

Army Regulation 40–502

Medical Services

Medical Readiness

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

UNCLASSIFIED

SUMMARY

AR 40–502

Medical Readiness

This new Department of the Army regulation, dated 27 June 2019—

- o Authorizes commander deployment status decisions for specific Medical Readiness Classification and deployment-limiting codes (table 2–1).
- o Incorporates Army Directive 2018–11, Update to Redesign of Personnel Readiness and Medical Deployability, dated 10 September 2018 (para 2–4).
- o Incorporates Army Directive 2019–07, Army Dental Readiness and Deployability, dated 25 February 2019 (para 2–4c).
- o Updates individual medical readiness classification (para 2–4c).
- o Describes that temporary profiles no longer have assigned physical capacity or stamina, upper extremities, lower extremities, hearing and ears, eyes, psychiatric designation (para 3–3).
- o Redesigns and prescribes the DA Form 3349 (Physical Profile Record) as a single source incorporating all duty limiting conditions and current functional limitations for providers, commanders, and trained staff (paras 3–1 and 3–3a).
- o Unit commanders will review profiles on Soldiers under their command and make a determination for deployability for all duty limiting conditions not identified by policy (paras 3–6a and 3–6e).
- o Requires a physician review and second signature for all permanent profile with a serial of “2” (para 3–6b(3)).
- o Implements DODI 6025.19 and DODI 6490.07; the Assistant Secretary of Defense for Health Affairs memorandum, Subject: Individual Medical Readiness Measure Goal, dated July 15, 2015; and supplements the information provided in AR 220–1 (throughout).
- o Implements the Commander Portal and clarifies required actions to support Soldier health and welfare, duty assignment, and medical readiness reporting (throughout).
- o Incorporates Army Directive 2016–07, Redesign of Personnel Readiness and Medical Deployability, dated 1 March 2016 (throughout).

Medical Services
Medical Readiness

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

History. This publication is a new Department of the Army regulation.

Summary. Implements DODI 6025.19 and DODI 6490.07, and the Assistant Secretary of Defense for Health Affairs memorandum, Subject: Individual Medical Readiness Measure Goal, dated July 15, 2015; and supplements the information provided in AR 220–1. This regulation provides policies and guidance for medical readiness and is to be used with DA Pam 40–502. This regulation provides information on medical deployment determinations and individual medical readiness elements. It de-

scribes the profiling system for communicating individual's functional abilities and establishes a readiness reporting system. It also provides administrative requirements for military examinations. Specifically, this regulation will more effectively manage, communicate, and report Soldier readiness to maximize deployment status.

Applicability. This regulation applies to the Regular Army, the Army National Guard/Army National Guard of the United States, the U.S. Army Reserve, and Department of the Army Civilians.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to 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 controls and identifies key internal controls that must be evaluated (appendix B).

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

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 Office of The Surgeon General (DASG–HCO) 7700 Arlington Boulevard, Falls Church, VA 22042.

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.

Contents (Listed by paragraph and page number)

Chapter 1
General Provisions, page 1

Section I

Overview, page 1

Purpose • 1–1, page 1

References and forms • 1–2, page 1

Explanation of abbreviations and terms • 1–3, page 1

Responsibilities • 1–4, page 1

Records management (recordkeeping) requirements • 1–5, page 1

Medical readiness classification • 1–6, page 1

Command application of medical readiness • 1–7, page 2

Access management and privacy protection • 1–8, page 2

Contents—Continued

Section II

Responsibilities, page 2

Deputy Chief of Staff, G-1 • 1-9, *page 2*

Deputy Chief of Staff, G-3/5/7 • 1-10, *page 2*

The Surgeon General • 1-11, *page 2*

Regional health commanders • 1-12, *page 3*

Commanders, Army commands, Army service component commands, and direct reporting units • 1-13, *page 4*

Military treatment facilities, the U.S. Army Reserve command surgeon, the Chief Surgeon of the Army National Guard • 1-14, *page 4*

Military treatment facilities commanders • 1-15, *page 5*

Brigade commanders or equivalent • 1-16, *page 5*

Battalion commanders or equivalent • 1-17, *page 5*

Unit commanders • 1-18, *page 6*

Soldiers and other deployable personnel • 1-19, *page 6*

Chapter 2

Individual Medical Readiness Key Elements, Standards, Categories, and Goals, page 6

Impacts • 2-1, *page 6*

Medical readiness appointments and documentation • 2-2, *page 7*

Individual medical readiness key elements • 2-3, *page 7*

Individual medical readiness classification • 2-4, *page 7*

Disposition of individual medical readiness data • 2-5, *page 10*

Unit medical readiness standard • 2-6, *page 10*

Chapter 3

Physical Profiling, page 10

General • 3-1, *page 10*

Application • 3-2, *page 10*

Profiling overview • 3-3, *page 10*

Physical profile serial system • 3-4, *page 13*

Representative profile serials and codes • 3-5, *page 13*

Profiling officer, approving authority, and commander • 3-6, *page 13*

Profiling Soldiers who are pregnant • 3-7, *page 14*

Postpartum profiles • 3-8, *page 15*

Concussion profiles • 3-9, *page 15*

Stinging insect allergy • 3-10, *page 15*

Cancer in remission • 3-11, *page 16*

Responsibility for personnel actions • 3-12, *page 16*

Physical profile and the Army Body Composition Program • 3-13, *page 16*

Chapter 4

Medical Readiness Examinations, Assessments, and Administrative Requirements, page 16

General • 4-1, *page 16*

Application • 4-2, *page 17*

Responsibilities • 4-3, *page 17*

Additional evaluations • 4-4, *page 17*

Distribution of medical reports • 4-5, *page 17*

Documentary medical evidence • 4-6, *page 18*

Facilities and examiners • 4-7, *page 18*

Objectives of medical examinations • 4-8, *page 18*

Recording of medical examinations and required forms • 4-9, *page 18*

Physical examinations • 4-10, *page 19*

Periodic health assessment • 4-11, *page 19*

Separation history and physical examination • 4-12, *page 19*

Miscellaneous medical examinations • 4-13, *page 21*

Cardiovascular Screening Program • 4-14, *page 21*

Contents—Continued

Military operational hearing test for H3 profile Soldiers • 4–15, *page 22*

Frequency of additional/alternate examinations • 4–16, *page 22*

Deferment of examinations • 4–17, *page 22*

Chapter 5

Deployment and Geographical Area Requirements, *page 22*

General • 5–1, *page 22*

Deployment, mobilization, and assignment-specific medical requirements • 5–2, *page 23*

Special circumstances • 5–3, *page 24*

Appendixes

A. References, *page 25*

B. Internal Control Evaluation Checklist, *page 31*

Table List

Table 2–1: Medical readiness classification chart, *page 9*

Table 2–2: Deployment-limiting codes, *page 9*

Glossary

Chapter 1 General Provisions

Section I

Overview

1–1. Purpose

This regulation governs individual medical readiness (IMR) requirements and standards; medical readiness processes and policies supporting commander deployability determinations; physical profiles; and medical examinations, periodic health assessments (PHAs), and the Deployment Health Assessment Program (DHAP). In the event provisions or guidance in this regulation conflict with those in AR 40–501, this regulation takes precedence. These conflicts will be addressed in the next revision of AR 40–501.

1–2. References and forms

See appendix A.

1–3. Explanation of abbreviations and terms

See the glossary.

1–4. Responsibilities

See section II of this chapter.

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. Medical readiness classification

a. Medical readiness classification (MRC) is an administrative determination by healthcare providers using a standardized system across the total force. This system enables the commander to measure, achieve, and sustain their Soldiers' health and ability to perform their wartime requirement in accordance with their military occupational specialty (MOS)/area of concentration (AOC) from induction to separation. Medical readiness is described in chapter 2.

b. Commanders administratively use the medical readiness information to determine if a Soldier is deployable and able to perform the unit's core designed mission or assigned mission in accordance with readiness reporting guidance in AR 220–1 and DA Pam 220–1. Soldiers are automatically medically deployable in the Medical Readiness System of Record if they are in MRC 1 or 2. This status is automatically uploaded to the readiness reporting system without additional commander action. Commanders can make deployability determinations for readiness reporting on Soldiers who are in MRC 3, with deployment-limiting (DL) 1 and 2, as well as for Soldiers in MRC 4. DL codes 3 to 7 are constrained by policy from deployment, and cannot be overridden by commanders.

c. Upon receipt of an assigned mission, the servicing health care providers will evaluate the Soldiers to determine if they meet the combatant command (CCMD) deployment requirements or require a waiver. CCMDs establish their deployment status guidance and processes. CCMD waivers do not influence a Soldier's medical readiness. Permanent and temporary conditions with DL codes 1, 2, and 7 may be evaluated for CCMD waiver requests. Conditions that do not meet CCMD deployment criteria, but otherwise do not require a profile (for example, excessive body mass index) will receive a temporary profile until the CCMD waiver is complete.

(1) In making deployability determinations, unit commanders should consider the Soldier's skills, responsibilities, duties, type of mission, and geographic conditions/concerns. Additionally, commanders should ensure close collaboration with unit supporting or military treatment facilities (MTFs) healthcare providers in making their deployability determination.

(2) The Commander Portal records deployable personnel determinations for Soldiers with duty limitations and an indeterminate status. The Medical Readiness System of Record feeds the deployability determinations to the Army Readiness

Reporting System. The electronic profiling system annotates on the profile when the commander reviews the Soldier's profile.

(3) Unit commander's deployable personnel determinations for their Soldiers in MRC 3, DL 1, and DL 2 are independent of the assessment and requirements for deployment medical waivers in accordance with CCMD specific guidance.

d. Specific medical readiness criteria are addressed in detail in chapters 2 through 5.

1-7. Command application of medical readiness

Commanders will make deployability determinations for all Soldiers authorized by policy for their MRC/DL. In making deployability determinations for readiness reporting, unit commanders should consider the classification categories in paragraph 2-4 and collaborate with a healthcare provider for any questions. Unit commanders will not override duty limitations or instructions on DA Form 3349 (Physical Profile Record). Healthcare providers do not make or engage directly in deployability determinations for readiness reporting. Profiling officers describe and indicate potentially DL conditions for commander review and consideration in their deployment determination. Readiness is a commanders program. Paragraph 3-4 describes the procedure if there is disagreement between the healthcare provider and commander regarding initiating the CCMD waiver process. Commanders will make a deployable or non-deployable determination within the Commander Portal. Readiness reporting criteria and policy are in AR 220-1. DA Pam 220-1 describes the processes and procedures of readiness reporting including the personnel deployability determinations made with medical readiness and administrative personnel data.

1-8. Access management and privacy protection

DODM 6025.18 authorizes covered entities to release protected health information of Armed Forces personnel for activities deemed necessary and appropriate to military command authorities to assure proper execution of the military mission. This means that the commander or his or her designee may see the reason for profile and the provider may discuss the minimal necessary medical information for the commander to make deployment or other pertinent personnel decisions as part of the military mission. The protected health information "in the reason for profile" will be obscured from other staff with read only access to the Commander Portal to protect patient privacy. Profiling officers will not copy their note from the medical record into the profile for medical instructions; this does not meet the minimum necessary standard.

Section II

Responsibilities

1-9. Deputy Chief of Staff, G-1

The DCS, G-1 will—

a. Recommend medical readiness and personnel policy integration and operational tasks to The Surgeon General (TSG).

b. Coordinate medical readiness and personnel policy with appropriate personnel programs and systems.

c. Facilitate commander's management, monitoring, and participation in personnel readiness. Support the implementation of the medical readiness tools and guidance provided by the Office of The Surgeon General (OTSG) to optimally support personnel readiness.

d. Implement standardized DHAP processes across the Army for deploying and redeployed Soldiers and Department of the Army Civilians (DACs) to address potential deployment-related physical and behavioral health concerns.

1-10. Deputy Chief of Staff, G-3/5/7

The DCS, G-3/5/7 will—

a. Monitor and ensure the integration of medical readiness policy with current operational readiness reporting policy.

b. Facilitate commander's engagement, monitoring, and participation in IMR programs to maximize Soldier and subsequently unit medical readiness.

c. Recommend medical readiness policy integration and operational tasks to policy proponent.

d. Coordinate operational programs and systems with medical readiness policy, processes, and procedures as described in DA Pam 40-502.

e. Ensure collaboration between appropriate organizations and activities integral to Army readiness reporting.

1-11. The Surgeon General

TSG will—

- a. Serve as the principal advisor to the Secretary of the Army and Chief of Staff of the Army on all health and medical matters of the Army, including strategic planning and policy development relating to such matters.
- b. Serve as the chief medical advisor of the Army to the Director of Defense Health Agency on matters pertaining to military health readiness requirements and safety of members of the Army.
- c. Serve as the Army proponent for IMR requirements, standards, policies, and procedures.
- d. Monitor and report Army IMR status to the Chief of Staff, Army and the Assistant Secretary of Defense, Health Affairs. DODI 6025.19 requires quarterly reporting of the IMR status of Regular Army (RA) and Selected Reserve Soldiers. The DOD reporting process is described in DA Pam 40–502.
- e. Develop Army policy for the management, tracking, and execution of the IMR program.
- f. Provide the medical information system support necessary to monitor, track, and report IMR status and requirements at all levels.
- g. Implement Department of Defense (DOD) requirements and criteria to designate Soldiers as medically ready. OTSG identifies the Army, Service-specific medical readiness requirements for deployment determinations. See chapter 2 for detailed descriptions of IMR elements, requirements for each element, and the criteria necessary to be determined either fully or partially medically ready.
- h. Provide Army representation to the Defense Health Agency, which charters the DOD IMR working group.
- i. Collaborate with the U.S. Army Training and Doctrine Command and Army Medical Department Center and School to develop informational and other educational products for personnel executing clinical readiness operations in accordance with directed requirements.
- j. Ensure adequate planning, programming, and budgeting of medical resources to support unit commanders and individuals in achieving and maintaining their IMR through MTF staffing and service level contract support.
- k. Monitor IMR medical support capabilities and services through regional health commands (RHCs) and MTF commanders, and collaborate with command surgeons to ensure necessary corrective action.
- l. Coordinate with the Defense Health Agency and the appropriate Medical Readiness Division (RHCs) to ensure compliance with the Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), and DODM 6025.18 requirements for IMR data.
- m. Develop the information technology platforms to implement the IMR policy and support data sharing of required medical readiness data between the Medical Readiness System of Record (that is, the Medical Protection System (MEDPROS)) and personnel information systems and DOD readiness reporting activities.
- n. Develop and provide medical readiness policies, systems, and reporting mechanisms for commanders throughout the Army.
- o. Develop templates for common medical instructions and physical readiness training capabilities to support standardization, completeness, and accuracy in the physical profiling system.
- p. Coordinate with the Chief Information Officer/G–6 and the U.S. Army Cyber Command to ensure Medical Readiness Systems Of Record meet current and future compliance standards.
- q. Collaborate with Headquarters, Department of the Army staff to ensure compliance with training requirements and implementation of this policy.
- r. Provide clinical oversight and support of the DHAP.

1–12. Regional health commanders

The RHC commanders will—

- a. Evaluate DOD, Army, and CCMD - specific medical readiness guidance and published supplemental directives as required. Support and ensure implementation of OTSG/MEDCOM policy for medical readiness processes, deployment/mobilization and redeployment/demobilization in accordance with directed requirements.
- b. Plan, coordinate, and conduct staff assistance visits and inspections under the authority of the RHC Organizational Inspection Program to ensure compliance of medical readiness processes within the RHC service area.
- c. Monitor medical readiness and provide reports and analysis of the status for organic MTFs and supported installations within the RHC service area.
- d. Research, identify, and track units (all components (COMPOs)), and provide reports and analysis of status for units deploying and redeploying within the RHC service area.
- e. Ensure access management for the automated Medical Readiness System of Record through a designated agent. Monitor/perform quality assurance assessments of the major command (U.S. Army) appointed approval authorities granting access to the Commander Portal for the commander, their designee and selected staff.
- f. Perform quality assurance reviews of data entries within the RHC service area and ensure correction of erroneous processes.

- g.* Provide clinical readiness, Medical Readiness Systems Of Record, and electronic health record (EHR) training and assistance, as needed.
- h.* Provide proponent oversight of the DHAP within the RHC service area.
- i.* Provide medical readiness support for Reserve Component (RC), Army National Guard (ARNG), and U.S. Army Reserve (USAR) on active duty orders with line of duty (LOD), DHAP support and continuity when transitioning status.
- j.* Conduct staff assistance visits and staff inspection visits at MTFs to ensure standardized DHAP processes and procedures occur in accordance with established guidance. Ensure local DHAP policies and procedures are in place to track individuals with priority self-assessment questionnaires.
- k.* Ensure MTFs have appropriate processes for DHAP related emergent behavioral health referrals and DHAP generated behavioral health referrals through completion of initial appointment.
- l.* Monitor and ensure access to care standards is met for DHAP generated referrals.
- m.* Coordinate with Joint Service MTFs within their regions to ensure Army personnel are able to obtain DHAP screening in the system of record.

1–13. Commanders, Army commands, Army service component commands, and direct reporting units

The ACOM, ASCC, and DRU commanders will—

- a.* Organize, train, and equip forces and installations to meet and maintain IMR requirements.
- b.* Establish a command expectation that unit commanders and individuals will meet and maintain IMR requirements. Readiness is a commander's program.
- c.* Establish a forum, or integrate into an existing forum with medical, human resources, and personnel leaders with installation leadership to regularly evaluate the IMR status of Soldiers on the installation. This forum must meet monthly at a minimum.
- d.* Direct the unit command teams or designated representatives to use the Commander Portal to track their unit members' profile status, IMR compliance, and requirements.
- e.* Ensure appropriate action is taken regarding units and members with IMR deficiencies.
- f.* Appoint dedicated medical MEDPROS unit administrators and commander clerks at ACOM, ASCC, and DRU headquarters to track Soldier and unit medical readiness.
- g.* Appoint appropriate approval authorities to grant access to the Commander Portal and ensure users have the required training, correct role designation and unit identification code structure.
- h.* Ensure processes are in place to review the IMR status of every Soldier using the automated Medical Readiness System of Record during in and out-processing through the installation MTF or COMPO specific processes.

1–14. Military treatment facilities, the U.S. Army Reserve command surgeon, the Chief Surgeon of the Army National Guard

The MTF commanders, the USAR command surgeon, and the chief surgeon of the ARNG are responsible to set policy to—

- a.* Ensure use of the Commander Portal to perform a monthly review of all temporary profiles 240 days or older at the command level.
- b.* Appoint dedicated MEDPROS unit administrators and commander clerks at senior command headquarters to track Soldier and unit medical readiness.
- c.* Maintain adequate capabilities and access to care in order to support Soldier compliance with IMR requirements. Where applicable, commanders will ensure Tri-Service Medical Care (TRICARE) access standards are met in their organization.
- d.* Notify installation commander, senior commander (to include Commanding General, U.S. Army Recruiting Command, The Adjutants General, if applicable), command surgeon, or medical operational leadership immediately when capabilities are not sufficient to keep Soldiers medically ready due to lack of services or access.
- e.* Plan, program, and submit budget requests for funds and procure supplies and equipment to accomplish IMR program requirements.
- f.* Ensure processes are in place to review the IMR status of every Soldier using the automated Medical Readiness System of Record during in and out-processing through the installation MTF or COMPO specific processes.
- g.* Ensure that all IMR-related services for RA and RC members are documented in the Medical Readiness System of Record and the EHR or service treatment record (STR).
- h.* Ensure installation, maintenance, and proper use of programs related to accessing the Medical Readiness System of Record with trained administrators and users.

- i.* Provide the necessary information technology support to ensure the installation and operation of the Medical Readiness System of Record and EHR are functional and meet all security and privacy requirements.
- j.* Be responsible for delegating approval authority for the various medical readiness applications in Medical Operational Data System and maintain oversight and control of user management.
- k.* Establish regional support command (RSC) surgeons and state surgeons responsibility to—
 - (1) Serve as approval authorities by their position for second signature profiles.
 - (2) Support the major subordinate command commanders within their area of operations with medical readiness deficiencies and training.
 - (3) Support the Soldier readiness processing requirements.
 - (4) Collaborate with profiling authorities regarding adjudicating the Military Occupational Specialty Administrative Retention Review (MAR2) processes.

1–15. Military treatment facilities commanders

The MTF commanders will, in addition to the responsibilities in paragraph 1–14—

- a.* Use the healthcare team to optimize the implementation of the medical readiness requirements by making every visit a readiness visit.
- b.* Ensure the Army healthcare team, in preparation for every visit, will use the Healthcare Portal to validate the IMR status of every Soldier, use the Medical Readiness Assessment Tool to identify Soldiers at risk for becoming non-deployable, and review e-Profile for Soldiers active profiles.
- c.* Ensure that the healthcare team addresses any due or overdue medical readiness requirements at the time of the visit or before the Soldier leaves the medical facility. Any deficiencies will be corrected, identified for the healthcare provider, or appointed for appropriate service. Readiness requirements will not delay or impede urgent or emergent care.
- d.* Implement the policies prescribed in this regulation with the processes and procedures described in DA Pam 40–502 in the care of all RA and TRICARE Prime Remote Soldiers within their specific health service area and geographic area of responsibility boundaries worldwide.
- e.* Ensure there is a DHAP coordinator appointed in writing, provide the resources, training, and allocated time to assist with tracking deployment readiness.
- f.* Ensure DHAP staff have training on and access to Soldier electronic system of record prescribed in DA Pam 40–502.
- g.* Ensure health care providers check Soldiers’ profile status (all COMPOs) in the readiness system of record during each DHAP screening (pre-, post-, and DD Form 2900 (Post Deployment Health Re-assessment (PDHRA))) and make changes/updates, as appropriate.
- h.* Ensure DHAP information is treated confidentially and in accordance with HIPAA and the DODM 6025.18.
- i.* Assist deploying personnel with completion of deployment readiness requirements. To support command readiness programs, the MTF personnel will collaborate with the unit healthcare providers on readiness issues and the DHAP process.
- j.* Ensure review of Soldiers’ priority self-assessment questionnaires and coordinate appointments.
- k.* Ensure collaboration between providers, unit commanders, and CCMD waiver authorities to address specific deployment status issues for Soldiers with an assigned mission.

1–16. Brigade commanders or equivalent

The brigade commanders or equivalent will—

- a.* Review the unit medical readiness and deployment status of subordinate units.
- b.* Participate in profile review boards as outlined in DA Pam 40–502.
- c.* Establish a unit health promotion team as the mechanism to assess gaps in medical readiness and report strategies and actions to the installation Community Health Promotion Council.
- d.* Appoint dedicated MEDPROS unit administrators and commander clerks at brigade headquarters to track Soldier and unit medical readiness.
- e.* Use the Commander Portal to perform a monthly review of temporary profiles lasting 180 days or more as described in DA Pam 40–502.

1–17. Battalion commanders or equivalent

The battalion commanders or equivalent will—

- a.* Review the unit medical readiness and deployment status of subordinate units.
- b.* Mentor unit commanders regarding deployability determinations and command support of medical readiness.
- c.* Participate in profile review boards as outlined in DA Pam 40–502.

- d.* Appoint dedicated MEDPROS unit managers and commander clerks at battalion headquarters to track Soldier and unit medical readiness.
- e.* Use the Commander Portal to perform a monthly review of temporary profiles lasting 120 days or more as described in DA Pam 40–502.

1–18. Unit commanders

The unit commanders will—

- a.* Establish a command expectation that individuals will be personally responsible for meeting and maintaining IMR requirements.
- b.* Monitor individual and unit IMR status using the Commander Portal as described in DA Pam 40–502. Commanders will take action when unit members fail to respond to notifications of due or overdue IMR requirements or fail to keep scheduled appointments to ensure the unit meets the published medical readiness goal.
- c.* Ensure unit medical readiness; determine deployable personnel when informed by medical readiness information and administration; and report unit readiness in accordance with AR 220–1 on the Commander Portal.
- d.* Formally appoint a commander’s designee who is a trusted and trained individual as an alternate to execute command readiness responsibilities. Commander designees will obtain system access after completing all training required for access to the Commander Portal.
- e.* Allocate adequate duty time for Soldiers to meet and maintain IMR requirements.
- f.* Ensure processes are in place and functioning to notify Soldiers of due and overdue IMR requirements, and deployment-related health assessments completion.
- g.* Review all physical profiles describing duty limitations within 14 days after a profiling officer issues a profile (30 days for RC) and make deployability determination on all profiles not constrained by regulation or policy for all Soldiers in their command through the Commander Portal.
- h.* Complete Commander Portal training and obtain system access no later than 14 days (RA) or 30 days (RC) after assuming their duties.
- i.* Commanders at all levels are responsible for ensuring Soldiers and DACs assigned to deploy with their unit receive deployment health assessment screenings and maintain readiness throughout the deployment cycle.
- j.* Commanders will ensure all Soldiers and DACs have access to the appropriate systems to complete the individual portion of all deployment health assessment forms. DHAP is a commander’s program to ensure Soldiers’ deployment, movement, and geographical area medical readiness requirements are met.

1–19. Soldiers and other deployable personnel

The Soldiers and other deployable personnel will—

- a.* Monitor and maintain currency of medical readiness requirements. RC personnel may have to accomplish some IMR requirements on their own time such as civilian dental exams or medical evaluations.
- b.* Complete all DHAP assessments on the required forms, within the published timelines, in accordance with DODI 6490.03, DODI 6490.12, and Army policy as specified in chapter 4.
- c.* Per DODI 6025.19, report medical (including mental health) and health issues that may affect their readiness to deploy or fitness to continue serving in an active status.

Chapter 2

Individual Medical Readiness Key Elements, Standards, Categories, and Goals

2–1. Impacts

This chapter establishes measurable, key medical elements as components of IMR. DODI 6025.19 establishes IMR standards; this chapter broadens these standards for the Army. Both DOD and Army senior leaders track the compliance with their respective IMR standards. The broader Army standards reflect the Service-specific needs of the Army to be able to mobilize Soldiers and meet the Army mission. The medical readiness criteria in this section identifies medically ready Soldiers and informs the commander’s deployability determinations for the commander’s unit status report (CUSR).

- a.* This policy establishes a point of service requirement for updating Soldiers’ electronic health records, and the Medical Readiness System of Record. Current and complete information is essential to equip unit commanders with the tools to monitor Soldiers’ individual medical readiness status so they can ensure their Soldiers take corrective action on any deficiencies, resulting in a healthy and a medically ready fighting force.
- b.* The IMR program informs the CUSR personnel level assessment. Soldier deployment status is based on both medical and administrative criteria. The metrics for determining personnel level are: deployable strength, assigned MOS skills

match, and the deployable senior grade composite level. IMR influences both deployable strength and senior grade composite metrics.

2–2. Medical readiness appointments and documentation

a. RHC commanders will ensure MTFs provide the necessary medical care to Soldiers for IMR currency and documentation within the Medical Readiness System of Record. MTFs and supporting medical assets will assist unit commanders to maximize the number of personnel classified as “medically ready” and “fully medically ready” when unit medical assets are not available to supply necessary services.

(1) The MTFs providing medical care to Soldiers during basic combat training will update or initiate the IMR status during initial in-processing. The MTFs will update the Soldier’s IMR in MEDPROS within 72 hours from the time of service.

(2) The MTFs will not refuse IMR-related appointments for RA Soldiers enrolled in TRICARE Prime Remote.

(3) RA Soldiers on active duty status enrolled in TRICARE Prime Remote may utilize the Reserve Health Readiness Program.

(4) Commanders will ensure that Soldiers’ IMR requirements are complete as a condition of their selection and attendance for Army resident courses.

(5) Soldiers in and out-processing through an MTF should be medically ready and current on all IMR elements, prior to clearing the MTF.

(6) The fitness for duty examination procedures are described in DA Pam 40–502 and will span from profile reviews with command input to formal clinical evaluations to determine if a Soldier meets retention standards.

b. All RC Soldiers will provide their unit records custodian, patient administration officer, unit administrator, and/or commander all relevant medical documentation, including civilian and VA health records, regarding their medical readiness status. Medical records personnel, designated by component, are responsible to scan any civilian health records or other documentary evidence into the Soldier’s EHR and file any paper documents into the STR. Commanders are responsible to ensure the personnel systems properly reflect a Soldier’s readiness and medical status and take appropriate follow-up action to assist the Soldier to correct any deficiencies.

c. The CUSR is a commander’s report. Unit commanders are solely responsible for the accuracy of the information and data in their reports. Unit commanders are responsible for monitoring their Soldiers’ IMR status and ensuring compliance within the Commander Portal. Unit medical assets, when available, are primarily responsible for supporting medical readiness.

2–3. Individual medical readiness key elements

The DOD mandates six IMR elements which include: PHA, deployment-limiting conditions, dental readiness, immunization status, medical readiness laboratory tests, and individual medical equipment. The Army IMR program consists of the six DOD and two additional Army-specific requirements: hearing and vision readiness. To be medically ready, all Soldiers must maintain these eight IMR elements. With regards to the deployment-limiting conditions IMR element, Soldiers must meet AR 40–501 retention standards or have completed a boarding action that returned them to duty without a deployment-limiting physical category code. DA Pam 40–502 describes the medical administrative processing after completion of a medical or administrative board. Soldiers who do not meet medical retention standards are not medically ready. They should be referred for disability evaluation system processing in accordance with the eligibility provisions of AR 635–40, and by DOD disability evaluation system policy (see DODI 1332.18).

2–4. Individual medical readiness classification

After evaluating the required IMR elements by viewing e-Profile, the Medical Readiness System of Record and the EHR information, the healthcare team will categorize the Soldier into one of four medical readiness categories listed below and depicted in table 2–1.

a. MRC 1: Soldiers in MRC 1 are fully medically ready and deployable if they fulfill the following categories:

(1) Soldier meets all medical readiness requirements.

(2) Soldier is in Dental Class 1 or Dental Class 2 in accordance with AR 40–35.

(3) Soldier may have a transient illness or minor injury with a profile 7 days or less in duration (for example, upper respiratory infection).

(4) Permanent duty limiting condition(s) with a 3 or 4 in the physical, upper, lower, hearing, eyes, psychiatric (PULHES) (PULHES is a United States military acronym used in the Military Physical Profile Serial System) series with a completed board and an assigned physical category code of “S, W, or Y”, if no F, V, or X code (see DA Pam 40–502 for physical category codes). Use of certain medications and medical conditions, as established by DOD or CCMD guidance,

will require a CCMD waiver for deployment. Upon receipt of an assigned mission, the servicing healthcare providers will evaluate the Soldier to determine the need for CCMD waivers. Each CCMD establishes the specific deployment status guidance and waiver processes for their area of responsibility. Medical readiness, commander deployability determinations, and CCMD waiver requirements are independent of each other.

b. MRC 2: Soldiers in MRC 2 are partially medically ready and deployable. Soldier has one or more of the following deficiencies:

(1) Hearing Readiness Class 4 (considered overdue with The Defense Occupational and Environmental Health Readiness System – Hearing Conservation hearing test greater than 365 days and all RC table of distribution and allowances Soldiers without an audiogram on file).

(2) Vision Readiness Class 4 (considered overdue at 15 months).

(3) Deoxyribonucleic acid (DNA) not on file with the Armed Forces Repository of Specimen Samples for the Identification of Remains.

(4) Human immunodeficiency virus (HIV) not drawn/validated with Armed Forces Repository of Specimen Samples for the Identification of Remains (within 24 months) without a previous diagnosis of HIV.

(5) Routine adult immunization profile immunizations to include hepatitis A; hepatitis B; tetanus-diphtheria or tetanus-diphtheria and acellular pertussis; measles, mumps, and rubella; poliovirus; varicella; influenza (seasonal); and if required, rabies (for personnel as required in accordance with AR 40–562).

(6) A Soldier who requires, but does not possess individual medical equipment (1 mask insert (1MI), 2 pairs of eyeglasses, military combat eye protection inserts (MCEP–I), medical warning tags, and hearing aid with batteries).

(7) A temporary profile 8 to 30 days in duration. Soldiers are deployable with these profiles, however, commanders have the discretion to make a commander’s determination that these Soldiers are non-deployable in the Commander Portal.

c. MRC 3: Soldiers in MRC 3 are not medically ready and will default to non-deployable. Soldiers in MRC 3 will be described by one or more of seven DL codes described below and in table 2–1:

(1) *DL 1 – Temporary profiles greater than 30 days.* Soldier is not medically ready and defaults to non-deployable. The commander can make a commander’s determination that these Soldiers are deployable and change the deployability status for all temporary profile(s) greater than 30 days in duration (total time to include extensions) in the Commander Portal. Soldier deployability remains DL 1 as long as there is an active temporary condition identified. Application of CCMD guidance will determine if a CCMD waiver is required for these conditions upon receipt of the assigned mission.

(2) *DL 2 – Dental Readiness Class 3 conditions.* Soldier is not medically ready and defaults to deployable. The commander has the discretion to make a commander’s determination that these Soldiers are non-deployable in the Commander Portal. The Soldier remains DL 2 as long as they have a Dental Readiness Class (DRC) 3 e-Profile. Dentists will use e-Profile to describe these conditions to the commander and guide the deployability determination. These conditions must be corrected before a Soldier deploys.

(3) *DL 3 – Soldier is pregnant or post-partum.* Soldier is not medically ready and is non-deployable. The commander cannot deem Soldier deployable until authorized by policy.

(4) *DL 4 – MAR2.* Soldier is not medically ready and is non-deployable. Soldier cannot be deemed deployable by the commander. This includes Soldiers with a permanent profile with a 3 or 4 in the PULHES without a completed MAR2 board. Soldiers who meet retention standards are eligible for MAR2 process. Soldier will remain DL 4 from when the condition is identified up to when MAR2 process is complete.

(5) *DL 5 – Soldier is not medically ready and is non-deployable.* Soldier cannot be deemed deployable by the commander. Soldiers with a permanent profile with a 3 or 4 in the PULHES, who do not meet retention standards without a completed medical evaluation board (MEB)/physical evaluation board (PEB). Soldiers who do not meet retention standards must be referred for Disability Evaluation System (DES) processing. MEB/PEB is appropriate for LOD conditions. Soldiers remain DL 5 from when the condition is identified until they are separated or have completed the MEB/PEB process.

(6) *DL 6 – Soldier is not medically ready and is non-deployable.* Permanent profile with a 3 or 4 in the PULHES without a completed non-duty PEB. Soldiers who do not meet retention standards due to a non-duty related condition can request a PEB. The Soldier will be DL 6 from when the condition is identified until they are separated or have completed the non-duty PEB process.

(7) *DL 7 – Soldier is not medically ready and is non-deployable.* Any profile with a physical category code of V, F, X, or Y. Soldiers in this category may be eligible for a CCMD waiver in accordance with the applicable published CCMD policy.

d. MRC 4: Soldiers in MRC 4 are not medically ready.

(1) Commanders determine deployment status (default is deployable).

(2) Status is unknown. Soldier is deficient in one of the following:

(a) PHA (current if administered within past 15 months).

(b) Dental Class 4.

Note. Table 2–1 displays revised medical readiness classifications.

Table 2–1
Medical readiness classification chart

MRC	Short definition	Medical definition	Commander deployment status personnel determination
MRC 1	Medically ready/deployable	Meets all medical readiness requirements and DRC 1 or 2 —Temporary profile ≤ 7 days	Not required.
MRC 2	Partially medically ready/deployable	Soldier is deficient in one or more of the following: —Temporary profile between 8 and 30 days inclusive —Hearing Readiness Class 4 (current within 13 months) —Vision Readiness Class 4 (current within 15 months) —DNA (drawn/on file with DOD Repository) —HIV (drawn/validated with DOD Repository) —Immunizations current or valid exception (routine adult immunization profile, to include HepA, HepB, TD or TDaP, MMR, polio, varicella, influenza-seasonal and, if required rabies) —Individual medical equipment if required; 1MI, 2 pair eye glasses, MCEP–I, MWT, and hearing aid with batteries	Not required, default to deployable. Commanders may make a deployability determination that a Soldier with a temporary profile between 14 and 30 days is not deployable.
MRC 3	Not medically ready/commander determines deployment status for: —Temporary profile >30 days (DL 1) —DRC 3 (DL 2)	Soldier is deficient in one or more of the following: DL 1–Temporary profile > 30 days DL 2–DRC 3 DL 3–Pregnancy or post-partum DL 4–Permanent profile indicating a MAR2 needed DL 5–Permanent profile indicating a MEB action is needed DL 6–Permanent profile indicating a non-duty related action is needed DL 7–Permanent profiles with a deployment/assignment restriction code (F, V, X, or Y)	DL 1 and 2: Soldier is not medically ready/commander determines deployment status. DL 3, 4, 5, and 6: Soldier is not medically ready/non-deployable. Unit commander cannot make a deployability determination for routine readiness reporting. DL 7: Soldier is not medically ready/non-deployable. Unit commander cannot make a deployability determination for routine readiness reporting. Upon receipt of an assigned mission, deployment status will be in accordance with CCMD policies.
MRC 4	Not medically ready/deployable and commander determines deployment status (default non-deployable)	Status is unknown Soldier is deficient in one of the following: –PHA (current within 15 months) –DRC 4 (current within 15 months)	Soldier is not medically ready/deployable and commander determines deployment status.

Legend:
HepA = Hepatitis A
HepB = Hepatitis B
MMR = Measles, mumps, and rubella
MWT = medical warning tags
TD = tetanus-diphtheria adult
TDaP= Tetanus, diphtheria, and acellular pertussis

Table 2–2
Deployment-limiting codes

Code	Description
DL 1	Temporary profile > 30 days

**Table 2–2
Deployment-limiting codes—Continued**

Code	Description
DL 2	DRC 3
DL 3	Pregnancy and postpartum
DL 4	Permanent profile indicating MAR2 needed (W)
DL 5	Permanent profile indicating MEB needed
DL 6	Permanent profile indicating non-duty related action is needed
DL 7	Permanent profiles with a deployment/assignment restriction code (F, V, X, or Y)

2–5. Disposition of individual medical readiness data

- a. MEDPROS is the medical system of record for all medical readiness data elements.
- b. All Army personnel (all COMPOs), regardless of TRICARE enrollment, and deploying DACs maintain up to date IMR data. MEDPROS does not automatically receive DACs Defense Occupational Environmental Health Readiness Application – Hearing Conservation data and must be manually entered upon selection for deployment.
- c. IMR services completed in the electronic health record must be updated in the Medical Readiness System of Record within 72 hours of completion.

2–6. Unit medical readiness standard

Refer to DODI 6025.19 for DOD current goal and category requirements. The Army’s unit medical readiness standard is 90 percent or above in medical readiness categories 1 and 2.

Chapter 3 Physical Profiling

3–1. General

This chapter prescribes a system, which is further described in DA Pam 40–502, for classifying individuals according to functional abilities; documents key aspects of medical readiness; and outlines the administrative management of Soldiers with duty limiting conditions. Healthcare providers will evaluate every Soldier at every medical encounter to identify and appropriately profile potential duty limitations in e-Profile on DA Form 3349. The DA Form 3349 is primarily a communication tool between the profiling officer, the Soldier, and the commander to address duty limitations. The Soldier’s profiling officer, the Soldier, and the commander collaborate to identify duty limiting conditions, describe functional limitations, capabilities, physical training requirements and assign appropriate duties. Physical profiles serve to protect and maintain the Soldier’s health by minimizing risk of further injury and illness. In all cases, command teams are teammates in Soldier readiness and utilization. They will make assignments to employ the Soldier and achieve the mission within the limitations described in the profile. The profiling officer will identify all duty limiting conditions in e-Profile, place an emphasis on what the Soldier can do during the profiled period and document restrictions completely but with minimum necessary restrictions. The profiling officer will determine if a Soldier is available to take a regular or modified Army Physical Fitness Test (APFT) with either a temporary or permanent profile. The commander will review all physical profiles for all Soldiers in their command through the Commander Portal. Healthcare providers will review the Soldier’s profile for all existing conditions in the system of record, during patient encounters. This will establish and maintain clear communication between the healthcare provider, Soldier, and commander. AR 40–501 is the Army regulation describing the medical standards of fitness that the profiling officer will utilize and cite when they issue profiles for duty limiting conditions.

3–2. Application

The physical profile system is applicable to members of any component of the Army throughout their military Service, whether or not the Soldier is on active duty.

3–3. Profiling overview

- a. DA Pam 40–502 describes the preparation of the DA Form 3349. The electronic profiling system of record is e-Profile. Profiling officers will complete an e-Profile for all temporary profiles greater than 7 days, and all permanent

profiles and can complete temporary profiles for illness and injuries for less than 7 days. Healthcare providers may use DD Form 689 (Individual Sick Slip), unless restricted by other policy, for short-term, minimally limiting injuries and illnesses, less than or equal to 7 days in duration. During medical encounters, healthcare providers will evaluate every Soldier for potential duty limitations or arrange for such evaluations to be completed.

b. In certain mission conditions, e-Profile may be unavailable. If the e-Profile is unavailable the profiling officer will issue a DD Form 689 and describe the duty limiting medical condition/s (less than or equal to 7 days) to the commander. There is no longer a paper option alternative to e-Profile. Printed copies are only for the Soldier's personal record. The creation and generation of a DA Form 3349 is required in e-Profile. The commander is required to review Soldiers profiles in the Commander Portal.

c. The DA Form 3349 contains all of a Soldier's current duty limiting conditions with built-in communication links between the profiling officer and commander. This form lists all permanent and temporary conditions in a single document. Only permanent conditions modify the PULHES. Profiling officers will evaluate all Soldiers with duty limiting conditions for Section 4: Functional Activities. Any permanent limitation in the functional activities section will either require a disability evaluation referral or initiate the RC medical disqualification process according to their duty status (see AR 635–40). Soldiers with permanent duty limitations that meet retention standards and prevent them from performing all physical tasks for their MOS/skill level per Smartbook DA Pam 611–21 (<https://www.milsuite.mil/book/groups/smartbookdapam611-21>), but that do not impair their abilities to any functional activities (DA Form 3349, section 4), will be referred to the MAR2 in accordance with AR 635–40 and DA Pam 611–21. The signature of the approval authority will provide an initiation date of the appropriate medical or administrative board or review.

(1) To improve standardization across the enterprise, OTSG will be the responsible agent for profile templates for common medical instructions and physical readiness training capabilities.

(2) Profiles will be maintained as long as the Soldier has duty limitations or a medical condition that needs to be communicated to the commander, or is directed by AR 40–501. Profiling officers will document these limitations by condition. Each condition will have only one set of instructions active at any given time. The profile officer associated with each condition will support the provider issuing a profile for a specific condition and will support the commander and commander communication.

(3) MTF commanders, the USAR command surgeon, the chief surgeon of the ARNG, and state surgeons will possess approval authority, and may delegate it to other physicians within their commands. The USAR RSC surgeons will be approval authorities by the nature of their position.

(4) There is no mandatory recovery period after a profile prior to a record APFT. The profiling officer in coordination with the provider will determine if a Soldier is available for an APFT for each condition, with the latest date to take the APFT identified on the profile. When a Soldier is not available for a record APFT, the profiling officer will extend the profile through the recovery period. This is a description of the Soldier's capabilities to take a full or alternate event APFT and not proscriptive.

d. The unit commander will review all profiles of Soldiers in their command. After reviewing a profile the unit commander—

(1) Addresses any questions or concerns, including when their observations of the Soldier's performance is inconsistent with the profile, with the profiling officer.

(2) If necessary, has the authority to request a fitness for duty evaluation to include a profile review and second opinion from another profiling officer. Input from the original profiling officer will ensure a comprehensive review and informed opinion. The applicable profile delegation authority will implement a consistent process to ensure timely completion of all requested command reviews, minimizing the impact on readiness. If the original profile deemed the Soldier non-deployable, then the Soldier will remain non-deployable until the fitness for duty evaluation or profile review is completed.

(3) Makes deployability determinations in the Commander Portal for MRC 4, MRC 3, DL 1 and 2, and when not constrained by policy.

(4) Should extend reasonable consideration to profile restrictions even after expiration if the environment or mission has prevented prompt follow up.

(5) Should exercise due diligence in requiring Soldiers to take and APFT following any temporary conditions that have affected the Soldier's ability to maintain optimal physical fitness and formulate their APFT policy according to command and leadership policy.

e. A profiling officer writes a temporary profile to describe temporary duty limitations or a medical condition that needs to be communicated to the commander, or is required per AR 40–501. Profiling officers will describe duty limitations, capabilities, and physical readiness training guidance for each reason for profile affecting the Soldier. Each temporary reason for profile must be written for the full duration of the limitations, up to 90 days. Extensions must be linked to the previous profile to maintain an accurate description of the total length of time the Soldier has had a profile for that reason.

Temporary profiles impact MRC by duration only, and there is no PULHES determination. Soldiers will be issued a temporary profile when receiving medical or surgical care during or while recovering from illness or injury for the same medical condition. The Medical Retention Determination Point (MRDP) is reached if the medical condition has stabilized or cannot be stabilized in a reasonable period of time for up to 12 months and impacts successful performance of duty. Successful performance of duty is defined as the ability to perform basic soldiering skills required by all military personnel (DA Form 3349, section 4 and passing one aerobic APFT event) and the ability to perform MOS specific duties. Medical evaluation of Soldiers with temporary profiles is required at least once every 90 days, to assess progress, response to treatment, and the currency of the duty limitations. Specific conditions in AR 40–501 will require specialty care and evaluation to determine if a Soldier meets retention standards. Specialty evaluations should start by the 6th month of the profiled period. If no specialty care is required by policy, a Soldier will have a physician evaluation after 6 months on profile for the same condition. These re-evaluations and progression of care are to ensure that the Soldiers who reach MRDP have recovered and rehabilitated to the point that they can transition to a permanent profile or initiate the appropriate DES process.

(1) A DD Form 689 or short-term temporary profile can describe conditions (less than or equal to 7 days). A temporary profile should convey more information to the commander, use standardized templates and establish the initiating event in e-Profile in accordance with AR 40–501.

(2) When the condition is stable, the profiling officer will communicate the permanent duty limiting conditions to the commander on a permanent profile. If the condition does not meet retention standards, the provider will initiate a referral to DES in accordance with the eligibility provisions of AR 635–40.

(3) The profiling officer must review previous profiles before making a decision to extend a temporary profile. Any extension of a temporary profile will be linked and described as a continuation of the same condition on DA Form 3349 in the EHR based on clinical judgment and the history of any other inciting injury.

(4) Temporary profiles will specify an expiration date. If no expiration date is specified, the profile will automatically expire at the end of 30 days from issuance of the profile.

(5) If a profile is required beyond a 12-month period, the condition will be documented in the form of a permanent profile. If the condition does not meet retention standards, the DES/RC–NDR process will commence. Exceptions to the 12-month temporary physical profile restriction must be approved by the first general officer in the Soldier’s chain of command, in consultation with the Secretary of the Army or the appropriate designee, senior approving authority, and/or senior medical officer.

(a) Profiling officers requesting an exception to the 12-month temporary physical profile restriction for the same or related medical condition(s) must submit all of the following with the request for an exception:

1. A written treatment plan.
2. An explanation why the Soldier was not referred to a MEB or why the MEB stopped.
3. An expected MRDP.

(b) The action will be documented in the STR, and the approval/disapproval will be documented in the medical instructions on the temporary profile.

f. A profile is considered permanent when the Soldier has reached MRDP for the condition(s). Because of the significance of permanent limitations of duty to medical readiness, all permanent profiles will have two profiling officer signatures. A physician approving authority will review all permanent “3” and “4” profiles.

(1) If the profile is permanent, the profiling officer must assess if the Soldier meets the medical retention standards located in AR 40–501. Soldiers who do not meet the medical retention standards, or cannot complete an aerobic APFT event, or cannot perform any of the functional activities in section 4 in DA Form 3349, must be referred to DES in accordance with AR 635–40. Soldiers in the RCs who are not on active duty and who do not meet medical retention standards for a non-duty related condition will be processed for medical disqualification in accordance with AR 135–175, AR 135–178, and AR 635–40, unless the Soldier requests a non-duty related PEB.

(2) Soldiers who meet retention standards but have a 3 or 4 PULHES serial will be referred to MAR2 in accordance with AR 635–40.

(3) Permanent profiles may be amended (expired and re-written) at any time, if and when clinically indicated, and all profiled conditions must be based on valid medical documentation contained in the Soldier’s medical record. Any amended profile will initiate the appropriate board action in accordance with AR 635–40.

(4) Permanent profiles must be reviewed and verified by the healthcare provider at the time of a Soldier’s annual PHA or other annual medical examination.

(5) The Soldier’s commander may request a review of a permanent profile.

(6) Soldiers are medically deployable in MRC 3 only when the unit commander determines they are deployable for DL Codes 1 and 2 and not constrained by policy.

g. DD Form 689.

(1) The DD Form 689 is not a substitute for a profile but a means of communication, management, and disposition of short-term acute, minor, self-limited illnesses and medical conditions that are expected to resolve quickly and do not limit the functional capabilities of the Soldier beyond 7 days. Temporary profiles of less than 7 days duration will convey more information for short-term conditions.

(2) DD Form 689s are not a profiling tool, and will not change the Soldier's PULHES.

(3) The disposition section of DD Form 689 describes various short-term scenarios as described in the prescribing policy, AR 40–66.

(4) The initial military training sick slip has transitioned to a series of templates in e-profile. The initial military training sick slips are no longer valid.

(5) Conditions with functional limitations expected to last more than 7 days will be entered into the e-Profile as a temporary profile for IMR accountability and tracking.

3–4. Physical profile serial system

a. The basis for the physical profile serial system is to identify the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are all considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignments and welfare of other Soldiers, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential.

b. In developing the physical profile serial system, body systems or regions were divided into six factors designated as PULHES: physical/systemic; upper extremity and spine; lower extremity and spine; hearing; eyes; and psychological. For each factor, a numerical designation (serial) of 1, 2, 3, or 4 indicates the overall functional capacity for that system or region. The functional capacity of a particular system or region of the body, rather than the defect per se, will determine the appropriate serial. DA Pam 40–502 describes the use of the physical profile serial system.

c. Soldiers who are medically ready may have health conditions that do not meet the specific CCMD deployment guidance. If the healthcare provider and commander concur that the Soldier is able to deploy, the CCMD policy will describe the initiation of the CCMD waiver process. When medical healthcare providers and unit commanders disagree on the deployment status of a Soldier, the decision to request a CCMD waiver will be raised to the first O–6 in the Soldier's chain of command (or higher approving authority) and the hospital commander. Both the first O–6 and hospital commander will review both medical and unit commander recommendations to make the final decision whether to seek a CCMD waiver to deploy the Soldier. CCMD deployment guidance is developed to protect both the Soldier's health and wellbeing and the mission. Guidance is continually updated and is based on consideration of DODIs. The commander will ensure implementation with these individual medical requirements in accordance with all applicable DODIs, to include DODI 6490.07. To the extent that the information within this chapter is inconsistent with later published DOD guidance, DOD guidance will be followed.

3–5. Representative profile serials and codes

To facilitate the assignment of individuals after they have been given a physical permanent profile serial and for statistical purposes, code designations have been adopted to represent certain combinations of physical limitations or assignment guidance as described in DA Pam 40–502. The alphabetical coding system will be utilized and the appropriate code(s) will be recorded on the DA Form 3349. The profile form will be completed as described in DA Pam 40–502. The numerical designations serials for each profile factor and the code system are presented DA Pam 40–502.

3–6. Profiling officer, approving authority, and commander

a. *Profiling officers.* MTF commanders, ARNG chief and state surgeons, and the USAR command surgeon and RSC surgeons may designate physicians, dentists, physical therapists, optometrists, podiatrists, audiologists, chiropractors, nurse practitioners, nurse midwives, licensed clinical psychologists, licensed clinical social workers, and physician assistants as profiling officers. Under no circumstances will a special forces medic or independent duty corpsman serve as a profiling officer. The designating authority will ensure that those designated are thoroughly familiar with the contents of this regulation, AR 40–501, and DA Pam 40–502. The profile will identify the profiling officer and associated duty limitations and any indicated medical or administrative boards. Permanent profiles will be maintained as long as the Soldier has duty limitations and medical conditions not meeting retention standards necessitating provider communication with the commander. The profiling officer will link and extend temporary profiles as long as there are duty limitations. Profiling officers will not write temporary or permanent profiles for themselves. Profiling officer limitations are as follows:

(1) *Physicians*. No limitations except for temporary profiles that exceed 6 months cumulative for each single condition and referral to a specialist is clinically indicated or required by policy (see para 3–3e). All permanent profiles require two signatures.

(2) *Dentists, optometrists, physical therapists, chiropractors, occupational therapists, audiologists, podiatrists, physician assistants, nurse midwives, nurse practitioners, licensed clinical psychologists, and licensed clinical social workers*. These healthcare providers have limitations awarding temporary and permanent profiles as described in DA Pam 40–502.

(3) *Athletic trainers*. Athletic trainers in command specified settings will have limited profiling authority, under the supervision of their physician or physical therapist, to award short-term temporary profiles up to 7 days in duration. They may extend the profile an additional 7 days. A healthcare provider will complete any profiling beyond 14 days (total). Significant illnesses or injuries that are not expected to heal in this period should be referred to the appropriate specialty healthcare provider to prevent any delay in care. All profiling by athletic trainers will be constrained to specifically designed templates for the musculoskeletal system in e-profile.

(4) *Other Department of Defense physicians*. In those instances where a Soldier does not have access to an Army MTF, with access to a DOD or other service's medical facility (Navy, Air Force), the profiling officer may be from another Service for all temporary profiles of 6 months or less.

(5) *Regular Army and Reserve Component on active duty participating in TRICARE Prime Remote, Ready Reserve (troop program unit, Active Guard Reserve), individual mobilization augmentee, Individual Ready Reserve and Inactive National Guard and Army National Guard Soldiers*. These Soldiers may have specific temporary or permanent profiles completed via the current agencies contracted to provide these medical services. Regardless of component, contracted healthcare providers will have established points of contact for the transition of responsibility and management of Soldier profiles. Many Soldiers in these categories receive their routine medical care from civilian healthcare providers. Medical recommendations from these healthcare providers will support and inform accurate, complete, and comprehensive profiles from DOD military, civilian, or contracted providers.

b. Profile preparation.

(1) The profile will list the profiling officer, reason for profile, and key descriptors on the same line of the form.

(2) The profiling officer will write and/or extend with linking the profile as long as there are duty limitations.

(3) Permanent “2” physical profiles will require physician review and second signature. This must not be the same person as the first signature.

(4) Permanent “3” or “4” physical profiles require an approving authority signature, as defined below.

(5) A single physical profile may cover multiple conditions. Profiling officers do not assume responsibility for other conditions written by other providers when they add a new reason for profile.

c. Approving authority. MTF commanders, ARNG chief and state surgeons, and the USAR command surgeon, may authorize physicians as approving authority. USAR RSC surgeons are designated approval authorities by position.

(1) The approving authority must be a physician.

(2) The designating officer will ensure that the approval authorities are thoroughly familiar with the contents of this regulation, DODI 1332.18, AR 635–40, AR 40–501, and DA Pam 40–502.

(3) The approval authority ensures that profiles are appropriate for entry into DES; the signature of the approval authority initiates the administrative review or boarding action.

d. Chief clinical officer or deputy commander for medical services as appointed by the military treatment facility commander. Serves as the senior approving authority within the MTF.

e. Unit commander. Reviews profiles on Soldiers under their command and make a deployability determination for all duty limiting conditions not limited by policy.

3–7. Profiling Soldiers who are pregnant

a. Pregnancy profile guidance. The intent of pregnancy provisions is to protect the health of the Soldier and fetus while ensuring productive employment of the Soldier. Common sense, good judgment, and cooperation must prevail between policy, Soldier, and Soldier's commander to ensure a viable program. The pregnancy profile guidance includes mandating an occupational health interview to assess risks to the Soldier and fetus, additional duty restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes. Profiles for Soldiers who are pregnant will authorize the wear of non-permethrin treated duty uniforms. Post-partum profiles describe the convalescent leave and recovery process as the Soldier returns to full duty and authorize the continued wear of permethrin free uniforms during lactation. The process and procedure of pregnancy, permethrin, and post-partum profiling is described in DA Pam 40–502. The profiling system templates are necessary to create a temporary profile beyond 90 days. Soldiers who are trying to get pregnant may be issued permethrin free uniforms with medical approval authorizing the wear of the uniform as described in DA Pam 40–502.

b. Responsibilities.

(1) *Soldier.* Soldiers trying to get pregnant will seek care from a healthcare provider and request medical authorization exempting the wear of the factory-treated permethrin duty uniforms. Pregnant Soldiers will seek medical confirmation of pregnancy, obtain a pregnancy profile and comply with the instructions of medical personnel and the individual's unit commander.

(2) *Medical personnel.* A profiling officer (physician, nurse midwife/practitioner or physician assistant) will create an e-Profile using the appropriate template in the profiling system.

(a) For pregnant Soldiers, a profiling officer (physician, nurse midwife/practitioner or physician assistant) will confirm pregnancy and initiate prenatal care of the Soldier to include establishing her duty limitations with a pregnancy profile by using the pregnancy profile template as described in DA Pam 40–502.

(b) After review of the occupational history, the profiling officer (physician, nurse midwife/practitioner, or physician assistant), in conjunction with the occupational health clinic as needed, will offer an occupational health exposure questionnaire and identify any additional occupational exposures to avoid for the remainder of the pregnancy. (Examples include but are not limited to hazardous chemicals, ionizing radiation, and excessive vibration.) If the occupational history or industrial hygiene sampling data indicates significant exposure to physical, chemical, biological, or other potential hazards, then the profiling officer will rewrite the profile to restrict exposure from these workplace hazards. Profiles will be issued for the duration of the pregnancy. The MTF will advise the unit commander as required or requested. If a pregnancy is completed, a new profile will be issued as a postpartum profile as described in paragraph 3–8.

(3) *Unit commander.* The unit commander will consult with medical personnel as required. This includes establishing liaison with the occupational health clinic and requesting site visits by the occupational health personnel if necessary to assess any work place hazards. Soldiers currently on fertility treatment are non-deployable.

c. Performance of duty. A Soldier who is experiencing a normal pregnancy may continue to perform military duty within the limits of her profile until delivery. Soldiers experiencing unusual difficulties or complicated problems (for example, pregnancy-induced hypertension) may be given modified duties or excused from all duties at the discretion of Soldier's commander in consultation with their treating obstetrician or primary care provider. Medical personnel will assist unit commanders in determining duties.

d. Sick in quarters. A pregnant Soldier will not be placed sick in quarters solely because of her pregnancy, unless there are complications present that would preclude any type of duty performance.

3–8. Postpartum profiles

a. Convalescent leave (as prescribed by AR 600–8–10) after delivery will be for a period determined by the attending physician as described in DA Pam 40–502.

b. Convalescent leave after the completion of pregnancy (to include miscarriage) will be determined on an individual basis by the attending physician who will issue a postpartum profile as described in DA Pam 40–502.

c. Soldiers will receive clearance from a profiling officer to return to full duty.

d. Postpartum (any pregnancy that lasts 20 weeks and beyond) Soldiers, in accordance with DODD 1308.1 are exempt from the APFT and from record weigh-in until at least 180 days after pregnancy termination. Medical clearance and training guidance is in DA Pam 40–502.

e. Postpartum and nursing Soldiers are authorized to wear the duty uniform without permethrin.

f. The above guidance will only be modified if, upon evaluation of a physician, it has been determined the postpartum Soldier requires a more restrictive or longer profile because of complicated or unusual medical problems.

3–9. Concussion profiles

Concussion, also known as mild Traumatic Brain Injury (mTBI), is a significant military concern that can adversely affect Soldier health, unit readiness, and mission accomplishment. Use of the concussion profiling system templates is required for all concussion/mTBI profiles. Policies are in place for the management of concussions in the garrison and deployed environment. In order to ensure optimal care, and reduce variance, profiling officers will use the appropriate concussion profile template. The DD Form 689 is not authorized for use for Soldiers diagnosed with a concussion.

3–10. Stinging insect allergy

A Soldier with a stinging insect allergy (examples include fire ant, wasp, hornet, bee, or yellow jacket) requires evaluation by an allergist and is an indication for referral to DES as described in AR 40–501. Soldiers who are unwilling to receive venom immunotherapy recommended by an allergist will be referred to DES. Soldiers who will not benefit from venom

immunotherapy will be referred to DES. When a Soldier elects to receive recommended venom immunotherapy, the Soldier needs referral by an allergist. See DA Pam 40–502 for instructions on profiling. The Soldier is required to carry an epinephrine autoinjector and medical warning tags.

3–11. Cancer in remission

When an oncologist determines a Soldier is in remission after cancer treatment and there are either no or only minor physical residuals, the oncologist will issue a P2 profile. See DA Pam 40–502 for instructions on profiling. When seeking to deploy Soldiers who have a history of cancer that is in remission, the oncologist and commander will consider and discuss the mission requirements, support available, and review the appropriate CCMD guidance.

3–12. Responsibility for personnel actions

Commanders and personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management records and the permanent assignment of the individual to military positions commensurate with the individual's physical profile and recorded assignment limitations. If the Soldier's commander believes the Soldier cannot perform within the limits of the permanent profile, the commander will request reconsideration of the profile by the profiling officer. The same profiling officer, who will either re-write the profile or revalidate the profile as appropriate, must accomplish reconsideration. Selective evaluations are not authorized at any level. Commanders may also request a review of temporary profiles.

3–13. Physical profile and the Army Body Composition Program

DA Form 3349 in the EHR or STR will not be used to excuse Soldiers from the provisions of AR 600–9. Pregnancy and post-partum profiles are authorized by policy to exempt Soldiers from the Army Body Composition Program. Any review or consideration of medically induced weight gain will be as directed in AR 600–9.

Chapter 4

Medical Readiness Examinations, Assessments, and Administrative Requirements

4–1. General

This chapter provides—

- a.* General administrative policies relative to all military medical examinations.
- b.* Requirements for accession physical exams, PHAs, aeromedical examinations and assessments, separation history and physical exams (SHPEs), mobilization/deployment/DHAP, and other medical examinations.
- c.* Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the military health record.
- d.* Policies relative to the scope and recording of medical examinations and assessments accomplished for stated purposes.
- e.* Requests for fitness for duty examinations—
 - (1) When a Soldier who has previously been found fit by a PEB and the commander notices a deterioration in the Soldier's ability to perform their mission attributable to their condition, or the Soldier develops a new condition, which affects their abilities or causes them to per se fail retention standards, the Soldier will be evaluated by a profiling officer with the potential of being sent back through DES. The provider may revise the profile during the course of the condition to ensure it accurately describes the capabilities and limitations. This may return the Soldier to DES process. The first O–6 in the Soldier's chain of command may request a supplemental referral after 120 days because the previously evaluated condition prevents satisfactory duty performance in accordance with AR 635–40.
 - (2) When a Soldier who has previously been retained by a MAR2 has deterioration in their condition(s) or abilities, or develops a new condition, which affects their abilities or causes them to per se fail retention standards, the Soldier will be evaluated by a profiling officer with the potential of being sent through DES. The first O–6 in the Soldier's chain of command may request a supplemental referral after 120 days because the previously evaluated condition prevents satisfactory duty performance in accordance with AR 635–40.
 - (3) When a profiling officer and commander cannot achieve consensus regarding a Soldier's duty limitations, the commander may request a fitness for duty evaluation to determine the Soldier's capabilities and limitations as described DA Pam 40–502. All exams will be conducted in accordance with DA Pam 40–502.

4–2. Application

The provisions contained in this chapter apply to all medical examinations and assessments accomplished by the Army, ARNG, USAR, and United States Military Entry Processing.

4–3. Responsibilities

a. Soldier. Each Soldier is responsible for authorizing and facilitating disclosures of health information by any non-DOD health care provider(s) to the Military Health System for inclusion in the EHR and/or STR. RC Soldiers not empaneled will follow the guidance and direction of commands to submit the documentation to the STR. Maintenance of physical and medical fitness is an individual Soldier responsibility. Each Soldier is responsible for maintaining their physical and medical fitness. Physical fitness is the level of function required to effectively perform all required military duties. Soldiers maintain their medical fitness by seeking timely medical care and advice when they have a medical issue that may affect their readiness. Soldiers will provide their unit records custodian, patient administration officer, unit administrator, and/or unit commander all civilian health records that may affect their medical readiness status or fitness to continue service. Soldiers should not wait until their annual PHA to make such a condition or defect known. Medical records personnel, designated by component, are responsible to scan any civilian health records or other documentary evidence into the Soldier's EHR and file any paper documents into the STR.

b. Unit commander. The unit commander is responsible for ensuring that each Soldier completes all medical readiness requirements; the accuracy of personnel and medical readiness systems of record, and taking appropriate follow-up action regarding each Soldier's readiness or medical status.

c. Military treatment facility commander. The MTF commander is responsible for ensuring the processing and appropriate storage of a Soldier's civilian health records and other documentary evidence in the EHR.

d. Profiling officer. The profiling officer is responsible for endorsing a complete and accurate DA Form 3349. The DA Form 3349 communicates to the Soldier's commander medically required duty limitations based on careful, deliberate consideration of the Soldier's history, any physical examination, and a comprehensive review of the medical information. The profiling officer will ensure that the supporting medical documentation is in the EHR/STR prior to initiating a profile.

4–4. Additional evaluations

Consultations performed by specialists or hospitalizations necessary for evaluations in connection with a physical examination or health assessment may be provided as authorized in AR 40–400.

4–5. Distribution of medical reports

a. Medical reports. A copy of the annual PHA will be filed as a permanent record in the EHR with the current DD Form 2005 (Privacy Act Statement – Health Care Records) in accordance with AR 40–66. All IMR elements will be documented on the DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) and in the automated Medical Readiness System of Record. Copies of medical reports may be reproduced from signed copies by any duplicating process that produces legible and permanent copies. Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies will be in full compliance with DODM 6025.18 and applicable Army regulations and policies. Copies will not be distributed in any form to unauthorized personnel or agencies.

b. DD Form 2807–1 and DD Form 2808.

(1) Except for the interim flying duty medical examinations (FDMEs) completed on DA Form 4497 (Interim (Abbreviated) Flying Duty Medical Examination), all Army military medical examinations are completed on the DD Form 2807–1 (Report of Medical History) and DD Form 2808 (Report of Medical Examination). This includes examinations to attend special schools, permanent separation from the military, and retirement. Previous medical examinations/histories on Soldiers in accordance with this chapter should be considered valid. DD Form 2807–2 (Accessions Medical Prescreen Report) is not required for military medical examinations after accession.

(2) The DD Form 2807–1 and DD Form 2808, along with all associated studies (for example, laboratory tests, radiograph readings, consults) will, if they are not already in the EHR, be scanned and placed in the Soldier's EHR.

c. General officers (grade O–7 and above). Verified PHA completion date and active DA Form 3349 if applicable (with expiration date as applicable) will be sent to the following:

(1) For RA general officers: General Officer Management Office (DACS–GO), Office of the Chief of Staff, Army, 200 Army Pentagon, Room 2A476, Washington, DC 20310–0200 or email to: usarmy.pentagon.hqda-gomo.mbx.gomo@mail.mil.

(2) For ARNG general officers: Chief, National Guard Bureau (NGB–GO–AR), Room 2D366, Pentagon, Washington, DC 20310–2500. Contact information for ARNG general officer organization: ng.ncr.arng.mbx.gomailbox@mail.mil.

(3) For USAR general officers: Office of the Chief, Army Reserve (GOMO), 6075 Goethals Road, Building 1908, Office 302-04, Fort Belvoir, VA 22060-5231 or email to: usarmy.usarc.ocar.mbx.gomo@mail.mil.

4-6. Documentary medical evidence

a. Documentary medical records and other documents prepared by physicians or other individuals may be submitted by, or on behalf of, an examinee as evidence of the presence, absence, or treatment of a defect or disease, and will be given due consideration by the examiner(s). Submission and use of such documentary medical evidence is encouraged. If insufficient copies are received, copies will be reproduced to meet the requirements of paragraph 4-6*b*.

b. Each copy of the DD Form 2808 or PHA will have a copy of each piece of documentary medical evidence, to include any consultation or special test obtained for an individual, appended, and scanned into the Soldier's EHR. The Summary of Defects section will contain a statement about the appended documentary medical evidence cross-referenced by the pertinent item number or the component STR.

c. Healthcare providers will review the STR and/or EHR of each examinee whenever the purpose of the examination is relief from active duty, resignation, retirement, separation from the Service, or when accomplished in connection with a PHA.

4-7. Facilities and examiners

a. Physicians, physician assistants, and nurse practitioners may perform medical examinations of any type except where a specific requirement exists for the examination to be conducted by a physician qualified in a specialty. Optometrists, audiologists, and podiatrists, properly qualified by appropriate training and experience, may accomplish such phases of the medical examination.

b. In general, medical examinations and PHAs conducted for the Army will be completed at facilities of the Armed Forces, using properly credentialed and or privileged military medical officers on active or reserve duty, or properly credentialed and or privileged civilian healthcare providers. The medical examination may be completed with the assistance of dentists, optometrists, audiologists, and podiatrists. There may be contract agreements with civilian or Department of Veterans Affairs (VA) facilities to perform military medical examinations, PHAs, or SHPEs for RA or RC forces. Negotiated agreements with the overseeing Army MTF or RC help ensure that individuals who are familiar with the medical retention standards of AR 40-501 review the medical examinations, SHPEs, and PHAs. For example, military physicians can make a competent determination whether the Soldier meets the standards for accession, retention, separation, or retirement.

c. Aeromedical examinations will be conducted by flight surgeons, aeromedical physician assistants, aviation medicine nurse practitioners, or aeromedical examiners.

4-8. Objectives of medical examinations

The objectives of the PHAs are to—

- a.* Review and update the Soldier's medical readiness, IMR status, and profiles, as necessary.
- b.* Identify and correct readiness issues at the time of examination or encounter or initiate plans to expeditiously correct all deficiencies.
- c.* Identify any potential health risks and suggest possible lifestyle modifications.
- d.* Initiate evaluation and, if medically advisable, treatment of illnesses and/or injuries.
- e.* Meet administrative and legal requirements.
- f.* Document current medical conditions and medications.
- g.* Identify any potential deployment-limiting conditions and initiate a plan for evaluation, treatment in the EHR or STR. Profiling officers will determine and document in e-Profile if the Soldier currently meets or will meet medical retention standards.

4-9. Recording of medical examinations and required forms

a. Recording of medical examinations. Except for PHAs and for flying duty health screens (FDHSs), the required forms for all Army military medical examinations are the DD Form 2807-1 and DD Form 2808. These forms are to be completed as described in DA Pam 40-502. If the DD Form 2808 and DD Form 2807-1 are current (within the last 12 months), the DD Form 2697 (Report of Medical Assessment) can bring the examination to currency for the purposes of the SHPE. Additional forms may be required. The results of the medical examination will include recording all diagnoses and symptoms on these forms.

- (1) PHA results will be recorded in the STR and the EHR updated to reflect completion of the PHA.
- (2) The EHR will be used to record medical examinations and the PHA.

(3) The Medical Readiness System of Record will update the completion date of the PHA within 3 days of the provider signing and closing the PHA encounter.

b. Required forms. PHA results will be recorded electronically in the EHR and a copy placed in STR. The EHR will be updated to reflect completion of the PHA. All IMR elements will be documented on the DD Form 2766.

c. Examination requirements. Items required on all Army military examinations and assessments to include additional items that may be accomplished if medically indicated are found in DA Pam 40–502.

d. Screening examinations. Limited or screening examinations, special tests, or inspections required for specific purposes (for example, drivers, personnel exposed to industrial hazards, blood donors, food handlers) may be prescribed by other regulations.

e. Aeromedical examinations. Require a U.S. Army aeromedical activity disposition stamp on the DD Form 2808 for FDMEs and DA Form 4497 for FDHS. The use of the DD Form 2992 (Medical Recommendation for Flying or Special Operational Duty) is prescribed by DA Pam 40–502, and does not require a U.S. Army aeromedical activity disposition stamp.

f. Individual medical readiness elements. All IMR elements, unless automatically updated by the electronic medical readiness systems involved, will be recorded in the appropriate electronic medical readiness system(s) within 3 days of all military examinations.

4–10. Physical examinations

a. Accession physical examinations. The accession medical examination will fulfill the requirement for a PHA for 1 year from the date of the examination with the inclusion of a mental health assessment. Accession physical examinations must be conducted in accordance with accession standards described in AR 40–501 and DA Pam 40–502.

b. Aeromedical fitness examinations. DA Pam 40–502 articulates the general policies for the review and disposition of aeromedically qualified or disqualified applicants and aviation personnel. The FDME and FDHS must use the accession and aeromedical fitness standards in AR 40–501, and are completed as described in DA Pam 40–502. The FDHS and FDME will not meet the annual PHA requirement.

c. Accessing into U.S. Army Reserve. RA or ARNG Soldiers accessing into the USAR from COMPO 1 or 2, must meet the AR 40–501 medical retention standards, have a valid PHA (within the last 12 months), and have no outstanding medical issues that require follow-up, to include a temporary profile (DA Form 3349).

d. Accessing into Army National Guard. RA or USAR Soldiers who are accessing into the ARNG must meet AR 40–501 medical retention standards, have a valid PHA (within 1 year), and have no outstanding medical issues that require follow-up, to include a temporary profile (DA Form 3349).

4–11. Periodic health assessment

The PHA is an annual DOD requirement for all officers, warrant officers, and enlisted personnel of the Army regardless of component. The PHA is an annual readiness assessment with a standardized question set designed to; assess the medical readiness of Soldiers, assess the currency of IMR requirements, provide preventive health screening, identify duty limiting and deployment-limiting conditions and determine if further health evaluation is indicated. Provider screening recommendations from the PHA are to be based on the U.S. Preventive Services Task Force guidelines. Other service examinations (for example flight physicals, deployment health assessments, and so forth) do not meet the annual DOD PHA requirement. RC units will receive their PHAs within the system designed and supported by their command. RC Soldiers may also receive PHAs from MTFs; RCs will ensure all requests for MTF support for PHAs is coordinated with the appropriate RHC prior to sending any non-empaneled (Defense Enrollment Eligibility Reporting System (DEERS) eligible) Soldier to an MTF for their PHA.

4–12. Separation history and physical examination

Application—

a. The SHPE is a joint program to facilitate the transfer of care from the DOD to the VA and support the evaluation of disability claims. Any Service MTF may perform the DOD SHPE evaluations. The electronic health record documents and tracks the completion of these required exams. The following categories of Soldiers must undergo a SHPE prior to their separation from active duty using the procedures described in the SHPE user guide and DA Pam 40–502:

(1) All Soldiers separating or retiring from the RA and Guard and Reserve on active duty, to include Active Guard Reserve personnel (see AR 635–40 concerning the referral of Soldiers into DES when pending retirement for length of service). A Soldier separating from active duty must have a determination that they meet retention standards on their SHPE to become a member of the RCs.

(2) A Soldier undergoing administrative separation from the RA or Active Guard and Reserve, must be available to complete the SHPE per the DODI 6040.46 and AR 635–200. The SHPE may be waived in cases where the Soldier is not under the control of the Secretary of the Army, such as in the case of unauthorized absences or civilian incarceration, see DA Pam 40–502, table 5–2.

(3) A Soldier of a RC who is separated from active duty to which they were called or ordered in support of a contingency operation, if the active duty was for a period of greater than 30 days before released from active duty.

(4) ARNG/Army National Guard of the United States (ARNGUS) or USAR Soldiers separating after greater than or equal to 180 days on active duty orders will undergo an SHPE prior to release from active duty.

b. The examining health care provider for the SHPE must have verified credentials deemed appropriate by the MTF privileging authority to perform such exams, such as a physician, physician’s assistant, or nurse practitioner. This examination is to determine any existing medical condition incurred during active duty Service, provide baseline information for future care, complete a member’s military medical record, and provide a final opportunity before separation to document any health concerns, exposures, or risk factors associated with active duty service. File all SHPE associated forms, studies, and laboratory test in the Soldier’s electronic health record.

c. When the Soldier is filing a Service connected disability claim, the VA completes the physical examination, when possible.

(1) The VA refers to separation health physical examinations as separation health assessments.

(2) When the VA processes a Soldier’s SHPE, the DOD and VA share the STR in accordance with their memorandum of understanding.

(3) RC members demobilizing and filing a pre-separation disability claim must file their claim before separation and schedule their examination with the VA. At pre-separation counseling, Soldiers are informed that they may choose to file a pre-separation disability claim with the VA, and the SHPE will be conducted as part of the disability examination. All benefits options are explained in detail during the mandatory VA benefits briefing.

d. When allegation of sexual assault is raised during a SHPE, the Soldier must be asked if counseling by a sexual assault response coordinator or victim advocate has been provided, including explanation of restricted and unrestricted reporting options. If such counseling has not previously been provided, then the examination will be paused and a sexual assault response coordinator or victim advocate will be contacted. Other parts of the examination may be performed, but the examination and report cannot be completed until that counseling has been provided. Whether the Soldier elects for restricted or unrestricted reporting, documentation of the alleged sexual assault will not be included in the SHPE (which becomes part of the STR). Medical record documentation will be consistent with the standard provided in Enclosure 7 of DODI 6495.02.

e. Soldiers from RA, ARNG, and USAR being considered for administrative separations and separation because of personality disorder under AR 635–200; other designated physical or mental conditions; and all separations with a characterization of other than honorable will be screened for post traumatic stress disorder (PTSD), mTBI, and other behavioral health disorders prior to their discharge. The screening must be in accordance with MEDCOM guidance and documented in the Soldier’s electronic health record. The appropriate DA form, currently DA Form 3822 (Report of Mental Status Evaluation) will be generated and remain accessible via the electronic health record. All Soldiers that are determined to fall below medical retention standards will be evaluated under the physical DES in accordance with AR 635–40. Unless found fit for duty by DES, a separation for personality disorder, or other mental disorder not constituting a physical disability, is not authorized if service-related PTSD is also diagnosed.

f. Section 1177, Title 10, United States Code (10 USC 1177) requires a medical examination in certain instances prior to administrative separation of Soldiers under conditions other than honorable. Medical authorities will ensure medical examinations are completed for any Soldier, officer or enlisted, pending administrative separation under other than honorable conditions who has been deployed overseas in support of a contingency operation or been sexually assaulted during the previous 24 months, and who is diagnosed with PTSD and/or Traumatic Brain Injury (TBI), or who otherwise reasonably alleges the influence of such condition based on their service while deployed or based on such sexual assault, in coordination with the administrative separation authorities per the separation policy.

(1) The purpose of the medical examination is to assess whether the effects of PTSD and/or TBI constitute matters in extenuation that relate to the basis for administrative separation under other than honorable conditions or the overall characterization of service of the member as other than honorable.

(2) In cases involving PTSD, the medical examination shall be performed by a clinical psychologist, psychiatrist, licensed clinical social worker, or psychiatric advanced practice registered nurse.

(3) In cases involving TBI, the medical examination may be performed by a physician, clinical psychologist, psychiatrist, or other health care professional, as appropriate.

(4) The examination will be in accordance with MEDCOM guidance and documented in the Soldier's electronic health record. The appropriate DA form, currently the DA Form 3822, will be generated and remain accessible via the electronic health record.

(5) The requirements of this subparagraph apply to every administrative separation meeting the criteria in paragraph 4–12*f*, regardless of whether separation is involuntary or at the Soldier's request. This includes cases involving enlisted Soldiers who request administrative separation under AR 635–200, in lieu of trial by court-martial, and officers who request resignation in lieu of trial by court-martial under AR 600–8–24. The medical examination and procedures required by 10 USC 1177 do not apply to courts-martial or other proceedings conducted pursuant to the Uniform Code of Military Justice.

(6) For purposes of paragraph 4–12*f* only, “sexually assaulted” means that the Soldier facing separation has made a report of sexual assault punishable under Article 120, Uniform Code of Military Justice. No finding of probable cause by an investigation is required.

4–13. Miscellaneous medical examinations

a. Special forces assessment and selection; special forces qualification course; military free fall parachutists; special forces/ranger combat divers; survival, evasion, resistance, and escape; civil affairs; and psychological operations. Entrance into any of the above programs requires a completed, reviewed, and approved DD Form 2808 and DD Form 2807–1 (and supporting documents). The approval authority is the U.S. Army Special Operations Command (USASOC) surgeon's office, or the surgeon's office designated by the USASOC surgeon's office.

b. U.S. Army John F. Kennedy Special Warfare Center and School. The Commander, U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS) is the waiver authority for USAJFKSWCS schools. Individuals not meeting the medical fitness standards for USAJFKSWCS training courses will have their physicals and requests for waiver forwarded to Commander, U.S. Army John F. Kennedy Special Warfare Center and School (AOJK–GRP–C), Fort Bragg, NC, 28307–5217.

c. Certain geographic assignments.

(1) When an individual is alerted for movement to or is placed on orders for assignment to the system of Army attachés, military missions, military assistance advisory groups, or to isolated areas, the unit commander will refer the individual and their dependents, if any, to the supporting MTF prior to departure.

(2) The unit, staff, or MTF medical healthcare provider will interview the Soldier regarding their current health status and review all available medical records. During this review, the healthcare provider will utilize DODI 6490.07 and current theater and/or region specific published guidance. The physician will consider such other factors as length of time since the last PHA or medical examination, age, and the physical adaptability of the individual to the new area. Based on their findings, the physician will conduct a complete medical examination if warranted.

(3) The healthcare provider will evaluate, as described in DA Pam 40–502 and complete DA Form 3083 (Medical Examination for Certain Geographical Areas) prior to a permanent change of station. A copy of this form will be filed in the health record or outpatient record (see AR 40–66) and scanned into the EHR.

(4) If the Soldier is disqualified due to a temporary condition, the commander will be informed and a reevaluation and examination will be scheduled.

d. Medical assignment eligibility. When a Soldier is disqualified due to a permanent condition or a temporary disqualifying condition will be present for an extended period, the physician must evaluate the Soldier to determine if they meet medical retention standards and have reached the MRDP for the condition(s). If the Soldier does not meet retention standards and has reached the MRDP, the physician will initiate a permanent physical profile (DA 3349) and refer the Soldier for DES consideration or other action in accordance with the provision of AR 635–40.

(1) The commander having out-processing responsibility will ensure that this medical action is completed prior to the individual's departure from his or her home station. Soldiers who have received a permanent physical profile that requires administrative processing or board action will not depart home station until these actions are completed.

(2) Family support and required services examinations and consults are necessary to implement the screening process in AR 608–75. Specific services may or may not be available in certain geographic assignments.

4–14. Cardiovascular Screening Program

The Cardiovascular Screening Program is complete when the Healthcare provider reviews and discusses cardiovascular risk factors and any preventive services that are indicated for that Soldier per the United States Preventive Services Task Force, A and B recommendations. Soldiers over 40 must have a cardiovascular disease risk evaluation per the United States Preventive Task Force guidelines during their PHA. If labs are available at the time of the PHA and an elevated

cardiac risk is identified using the most current United States Preventive Task Force guidelines and American Heart Association/American College of Cardiology risk assessment tool (greater than or equal to 7.5 percent), the Soldier must be referred to cardiology for further evaluation.

4–15. Military operational hearing test for H3 profile Soldiers

Audiologists at all Army facilities will assess all H–3 Soldiers to provide recommendations concerning potential hearing impairments that might have negative operational impacts using the Army approved military operational hearing tests (MOHTs) such as the speech recognition in noise test. The MOHT will be administered by audiologists, trained ear, nose, and throat specialists (MOS 68U), or trained civilian technicians in a sound treated room, under earphones without use of hearing aids. These tests provide support for recommendations concerning operational impacts of hearing loss for consideration when completing the physical profile assignment limitations on DA Form 3349 and provide appropriate information for medical and administrative board determination.

4–16. Frequency of additional/alternate examinations

a. Female examinations. Examinations specific to females are no longer mandatory. Soldiers need to be aware of the continued importance of evidence-based women’s preventive health services and should follow the current published guidelines. All cervical cytology screening, breast examinations, and any other preventative service will be done in accordance with the U.S. Preventative Service Task Force A and B recommendations. (See website for most current recommendations: <https://www.uspreventiveservicestaskforce.org/page/name/recommendations>.)

b. Medical surveillance examinations. The frequency of medical surveillance examinations varies according to job exposure. Annual or less frequent examinations will be performed during the Soldier’s birth month. Examinations that are more frequent will be scheduled during the birth month and at appropriate intervals thereafter.

c. Potential rabies exposure examinations. Examinations performed as required in AR 40–562 and described in DA Pam 40–502.

4–17. Deferment of examinations

a. Armywide or at specific installations. In circumstances requiring Armywide or installation deferment of periodic examinations where conditions of the Service preclude the accomplishment of periodic examinations or PHAs because resources are being directed to other missions (for example, screening for mobilization/contingency operations, heavy casualties, and so on), requests for exceptions to policies deferring examinations will be forwarded to: The Office of the Surgeon General (DASG–HCO), 7700 Arlington Boulevard, Falls Church VA 22042, usarmy.ncr.hqda-otsg.list.otsg-med-com-g37-med-readiness@mail.mil.

b. Soldiers in isolated areas. The commander concerned for those Soldiers stationed in isolated areas may delay PHAs; for example, Army attachés, military missions, and military assistance advisory groups, where medical facilities are not available. Delayed PHAs will be accomplished at the earliest opportunity in conjunction with leave, temporary duty, or when the individual concerned is assigned or attached to a military installation with a medical facility. Medical examination of such individuals for retirement purposes may not be delayed.

c. Other deferments. In exceptional circumstances, in the case of an individual Soldier, where conditions of the Service preclude the accomplishment of the annual PHA, it may be deferred by direction of the commander having custody of personnel files until its accomplishment becomes feasible. An appropriate entry explaining the deferment will be made in the EHR or personnel file when such a situation exists.

Chapter 5

Deployment and Geographical Area Requirements

5–1. General

This chapter describes the medical readiness support for DODI 6490.03, DODI 6490.12, and the DHAP as overseen by the DCS, G–1. The DHAP is an Armywide program that supports commanders to monitor, assess, and prevent disease and injury; and to control or reduce occupational environmental health risks for maximizing unit readiness. Soldiers with CCMD limited conditions will not deploy unless the CCMD grants a waiver in accordance with the specific CCMD guidance. The intent of these programs is to identify and address Soldiers’ and specified DACs’ readiness needs for movement to all geographical areas to include all CCMDs, mobilizations, assignment to remote locations, and to ensure accurate medical readiness for the command.

5–2. Deployment, mobilization, and assignment-specific medical requirements

a. Deployment health. DODI 6490.03, DODI 6490.12, DTM–17–004, and DODI 3020.41, as well as CCMD specific force health protection guidance, detail individual deployment-specific medical requirements by status. Army policy and CCMD specific force health protection and theater entry guidance derive from an overall preventive medicine health risk assessment. Leaders will review these policies prior to any contingency deployment to ensure Soldiers are optimally ready and protected to conduct their mission. The unit commander will ensure implementation of the following individual medical requirements in accordance with DODI 6490.03:

- (1) Ensure deployable personnel maintain a high state of pre-deployment health and medical readiness.
- (2) Ensure deploying personnel are briefed on deployment health threats and are trained and equipped with necessary countermeasures.
- (3) Ensure that force health protection prescription products are prescribed; that readiness testing, automated neuropsychological assessment metrics, and laboratory studies are drawn; and that immunizations are administered as required per DOD, Army, and/or CCMD guidance.
- (4) Ensure all deployable medical personnel are trained on the signs, symptoms, medical countermeasures, and treatments of exposure to endemic diseases, environmental, occupational, and chemical, biological, radiological, and nuclear health threats.
- (5) Ensure deployable individuals' immunization status, medical records, and dental readiness status are updated in the EHR and MEDPROS.
- (6) Ensure with coordination of patient administration that the deployed personnel's inpatient and outpatient medical and dental encounter documentation (including medical and dental treatment records on DOD personnel from allies and coalition partners) are combined with their permanent medical and dental records within 30 days of redeployment.
- (7) Ensure pre- and post-deployment health assessments and DD Form 2900s are completed when required and that personnel are provided a person-to-person interview with a trained health care provider to review these assessments.
- (8) Ensure RC members receive medical and dental care and disability evaluations according to DODI 1241.01 and any necessary LOD prior to the release of the member from active duty. If the member does not stay on active duty, ensure arrangements are made for medical and dental care after being released.
- (9) Ensure post-deployment health and risk debriefings are provided to personnel who have returned or are returning from deployment.

b. Command deployability determinations. Medically ready Soldiers and Soldiers who are deemed medically deployable by their commands and meet CCMD specific requirements can deploy.

- (1) Commanders will ensure correction of individual medical readiness and specific health deficiencies prior to individual deployment or assignment to remote locations.
- (2) When notified of their unit's or Soldier(s)' mobilization or deployment, the command will counsel those Soldiers with profiles, temporary and permanent, which may affect their ability to deploy to that specific CCMD as the CCMD force health protection standards are applied. This counseling will include the actions the Soldier should take to maximize their opportunity to deploy (active medical treatment, CCMD waiver request, and so forth). For Soldiers unable to deploy, the commander will counsel the Soldier both on the necessity to continue to perform duties within, and ensure assignment of duties within the limits of their profile.
- (3) The commander will assign appropriate duties and advise the counseled Soldier not to violate their profiles by performing duties with undue risk to their health and safety.
- (4) Use of certain medications and medical conditions, as established by DOD or CCMD guidance, will require a waiver regardless of a Soldier's deployment status. Commanders will ensure requests for medical waivers are submitted to the CCMD surgeon, using established DOD or CCMD guidance, for those deploying personnel who have a medical condition requiring a waiver. Refer to Assistant Secretary of Defense (Health Affairs) Policy Memorandum, Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications, dated 7 October 2013; and published CCMD requirements for behavioral health guidance regarding deployment-limiting conditions.

c. Psychiatric health. (See Assistant Secretary of Defense (Health Affairs) Policy Memorandum, Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications, dated 7 October 2013). Individuals with a psychiatric condition controlled by medication who are otherwise medically deployable should not automatically be classified as non-deployable. Commanders may consider Soldiers whose psychiatric disorder is in remission, or residual symptoms do not impair duty performance, for deployment. In such cases, the commander makes the ultimate decision to deploy after consulting with the treating physician or other healthcare provider. The availability, accessibility, and practicality of a course of treatment or continuation of treatment in theater or austere environment should be consistent with clinical practice standards. A psychiatric consult is required for any questions on the safety of psychiatric medications.

d. Dental health. Oral conditions, which can reasonably be expected to result in dental emergencies within 12 months and require dental treatment, are deployment limiting. Dental readiness evaluations are deferred during a deployment outside the 50 United States, the territories of American Samoa, Guam, the Northern Mariana islands, Puerto Rico, the U.S. Virgin Islands, and the District of Columbia. Individual readiness evaluations will be completed within 3 months of returning from an OCONUS deployment. A non-DOD civilian dentist should use DD Form 2813 (Department of Defense Active Duty/Reserve/Guard/Civilian Forces Dental Examination) as proof of dental examination.

5-3. Special circumstances

a. Transition. Every effort will be made to ensure completion of the DHAP assessments according to the published timelines. Prior to installation clearance for expiration term of service, retirement, separation from the Service or transition to the Individual Ready Reserve, regardless of timeframe, Soldiers will complete their DHAP assessments and a SHPE. Soldiers transitioning due to permanent change of station or to the USAR or ARNG are required to complete DD Form 2900 within the 90 to 180 day period in accordance with DODI 6490.03.

b. Frequent deployers. Personnel who deploy again within 180 days following the end of a deployment may not have sufficient time to complete the DD Form 2900. A DD Form 2795 (Pre-Deployment Health Assessment) completed within 180 days after returning from a deployment will meet the DD Form 2900 requirement.

c. Warrior Transition Units. Soldiers assigned or attached to a Warrior Transition Unit or Community Care Units will complete all required deployment health assessment screenings. There are no exceptions or exemptions regardless of component for Soldiers in a Warrior Transition Unit.

d. Remote. Soldiers enrolled in Active Duty TRICARE Prime Remote and TRICARE Prime Remote Overseas obtain their DHAP support and administration through the Reserve Health Readiness Program and are supported by the RHC as described in the responsibilities and DA Pam 40-502.

Appendix A

References

Section I

Required Publications

Unless otherwise indicated, DOD publications are available at <http://www.esd.whs.mil/dd/dod-issuances/> and the USC is available at <http://uscode.house.gov/>.

AR 40–35

Preventive Dentistry and Dental Readiness (Cited in para 2–4a(2).)

AR 40–66

Medical Record Administration and Health Care Documentation (Cited in para 3–3g(3).)

AR 40–400

Patient Administration (Cited in paras 4–4.)

AR 40–501

Standards of Medical Fitness (Cited in para 1–1.)

AR 40–562

Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases (Cited in para 2–4b(5).)

AR 135–175

Separation of Officers (Cited in para 3–3f(1).)

AR 135–178

Enlisted Administrative Separations (Cited in para 3–3f(1).)

AR 220–1

Army Unit Status Reporting and Force Registration – Consolidated Policies (Cited on title page.)

AR 600–8–10

Leaves and Passes (Cited in para 3–8a.)

AR 600–8–24

Officer Transfers and Discharges (Cited in para 4–12f(5).)

AR 600–9

The Army Body Composition Program (Cited in paras 3–13.)

AR 608–75

Exceptional Family Member Program (Cited in para 4–13d(2).)

AR 635–40

Disability Evaluation for Retention, Retirement, or Separation (Cited in para 2–3.)

AR 635–200

Active Duty Enlisted Administrative Separations (Cited in para 4–12a(2).)

Assistant Secretary of Defense (Health Affairs) Policy Memorandum

Clinical Practice Guidelines for Deployment-Limiting Mental Disorders and Psychotropic Medications, 7 October 2013 (Cited in para 5–2b(4).) (Available at <https://www.pdhealth.mil/clinical-guidance/deployment-limiting-conditions.>)

DA Pam 40–502

Medical Readiness (Cited on title page.)

DA Pam 220–1

Defense Readiness Reporting System – Army Procedures (Cited in para 1–6b.)

DODD 1308.1

DOD Physical Fitness and Body Fat Program (Cited in para 3–8d.)

DODI 1241.01

Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements (Cited in para 5–2a(8).)

DODI 1332.18

Disability Evaluation System (DES) (Cited in para 2–3.)

DODI 3020.41

Operational Contract Support (OCS) (Cited in para 5–2a.)

DODI 6025.19

Individual Medical Readiness (IMR) (Cited on title page.)

DODI 6490.03

Deployment Health (Cited in para 1–19b.)

DODI 6490.07

Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees (Cited on title page.)

DODI 6490.12

Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation (Cited in para 1–19b.)

DODI 6495.02

Sexual Assault Prevention and Response (SAPR) Program Procedures (Cited in para 4–12d.)

DODM 6025.18

DOD Health Information Privacy Regulation (Cited in para 1–8.)

DTM–17–004

Department of Defense Expeditionary Civilian Workforce (Cited in para. 5–2a.)

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read a related publication to understand this regulation. Unless otherwise indicated, DOD publications are available at <http://www.esd.whs.mil/dd/dod-issuances/>; the USC is available at <http://uscode.house.gov/>; and the Code of Federal regulations are available at <https://www.ecfr.gov/cgi-bin/ecfr?page=browse>.

AR 11–2

Managers' Internal Control Program

AR 25–30

Army Publishing Program

AR 40–5

Preventive Medicine

AR 40–68

Clinical Quality Management

AR 135–18

The Active Guard Reserve Program

AR 135–91

Service Obligations, Methods of Fulfillment, Participation Requirements, and Enforcement Provisions

AR 135–133

Ready Reserve Screening, Qualification Records System, and Change of Address Reporting

AR 140–1

Mission, Organization, and Training

AR 140–185

Training and Retirement Point Credits and Unit Level Strength Accounting Records

AR 350–1

Army Training and Leader Development

AR 600–8–11

Reassignment

AR 600–8–101

Personnel Readiness Processing

AR 600–20

Army Command Policy

AR 601–210

Regular Army and Reserve Components Enlisted Program

AR 611–75

Management of Army Divers

AR 614–10

Army Military Personnel Exchange Program with Military Services of Other Nations

AR 635–8

Separation Processing and Documents

AR 670–1

Wear and Appearance of Army Uniforms and Insignia

Assistant Secretary of Defense (Health Affairs) DOD Health Information Privacy Regulation

(Available at http://health.mil/military-health-topics/privacy-and-civil-liberties_)

CJCSM 3150.13

Joint Reporting Structure—Personnel Manual (Available at <https://www.jcs.mil/library/cjcs-manuals/>.)

DA Pam 25–40

Army Publishing Program Procedures

DA Pam 25–403

Guide to Recordkeeping in the Army

DA Pam 40–11

Preventive Medicine

DA Pam 40–501

Army Hearing Program

DA Pam 385–90

Army Aviation Accident Prevention Program

DA Pam 600–8

Military Human Resources Management Administrative Procedures

DA Pam 611–21

Military Occupational Classification and Structure

DFAS–IN Regulation 37–1

Finance and Accounting Policy Implementation. (Available at <http://www.asafm.army.mil>.)

DOD Dictionary of Military and Associated Terms

(Available at <https://www.jcs.mil/doctrine/dod-terminology-program/>.)

DOD 5400.11–R

Department of Defense Privacy Program

DOD 6055.05–M

Occupational Medical Examinations and Surveillance Manual

DOD 7000.14–R, Vol 7A

DODFMR: Military Pay Policy – Active Duty and Reserve Pay (Available at <http://comptroller.defense.gov/fmr.aspx>.)

DODI 6130.03

Medical Standards for Appointment, Enlistment, or Induction in the Military Services

DSM-5

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5), American Psychiatric (Available at <http://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5>.)

FM 7-22

Army Physical Readiness Training

MIL-PRF-680C

Degreasing Solvent (Available at <http://quicksearch.dla.mil/qssearch.aspx>.)

NATO STANAG 3526

Interchangeability of NATO Aircrew Medical Categories (Available at <https://standards.globalspec.com/>.)

NGR 600-200

Enlisted Personnel Management (Available at <http://www.ngbpdc.ngb.army.mil/>.)

NGR 635-101

Efficiency and Physical Fitness Boards (Available at <http://www.ngbpdc.ngb.army.mil/>.)

Office of Personnel Management Operating Manual

Qualification Standards Handbook for General Schedule Positions (Available at <https://www.opm.gov/policy-data-oversight/classification-qualifications/>.)

Periodic Health Assessment

U.S. Army Implementation Plan (Available at <https://health.mil/military-health-topics/health-readiness/reserve-health-readiness-program/our-services/pha>.)

TB MED 250

Dental Record Administration, Recording and Appointment Control

TB MED 507

Heat Stress Control and Heat Casualty Management

TB MED 508

Prevention and Management of Cold-Weather Injuries

TB MED 523

Control of Hazards to Health from Microwave and Radio Frequency Radiation and Ultrasound

TB MED 524

Control of Hazards to Health from Laser Radiation

TC 3-04.8

Individual Flight Records Folder Management

5 CFR Part 339

Medical Qualification Determinations

14 CFR Part 61

Certification: Pilots, Flight Instructors, and Ground Instructors

14 CFR Part 65

Certification: Airmen Other Than Flight Crewmembers

14 CFR Part 67

Medical Standards and Certification

5 USC 552a

Records maintained on individuals

10 USC 101

Definitions

10 USC 1177

Members diagnosed with or reasonably asserting post-traumatic stress disorder or traumatic brain injury: medical examination required before administrative separation

10 USC 10148

Ready Reserve: failure to satisfactorily perform prescribed training

10 USC 10206

Members: physical examinations

10 USC 12303

Ready Reserve: members not assigned to, or participating satisfactorily in, units

Section III**Prescribed Forms**

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate website (<https://armypubs.army.mil>).

DA Form 3083

Medical Examination for Certain Geographical Areas (Prescribed in para 4–13c(3).)

DA Form 3349

Physical Profile Record (Prescribed in para 1–7.)

Section IV**Referenced Forms**

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate website (<https://armypubs.army.mil>); and DD forms are available at the WHS Executive Services Directorate 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 3822

Report of Mental Status Evaluation

DA Form 4497

Interim (Abbreviated) Flying Duty Medical Examination

DD Form 689

Individual Sick Slip

DD Form 2005

Privacy Act Statement—Health Care Records

DD Form 2697

Report of Medical Assessment

DD Form 2766

Adult Preventive and Chronic Care Flowsheet (Available through normal forms supply channels.)

DD Form 2795

Pre-Deployment Health Assessment

DD Form 2796

Post-Deployment Health Assessment (PDHA)

DD Form 2807–1

Report of Medical History

DD Form 2807–2

Accessions Medical Prescreen Report

DD Form 2808

Report of Medical Examination

DD Form 2813

Department of Defense Active Duty/Reserve/Guard/Civilian Forces Dental Examination

DD Form 2900

Post Deployment Health Re-assessment (PDHRA)

DD Form 2992

Medical Recommendation for Flying or Special Operational Duty

Appendix B

Internal Control Evaluation

B–1. Function

The functions covered by this document address the Army’s ability to maintain medical readiness.

B–2. Purpose

The purpose of this evaluation is to assist medical, administrative, and commanders in maintaining IMR requirements and standards, medical readiness processes and policies, supporting commander deployability determinations and redesigning physical profiles. It is not intended to cover all controls.

B–3. Instructions

Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, or other). Answers that indicate deficiencies must be explained and the corrective action identified in supporting documentation. These internal controls must be evaluated at least annually or whenever the commander and/or designating authority changes. 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. Commander deployability determinations.

(1) Do all commanders perform an annual review of the access management for the Commander Portal for the units in their area of responsibility? Do the officials responsible for deployability determinations and medical readiness have access to the Commander Portal and are they knowledgeable regarding privacy policy and the provisions of AR 40–502, DA Pam 40–502 and other required references available and in use?

(2) Do all commanders annually ensure access to the Commander Portal is limited to those with a need to know? Do the people with access to the Commander Portal have assumption of command orders or an appointment memorandum, documentation of required Commander Portal training, and current privacy act training prior to system approval?

b. Profiling officers. Are designating officials annually ensuring that all profiling officers are thoroughly familiar with AR 40–502, AR 40–501, and DA Pam 40–502?

c. Approval authorities. Do designating officials annually ensure that the approval authorities are thoroughly familiar with DODI 1332.18, AR 635–40, AR 40–502, AR 40–501, and DA Pam 40–502?

B–5. Supersession

Not applicable.

B–6. Comments

Help makes this a better tool for evaluating the medical readiness. Comments regarding this checklist should be addressed to the Office of the Surgeon General (DASG–HCO–MRD), 7700 Arlington Boulevard, Falls Church, VA 22042–5142.

Glossary

Section I

Abbreviations

ACOM

Army command

AOC

area of concentration

APFT

Army physical fitness test

AR

Army Regulation

ARIMS

Army Records Information Management System

ARNG

Army National Guard

ARNGUS

Army National Guard of the United States

ASCC

Army service component command

CCMD

combatant command

CJCSM

Chairman of the Joint Chiefs of Staff manual

COMPO

component

CUSR

commander's unit status report

DA

Department of the Army

DAC

Department of the Army Civilian

DCS

Deputy Chief of Staff

DD Form

Department of Defense form

DES

Disability Evaluation System

DHAP

Deployment Health Assessment Program

DL

deployment-limiting

DNA

deoxyribonucleic acid

DOD

Department of Defense

DODD
Department of Defense directive

DODI
Department of Defense instruction

DRC
dental readiness class

DRU
direct reporting unit

DTM
Directive-Type Memorandum

EHR
electronic health record

FDHS
flying duty health screen

FDME
flying duty medical examination

HIPAA
Health Insurance Portability and Accountability Act

HIV
human immunodeficiency virus

IMR
individual medical readiness

LOD
line of duty

MAR2
Military Occupational Specialty Administrative Retention Review

MCEP-I
military combat eye protection inserts

MEB
medical evaluation board

MEDCOM
U.S. Army Medical Command

MEDPROS
Medical Protection System

MOHT
military operational hearing test

MOS
military occupational specialty

MRC
medical readiness classification

MRDP
Medical Retention Determination Point

mTBI
mild traumatic brain injury

MTF
military treatment facility

OCONUS

outside continental United States

OTSG

Office of The Surgeon General

PEB

physical evaluation board

PHA

periodic health assessment

PMOS

primary military occupational specialty

PTSD

post traumatic stress disorder

PULHES

physical, upper, lower, hearing, eyes, psychiatric

RA

Regular Army

RC

Reserve Component

RHC

regional health command

RRS–A

Records Retention Schedule–Army

RSC

regional support command

SHPE

separation history and physical exams

STR

service treatment record

TBI

Traumatic Brain Injury

TRICARE

Tri-Service Medical Care

TSG

The Surgeon General

USAJFKSWCS

U.S. Army John F. Kennedy Special Warfare Center and School

USAR

U.S. Army Reserve

USASOC

U.S. Army Special Operations Command

USC

United States Code

1MI

1 mask insert

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 and be as 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 10 USC 101).

Active Guard Reserve

(DOD) National Guard and Reserve members who are on voluntary active duty providing full-time support to National Guard, Reserve, and RA organizations for the purpose of organizing, administering, recruiting, instructing, or training the RCs. Also called Active Guard Reserve. (See CJCSM 3150.13.)

Applicant

A person not in a military status who applies for appointment, enlistment, or reenlistment in the 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. (Source: 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 Reserves of the Army. (Source: NGR 600–200).

Candidate

Any individual under consideration for military status or for a military Service program whether voluntary (appointment, enlistment, Reserve Officers' Training Corps) or involuntary (induction).

COMPO 1

Those Army organizations that, as a result of Total Army Analysis and program objective memorandum processes, are designated as force structure COMPO 1 and registered as such by unit identification code in the Defense Readiness Reporting System–Army (DRRS–Army) database, the authorized database of record for operational Army organizations (also known as the “Regular Army”). Upon mobilization, ARNGUS/ARNG (COMPO 2) and USAR (COMPO 3) units do not become COMPO 1 organizations; they retain their applicable force structure component designations while on active duty.

Contingency

A situation requiring military operations in response to natural disasters, terrorists, subversives, or as otherwise directed by appropriate authority to protect U.S. interests.

Contingency deployment

Per DODI 6490.07, a deployment that is limited to outside the continental United States, over 30 days in duration and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. The relocation of forces and materiel is to an operational area in which a contingency is or may be occurring in a deployment.

Deployable

A Soldier under the direct operational control of the reporting unit, whether present or able to be present within 72 hours, who is in compliance with all required personnel readiness standards and not restricted from deploying to perform the unit's core designed and assigned missions. Commanders use the medical readiness information to determine if a Soldier is medically deployable and can contribute to the unit's core designed mission or assigned mission in accordance with readiness reporting guidance.

Deployment

The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intercontinental United States, intertheater, and intratheater movement legs, staging, and holding areas.

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. DES consists of medical evaluation boards (a function of the Army Medical Department), physical evaluation boards (elements of the U.S. Army Physical Disability Agency), and case reviews, when applicable, by the U.S. Army Physical Disability Agency.

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.

Fully medically ready

Soldiers classified as MRC 1 in MEDPROS.

Healthcare provider

Licensed or certified health care personnel (specifically, a physician, physician assistant, nurse practitioner, dentist, optometrist, physical therapist, chiropractor, occupational therapist, audiologist, podiatrist, nurse midwives, clinical psychologist, clinical social worker, advanced practice nurse, independent duty corpsman, special forces medical sergeant, independent duty medical technician, or independent duty health services technician) who have received PHA program-specific training. This definition does not imply authority to prescribe use of prescription drugs.

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. (See DOD Dictionary of Military and Associated Terms.)

Medical capability

General ability, fitness, or efficiency (to perform military duty) based on accepted medical principles.

Medical readiness

A standardized system across the total force to enable the commander to measure, achieve, and sustain Soldiers' health to perform their war time requirement (MOS/AOC) from induction to separation.

Medical Readiness Class 1 (fully medically ready)

Soldiers who are current in PHA (completed), dental readiness assessment classified as Dental Class 1 or 2, immunization status, medical readiness and laboratory studies, individual medical equipment, and without any deployment-limiting medical conditions or medications.

Medical Readiness Class 2 (partially medically ready)

Soldiers who are lacking one or more immunizations, medical readiness laboratory studies, Hearing Readiness Class 4, Vision Readiness Class 4, and/or individual medical equipment.

Medical Readiness Class 3 (not medically ready)

Soldiers who have a deployment-limiting condition described by the deployment-limiting codes 1 through 7. This may include chronic or prolonged deployment-limiting medical or mental conditions, serious illness or injury with associated hospitalization and recovery time, and DRC 3 dental conditions.

Medical Readiness Class 4 (medical readiness indeterminate)

Inability to determine the Soldiers current health status because of missing health information, including Soldiers with an overdue PHA, and/or those in Dental Class 4.

Medical Retention Determination Point

The MRDP is reached if a medical condition which has been temporarily profiled has stabilized or cannot be stabilized in a reasonable period of time for up to 12 months and impacts successful performance of duty. Successful performance of duty is defined as the ability to perform basic soldiering skills required by all military personnel (DA Form 3349, section 4) and passing one aerobic APFT event and perform the duties required of their MOS, grade, or rank.

Medically deployable

A Soldier who is medically ready and/or has had a commander's deployability determination if required, and meets the DOD, Service-specific, and CCMD medical deployment requirements

Military Occupational Specialty Administrative Retention Review

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 DES. The MAR2 replaces the MOS medical retention board.

Non-deployable

A Soldier who is restricted from worldwide deployment for a unit's core designed or assigned mission because the Soldier—

- (1) Does not meet the baseline individual readiness standards for worldwide deployment as defined in this regulation and other pertinent regulations;
- (2) Does not meet a combatant commander's mission-specific individual readiness standards when tailored for accomplishment of an assigned mission;
- (3) Cannot be under the direct operational control of the reporting unit (not able to be present within 72 hours);
- (4) Has not graduated from a course awarding an AOC or MOS; or
- (5) Is determined by their commander to be non-deployable for any other reason not stated above (commander's call).

Obesity

Excessive accumulation of fat in the body often manifested by poor muscle tone, flabbiness and folds, bulk out of proportion to body build, dyspnea and fatigue upon mild exertion, and frequently accompanied by flat feet and weakness of the legs and lower back.

Physical disability

Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment, 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 behavior disorders, personality disorders, and primary mental deficiency.

Physician

An individual possessing a degree in medicine or osteopathy and licensed by a state, commonwealth, territory, or jurisdiction to practice medicine.

Retirement

Release from active military Services because of age, length of service, disability, or other causes, in accordance with Army regulations and applicable laws with or without entitlement to receive retired pay. For purposes of this regulation, this includes both temporary and permanent disability retirement.

Sedentary duties

Tasks to which military personnel are assigned that are primarily sitting in nature, do not involve any strenuous physical efforts, and permit the individual to have relatively regular eating and sleeping habits.

Senior approving authority

Chief clinical officer or deputy commander for medical services as appointed by the MTF commander serves as the senior approving authority within the MTF. MTF commanders, ARNG chief and state surgeons, and the USAR command surgeon, may authorize physicians as approving authorities. USAR RSC surgeons are designated approval authorities by position.

Senior medical officer

The senior medical officer for this purpose is an experienced, field grade physician (MC) who can advise a commander regarding medical readiness. This will generally be a brigade, division, or CORP surgeon.

Separation

An all-inclusive term that is applied to personnel actions resulting from release from active duty, discharge, retirement, dropped from rolls, release from military control or personnel without a military status, death, or discharge from the ARNGUS with concurrent transfer to the Individual Ready, Standby, or Retired Reserve. Reassignments between the various categories of the U.S. Army Reserve (Selected, Ready, Standby, or Retired) are not considered as separations.

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. (Source: 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 active duty in the event of a national emergency. (Source: AR 140–1.)

UNCLASSIFIED

PIN 203632-000