers with certain medical conditions require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions ensures these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensures they do not produce a hazard to the health or well-being of other Soldiers.
- b.* Excluding Soldiers affected by paragraph 5–16a, all Soldiers considered medically qualified for continued military service and medically qualified to serve in all or certain CONUS areas are medically qualified to serve in similar or corresponding areas OCONUS in accordance with the AR 635–40 definition of deployability as the minimum standard of fitness for duty.
- c.* Soldiers who do not meet the medical retention standards in chapter 3 of this regulation must be referred to the DES (see AR 635–40 for fitness determination guidance). However, Soldiers returned to duty by an MAR2, PEB, or Soldiers

with temporary medical conditions may still have some assignment/deployment limitations that must be considered before a decision is made to assign to certain geographical areas, such as Korea and other OCONUS areas.

d. Medical Standards for Military Assistance Advisory Groups (MAAGs), military attaches, military missions, and duty in isolated areas where adequate medical or dental care may not be available will consider the following medical conditions and defects to preclude assignments or attachment to duty with MAAGs, military attaches, military missions, or any type of duty in OCONUS isolated areas where adequate medical care is not available:

(1) A history of emotional or behavioral health disorders, including recurrent acute adjustment disorder, of such a degree as to have interfered significantly with adjustment or is likely to require treatment during the extent of the tour. For example, a single acute adjustment disorder that resolved with a period of stability of over a year would pose no limitations pending combatant command guidance.

(2) Any medical conditions where maintenance medication is of such toxicity as to require frequent clinical and laboratory follow up or where the medical condition requires frequent follow up that cannot be delayed for the extent of the tour.

(3) Inherent, latent, or incipient medical or dental conditions that are likely to be aggravated by the climate or general living environment prevailing in the area where the Soldier is expected to reside, to such a degree as to preclude acceptable performance of duty.

(4) Of special consideration are Soldiers with a history of chronic cardiovascular, respiratory, or nervous system disorders that are scheduled for assignment and/or residence in an area 6,000 feet or more above sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Colombia; and Addis Ababa, Ethiopia.

(5) Medical, dental, or physical conditions or defects that might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure from CONUS.

Appendix A

References

Section I

Required Publications

Unless otherwise indicated, DOD publications are available at <http://www.esd.whs.mil/dd/>. NGB publications are available at <http://www.ngbpdc.ngb.army.mil/>.

AR 40–502

Medical Readiness (Cited in para 1–4*d*.)

AR 56–9

Watercraft (Cited in para 5–13.)

AR 135–175

Separation of Officers (Cited in para 3–3*b*.)

AR 135–178

Enlisted Administrative Separations (Cited in para 3–3*b*.)

AR 600–8–24

Officer Transfers and Discharges (Cited in para 3–3*b*.)

AR 600–9

The Army Body Composition Program (Cited in para 2–3*a*.)

AR 600–105

Aviation Service of Rated Army Officers (Cited in para 4–2*b*(2).)

AR 600–106

Flying Status for Nonrated Army Aviation Personnel (Cited in para 4–2*c*.)

AR 600–110

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV) (Cited in para 3–26*j*(2).)

AR 611–75

Management of Army Divers (Cited in para 1–6*o*.)

AR 611–110

Selection and Training of Army Aviation Officers (Cited in para 4–2*a*(1).)

AR 635–40

Disability Evaluation for Retention, Retirement, or Separation (Cited in para 2–2*a*(2).)

AR 635–200

Active Duty Enlisted Administrative Separations (Cited in para 2–2*c*(2).)

Army Directive 2013–12

Implementation of Department of Defense Policy Change Concerning Chronic Adjustment Disorder (Cited on title page.)

Army Directive 2016–28

Sharing U.S. Department of Veterans Affairs Disability Rating for Members of the Ready Reserve (Cited on title page.)

DA Pam 40–502

Medical Readiness Procedures (Cited in para 1–4*d*.)

DA Pam 611–21

Military Occupational Classification and Structure (Cited in para 5–13.)

DOD 6025.18–R

DOD Health Information Privacy Regulation (Cited in para 1–7.)

DODI 6025.19

Individual Medical Readiness (IMR) (Cited on title page.)

DODI 6130.03

Medical Standards for Appointment, Enlistment, or Induction into the Military Services (Cited on title page.)

DODI 6490.07

Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees (Cited on title page.)

NGR 600–200

Enlisted Personnel Management (cited in para 3–26j(3).)

NGR 635–101

Efficiency and Physical Fitness Boards (Cited in para 3–26j(3).)

10 USC 1177

Members diagnosed with or reasonably asserting post-traumatic stress disorder or traumatic brain injury: medical examination required before administrative separation (Cited in para 3–37a.)

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this regulation. DOD publications are available at <http://www.esd.whs.mil/dd/>. NGB publications are available at <http://www.ngbpc.ngb.army.mil/>. USC and CFR materials are available at <https://www.gpo.gov/fdsys/>.

AR 11–2

Managers' Internal Control Program

AR 25–30

Army Publishing Program

AR 40–66

Medical Record Administration and Healthcare Documentation

AR 40–400

Patient Administration

AR 140–1

Mission, Organization, and Training

AR 220–1

Army Unit Status Reporting and Force Registration–Consolidated Policies

Assistant Secretary of Defense (Health Affairs) Policy Memorandum

Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications (Available at <https://health.mil/reference-center/policies/2013/10/07/deployment-limiting-mental-disorders-and-psychotropic-medications>.)

CJCSM 3150.13C

Joint Reporting Structure–Personnel Manual (Available at <http://www.jcs.mil/library/cjcs-manuals/>.)

DA Pam 25–403

Guide to Recordkeeping in the Army

DA Pam 40–501

Army Hearing Program

DA Pam 220–1

Defense Readiness Reporting System–Army Procedures

DA Pam 635–40

Procedures for Disability Evaluation for Retention, Retirement, or Separation

DODI 1332.14

Enlisted Administrative Separations

DODI 1332.18

Disability Evaluation System (DES)

DODI 6040.44

Physical Disability Board of Review (PDBR)

DODI 6040.46

The Separation History and Physical Examination (SHPE) for the DOD Separation Health Assessment (SHA) Program

DODI 6200.03

Public Health Emergency Management within the Department of Defense

DSM–5

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, American Psychiatric Association (Available at <https://medline.amedd.army.mil/subject/bh.htm> under PsychiatryOnline.)

JP 3–35

Deployment and Redeployment Operations (Available at <http://www.jcs.mil/doctrine/joint-doctrine-pubs/>.)

JP 4–05

Joint Mobilization Planning (Available at <http://www.jcs.mil/doctrine/joint-doctrine-pubs/>.)

MEDCOM Regulation 40–64

The Tuberculosis Surveillance and Control Program (Available at https://army.deps.mil/army/cmds/amp_docnt/sitepages/home.aspx.)

TB MED 507

Heat Stress Control and Heat Casualty Management

10 USC

Armed Forces

10 USC Chapter 61

Retirement or Separation for Physical Disability

10 USC 113

Secretary of Defense

10 USC 1074n

Annual mental health assessments for members of the armed forces

10 USC 10148

Ready Reserve: failure to satisfactorily perform prescribed training

10 USC 12304

Selected Reserve and certain Individual Ready Reserve members; order to active duty other than during war or national emergency

Section III**Prescribed Forms**

Unless otherwise indicated, DD Forms are available on the Office of the Secretary of Defense website (<http://www.esd.whs.mil/directives/forms/>).

DD Form 2992

Medical Recommendation for Flying or Special Operational Duty (Prescribed in paras 4–35a, 4–35b, and 4–35f.)

Section IV**Referenced Forms**

Unless otherwise indicated, DA Forms are available on the Army Publishing Directorate website (<http://armypubs.army.mil/>) and DD Forms are available on the Office of the Secretary of Defense website (<http://www.esd.whs.mil/directives/forms/>).

DA Form 11–2

Internal Control Evaluation Certification

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 3349

Physical Profile

DD Form 2807-1

Report of Medical History

DD Form 2808

Report of Medical Examination

DD Form 2870

Authorization for Disclosure of Medical or Dental Information

SF Form 527

Medical Record—Group Muscle Strength, Joint R.O.M. Girth and Length Measurements

Appendix B

Internal Control Evaluation

B–1. Function

The function covered by this evaluation is service treatment records and healthcare documentation.

B–2. Purpose

The purpose of this evaluation is to assist medical, administrative, and recruiting command personnel in evaluating the key management controls listed below. It is not intended to cover all controls.

B–3. Instructions

These key internal controls must be formally evaluated at least annually or whenever the commander and/or designating authority changes. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. Certification that this annual evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification).

B–4. Test questions

a. Accession standards.

- (1) Are officials with responsibilities in accession familiar with both the DOD and Army specific standards?
- (2) Are initial appointments, accessions, and commissioning Soldiers able to complete at least their first tour successfully?

b. Retention standards.

- (1) Are policies in place to train incoming providers regarding retention standards?
- (2) Are policies in place to ensure Soldiers are screened at least annually for conditions that do not meet retention standards?

c. Special Duty standards (see chaps 4 and 5).

- (1) Are Soldiers who are selected for special duty assignments able to complete the necessary training?

B–5. Supersession

This evaluation replaces the evaluation previously published in AR 40–501, dated 14 June 2017.

B–6. Comments

Help make this a better tool for evaluating the standards of medical fitness. Comments regarding this evaluation should be addressed to The Surgeon General (DASG–HSZ), 7700 Arlington Boulevard, Falls Church, VA 22042–5142.

Glossary

Section I

Abbreviations

AA

aeronautical adaptability

AD

active duty

ADT

active duty for training

AERO

Aeromedical Electronic Resource Office

AFVT

Armed Forces vision tester

AGE

air gas embolism

AMEDD

Army Medical Department

ANSI

American National Standards Institute

AO

airborne operations

APFT

Army physical fitness test

APL

aeromedical policy letter

AR

Army regulation

ARNG

Army National Guard

ARNGUS

Army National Guard of the United States

ATC

air traffic controller

AV

atrioventricular

BMI

body mass index

CG

commanding general

CHAMP

Consortium for Health and Military Performance

CJCSM

Chairman of the Joint Chiefs of Staff Manual

COMPO

component

CONUS

continental United States

COPD

chronic obstructive pulmonary disease

CT

computed tomography

DA

Department of the Army

DA Form

Department of the Army form

DA Pam

Department of the Army pamphlet

DAC

Department of the Army Civilian

dB

decibels

DCS

Deputy Chief of Staff

DD Form

Department of Defense form

DES

Disability Evaluation System

DMO

diving medical officer

DOD

Department of Defense

DODI

Department of Defense instruction

DQ

aeromedical disqualification

DRC

Dental Readiness Classification

EEG

electroencephalogram

EPSBD

entrance physical standards board

FAA

Federal Aviation Administration

FEV1

forced expiratory volume in 1 second

FS

flight surgeon

G6PD

glucose-6 phosphate dehydrogenase

GFR

glomerulofiltration rate

GS
general schedule

HCT
hematocrit

HCV
hepatitis c virus

HE
heat exhaustion

HI
heat injury

HIV
human immunodeficiency virus

HPSP
Health Professions Scholarship Program

HQDA
Headquarters, Department of the Army

HRC
U.S. Army Human Resources Command

HS
heat stroke

Hz
hertz

IBA
Interceptor Multi-Threat Body Armor

ICL
implantable collamer lens

ISO
International Organization for Standardization

JP
Joint publication

LASEK
laser epithelial keratomileusis

LASIK
laser-assisted in situ keratomileusis

LOC
loss of consciousness

LTBI
latent tuberculosis infection

MAAG
Military Assistance Advisory Group

MAR2
Military Occupational Specialty Administrative Retention Review

MDAR
military diving adaptability rating

MEB
medical evaluation board

MEDCOM

U.S. Army Medical Command

MEPS

military entrance processing station

METS

metabolic equivalents

MFF

military free fall

mg

milligrams

mL

milliliters

mmHg

millimeters of mercury

MOPP

mission oriented protective posture

MOS

military occupational specialty

MRDP

medical retention determination point

MRI

magnetic resonance imaging

MTF

military treatment facility

NGB

National Guard Bureau

NGR

National Guard regulation

OCONUS

outside the continental United States

OCS

Officer Candidate School

OPM

Office of Personnel Management

OSA

obstructive sleep apnea

PAP

positive airway pressure

PEB

physical evaluation board

PHA

periodic health assessment

PIP

pseudoisochromatic plate

PMOS

Primary military occupational specialty

PRK
photorefractive keratectomy

PTSD
post-traumatic stress disorder

PULHES
physical, upper, lower, hearing, eyes, psychiatric

RA
Regular Army

RC
Reserve Component

ROM
range of motion

ROTC
Reserve Officers' Training Corps

RSLC
Reconnaissance and Surveillance Leaders Course

SERE
survival, evasion, resistance, and escape

SF Form
standard form

SHPE
separation history and physical examination

SPRINT
speech recognition in noise test

SUAS
small unmanned aircraft system

SVT
stereoscope vision testing

TB
technical bulletin

TDRL
temporary disability retired list

TSG
The Surgeon General

UAS
unmanned aircraft system

UMO
undersea medical officer

USAAMA
U.S. Army Aeromedical Activity

USACC
U.S. Army Cadet Command

USAPDA
U.S. Army Physical Disability Agency

USAR
U.S. Army Reserve

USAREC

U.S. Army Recruiting Command

USARIEM

U.S. Army Research Institute of Environmental Medicine

USC

United States Code

USMA

U.S. Military Academy

USMEPCOM

U.S. Military Entrance Processing Command

USUHS

Uniformed Services University of the Health Sciences

VASRD

Veterans Administration Schedule for Rating Disabilities

VIT

venom immunotherapy

Section II**Terms****Accepted medical principles**

Fundamental deduction consistent with medical facts and based upon the observation of a large number of cases. To constitute accepted medical principles, the deduction must be based upon the observation of a large number of cases over a significant period of time and be so reasonable and logical as to create a moral certainty that they are correct.

Active Duty

Full-time duty in the active military service of the United States. Includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Does not include full-time National Guard duty (see DA Pam 220–1).

Active Guard and Reserve

(DOD) National Guard and Reserve members who are on voluntary AD providing full-time support to National Guard, Reserve, and RA organizations for the purpose of organizing, administering, recruiting, instructing, or training the RCs (see CJCSM 3150.13C).

Applicant

A person not in a military status who applies for appointment, enlistment, or re-enlistment in the Army, ARNG/ARNGUS or USAR.

Army National Guard

That part of the organized militia of the several States and Territories, Puerto Rico, and the District of Columbia, active and inactive, that is a land force; is trained, and has its officers appointed, under the sixteenth clause of section 8, article I, of the Constitution; is organized, armed, and equipped wholly or partly at Federal expense; and is federally recognized. (See NGR 600–200.)

Army National Guard of the United States

The RC of the Army all of whose members are members of the ARNG. The ARNGUS consists of federally recognized units and organizations of the ARNG; and members of the ARNG who are also Reserves of the Army. (See NGR 600–200.)

Candidate

Any individual under consideration for military status or for a military service program whether voluntary (appointment, enlistment, ROTC) or involuntary (induction).

Component

Refers to the RA (COMPO 1), ARNGUS/ARNG (COMPO 2), and USAR (COMPO 3). (See AR 220–1.)

Deployment

The rotation of forces into and out of an operational area (see JP 3–35).

Disability Evaluation System

Procedures that apply in determining whether a Soldier is unfit because of physical disability to reasonably perform the duties of their office, grade, rank, or rating. The DES consists of medical evaluation boards (a function of AMEDD), physical evaluation boards (elements of the U.S. Army Physical Disability Agency (USAPDA)), and case reviews, when applicable, by USAPDA.

Enlistment

The voluntary enrollment for a specific term of service in one of the Armed Forces as contrasted with induction under the Military Selective Service Act.

Impairment of function

Any anatomic or functional loss, lessening, or weakening of the capacity of the body, or any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in the body economy.

Individual Ready Reserve

A manpower pool consisting of individuals who have had some training or who have served previously in the RA or in the Selected Reserve and may have some period of their military service obligation remaining. Members may voluntarily participate in training for retirement points and promotion with or without pay (see JP 4–05).

Latent impairment

Impairment of function that is not accompanied by signs and/or symptoms but is of such a nature that there is reasonable and moral certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time or upon change of environment.

Manifest impairment

Impairment of function that is accompanied by signs and/or symptoms.

Medical capability

General ability, fitness, or efficiency (to perform military duty) based on accepted medical principles.

Military Occupational Specialty Administrative Retention Review

MAR2 is an administrative process for Soldiers who meet medical retention standards, have a permanent profile of 3 or 4, and may not be able to satisfactorily perform the duties their primary military occupational specialty (PMOS) requires. The MAR2 process will be used to determine whether a Soldier will be retained in his/her PMOS or reclassified into another PMOS. Soldiers who do not meet PMOS standards and who do not qualify for reclassification will be referred to the DES. The MAR2 replaces the MOS medical retention board.

Physical disability

Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment that reduces or precludes an individual's actual or presumed ability to perform military duty. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term "physical disability" includes mental diseases, other than such inherent defects as personality disorders, and primary mental deficiency.

Physician

A doctor of medicine or doctor of osteopathy legally qualified to prescribe and administer all drugs and to perform all surgical procedures.

Range of motion

Measurements should be obtained using a goniometer. SF Form 527 should be used to document the ROM and the method of measurement. Use the VA's instructions for completion of spine and joint evaluations. This includes the six measurements shown on VASRD Plate V ROM of cervical and thoracolumbar spine.

Regular Army

A federal force of full-time Soldiers and Department of the Army civilians who make up the operational and institutional organizations engaged in the day-to-day missions of the Army. Upon mobilization, ARNGUS/ARNG (COMPO 2) and USAR (COMPO 3) retain their applicable force structure COMPO designations while on active duty (see DA Pam 220–1).

Reserve Component

Consists of ARNG (COMPO 2) and USAR (COMPO 3). (See DA Pam 220–1.)

Retirement

Release from active military services because of age, length of service, disability, or other causes, in accordance with Army regulations and applicable laws with or without entitlement to receive retired pay. For purposes of this regulation, this includes both temporary and permanent disability retirement.

Service treatment record

Includes both the treatment record and the dental record; it is a permanent and continuous file that is initiated when a member enters the service (see AR 40–66).

U.S. Army Reserve

A Federal force, consisting of individual reinforcements and combat, combat support, and training type units organized and maintained to provide military training in peacetime and a reservoir of trained units and individual reservists to be ordered to AD in the event of a national emergency (see AR 140–1).

UNCLASSIFIED

PIN 015562-000