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***Department of the Army Pamphlet 40–502**

**Medical Services**

# Medical Readiness Procedures

By Order of the Secretary of the Army:

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**History.** This publication is an administrative revision. The portions affected by this administrative revision are listed in the summary of change.

**Applicability.** This pamphlet applies to the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

**Proponent and exception authority.** The proponent of this pamphlet is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this pamphlet 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 pamphlet 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 requirements.

**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 pamphlet 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.

*This pamphlet supersedes DA Pam 40–502, dated 27 June 2019.

# *Summary of Change*

DA PAM 40–502
Medical Readiness Procedures

This administrative revision, dated 2 May 2025—

- Changes “gender” to “sex” per Executive Order 14168 (throughout).

This mandated revision, dated 18 December 2023—

- Updates history statement (title page).
- Updates and re-numbers the preparation, approval, and disposition of DA Form 3349–SG (Physical Profile Record) (paras 4–14*a*(4)(c-h)).
- Makes administrative changes (throughout).

**Contents** (Listed by chapter and page number)

## Chapter 1
## Introduction

### 1–1. Purpose
This Department of the Army (DA) pamphlet explains and documents the basic processes and general procedures for assessing, documenting, and reporting medical readiness. It contains individual medical readiness (IMR) definitions, assessment, reporting, and monitoring; physical profile definitions, assessment, reporting, and monitoring; medical examinations and assessments; deployment and geographical area considerations. AR 40–501 is the authoritative publication for medical standards of fitness; AR 40–502 is the authoritative publication for medical readiness. If any provisions in this DA Pam conflict with the most recent versions of these policies, the provisions in AR 40–502 take precedence.

### 1–2. References, forms, and explanation of abbreviations
See appendix A. The abbreviations, brevity codes, and acronyms (ABCAs) used in this electronic publication are defined when you hover over them. All ABCAs are listed in the ABCA directory located at https://armypubs.army.mil/.

### 1–3. Associated publications
Policy associated with this pamphlet is found in AR 40–501.

### 1–4. Records management (recordkeeping) requirements
The records management requirement for all record numbers, associated forms, and reports required by this publication are addressed in the Records Retention Schedule–Army (RRS–A). Detailed information for all related record numbers, forms, and reports are located in Army Records Information Management System (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.

### 1–5. Basic processes and general procedures for accessing, documenting, and reporting medical readiness
*a.* To describe the basic processes and general procedures for accessing, documenting, and reporting medical readiness the following definitions are used throughout this pamphlet.

(1) Deployable personnel – Soldiers under the direct operational control of the reporting unit, whether present or able to be present within 72 hours, who are in compliance with all required personnel readiness standards and are not restricted from deploying to perform the unit's core designed and/or assigned mission. Commanders use the medical readiness information to determine if a Soldier is deployable and can contribute to the unit's core designed mission or assigned mission, in accordance with readiness reporting guidance (see AR 220–1 and DA Pam 220–1).

(2) Medical readiness – Medical readiness classification (MRC) is an administrative determination made by health care 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 his or her wartime requirement in accordance with their military occupational specialty (MOS) or area of concentration (AOC) from accession to separation.

*b.* Also see the glossary.

### 1–6. Overview
*a.* Soldiers, health care providers, unit commanders, and oversight and reporting officials will find basic processes and general procedures to provide medical information and to support force management officials and senior Army leaders. This DA Pam is not intended to provide detailed instructions for every data entry option or requirement in the medical readiness application. It must be used in concert with the supporting medical readiness application help features, the applicable user's guide, training support package, online tutorials, and/or other user assistance materials that are available at, or linked to, the medical readiness suite of applications. AR 40–502 is the authoritative publication for medical readiness policy.

*b.* The medical readiness and electronic profiling systems of record will post updates to the Healthcare Portal and Commander's Portal (see para 2–2). The systems will also maintain current policy and doctrine, processes, information, information technology, training guidance, and reporting requirements.

*c.* The Medical Protection System (MEDPROS) is the system of record for all medical readiness data elements (see AR 40–502). e-Profile is the electronic profiling system of record and is required by AR 40–502 for all temporary profiles greater than 7 days, and all permanent profiles.

*d.* IMR is a Soldier responsibility that contributes to unit readiness as managed by commanders and supported by the medical assets.

### 1–7. Command application of medical readiness

Unit commanders will collaborate closely with unit, staff, or military treatment facility (MTF) providers and use the medical classification, profile review, and their knowledge of the Soldier to make deployability determinations. Commanders will make a deployable or non-deployable determination within MEDPROS in accordance with AR 40–502. Commanders will consider the expected Soldier duties, unit mission, geographic force health protection (FHP) requirements, and policy conditions in their deployability determination. This means that a detailed consideration of the Soldier's capabilities and limitations should be considered with the mission, tasks, responsibilities, and role in the organization that will influence the command decision regarding the Soldier's deployment status. Limitations in the functional activities of the profile are likely to have universal mission impact as they relate to basic Soldier skills that all Soldiers should be able to perform. These deployability determinations do not change the medical readiness of the Soldier. The determinations are merged with the personnel deployability determinations to determine deployment status for readiness reporting. The design of the commander portal consolidates operational medical information to inform the commander regarding Soldier medical readiness. To comply with the Department of Defense (DoD) privacy policy, the reason for a profile is obscured for all users except the commander. The medical instructions, which convey the capabilities and limitations, and the Army Physical Readiness Training (PRT) information must remain operational in nature and should never have the diagnosis or documentation of medical care.

### 1–8. Medical readiness classification

Healthcare providers determine medical readiness. The medical readiness classes are described below:

*a. Medical readiness class 1 – fully medically ready.* The MRC 1 – fully medically ready Soldiers have a current status for; a completed Periodic Health Assessment (PHA), dental readiness classification (DRC) 1 or DRC 2 assessment, immunization requirements, medical readiness and laboratory studies, individual medical equipment; and are without any deployment-limiting (DL) medical conditions or medications. This class includes Soldiers with temporary profiles up to seven days in length.

*b. Medical readiness class 2 – partially medically ready.* The MRC 2 – partially medically ready classification includes Soldiers who lack one or more immunizations, human immunodeficiency virus (HIV) test, Deoxyribonucleic acid (DNA) specimen, individual medical equipment, or are hearing readiness class (HRC) or vision readiness class (VRC) 4. This class includes Soldiers with temporary profiles greater than 8 and up to 30 days in duration.

*c. Medical readiness class 3 – not medically ready.* The MRC 3 – not medically ready Soldiers have DL conditions for longer than 30 days. Specific DL conditions or medications may be identified by combatant command (CCMD) FHP requirements, policies, and DoD guidance. See table 1–1. The physical profile describes duty limitations of Soldiers within MRC 3. These conditions may include temporary or permanent profiles over 30 days, pregnancy, those undergoing administrative review or medical board process, permanent assignment limitations, hospitalization, recovery, or rehabilitation time from serious illness or injury, and/or individuals in DRC 3.

*d. Medical readiness class 4 – medical readiness indeterminate.* MRC 4 – medical readiness indeterminate is used when the Soldier's current health status cannot be determined due to missing health information; this includes an overdue PHA and/or dental exam. A missing dental exam is described as a DRC 4. See table 1–2 for medical readiness.

**Table 1–1**
**Deployment-limiting codes**

| Code | Description |
|---|---|
| DL 1 | Temporary profile > 30 days |
| DL 2 | Dental readiness class 3 |
| DL 3 | Pregnancy and postpartum |
| DL 4 | Permanent profile indicating MOS Administrative Retention Review Program (MAR2) needed[1] |
| DL 5 | Permanent profile indicating Medical Evaluation Board (MEB) needed[2] |
| DL 6 | Permanent profile indicating non-duty related action is needed |
| DL 7 | Permanent profiles with a deployment/assignment restriction code (F, V, or X)[3] |

1. See AR 635–40 for description of MAR2.
2. See AR 40–400 for description of the MEB.
3. See table 4–3 for description of these codes.

**Table 1–2**
**Medical readiness classification chart**

| Medical readiness class | Short definition | Medical definition | Commander's deployment status personnel determination |
|---|---|---|---|
| **MRC 1** | Medically ready/deployable | **MRC 1**<br>Meets all medical readiness requirements and has dental readiness class 1 or 2<br><br>– Temp profile ≤ 7 days | Not required |
| **MRC 2** | Partially medically ready/deployable | **MRC 2**<br>*Soldier is deficient in one or more of the following:*<br>– Temp profile between 8 and 30 days inclusive<br>– HRC 4 (current within 13 months)<br>– Vision readiness class 4 (current within 15 months)<br>– DNA (drawn, on file with DoD repository)<br>– HIV (drawn, validated with DoD repository)<br>– Immunizations current or valid exception (routine adult immunization profile, to include HepA, HepB, TDA, or TDaP, MMR, polio, varicella, (influenza-seasonal))<br>– Individual medical equipment (1 pair of mask inserts, 2 pairs eye glasses, MCEP–I, medical warning tag, and hearing aid with batteries (HAB) if required) | Not required |
| **MRC 3** | Not medically ready/non-deployable (Commander determines deployment status for):<br><br>– Temp profile >30 days (DL 1) to include VRC 3 or HRC 3 profiled conditions<br><br>– Dental readiness class 3 (DL 2) | **MRC 3**<br>Soldier is deficient in one or more of the following:<br><br>**DL 1 –** Temp profile > 30 days<br>**DL 2 –** Dental readiness class 3<br>**DL 3 –** Pregnancy and post-partum<br>**DL 4 –** Permanent profile indicating a MAR2 action is needed<br>**DL 5 –** Permanent profile indicating a MEB action is needed<br>**DL 6 –** Permanent profile indicating a non-duty related action is needed<br>**DL 7 –** Permanent profiles with a deployment /assignment restriction code (F, V, or X) | DL conditions:<br><br>DL 1 or 2: Soldier is not medically ready/non-deployable, and commander determines deployment status<br><br>DL 3, 4, 5, 6, or 7: Soldier is not medically ready/non-deployable. Unit commander cannot make a deployability determination for routine readiness reporting<br><br>When assigned a mission, deployment status will be in |

**Table 1–2**
**Medical readiness classification chart—Continued**

| | | | |
|---|---|---|---|
| | | | accordance with Combatant Command Force Health Protection requirements and policies |
| **MRC 4** | Not medically ready/non-deployable and Commander determines deployment status (default non-deployable) | **MRC 4**<br>Status is unknown<br><br>Soldier is deficient in one of the following:<br>–PHA (current within 15 months)<br>–Dental readiness class 4 (current within 15 months) | Soldier is not medically ready/non-deployable, and commander determines deployment status |

# Chapter 2
# Medical Readiness Information Management and Information Technology

## 2–1. Overview

MEDPROS is a software application in the Medical Operational Data System (MODS). MEDPROS interfaces with systems across the Army that support personnel actions, readiness reporting, assignments, logistics, and senior leader decisions. MEDPROS receives data from many other applications on MODS and systems across the Army. This information informs leaders, commanders, and health care providers guiding the policies and procedures, resource management and medical support planning to achieve and maintain a medically ready and deployable force. This supports the DoD and Army senior leader's medical readiness goals to achieve and maintain a high level of Army readiness. MEDPROS data is accessible through the commander, healthcare, and administrative portals. These portals increase transparency, involve the chain of command in medical readiness, improve reporting mechanisms, and link commanders to profiling providers for communication in making accurate deployability determinations throughout the Army. The healthcare team portals provide the tools to enhance readiness, support medical team development, and enhance administrative review and support of readiness at every visit.

## 2–2. Commander's Portal

*a.* The Commander's Portal synthesizes and displays the data from MEDPROS and other MODS applications into actionable information for the company commander. The commanders, or their trained designees, use this information to improve medical readiness and make deployability determinations at the company level. Battalion commands can view the same information as the company commanders, to include communication with the profiling provider. The battalion commander may override a company commander decision. Higher commands can view medical readiness data for Soldiers who have been on profile long enough to require a review at that leader's level. Senior commanders can view aggregate medical readiness of their subordinate commands, and one level down, to support their ability to assess and impact the health and readiness of their subordinate commands. Actions that improve IMR will culminate in improved unit medical readiness. Various user guides describe the details and use of the Commander's Portal.

*b.* The four areas of focus are "dashboard," "manage readiness," "categories overview," and "messages." Key components (COMPOs) of the dashboard include unit readiness, profile management, action items and deployment status management with links to predictive analytics through the Medical Readiness Assessment Tool (MRAT) statistics and Integrated Disability Evaluation System (IDES) dashboard, which tracks actions through the disability process.

(1) Commanders will use the "manage readiness" section to make deployability determinations.

(2) The categories overview displays the unit medical readiness by the MRC and DL codes with the Deployment Health Assessment (DHA) exam status.

(3) Messaging supports one of the essential functions of communication between providers and commanders for profile clarifications or concerns. Profiling providers provide medical instructions and describe potential duty limitations through the Soldier's profile. Commanders use the profile to make the duty assignment and deployability determinations, balancing mission accomplishment, Soldier employment, and the health and welfare of the Soldiers. As an example, a profile might be written as follows: "Soldier is on a sedating medication which will impact concentration and memory and requires increased rest; no

climbing or range operations." The commander makes the duty modifications of duty hours and adjusts task performance for the Soldier. Unit commanders may not override duty limitations or instructions on DA Form 3349–SG (Physical Profile Record) (see AR 40–502); communication with the profiling provider is essential for clarification, concerns, and optimal individual and unit medical readiness. IMR and profiling will be described in more detail in subsequent chapters.

### 2–3. e-Profile

e-Profile is an application within MODS, and is the Army profiling system of record. All duty limitations of more than 7 days must be written in e-Profile by profiling providers as described in the profiling chapter of this document and AR 40–502. The system supports provider and commander communication, tracks historical data, and describes the capabilities and duty limitations that impact the Soldier's duty assignment, IMR class, and applicable board process.

*a.* e-Profile tracks temporary and permanent profiles describing capabilities, training, and duty limitations. The medical instructions, duty limitations, physical training (PT) adjustments, and duration are displayed on DA Form 3349–SG. The physical profile is displayed in the commander portal for review, duty assignments and deployability determination. The DA Form 3349–SG is an electronically system-generated form, and no hand-written forms are valid.

*b.* Variance across the Army decreases with the use of customizable templates approved by the Office of the Surgeon General (TSG) consultants within e-Profile. These templates maximize plain language, clearly describe medical instructions and PT requirements, and support accurate administrative data entry. Some profile templates associated with unique medical conditions are mandatory, as they are centrally tracked. The best examples are the concussion, pregnancy, and tuberculosis templates. Pregnancy and tuberculosis profiles are the only temporary profiles that extend beyond 90 days (described in more detail in the profiling chapter). Manually entering profiles without templates increases workload and adds unwanted variance by provider, by specialty, and installation. This variance confuses commanders and obscures the clear communication of capabilities and limitations. Temporary profiles are no longer associated with the physical profile serial system (or "physical capacity, upper, lower, hearing, eyes, psychiatric (PULHES);" see AR 40–502). There are more detailed descriptions of the profiling process in subsequent chapters of this pamphlet and the associated user's guide.

*c.* When a Soldier receives healthcare from a civilian provider, and they have limitations that need to be communicated to the command, the Soldier will request a copy of the medical records, and provide a DA Form 7809 (Summary of Care by Non-Military Medical Provider), as a communication tool. The profiling provider may complete a profile from the information in the medical record or the DA Form 7809. This form helps civilian providers by asking for specific information that will be necessary to complete a quality profile.

*d.* e-Profile is the cornerstone tool for communication between the profiling provider and commander regarding medical instructions and Soldier duty assignments. It records the commander's electronic signature when they view a profile in the commander portal and documents it on DA Form 3349–SG. The provider's electronic signature is prominently displayed on the same line as the reason or condition that they described in the profile. The commander's and provider's signatures link to their contact information through the messaging feature for any necessary further communication and to ensure appropriate disposition. The messaging feature in the commander portal is restricted to the commander, and not available to a designee, or staff. This allows providers to share appropriate medical information. The reason for profile is only visible to the commander or their designee. The minimum necessary rule under the Health Insurance Portability and Accountability Act (HIPAA) applies to these communications.

*e.* The duration of the Soldier's temporary profile, or PULHES for a permanent profile, will impact the medical readiness class described in chapter 3.

### 2–4. Medical Readiness Assessment Tool

The MRAT is a 3-in-1 medical readiness risk-decision support tool. This tool displays the composite risk, and component risk factors, for permanent medical non-deployable status. Permanent medical non-deployable status is defined as a permanent level three or four profile in the physical (P), upper extremity (U), lower extremity (L), or behavior health (S) domains of the PULHES system. Role-based access to the tool is available for members of the following cohorts: commanders and commander designees; hospital clinicians and support staff; unit clinicians and support staff. This data currently are for Active Component (AC) Soldiers only.

*a.* Commanders and commander designees may access the MRAT Leader Tool by clicking the MRAT Statistics link from the Medical Readiness Commander's Portal. Commanders will see the percent of their unit's Soldiers at high-risk, or with key risk factors. With training, the commander's designee can build custom graphs comparing the commander's unit against peer units, or comparing subordinate units. Based on review of trends and identification of outlying units, commanders may resource focused efforts to mitigate future medical readiness risk.

*b.* Hospital clinicians and support staff may access the MRAT 24-Month Trend Tool through links in the electronic health record, the Medical Readiness Clinician Portal, and the health assessment modules (such as the PHA) in MODS. A 10–45 second review enables the medical team to identify Soldiers who are not responding to treatment and optimize therapeutic plans. The 24-month trend review supports clinicians' accurate response to a commander's questions regarding return to duty timeframes and fitness for duty. As musculoskeletal and/or behavioral health conditions comprise the majority of DL conditions, review is recommended in primary care, physical therapy, behavioral health, and readiness clinics. A 24-month trend review will be conducted during inprocessing, out-processing, and Soldier readiness processing (SRP). Specific elements available to hospital care teams include:

(1) 24-month trends on permanent medically non-deployable risk.
(2) Healthcare utilization.
(3) Body mass index.
(4) Army Combat Fitness Test (ACFT) scores.
(5) Non-deployment medication days' supply.
(6) Days on profile and max pain scores.
(7) A summary table.

*c.* In addition to the 24-Month Trend Tool, unit clinicians also have access the MRAT Screening Tool. This tool displays similar risk factors, by Soldier, based on unit identification code. By default the display is ordered by highest risk for permanent medically non-deployable. The MRAT Screening Tool may be sorted by specific risk factors, like number of consecutive or non-consecutive days on profile in the last 365 days, body mass index, or DL medications. Unit-based providers can access these tools through the Medical Readiness Clinician Portal and the MODS Command Management System. This consolidated unit view supports proactive risk identification and effective mitigation strategies throughout the command.

*d.* It is essential to understand that the detailed Soldier data needs to be interpreted by a medically trained professional and represents a component of a Soldier's holistic health assessment. The calculated MRAT score represents percentile individualized risk, not probability of outcome. Administrative actions should never be based on the MRAT permanent medical non-deployment status risk scores. Specific information about this tool is available in the MRAT handbook.

*e.* Hospital clinicians and support staff may access the MRAT 24-Month Trend Tool through links in the electronic health record, the Medical Readiness Clinician Portal, and the health assessment modules (such as the PHA) in MODS. A 10–45 second review enables the medical team to identify Soldiers who are not responding to treatment and optimize therapeutic plans. The 24-month trend review supports clinicians' accurate response to a commander's questions regarding return to duty timeframes and fitness for duty. As musculoskeletal and/or behavioral health conditions comprise the majority of DL conditions, review is recommended in primary care, physical therapy, behavioral health, and readiness clinics. A 24-month trend review will be conducted during in-processing, out-processing, and SRP. Specific elements available to hospital care teams include:

### 2–5. Medical Protection System

*a.* MEDPROS is the Army's authoritative data source for medical readiness. MEDPROS obtains other aspects of IMR, such as the PHA, audiogram, vision, and dental screening dates from other MODS applications or supporting systems. MEDPROS receives the information from e-Profile, describing the medical readiness impacts of the duty limitations. All of this information determines the Soldier's medical readiness category, as described in chapter 1 of this pamphlet. Integration of MEDPROS and the electronic health record (EHR) continue to improve and streamline health care and medical readiness operations.

*b.* Per DoDI 6025.19, Soldiers' PHA and annual dental exam expire at 12 months and is overdue at 15 months. To help commanders prevent Soldiers from becoming overdue in IMR-related services, MEDPROS notifies all Soldiers via email at 9 months, providing more lead time. These emails contain all other IMR deficiencies (vision, hearing, DNA, and so forth), with instructions on how to resolve each issue

until the deficiency is corrected. Additionally, modifications to the stoplight functionality within Army Knowledge Online (AKOs) “My Medical Readiness” and the new Soldier landing page within MEDPROS will alert commanders via email. As such, the stoplight colors may not directly correlate to the MRC color. MRC logic is predefined to identify all Soldiers who are MRC 3, then MRC 4, then MRC 2, and finally MRC 1.

*c.* As Army readiness requirements evolve, the timelines and definitions of IMR deficiencies are subject to change. However, managing individual readiness is the Soldier’s responsibility, along with their unit Commander.

*d.* With the full implementation of the new Healthcare and Administrative Portals, the design and functionality of MEDPROS will change drastically to incorporate all readiness elements into a single sign-on system based on user roles. Individual Soldiers who need to see their own medical readiness data within MEDPROS will not require any special access privileges or training requirements. Other users (such as commanders, administrative personnel, and providers) will have to meet mandatory training requirements and be granted approval by a Commander’s Portal access manager (CPAM). Each one and two star command will appoint a Commander’s Portal approval authority (CPAA). Each command at the brigade (BDE) level is directed to have at least two CPAMs. CPAAs will train, support, and ensure the CPAMs maintain accurate access for commanders and staff/designee. This process will work through the operational command lines. Medical command (MEDCOM) will establish training requirements and transition to Joint Knowledge On-line (JKO) as the primary source to train the force. Commands are free to direct how many CPAAs are needed within their direct reporting units. There is no MOS, AOC, rank, or grade restriction; however, CPAAs must have knowledge of user’s roles in order to validate user’s requests. CPAMs and CPAAs ensure the right person makes deployability determinations and has the right level of access to Soldier health data.

### 2–6. Healthcare Portal

The Healthcare Portal is a role-based application with functionality built to support the responsibilities of the health care team member. This portal will help integrate medical readiness into every patient encounter with the health care team. Roles will include differentiation of the levels of function between types of providers and medical staff members. The health care team will have a single location to access the medical readiness functionality that was previously in multiple readiness applications with a single sign-on. Examples of the medical readiness functionality include the ability to do a PHA, write a profile, and update immunizations all from the same location. The provider role will also have the messaging and an integrated action item list. An individual search will yield all their medical readiness information in a single view to support the integration of all readiness services with optimal efficiency. Support staff will be able to use this capability to pro-actively manage readiness, prevent IMR items from becoming overdue, and improve patient care with optimal efficiency.

### 2–7. Administrative Portal

This portal gives those in an administrative role the ability to appropriately post administrative codes, manage access, create, and use customizable administrative reports that will pull data from all of the readiness systems. A single report will be able to use data from multiple or all the medical readiness functionality, for example e-Profile, MEDPROS web reporting, and medical health assessments.

## Chapter 3
## Individual Medical Readiness - Key Elements, Standards, Categories, and Goals

### 3–1. Overview

Maintaining readiness is an individual Soldier’s responsibility. In accordance with DoDI 1332.45, Soldiers, commanders, and healthcare providers must immediately correct all IMR deficits to ensure Soldier members are medically ready to deploy. IMR is the foundation of a unit’s Armywide medical readiness and deployability determinations. Medical readiness is a key component of Army personnel readiness, which impacts the Army’s mission. MEDPROS reports IMR and the commander’s deployability determination to the Integrated Personnel and Pay System – Army. AR 220–1 describes the Army readiness reporting process and will govern whether commanders can override determinations made in the Commander Portal. MRC and a commander’s deployability determination in MEDPROS combine with administrative

deployment status requirements to determine personnel deployment status as part of the Army readiness reporting process. Not being medically ready is a leading cause of non-deployable status. IMR information is initially entered into e-Profile or MEDPROS by profiling providers and teams. The healthcare and administrative portals streamline the system access requirements and medical readiness support for every healthcare visit to be a readiness visit. The Commander's Portal brings medical reporting capabilities developed over the last decade to commands throughout the Army on a single cohesive platform.

**3–2. Individual medical readiness**

*a. General.* DODI 6025.19 establishes IMR as a Soldier's responsibility. There are six measurable elements of IMR for all Services. Senior leaders report IMR data to the DoD. The Army reports IMR as:

(1) PHA currency (required by DoD).
(2) DL conditions (required by DoD).
(3) DRC (required by DoD).
(4) Immunization status (required by DoD).
(5) HIV test and DNA specimen (required by DoD).
(6) Individual medical equipment (required by DoD).
(7) Hearing readiness (Army-specific requirement).
(8) Vision readiness (Army-specific requirement).

*b. Commander programs.* Since IMR is the basis of unit readiness, commanders must ensure that all unit members comply with IMR requirements and coordinate with supporting medical assets to achieve the Army's readiness goals. Commanders should develop programs to monitor and intervene to ensure their units achieve or exceed the DoD IMR goal. This is essential, since there are additional requirements for personnel readiness beyond being medically ready. The leadership goals for medical readiness and deployment status are different. Optimizing the unit medical readiness supports optimal Army readiness and the unit status report.

*c. Medical asset support of individual medical readiness.* Key areas of support include accurate and timely update of the EHR and the medical readiness system of record, referral management, and access to medical support. It is best practice to update applicable systems at the time medical service is provided, but if impractical during service provision, all providers (to include Reserve Health Readiness Program (RHRP) providers) and profiling officials will update applicable systems within 72 hours from the time of service. e-Profile will be reviewed and all active profiles updated by a profiling officer, in conjunction with completion of the PHA, as directed in AR 40–502. All active and recently expired profiles should be extended, linked, expired, or modified to most accurately describe the Soldier's capabilities and limitations. Unit medical readiness and organizational management improve with active referral management and clinical support of DL conditions. Finally, timely access to care and medical services is essential to ensure medical personnel and Soldiers remain physically, mentally, and medically ready to deploy.

*d. Commander tracking.* Commanders and leaders at all levels of the Army ensure support of the medical readiness requirements and needs of our Soldiers. Leaders will track their unit's IMR against published DoD goals in the medical readiness system of record as directed in AR 40–502. The Army supports all Soldiers' medical readiness needs while optimizing both the individual and unit.

*e. Reporting.* For DoD IMR reporting purposes, the Army includes Active and Selected Reserve Soldiers, both officers and enlisted, except those specifically excluded as directed in DODI 6025.19 and agreed upon by the deputy chief of staff (DCS), G–1 and the respective Reserve Component (RC) commands.

**3–3. Individual medical readiness - key elements**

The eight key elements in the Army's IMR program are described in detail below:

*a. Periodic Health Assessment.*

(1) The PHA is an annual (every 12 months) screening assessment for changes in health status, especially those that could impact a Soldier's ability to perform military duties. However, for DoD reporting purposes, the Army will use the reporting criteria directed in DoDI 6025.19 to determine when a PHA is overdue. Per this DoDI, the PHA is overdue if not completed within 3 months of the month due date (for example, a PHA due in October 2023 will be counted as overdue if it has not been completed by the last day of January 2024). Once overdue, the Soldier's readiness status will transition to "indeterminate" for PHA currency and become MRC 4 (medically not ready). Commanders and health care providers need to make every effort to prevent Soldiers from becoming non-compliant with their PHA. A commander can make

individual deployability determinations within the Commander's Portal, as authorized by AR 40–502. Not making a deployability determination can increase a commander's non-deployable population, decrease their unit's medical readiness, and decrease personnel readiness in their unit readiness reporting. Maintaining their readiness is an individual Soldier's responsibility. Per DoDI 1332.45, Soldiers, commanders, and health care providers must immediately correct all IMR deficits to ensure Servicemembers are medically ready to deploy.

(2) Healthcare personnel ensure the PHA results and e-Profile updates are entered into the medical readiness system of record during the patient encounter. The medical readiness information (PULHES, profile codes, and date of PHA) will automatically update the information in the medical readiness system of record and associated personnel databases. The PULHES is updated through the e-Profile module.

(3) Deployed Soldiers' PHA requirements are deferred until 3 months after their return. This allows the Soldiers ample time to complete their PHA. These opportunities support minimizing the MRC 4 rate.

(4) Members of the Individual Ready Reserve (IRR) have a requirement to promptly report any medical (including mental health) conditions that may affect their readiness to deploy. Human Resources Command will determine what reporting tools the IRR Soldiers (not on active duty (AD)) will use to meet the annual PHA requirement. For example, an IRR Soldier may be directed to use the DA Form 3725 (Army Reserve Status and Address Verification) or the virtual muster. If the Soldier reports any conditions, they are required to provide supporting documentation to the Human Resources Command, if requested.

*b. Deployment-limiting medical conditions.* As directed in AR 40–502, profiling providers describe all medical conditions, including potentially DL conditions, on a DA Form 3349–SG. When a medical condition places the Soldier in MRC3, they will receive one of seven DL codes (see table 1–1). Commanders must make initial deployability determinations for MRC 3, DL 1 in the Commander's Portal upon review of the profile. The determination will be reviewed monthly while the Soldier has a condition that makes them DL 1. All IMR deficiencies must be immediately corrected to ensure Servicmembers are medically ready to deploy.

*c. Dental readiness classification.* DODI 6490.07, DODI 6025.19 (as implemented by AR 40–3), and AR 40–502 establish the requirements for dental readiness.

(1) *Dental readiness classification 1.* DRC 1 Soldiers hold a current dental examination and no requirement for dental treatment or reevaluation. DRC 1 Soldiers are medically ready and deployable; these Soldiers align with MRC 1.

(2) *Dental readiness classification 2.* DRC 2 Soldiers hold a current dental examination, which requires non-urgent dental treatment or reevaluation for oral conditions that are unlikely to result in dental emergencies within 12 months. DRC 2 Soldiers have active dental disease that requires treatment. DRC 2 Soldiers are medically ready and deployable; these Soldiers align with MRC 1.

(3) *Dental readiness classification 3.* DRC 3 Soldiers require urgent or emergent dental treatment, or are expected to need urgent or emergent treatment within the next year. DRC 3 Soldiers are not medically ready. All DRC 3 conditions must be treated and resolved prior to deploying. These Soldiers are part of the MRC 3 population.

(4) *Dental readiness classification 4.* DRC 4 Soldiers require annual or other dental examinations, such as a digital panoramic image of diagnostic quality for the Army Dental Digital Repository (ADDR). Soldiers whose ADDR data is blank in MEDPROS (dental class unknown) are also DRC 4 (in accordance with AR 40–3 and AR 40–35). DRC 4 Soldiers are not medically ready and are part of the MRC 4 population. This IMR deficiency must be corrected immediately, per DODI 1332.45. These Soldiers contribute to the medically non-deployable population and are eligible for monthly commander's determinations.

*d. Immunizations.*

(1) *Readiness reporting tracks the adult routine immunization profile.* (See AR 40–562 for complete information.) If there is an interruption in an immunization series, Soldiers should receive the delayed doses as soon as feasible. Do not restart the series unless clinically indicated. Ensure patients receive doses according to the published vaccine schedule, since in an immunization series, receiving an immunization early may require additional doses for completion. Ensure validation of all immunization medical exemptions with either a lab result or a documented medical encounter. MTFs and facilities providing immunizations must enter the immunizations into the medical readiness system of record within 24 hours whenever practicable, and no later than 72 hours after the immunization is given in accordance with AR 40–502. MTFs do not turn away any Army Soldier, who can be validated within the Defense Enrollment Eligibility Reporting System (DEERS), who requires readiness services and data entry. Profiling providers

conducting serological titer testing ensure that all positive results are entered into the medical readiness system of record.

(2) *Routine adult series:* See AR 40–562 for guidance on mandatory immunizations. Soldiers are medically ready if they are current on all mandatory immunizations. If the Soldier is missing one or more mandatory immunizations, the Soldier is partially medically ready (MRC 2) unless there are other IMR deficiencies.

(3) *Other immunizations.* Other immunization requirements specified in AR 40–562 are just as important to successful service, but not reflected in the IMR since they apply only to limited populations or are mission specific. Examples include the rabies pre-exposure prophylaxis for those with occupational risk of exposure to rabid animals or forces assigned to locations where access to definitive care is likely to exceed 24 hours.

*e. Deoxyribonucleic acid specimen and human immunodeficiency virus test.*

(1) *Deoxyribonucleic acid* Soldiers provide a single DNA specimen for storage at the DoD Serum Repository at the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR). Soldiers with a DNA sample on file and recorded in the medical readiness system of record are medically ready. Soldiers are partially medically ready (MRC 2) if:

*(a)* There is no evidence that a DNA specimen was drawn ("D" in MEDPROS).

*(b)* There is no evidence that a specimen is on file at the AFRSSIR.

*(c)* The DNA on file category in MEDPROS is blank.

(2) *Entering the record.* A "D" for drawn will be entered into the medical readiness system of record within 24 hours, and no later than 72 hours after the DNA sample is drawn.

(3) *Current human immunodeficiency virus test.* Soldiers with a current HIV antibody test received at the Armed Forces Health Surveillance Branch, in accordance with the AR 600–110 testing timeframe (once every 2 years), are medically ready. Soldiers without a current HIV test are partially medically ready (MRC 2).

*(a)* A "D" for drawn will be entered into the medical readiness system of record within 24 hours whenever practicable, and no later than 72 hours after the DNA sample is drawn.

*(b)* In accordance with AR 600–110, Soldiers with confirmed HIV infection are exempt from this requirement.

*f. Individual medical equipment.* The DoD core IMR requirement is one pair of gas mask inserts for Soldiers needing visual correction. The Army individual medical equipment requirement also includes:

(1) Documentation of a current eyewear prescription, such as DD Form 771 (Eyewear Prescription) if required, that is less than 4 years old in MEDPROS VRC.

(2) Physical possession of two pairs of glasses (2PG).

(3) One pair of military combat eye protection (MCEP) inserts (MCEP–I).

(4) One pair of mask inserts (1MI).

(5) One pair of serviceable MCEP eyewear (MCEP) from the authorized protective eyewear list (APEL).

(6) One HAB, if required.

(7) One medical warning tag (MWT), if required.

*Note:* AD, State Army National Guard (ARNG), and U.S. Army Reserve (USAR) Soldiers in deployment status missing any of the above items are partially medically ready.

*g. Hearing readiness.* (See DA Pam 40–501.)

(1) The Army Hearing Program is described in detail in DA Pam 40–501. The Defense Occupational and Environmental Health Readiness System – Hearing Conservation (DOEHRS–HC) hearing test system is the only authorized system for conducting and recording audiograms (DD Form 2215 (Reference Audiogram) and DD Form 2216 (Hearing Conservation Data)). The DOEHRS–HC hearing test system is comprised of the DOEHRS–HC software application; current DoD approved audiometer; and the DOEHRS–HC data repository web based application.

(2) All military personnel receive a reference audiogram DD Form 2215 at initial entry training, or Basic Officer Leader Course, prior to noise exposure.

(3) DA Pam 40–501 requires all AD Soldiers (regardless of unit assignment) and RC Soldiers assigned to table of organization and equipment (TO&E) units to complete an annual (12 months) DD Form 2216 to determine hearing readiness.

(4) Hearing readiness categories are as follows:

*(a) Hearing readiness category 1.* The HRC 1 Soldier had a DOEHRS–HC audiogram within 12 months; unaided hearing is within H–1 standards for both ears. See table 4–1. Soldier is medically ready, and this aligns with MRC 1.

*(b) Hearing readiness category 2.* The HRC 2 Soldier had a DOEHRS–HC audiogram within 12 months; unaided hearing is within H–2 or H–3 standards. The Soldier has a current DA Form 3349–SG in e-Profile assigned (H–2 or H–3) and has completed both the appropriate Military Operational Hearing Test (MOHT) battery (for example, the Speech Recognition in Noise Test) and MOS administrative retention review (MAR2). Soldier has hearing aids, if required, and a 6-month supply of batteries. Soldier is medically ready, and this aligns with the MRC 1 population.

*(c) Hearing readiness category 3.* The HRC 3 Soldier has a DOEHRS–HC audiogram within 12 months; unaided hearing is within H–2 or H–3 standards in table 4–2, but the Soldier requires audiological evaluation to determine and document an H–2 or H–3 hearing profile on a DA Form 3349–SG in e-Profile. Routine hearing loss profiles will not be written until the comprehensive audiological evaluation is completed. Soldiers with permanent H–3 hearing loss confirmed in the comprehensive audiological evaluation will require referral to the MAR2. This Soldier is not medically ready, nor deployable. Their medical readiness is described as MRC 3, DL 4. Temporary hearing loss profiles are for conditions that temporarily prevent the wearing of hearing protection, or an acute acoustic trauma that has not stabilized for permanent evaluation.

*(d) Hearing readiness category 4.* The HRC 4 Soldier either does not have a DOEHRS–HC audiogram within 12 months or requires a follow-up test to assess a pure tone standard threshold shift. This designation includes Soldiers who do not have a DD Form 2215 (Reference Audiogram). These HRC4 Soldiers are partially medically ready (MRC2). Commanders ensure completion of all required evaluations and correction of any deficiencies identified prior to deployment.

*h. Vision readiness.* The Army Vision Conservation and Readiness Program is described in DA Pam 40–506, and contributes to medical readiness. Vision readiness includes an annual (12 months) assessment of a Soldier's distance visual acuity, near acuity if age 45 or older, and currency of the Soldier's optical devices, if required. Health care personnel will not conduct visual acuity testing with the Soldier wearing contact lenses. For Soldiers prescribed spectacles, undergoing a military examination (to include the PHA), health care personnel will measure visual acuity first without spectacles and then with spectacles. During pre-deployment processing, SRP, and after bring provided optometric care to correct a non-deployable status, health care personnel will update the vision readiness module of the medical readiness system of record. Soldiers using civilian eye care should submit a complete DA Form 7655 (Armed Forces Eye and Vision Readiness Summary) to an MTF or unit readiness coordinator to update their vision readiness status in MEDPROS. The vision readiness categories are as follows:

(1) *Vision readiness classification 1.* The VRC 1 Soldier possesses one serviceable APEL-approved MCEP system and achieves distance and near (if age 45 or older) visual acuity of 20/40 or better with both eyes open. Or, the Soldier possesses a medical waiver for correctable vision worse than 20/40. If the Soldier requires spectacles to achieve 20/40 binocular vision, or as a condition of the medical waiver, a record of the required spectacle prescription that is less than 4 years old must be recorded in MEDPROS and must validate possession of two pairs of glasses, one combat eye protection insert, and one protective mask insert. Referral to optometry is recommended if best vision is worse than 20/20. VRC 1 Soldiers are visually and optically medically ready and align with MRC 1.

(2) *Vision readiness classification 2.* The VRC 2 classification only applies to Soldiers who do not have an APEL-approved MCEP system and Soldiers who require spectacles either to achieve 20/40 or better binocular vision, or as a condition of their medical waiver. The Soldier's spectacle prescription must be less than 4 years old and recorded in MEDPROS, but possession of all optical devices may not be complete. VRC 2 Soldiers are visually prepared for deployment and possess a current spectacle prescription but lack one or more optical devices. VRC 2 Soldiers are considered medically ready and align with MRC 1.

(3) *Vision readiness classification 3.* VRC 3 Soldiers require optometric treatment, because their best corrected visual acuity at a distance or near (if age 45 or older) is worse than 20/40 at the time of screening, or their required spectacle prescription listed in MEDPROS is older than 4 years. VRC 3 Soldiers are not visually and/or optically ready, not medically ready, and align with MRC 3. Duty limitations of Soldiers in the VRC 3 will be documented through the profiling process with the appropriate DL code to describe the condition and any board requirements.

(4) *Vision readiness classification 4.* VRC 4 Soldiers do not have a documented vision readiness screening in MEDPROS, or have a vision readiness screening in MEDPROS that is older than 15 months. VRC 4 Soldiers are classified as indeterminate, partially medically ready, and align with MRC 2. Commanders ensure completion of all required evaluations and correction of any deficiencies identified prior to deployment.

### 3–4. Commander deployability determinations

*a.* In making deployability determinations, unit commanders should consider the Soldier's duties, type of mission, and geographic conditions or concerns. Execution and support for medical readiness both improve when there is close collaboration with supporting (unit or MTF) health care providers. Army leaders needs accurate deployment statuses and readiness assessments to train, man, and equip the force.

*b.* Deployability determinations for Soldiers with missing IMR requirements and duty limitations will be made upon review of a Soldier's medical readiness information and profile. The determination will be documented in the Commander's Portal. The electronic profiling system digitally tracks and documents the commander's profile review. The command staff and commander's designee may view the described capabilities, duty limitations, and training guidance, but will not be able to view the reason for the profile, and their signatures will not be digitally captured on the profile. The Commander's Portal tracks and submits Soldier deployment status defaults and/or commander's determinations and submits them to personnel and Army readiness systems.

*c.* While unit commanders can make deployability determinations for their Soldiers in MRC 3 or DL 1, a Soldier deemed deployable will not preclude the need for a deployment medical waiver. CCMDs establish the medical deployment policy and waiver process for their area of responsibility. Upon receipt of an assigned mission, the deploying Soldier will be screened according to the currently published CCMD guidance applicable to the assigned mission. Any Soldier with a DL condition or requiring a waiver will receive a temporary profile to identify their deployment status limitation and the need to fix the DL condition (for example DRC 3) or engage in the CCMD waiver process if the commander wishes to deploy the Soldier. The commander reviews and discusses with the evaluating provider, and can request a CCMD waiver in accordance with the published policy. When the CCMD waiver decision is returned, the originating medical authority indicates the result in e-Profile and expires the temporary profile for the CCMD waiver process. A successful CCMD waiver allows the commander to make the deployability determination for Soldiers who are in MRC 3, DL7 for up to 1 year.

*d.* Commanders ensure Soldiers are medically ready prior to deployment. During a deployment, the commander assesses changes in a Soldier's deployment status, whether from injuries, worsening of known medical conditions, or the diagnosis of new medical conditions.

### 3–5. Individual medical readiness categories

Using the eight key elements of IMR and e-Profile information, the medical readiness system of record will indicate the MRC assigned in accordance with paragraph 1–5. This application of the IMR to determine the MRC subsequently supports many personnel actions throughout the Army, from readiness to permanent change of station (PCS) requirements.

### 3–6. Disposition of individual medical readiness data

*a.* MEDPROS is the database of record for all medical readiness data elements. Profiling providers will also document all readiness assessments in the EHR or the service treatment record (STR). The medical readiness system of record and the EHR continue to gain efficiencies of communication and connectivity.

*b.* All IMR data will be updated in MEDPROS for all Army personnel (all COMPOs), including deploying DA Civilians, regardless of Tri-Service Medical Care (TRICARE) enrollment.

*c.* Healthcare personnel who document IMR services in the EHR (with the exception of immunizations) will update MEDPROS within 72 hours.

### 3–7. Individual medical readiness goals

See AR 40–502 for the Army's goals. AR 40–502 and current guidance from the Assistant Secretary of Defense, Health Affairs establish the Army IMR goal. There are no published goals for each element of IMR. Reports that provide medically ready statistics, by element, display all personnel who are current or deficient for that element. A Soldier is placed in the order of precedence for the MRCs as follows: MRC 3, then MRC 4, then MRC 2, and finally MRC 1. Personnel may be deficient for more than one element, but

will only count once against the unit IMR. For example, Soldier 1 is deficient in three elements and Soldier 2 is deficient in only one element; both deficiencies count against the unit IMR score equally and only once. Soldier 1 needs to correct three items to resolve their IMR deficits and improve unit readiness. Soldier 2 needs to correct one item to become ready and improve the unit readiness.

## Chapter 4
## Physical Profiles

### 4–1. General

*a.* This chapter describes processes for communicating functional abilities, medical instructions and recovery time estimates to commanders, for accurate readiness and duty assignment. The Commander's Portal increases transparency in communication between profiling providers and commanders. Commanders must use the Commander's Portal to track and report personnel deployment status metrics. Standardized, accurate, and clearly worded profiles are critical to inform commanders of both a Soldier's capabilities and functional limitations, such as those outlined in table 4–1. In accordance with AR 40–502, unit commanders may not override duty limitations or instructions on DA Form 3349–SG. Commanders will use these instructions and the functional information about the Soldier in making duty assignments to include deployment determinations. AR 40–501 provides disease-specific profiling requirements for certain medical conditions, to include but not limited to, asthma, and coronary artery disease, and establishes the retention standards for medical conditions. Anatomical defects, pathological conditions, prognosis, and the possibility of further aggravation all contribute to the Soldier's ability to perform his or her duty. Profiles must be realistic with specific functional limitations written in lay terms.

*b.* Determining individual assignments or duties is a commander's decision. Limitations such as "no field duty," or "no overseas duty," are not proper medical recommendations. Administratively, Soldiers in certain DL categories will have these constraints (such as pregnant Soldiers and Soldiers pending medical and administrative boarding action). Profiling providers must provide specific information on the Soldier's functional limitations, capabilities, and a description of what the Soldier "can do" to enable assignment or duty determination by the nonmedical commander or U.S. Army Human Resources Command (AHRC). The profiling provider ensures that complete and accurate administrative information is annotated on the DA Form 3349–SG.

**Table 4–1**
**Profiling comment examples**

| Profiling comments with specific duty limitations and rationale: generally appropriate | Overly restrictive comments without guidance to a commander: generally inappropriate |
|---|---|
| Requires eight consecutive hours of sleep in every 24 hour period | SM can only work from 9–5, or Soldier cannot present to work until 1000 hours |
| Soldier should not be exposed to stimuli suggestive of combat experiences (for example, no simulator training, no ranges, no simulated mortars, no patrol lanes, no IED training, and so forth) | No uniforms |
| No alcohol | No formations |
| No weapons or ammunition | No 24-hour duty |
| Soldier has been referred to the MEB process. No deployments to an austere environment per personnel policy regulations. This Soldier should not be issued an individually assigned military weapon, or attend any live fire drills or ranges. Soldier should remain stationed near an MTF where definitive specialty care is available for timely IDES processing | |

*c.* The commander or personnel management officer determines proper assignment and duty, based on knowledge of the Soldier's profile, assignment limitations, and the duties of the grade and MOS.

*d.* The commander has the final decision on the deployment of Soldiers in his or her unit. When health care providers and commanders disagree on the medical readiness status of a Soldier, the decision will be raised to the first O–6 in the Soldier's chain of command, who makes the final decision whether to

deploy the Soldier in consultation with the appropriate medical officer. Deployment waivers may be required for certain areas of operation.

### 4–2. Application

As specified in AR 40–502, the physical profile system applies to members of any COMPO of the U.S. Army throughout their military service, from accession to separation.

### 4–3. Physical profile serial system

*a.* The basis for the physical profile serial system is the function of body systems and their relation to military duties. Profiling providers will use permanent profiles to describe and rate the function of the extremities, sensory organs, physical capacity, and mental health according to the system described in the following paragraphs. The analysis of the individual's medical function plays an important role in assignments and welfare of Soldiers. Individual duty limitations can impact other Soldiers and unit mission capability. The profiling providers must execute the functional grading, restrictions, and medical instructions with great care and accuracy. Clear and accurate medical instructions to support the recovery, stable function, and maximal safe employment of Soldiers are essential.

*b.* The permanent physical profile has six functional areas “P–U–L–H–E–S” with four numerical designations used to reflect different levels of functional capacity, described in the following paragraph and table 4–2. The determination of the numerical designation 1, 2, 3, or 4 evaluates the functional capacity of a particular organ or system of the body.

*c.* The functional areas for consideration are:

(1) *P – Physical capacity or stamina.* This is general physical capacity and normally includes conditions of the heart; respiratory system; gastrointestinal system and genitourinary system; nervous system; allergic, endocrine, metabolic, and nutritional diseases; diseases of the blood and blood-forming tissues; oral maxillofacial conditions; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.

(2) *U – Upper extremities.* This is the function and/or diseases of hands, arms, shoulder girdle, and upper spine (cervical and thoracic); as they affect strength, range of motion (ROM), and general efficiency.

(3) *L – Lower extremities.* This is the function and/or diseases of feet, legs, pelvic girdle, lower back musculature, and lower spine (lumbar and sacral) as they affect strength, ROM, and general efficiency.

(4) *H – Hearing and ears.* This is auditory performance.

(5) *E – Eyes.* This is visual acuity and diseases and defects of the eye.

(6) *S – Psychiatric.* This is personality, emotional stability, and psychiatric diseases.

*d.* There are four numerical designations to describe a Soldier’s functional capacity, in each of the six functional areas of the physical profile serial system, applied to the permanent profiles. Guidance for assigning numerical designators is in table 4–2. Soldiers with a numerical designator of 3 or 4 are non-deployable until they have completed the medical or administrative board process described in AR 635–40. The profile serial and physical-category codes described in para 4–5 support and document progress through the medical or administrative board processes.

*e.* All profiles will describe the Soldier’s functional limitations whether the condition is just presenting or has a thorough evaluation and has reached the Medical Retention Determination Point (MRDP). 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 (section 4 of DA Form 3349–SG and passing one aerobic AFPT event) and perform the duties required of his or her MOS, grade, or rank. If after reaching MRDP, and transitioning to a permanent profile, the Soldier does not meet the medical retention standards listed in AR 40–501, then the numerical designator must be a 3 or a 4. Any persistent DL condition requires inherently significant duty limitation and indicates a numerical designator of 3 or 4. This clearly communicates the significance of the duty limitations and any known DL conditions to the commander. The Soldier’s functional limitations identified in e-Profile, the ability to meet retention standards and the numerical designator of the profile (permanent 3 or 4), determines the disability evaluation system (DES) initiation (see AR 635–40 for description of the DES). The numerical designators described below are also exemplified in table 4–2.

(1) An individual having a numerical designation of “1” describes a high level of medical fitness, deployable.

(2) A physical profile designator of “2” under any factors indicates some medical condition or physical defect that requires some minor functional or activity limitations, deployable. (Note, a Soldier may meet medical retention standards but require a permanent 3, thus, requiring referral to MAR2 in accordance with AR 635–40).

(3) A profile containing one or more numerical designators of “3” describes one or more medical conditions or physical defects with significant functional or activity limitations and warrant processing through a MAR2 or DES process.

(4) A profile containing one or more numerical designators of “4” describes one or more medical conditions or physical defects with severe limitations of military duty performance, requires a DES board evaluation.

**Table 4–2**
**Physical profile functional capacity guide-**

| **Profile**<br><br>**Serial** | **P**<br><br>**Physical capacity** | **U**<br><br>**Upper extremities** | **L**<br><br>**Lower extremities** | **H**<br><br>**Hearing–ears** | **E**<br><br>**Vision–eyes** | **S**<br><br>**Psychiatric** |
|---|---|---|---|---|---|---|
| Factors to consider | Organic defects, strength, stamina, agility, energy, muscular coordination, function, and similar factors. | Strength, ROM, and general efficiency of upper arm, shoulder girdle, and upper back, including cervical and thoracic vertebrae. | Strength, ROM, and efficiency of feet, legs, lower back to include lumbar, sacral, and pelvic girdle. | Auditory performance. | Best corrected visual acuity at distance and organic diseases, defects, or injuries of the eyes, eyelids, and/or visual system that affect the visual field and overall visual function. | Type. Severity. and duration of current psychiatric symptoms, disorder, or prognosis. Environmental and individual factors that may affect prognosis for recovery and risk for future decompensation. |
| 1 | Good muscular development with ability to perform maximum effort for indefinite periods. | No loss of digits or limitation of motion; no demonstrable abnormality; able to grasp and hold body weight (hanging bar); able to push or pull body weight; able to perform upper body combative to include grappling and submission holds. | No loss of digits or limitation of motion; no demonstrable abnormality; able to perform long marches; stand over long periods, run. | Audiometric threshold at 500, 1000, and 2000 Hz not more than 25 dB in better ear and not more than 30 dB in worse ear; at 3000 Hz not more than 25 dB in better ear and not more than 35 dB in worse ear; at 4000 Hz not more than 25 dB in better ear and not more than 45 dB in worse ear; at 6000 Hz not more than 60 dB in better ear. The better or worse ear is determined for | Distance visual acuity of 20/20, or better, in each eye with or without spectacle lenses and the absence of any visual functional limitation due to diseases, defects, or injuries. | No current psychiatric disorder. May have a behavioral health disorder in complete remission that requires no duty limitation. |

**Table 4–2**
**Physical profile functional capacity guide—Continued**

| Profile | P | U | L | H | E | S |
|---|---|---|---|---|---|---|
| | | | | each frequency and may not be the same at all frequencies. | | |
| 2 | Able to perform maximum effort over long periods of time but may require shaving restriction, the use of daily medication such as for hypertension or asthma but remains fully deployable without deployment restrictive administrative codes. | Minimal limitations that may have slight joint mobility limitations, muscle weakness or skeletal defects that do not prevent combatives (excluding grappling and submission holds), PRT climbing drills and prolonged effort. | Minimal limitations that may have slight joint mobility limitations, muscle weakness or skeletal defects that do not prevent Marching up to 2 miles with full IOTV and 5 miles in standard uniform, ACFT timed walk, ability to bike 3 miles and swim up to 300 meters, running at own pace and distance or prolonged effort. | Audiometric thresholds in both ears not more than 40 dB at 500 Hz, 40 dB at 1000 Hz, and 60 dB at 2000 Hz and audiometric thresholds in at least one ear not more than 25 dB at 500 Hz, 30 dB at 1000 Hz, 25 dB at 2000 Hz, 40 dB at 3000 Hz, 60 dB at 4000 Hz, and 70 dB at 6000 Hz or meets MOHT battery H2 criteria. | Best corrected distance visual acuity or the presence of organic diseases, defects, or injuries with mild visual functional limitations that may require non-standard spectacles (tinted lenses, prism, and so forth) or workplace accommodations. | Mild, residual symptoms of a behavioral health disorder responding to outpatient treatment. Minimal risk of decompensating without continuous behavioral health support. Stable on medications without impairing side effects. |
| 3 | Unable to perform full effort for more than 15 minutes without rest. | Defects or impairments that require significant restriction of use but able to lift, push, or pull up to 40 lbs. | Defects or impairments that require no running, inability to stand over 30 minutes but able to perform the ACFT bike or swim. | Exceeds H2 audiometric threshold criteria and meets MOHT battery H3 criteria. | Best corrected distance visual acuity of 20/40 in the better-seeing eye that requires the use of optical devices other than spectacle lenses or the presence of organic diseases, defects, or injuries that result in moderate visual functional limitations. | Active behavioral health disorder that limits mission capability and/or social/ occupational functioning. Recent need for inpatient or intensive outpatient treatment. Impairing side effects or significant lab monitoring requirements from medications for behavioral health disorders. |
| 4 | Functional level below P3. | Functional level below U3. | Functional level below L3. | Functional level below H3 as determined by exceeding H2 audiometric threshold criteria and | Functional level below E3. | Chronic psychiatric symptoms that drastically limit the performance of military duties. |

**Table 4–2**
**Physical profile functional capacity guide—Continued**

| Profile | P | U | L | H | E | S |
|---|---|---|---|---|---|---|
| | | | | meets MOHT battery H4 criteria. | | |

## 4–4. Temporary vs. permanent profiles

There are many electronic requirements for recording profiles. As designated in AR 40–502, profiling provider must complete all profiles for medical conditions lasting greater than 3 days, both temporary and permanent, in e-Profile. The DD Form 689 (Individual Sick Slip) may be used only once for a medical condition limited to acute, minor, self-limited illnesses requiring only one to a maximum of seven days of recovery. DD Form 689 may also be used to write out medical instructions for Servicemembers from other Services, to communicate back to other commanders. Any residual duty limitations and all conditions with functional limitations clinically expected to extend beyond 7 days must be recorded on a temporary profile in accordance with AR 40–502. Profiling for the full expected duration of the condition is essential to the integrity and transparency of the readiness system. This ensures adequate communication with the commander and appropriate duty expectation for the Soldier. Temporary profiles are not associated with a PULHES or the physical function capacity; rather they are assessed by duration only. To prevent unnecessary restrictions for predictable conditions, progressive medical instructions may be written, or the profile can be modified during re-evaluation and progress in care. Additionally, to ensure maximal Soldier participation and readiness, health care providers should support duty assignments and expectations with positive profiling that clearly indicates what necessary Soldier functions a Soldier can perform. No profile will be printed without having been created in the e-Profile electronic application. Leaders accept only valid profiles created and completed within e-Profile.

*a. Application.* e-Profile is an application in MODS with connectivity to the EHR. Interface capabilities will change over time, and the process will become more seamless with further integration between the EHR and the medical readiness system. Access to e-Profile is role-based. Authorized users can always access the e-Profile application at: www.mods.army.mil and then linking to e-Profile. Commanders and their designees view e-Profile information in the Commander's Portal and are no longer authorized to access e-Profile directly.

*b. Conditions.* The DA Form 3349–SG consolidates all of the Soldier's permanent and temporary duty limiting conditions on a single form.

(1) Section 1 is the Soldier information.

(2) Section 2 is the permanent conditions with physical profile serial and any applicable profile codes. The profiling provider and approval authority electronically sign in the designated blocks at the end of each reason for profile.

(3) Section 3 is the active temporary conditions for a profile. Temporary conditions are described by the severity, mechanism of injury, duty status, and expiration date. The days on profile updates automatically in the system even after the document are signed. When reviewing a printed profile, the "days on profile" is static, and it becomes important to consider the date the profile was printed. Each reason for profile has the electronic signature of the profiling provider on the same line. Profiling providers will describe when a Soldier will be eligible for a record ACFT for both temporary and permanent conditions. This clinical decision and clearance for activity, which may be up to twice the length of the profile and may not exceed 90 days, will determine when a Soldier is authorized to take a record ACFT. There is no mandatory recovery period. For example, if a medication requires a profile by policy with no limitations on their ability to do an ACFT, the Soldier would be available for a record ACFT throughout the profile, and no recovery period should be authorized. This section also captures the number of days a Soldier has been on a profile within a 12- and 24-month period.

(4) Sections 4–7 describe the medical instructions, limitations, and PT guidance. All aspects that are permanent are in bold type in the form.

*(a)* Section 4 is the functional activities for all Soldiers, regardless of MOS and AOC. Any permanent limitation in these functional activities indicates severe limitations and requires the condition to have a numerical designation of 3 or 4. This will initiate Soldier referral to the appropriate medical or administrative board.

*(b)* Section 5 contains the medical instructions. These instructions cannot be ignored. Temporary instructions will be in plain type, and permanent instructions will be in bold type.

*(c)* Section 6 describes any permanent or temporary ACFT limitations. To complete the ACFT a Soldier must complete the 2-mile run or an alternate aerobic event. If a Soldier permanently cannot perform at least an alternate aerobic event, the profile serial will have a 3 in the appropriate PULHES designator, and the Soldier will be referred to the MEB.

*(d)* Section 7 describes the PRT capabilities. Healthcare providers will describe authorized alternate PT events from a medical perspective, for temporary and permanent conditions. For permanent conditions, a Soldier cannot perform at least an alternate aerobic event, the profile serial will have a permanent 3 in the appropriate PULHES designator. The templates will help guide the implementation of FM 7–22 in this section.

*(e)* Section 8 is the commander's signature block. This will automatically populate with the commander's signature when they view the profile in the Commander's Portal application.

*c. Temporary profiles.* Indications for a temporary profile are conditions with limitations that will improve over time. Correction or treatment of temporary conditions is medically advisable, and should usually result in a higher level of function and employment. Profiling providers manage Soldiers receiving medical or surgical care, recovering from illness, injury, or surgery by designating a temporary condition on the Soldier's DA Form 3349–SG. The addition of the limitations to any previously existing temporary or permanent limitations in the e-Profile system will provide the commander a single source for the Soldier's medical instructions and duty limitations.

(1) Duration: The profiling provider will write the profile for the entire length of the expected recovery up to 90 days (except as directed in paras 4–8*d* (tuberculosis) and 4–9 (pregnancy)). The profiling provider will extend and modify the profile for the temporary condition, to communicate with the command, until the Soldier reaches the point in their evaluation, recovery, or rehabilitation where they have returned to full duty or the profiling provider determines that the Soldier has achieved the MRDP. MRDP may occur before the 12-month administrative timeline if the condition is stable and no further functional progress is expected. At MRDP, the profiling provider will transition any remaining duty limitations to a permanent profile. All permanent profiles require two profiling provider signatures. The second signature will need to be a physician, or for profiles within their area of expertise, an audiologist or podiatrist are second signature authorities for profiles without deployment limitations. If the profile has deployment limitations, either a 3 or 4 in the PULHES or a DL physical-category code, the second signature must be an approval authority. The maximum duration of temporary profiles is 12 months for the same medical condition without an exception, as described in paragraph 4–4*c*(4) below. At 12 months, the Soldier is administratively defined to have reached MRDP. Profiling providers need to ensure that extensions link to the original profile. Extensions will continue to contribute to the days on profile for that condition. Creating new temporary conditions without linking them to the previous temporary profile will disrupt the tracking system for the days on profile for that condition and can compromise the accuracy of the days on profile, or delay a Soldier's progress toward MRDP. This loss of transparency impedes a commander's ability to manage their formations and undermines the readiness of the Army. All Soldiers with a temporary profile will have an updated functional assessment with medical instructions at least every 3 months and prior to extending the profile.

(2) Temporary profiles exceeding 6 months' duration, for the same medical condition, will be referred to a physician or medical specialist if clinically indicated, for that medical condition, or as required by policy. Specific conditions in AR 40–501 require specialty evaluation to determine if the Soldier meets retention standards. These referrals ensure the optimal care and support to help the Soldier return to duty, or ensure documentation of the injury or illness that supports the medical or administrative board process. Reviewing physicians or specialty health care providers will consider one of the following actions:

*(a)* Continuation of a temporary profile, for the same medical condition or injury, up to a maximum of 12 months from the initial profile start date;

*(b)* If the condition has reached MRDP, transition to a permanent profile;

*(c)* Determination of whether the Soldier meets the medical fitness standards for retention in accordance with AR 40–501 and, if not, refer to the DES. Once MRDP is met for one condition which does not meet retention standards, referral into the DES must commence regardless of the status of other co-existing conditions. If MRDP is met, and the Soldier meets the medical retention standards of AR 40–501, the permanent profile must address the requirements of the MOS or AOC and may indicate referral to an administrative board in accordance with AR 635–40.

(3) Prolonged Soldier review: There are higher authority reviews for profiles lasting over 120 days. Profiles over 120 days in duration will be reviewed by operational profile review boards, above company level, every month. Commanders above the company level will use the Commander's Portal to perform a monthly review of all temporary profiles as noted below:

*(a)* Battalion and squadron (O–5 or equivalent) commanders will perform a monthly review of temporary profiles lasting 120 days or more.

*(b)* BDE commanders (O–6 or equivalent) will perform a monthly review of temporary profiles lasting 180 days or more.

*(c)* Senior general officer commanders (above BDE, installation level, or equivalent) will perform a review of temporary profiles 240 days or older.

(4) Temporary profiles for conditions with duty limitations beyond 12 months are usually converted to permanent profiles. For all Soldiers, the application of the second signature for a permanent profile that does not meet retention standards initiates the requirement for DES or appropriate processing. For AD Soldiers whose condition does not meet retention standards, the second signature on the permanent profile also initiates the DES timeline. For the Reserve COMPOs 2 and 3, the receipt of the MEB packet at the MEB Tracking Office initiates the timeline for the DES and the RC non-duty related (RC–NDR) process. Requests for exceptions are very rare because the 12-month limit for temporary profiles to reach MRDP ensures timely access to DES and RC–NDR processes, ensures consistent application of the standards, and supports Army readiness. 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 senior approval authority and the senior medical officer. Requests for exceptions to the 12-month temporary profile restriction must include:

*(a)* A detailed written treatment plan: who, what, when, where, and how.

*(b)* An explanation of why the Soldier has not been referred to the DES or administrative review board.

*(c)* An expected MRDP.

(5) Providers who see Soldiers (officer and enlisted) in basic training, and MOS- and AOC-specific training may utilize the initial military training (IMT) templates in e-Profile to prescribe clear and concise medical recommendations to the Basic Combat Training (BCT) and Advanced Individualized Training (AIT) commanders and their drill sergeants, regarding the injured Soldier's training.

*d. DD Form 689.*

(1) The DD Form 689 is a means of communication, management, and disposition of short term (1 to 7 days) 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.

(2) The concepts from the IMT sick slip (established by OTSG/MEDCOM Policy Memo 11–095, now expired) were instrumental in the design of the new profile form to capture what the Soldier can do to train and avoid excessive limitation while protecting the Soldier to allow healing and return to full duty. The staff that provides care for BCT and AIT Soldier population will complete their profile training and utilize the IMT templates instead of the legacy IMT sick slips.

(3) See AR 40–66 for instructions on completing the "Disposition of patient" block on the form.

(4) Functional limitations expected to be greater than 3 days will be entered into e-Profile as a temporary profile, by a profiling provider, for the commander's medical readiness accountability and tracking.

*e. Permanent profiles.* Soldiers whose condition(s) have reached MRDP will receive a permanent profile. All permanent profiles require two profiling provider signatures; paragraph 4–6 authorizes specific roles to be the second signature. If the profile has deployment impacts either with a 3 or 4 in the PULHES or a DL physical-category code, the second signature must be an approval authority. Some diagnoses do not meet retention standards by definition and will be referred to DES upon diagnosis, in accordance with AR 40–501.

(1) The profiling provider must evaluate whether or not the Soldier meets the medical retention standards in accordance with AR 40–501. A comprehensive review the Soldiers medical records, to include consultation notes and other pertinent medical documentation is essential to ensure that the Soldier's medical condition and treatment meet MRDP requirements. The numerical designator will describe the severity of the functional limitation and will guide further processing. Permanent profiles are reviewed annually with each PHA and will be updated to reflect any clinical change. There is no requirement to rewrite the profiles every 5 years.

(2) The MEB physician or RC approving authority reviews all MEB referrals from e-Profile prior to signing as the approval authority and second signature:

*(a)* To ensure that MRDP has been achieved prior to initiating referral into the DES.

*(b)* To coordinate inappropriate DES referrals, via e-Profile, back through the profiling provider for appropriate disposition.

*(c)* To assist physician approving authorities in reconciling profiling provider's questions and concerns about MRDP timing.

*(d)* To help discern MAR2 versus DES referrals.

(3) Medical and administrative processes once a Soldier reaches MRDP and does not meet medical retention standards.

*(a)* Duty related processes through one of the three forms of DES: legacy DES, IDES, or expedited DES.

*(b)* Non-duty related physical evaluation board (PEB) processing is for the reserve COMPOs only. Soldiers who do not meet retention standards due to a non-duty related condition may request non-duty processing to determine if they may be retained and continue to serve.

*(c)* Administrative processing for Reserve COMPO Soldiers with non-duty related conditions proceeds when the Soldier does not request a non-deployable–PEB.

(4) Medical and administrative processes once a Soldier reaches MRDP and meets medical retention standards.

*(a)* Transition to a permanent profile describing the permanent duty limitations. The Soldier's commander may also discuss a permanent profile, with the profiling provider, request a review of an established permanent profile, and/or initiate a fitness for duty request to clarify any duty performance observations or deployment status concerns. Specific guidance regarding profiling Soldiers with pseudo folliculitis is available in TB MED 287.

*(b)* The MAR2 is an administrative process to evaluate the Soldier's ability to serve in their MOS. Outcomes from the MAR2 are to retain the Soldier in their MOS, reclassify them to another MOS, or refer the Soldier for DES processing in accordance with AR 635–40.

### 4–5. Physical-category codes

The physical-category codes indicate limitations in personnel and administrative matters and are used in numerous Army systems. The current physical-category codes described in tables 4–3 and 4–4 describe a history of an accession waiver, assignment, and deployment limitations, or the completion of medical board or administrative processing. Previously there were medically descriptive codes, but in accordance with AR 40–502, these are rescinded, and the profiling provider will describe these limitations in plain language on the profile to inform the commander's duty assignments and deployment determinations. The profiling provider may record up to three physical-category codes on the DA Form 3349–SG, in section 2, block 12. In the unlikely event that more than three codes are necessary, the additional codes will present in section 5, preceding any other medical instructions to the commander. These codes are administrative in nature and are not authorized for use in medical records to identify limitations.

**Table 4–3**
**Physical-category codes (deployment options)**

| Code | Description or assignment limitation | Medical criteria (examples) |
|---|---|---|
| Code F | No assignment or deployment to OCONUS areas where definitive medical care for the Soldier's medical condition is not available. | Individuals who require continued medical supervision with hospitalization or frequent outpatient visits for serious illness or injury. |
| Code V | This code identifies a Soldier with deployment restrictions to certain areas. | Explanations of condition(s) and specific restrictions are noted in the medical record. |
| Code X | This Soldier is allowed to continue in the military service with a disease, injury, or medical defect that is below medical retention standards, pursuant to a waiver of an unfit finding and continued on AD or in Active Reserve status under AR 635–40. | |

**Table 4–4**
**Physical-category codes (post board options)**

| Code | Description/assignment limitation |
|---|---|
| Code S | Soldier has been determined to meet medical retention standards of chapter 3 by a MEB. |
| Code T | Waiver granted for a disqualifying medical condition, or standard, for initial enlistment or appointment. The disqualifying medical condition, or standard, for which a waiver was granted will be documented in the Soldier's accession medical examination. |
| Code W | This Soldier has a permanent 3 or 4 profile that has been evaluated by a MAR2 with a recommendation to retain or reclassify and return to duty. |
| Code Y | This Soldier has been found fit for duty through the IDES (not entitled to separation or retirement because of physical disability) after complete processing under AR 635–40. |

## 4–6. Profiling provider and approving authority

*a. Profiling providers.* Commanders of Army MTFs, U.S. Army Reserve Command (USARC) surgeons, regional support command (RSC) surgeons, and the State surgeons may designate one or more physicians, dentists, optometrists, podiatrists, audiologists, chiropractors, nurse practitioners, nurse midwives, licensed clinical psychologists, licensed clinical social workers (master's level), and physician assistants (PA) as credentialed profiling providers. The commander ensures the designated profiling providers are thoroughly familiar with the contents of AR 40–502, AR 40–501, AR 635–40, and DA Pam 40–502. Profiling providers will attain and maintain profiling credentials within their scope of practice. Designating authorities will develop and institute a peer review quality assurance process for profiling providers. Profiling providers will not write temporary or permanent profiles for themselves. All permanent profiles require two profiling provider signatures. If the profile impacts deployment status with either a three or four in the PULHES, or a DL physical-category code, the second signature must be an approval authority. Profiling provider limitations are as follows:

(1) *Physicians.* No limitations except for temporary profiles that exceed 6 months when there is a clinical indication for specialty evaluation or care. Physicians may provide second signature authority for profiles with permanent profiles with a two in the PULHES that do not impact deployment status. Approval authorities are required to be the second signature for permanent profiles with a three or four in the PULHES or those that assign a DL physical-category code.

(2) *Dentists.* Dentists are specialty health care providers with no limitations within their field. Dentists will write temporary profiles for dental and oral medical conditions. Dentists may be the first signature authority on a permanent 2, 3, or 4 profiles and the second signature on permanent MRC 2 profiles without a DL physical-category code. If a temporary dental profile is created through a system interface, it will remain active until the Soldier's dental classification changes in the medical readiness and profiling systems of record. Permanent and temporary profiles need to inform the commander's deployability determinations. Dentists have no profiling authority outside their field.

(3) *Optometrists.* No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician. Optometrists have no profiling authority outside their field.

(4) *Chiropractors.* No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician. Chiropractors have no profiling authority outside their field.

(5) *Physical therapists, occupational therapists, licensed clinical psychologists, and licensed clinical social workers.* No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician. Physical therapists and occupational therapists, licensed clinical psychologists, and licensed clinical social workers may initiate a permanent profile.

(6) *Audiologists.* No limitation within their specialty for awarding temporary profiles and permanent profiles in cases of sensorineural hearing loss. Physicians and audiologists can serve as the second signature on a permanent profile with an H–2 within their specialty. Any profile that assigns DL physical-category codes must have an approval authority as the second signature. Changing to or from a permanent numerical designator "3" or "4", adding, or removing a DL code requires an approval authority for the second signature. Audiologists have no profiling authority outside their field.

(7) *Physician assistants, nurse midwives, and nurse practitioners.* Any extension of a temporary profile beyond 180 days must be reviewed by a physician, except when the provisions of paragraph 4–9 apply. However, physicians assistants (PAs) with AOC 65DM1, certified in orthopedics, have no limitations on awarding temporary orthopedic profiles or permanent profiles. PAs, nurse midwives, and nurse practitioners may initiate permanent profiles for submission to a physician profiling provider, or the approving authority, for second signature.

(8) *Podiatrists.* No limitation within their specialty for awarding temporary and permanent profiles. Physicians and podiatrists can serve as the second signature on a permanent 2 without a DL physical-category code within their specialty. Changing to or from a permanent numerical designator 3 or 4, or adding or removing a DL physical-category code requires an approval authority second signature. Podiatrists have no profiling authority outside their field.

(9) *Athletic trainers.* Athletic trainers are not profiling providers, but in command-specified settings will have limited profiling authority, under the supervision of their physician or physical therapist. Athletic trainers may award short term, temporary profiles up to 7 days' in duration. They may make a one-time extension of the profile for seven additional days. A profiling 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 health care provider to prevent any delay in care. All profiling by athletic trainers will be constrained to designated templates for the musculoskeletal system. Athletic trainers may generate temporary profiles for upper and lower extremities for mild and moderate severity.

(10) *Military entrance processing station physicians, PAs, and nurse practitioners.* MEPS physicians, PAs, and nurse practitioners will be designated as profiling providers. The profiling provider must generate the profile electronically, in e-Profile.

(11) *Other Department of Defense physicians.* A physician from another Service can be a profiling provider, upon completing required training. The profiling provider must generate the profile electronically, in e-Profile. Other methods of communicating capabilities and limitations will be received as clinical input, pending the review, and to inform a valid profile from a profiling provider.

(12) *TRICARE Prime Remote profiling providers.* The RHRP profiling officials may generate profiles in accordance with contractual guidance from the supported component and Army policy. The profiling provider must generate the profile electronically, in e-Profile and ensure clinical coordination as directed by the supported component. RHRP will provide the regional health commands with a referral list of Soldiers requiring further evaluation or care coordination for AD Soldiers.

*b. Approving authority.* Army MTF commanders, USARC surgeons, and the State surgeons may designate or delegate one or more physicians as approving authorities serving within their command. They ensure that the designated approval authorities are thoroughly familiar with AR 40–502, AR 40–501, AR 635–40 and DA Pam 40–502. The approving authority must be a physician. Generally, the chief medical officer or deputy commander for medical services, as appointed by the MTF commander, serves as the senior approving authority by position. Army Reserve RSC surgeons are approval authorities by position, but cannot designate other approval authorities. All permanent profiles require two profiling provider signatures. If the profile has a three or four in the PULHES or assigns a DL physical-category code, the second signature must be an approval authority. If the approval authority determines that a permanent 2 profile with a DL physical-category code should be a permanent 3 profile, they should return the profile to the original profiling provider for adjustment and to initiate MEB processing in accordance with their standard procedures.

### 4–7. Recording and reporting of an accession physical profile

*a.* Individuals accepted for initial appointment, enlistment, or induction normally will be given a numerical designator of 1 or 2. The initial numerical designator will be recorded on DD Form 2808 (Report of Medical Examination) by the MEPS medical officer, at the time of the initial appointment, enlistment, or induction medical examination. The numerical designators assigned by a MEPS physician are for MEPS administrative purposes only and do not represent a "profile" as defined in accordance with this regulation.

*b.* The accession documentation will identify the initial numerical designator serial (DD Form 2808 and DD Form 1966 (Record of Military Processing—Armed Forces of the United States)). The modifier "T" with a brief, nontechnical description of the defect on the serial, or in those exceptional cases where the numerical designator "3" is used on initial examination, is recorded in the "Summary of Defects" section on the DD Form 2808, in addition to the exact diagnosis. It is the practice for the MEPS to assign a

numerical designator “3” pending a medical waiver review of a disqualifying condition. This initial PULHES numerical designator is for MEPS administrative purposes only. It is not a PULHES from a DA Form 3349–SG in e-Profile. If the individual receives a medical waiver, the waiver documentation completed by the waiver authority should indicate the appropriate PULHES, in accordance with table 4–1. If the applicant enters the Army with any documented functional limitations or any numerical designator other than a 1 on the DD Form 2808, a DA Form 3349–SG in e-Profile must be completed at initial entry training.

**4–8. Profiling reviews and approvals**

*a.* Permanent “3” or “4” profiles, or profiles with a DL physical-category code require the signatures of a profiling provider, and a physician approving authority, unless specified by policy. Permanent profiles of “3” or “4” for the IRR require two signatures to include the Army Human Resources Command Surgeon, or his or her designee. Temporary profiles require the signature of an authorized profiling provider. Permanent profiles with a PULHES of “2” without a DL code require the initial signature of one profiling provider and the second signature of an approved profiling provider authorized in paragraph 4–6.

*b.* Situations that require a mandatory review of an existing physical profile include—

(1) Return to duty of a previously hospitalized Soldier. The attending physician will ensure that the patient has the correct e-Profile, assignment limitations(s), and medical follow-up instructions, as appropriate.

(2) Placing a Soldier on convalescent leave. The attending physician or component profiling provider, ensures that the patient has a profile entered into e-Profile, functional limitations(s), and medical follow-up instructions, as appropriate.

(3) When directed by the approving authority in cases of discrepancy or controversial nature requiring temporary revision of profile.

(4) At the time of the PHA or other medical examination.

(5) Upon request of the unit commander.

(6) Upon request of a PEB.

(7) A profiling provider and approving authority signatures are necessary to either change a permanent “3” or “4” profile to a permanent “1” or “2” or remove a DL physical-category code.

(8) A change in the Soldier’s health that impacts his or her basic Soldier function and ability to perform their duty.

*c.* The profiling provider adds a temporary condition for a Soldier in e-Profile when, in their opinion, the functional limitations or capacity of the individual temporarily alters their ability to perform their duty. Temporary e-Profiles will not exceed 3 months (90 days) except as provided for in paragraphs 4–8*d* and 4–9. Temporary functional limitations limited to acute, minor, and self-limited illnesses written on DD Form 689 will not exceed 3 days. The utilization of e-Profile for acute conditions lasting for 3–7 days supports the tracking, medical support, and communication with commands regarding the recovery of their Soldiers.

*d.* Tuberculosis patients returned to a duty status that requires anti-tuberculosis chemotherapy, following hospitalization, will be given a temporary profile for 1 year. The medical instructions will include assignment limitations to a fixed installation for the required medical care, support, and supervision for 1 year.

*e.* The hospital commander, appropriate clinical deputy, or command surgeon may verify or revise the physical profile in controversial or equivocal cases.

*f.* Reserve COMPO reviews and approvals are as follows. The USAR RC support surgeons, major subordinate commands staff surgeons, Regular Army (RA) medical facility profiling providers, ARNG, and USAR contracted profiling providers, the USAR Command (USARC) Surgeon, and the U.S. AHRC Surgeon, or their designees (IRR only), may accomplish physical profiles for Reserve COMPO Soldiers not on AD and for those Soldiers activated on orders for less than 30 days in the Ready Reserve (ARNG/USAR), Standby Reserve (USAR), and Retired Reserve (USAR).

(1) Army Reserve profile providers will accomplish profiles for Army Reserve Soldiers, in accordance with USARC surgeon policy and procedures. The approving authority for the Army Reserve to include troop program unit (TPU) Soldiers is the USARC command surgeon and the RSC surgeons. The USARC command surgeon may delegate profile approving authorities to the operational, functional, training, and support command surgeons, and other physicians, depending on their current duty position and the need for additional approving authorities.

(2) State ARNG/Army National Guard of the United States (ARNGUS) profile providers will accomplish profiles for ARNG/ARNGUS Soldiers not on AD in accordance with State policy. The respective State Surgeon, or their designated physician alternate, is the approving authority for permanent "3" or "4" profiles. The National Guard Bureau (NGB) Chief Surgeon is an ARNG approving authority for all ARNG/ARNGUS Soldiers. The State surgeons establish processes for awarding profiles to Soldiers with the W, V, and/or F codes, if warranted.

*g.* The Army Physical Disability Agency identifies Soldiers who are found unfit by a PEB but approved or continued on AD, or continued on Active Reserve status with an “X” code.

*h.* When Soldiers are returned to duty pursuant to a PEB finding of “fit” in accordance with AR 635–40, the Army Physical Disability Agency applies the Y physical-category code. The Army Physical Disability Agency submits the case file to the MEB physician to review and update the profile, to include but not limited to, adding, or removing DL physical-category codes. MEB providers either determine that residual limitations warrant a permanent 2 profile, or retain the 3. Additionally, the MEB providers apply any appropriate DL physical-category code. For ND–PEB “fit” determinations, the Army Physical Disability Agency applies the Y physical-category code and return to the originating approval authority. The originating approval authority either determines that residual limitations warrant a permanent 2 profile, or retain the 3 status. Additionally, the originating approval authority applies any appropriate DL physical-category code. This is to ensure the returning Soldier receives a physical profile commensurate with their functional capacity under the appropriate PULHES factor. The modified profile includes assignment limitations and specific medical instructions determined in the medical board process.

*i.* MEB physicians, when completing the narrative summary, ensure a full record of all functional limitations is on the DA Form 3349–SG, in e-Profile. The MEB proceeding referring the Soldier to a PEB submits the consolidated DA Form 3349–SG. On that form, the MEB physician may be the profiling provider (1st signature). Cooperation between the MEB physician, PEB liaison officers, and the PEB is essential to support when the PEB requests additional medical information or profile reconsideration by the MTF. The functional limitations described on the profile form may affect the decision of fitness by the PEB.

*j.* When a MAR2 is complete:

(1) RA. U.S. AHRC applies the W code for retained and reclassified Soldiers returning to duty. At completion of the administrative review, the Soldier’s primary care health care provider determines if the Soldier has any DL conditions, and applies a V or F physical-category code as indicated.

(2) ARNG/ARNGUS: The State surgeons establish policies and processes for awarding profiles to Soldiers with the W, V, and/or F codes, if warranted.

(3) The USARC Surgeon establishes policies and processes for awarding profiles to Soldiers with the W, V, and/or F codes if warranted.

*k.* Commanders review all DA Form 3349-SGs in e-Profile on their assigned and attached Soldiers. The Commander’s Portal supports the commander by presenting this information in a single consolidated location.

**4–9. Profiling Soldiers who are pregnant**

*a. Intent.* The intent of these provisions is to protect the health of the Soldier and fetus while ensuring productive use of the Soldier. The commander ensures a viable program, in consultation with the Soldier and the provider. This profile guidance has been revised and includes: mandating an occupational health interview to assess risks to the Soldier and fetus; adding additional restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes; and authorizing the wearing of non-permethrin treated uniforms for Soldiers who are pregnant and or post-partum. After a review of the risks and benefits of permethrin treatment and that non-permethrin treated uniforms are limited to the garrison environment, the health care team may provide medical authorization for issue of non-permethrin treated uniforms. The Soldier brings this documentation to the commander who provides the paperwork to order the requested uniforms at clothing and sales.

*b. Responsibilities.*

(1) *Soldier.* Soldiers trying to get pregnant should seek appropriate pre-natal care. They may also request medical authorization to obtain and wear permethrin-free uniforms. Pregnant Soldiers seek medical confirmation of pregnancy and comply with the instructions of medical personnel and the individual's unit commander.

(2) *Medical personnel.*

*(a)* The health care team reviews the risks and benefits of permethrin treatment and may provide medical authorization for the command to issue non-permethrin treated uniforms when a Soldier intends to get pregnant. Soldiers are authorized the wear of the maternity and non-maternity permethrin-free Army Combat Uniform (ACU) and Improved Hot Weather Combat Uniform during and after pregnancy while safely returning to optimal fitness and body composition during the postpartum period.

*(b)* For pregnant Soldiers, a credentialed health care provider (physician, nurse midwife, nurse practitioner, or PA) confirms pregnancy and, once confirmed, initiate prenatal care of the Soldier and issue a pregnancy profile by using the pregnancy profile template in e-Profile. Nurse midwives, nurse practitioners, and PAs are authorized to issue routine or standard pregnancy e-Profiles for the duration of the pregnancy. An occupational history, using DD Form 2807–1 (Report of Medical History), is taken at the first visit to assess potential exposures related to the Soldier's specific MOS. This history is ideally taken by the occupational medicine physician, occupational health PA, or occupational health nurse. However, if not feasible, the profiling provider completes the occupational history. After reviewing the occupational history, the profiling provider (physician, nurse midwife, nurse practitioner, or PA), in conjunction with the occupational health clinic as needed, determines whether any additional occupational exposures, other than those indicated in the paragraphs below, should be avoided 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 (that is, motor pool) data indicate significant exposure to physical, chemical, or biological hazards, then the e-Profile is rewritten to restrict exposure from these workplace hazards.

(3) *Unit commander.* The commander counsels all female Soldiers as required by AR 600–8–24, or AR 635–200. The unit commander consults with medical personnel as required. This includes establishing liaison with the occupational health clinic and requesting site visits by the occupational health and industrial hygiene personnel, if necessary, to assess any work place hazards.

*c. Physical profiles.* Pregnancy profiles stand for the duration of the pregnancy (use the pregnancy profile template in e-Profile). Pregnancy profiles list the diagnosis as “pregnancy, estimated delivery date”; prenatal ultrasounds or other testing are not required to validate an estimated delivery date for the profile. The unit commander reviews the profile in e-Profile. Upon completion of pregnancy, the profiling provider describes the Soldier’s duty limitations in a new profile.

*d. Limitations.* Unless superseded by an occupational health assessment, the standard pregnancy profile, DA Form 3349–SG, indicates the following limitations:

(1) Except under unusual circumstances, the Soldier should not be reassigned to overseas commands until pregnancy is complete. (See AR 614–30 for waiver provisions and for criteria curtailing outside the continental United States (OCONUS) tours.) She may be assigned within the continental United States (CONUS). Medical clearance must be obtained prior to any reassignment.

(2) The Soldier will not receive an assignment to duties where nausea, easy fatigue, or sudden lightheadedness would be hazardous to her, or others, to include all aviation duty, classes 1, 2, 3, or 4. However, there are specific provisions in the medical fitness standards for flying duty of AR 40–501 that allow the aircrew member to request, and be permitted, to remain on flight status as further described in the aeromedical policy letters (APL). Air traffic control (ATC) personnel may continue ATC duties with approval of the flight surgeon (FS), obstetrician, and ATC supervisor.

(3) Restrict exposures to military fuels. Pregnant Soldiers must be restricted from assignments involving frequent or routine exposures to fuel vapors or skin exposure to spilled fuel such as fuel handling, or otherwise filling military vehicles with fuels such as motor gasoline, JP8, and JP4.

(4) No weapons training in indoor firing ranges is allowed, due to airborne lead concentrations and bore gas emissions. Firing of weapons is permitted at outdoor sites. (See para (13) below, for other weapons training restrictions.) No exposure to organic solvent vapors above permissible levels. (For example, work in arms room is permitted if solvents are restricted to 1999 MIL–PRF–680, degreasing solvent.)

(5) No work in the motor pool involving painting, welding, soldering, grinding, and sanding on metal, parts washing, or other duties where the Soldier is routinely exposed to carbon monoxide, diesel exhaust, hazardous chemicals, paints, organic solvent vapors, or metal dusts and fumes (for example, motor vehicle mechanics). It does not apply to pregnant Soldiers who perform preventive maintenance checks and services (PMCS) on military vehicles using impermeable gloves and coveralls, nor does it apply to Soldiers who do work in areas adjacent to the motor pool bay (for example, administrative offices) if the work site is adequately ventilated, and industrial hygiene sampling shows carbon monoxide, benzene, organic

solvent vapors, metal dusts and fumes do not pose a hazard to pregnant Soldiers. (See para (13), below, for PMCS restrictions at 20 weeks of pregnancy.)

(6) The Soldier must avoid excessive vibrations. These occur in larger ground vehicles (greater than 1 1/4 ton) when the vehicle is driven on unpaved surfaces.

(7) Upon a diagnosis of pregnancy, the Soldier is exempt from regular unit PRT for 180 days after the conclusion of pregnancy and, ACFT testing and body composition standards for the duration of the pregnancy and 365 days past pregnancy completion. After receiving medical clearance from a health care provider to participate in PT, commanders enroll Soldiers who are pregnant or postpartum to take part in Army Pregnancy Postpartum PT (P3T), in accordance with AR 350–1 and FM 7–22. P3T is designed to maintain health and fitness levels of pregnant Soldiers, and successfully integrate postpartum Soldiers back into unit PRT programs, with emphasis on achieving the ACFT standards, in accordance with guidance provided in the Army PRT Program, and meeting body composition standards in accordance with guidance provided in AR 600–9. Pregnant and postpartum Soldiers must be cleared by a health care provider prior to participating in P3T.

(8) Once pregnancy is confirmed, the Soldier is exempt from wearing load carrying equipment to include interceptor body armor and/or any other additional equipment. Wearing individual body armor and/or any other additional equipment is not recommended and must be avoided after 14 weeks' gestation.

(9) The Soldier is exempt from all immunizations except influenza and tetanus-diphtheria and from exposure to all fetotoxic chemicals noted on the occupational history form. The Soldier is exempt from exposure to chemical warfare and riot control agents (for example, nuclear, biological, and chemical training) and from wearing mission-oriented protective posture gear at any time.

(10) The Soldier may work shifts.

(11) The Soldier must not climb or work on ladders or scaffolding.

(12) The Soldier is authorized to wear the ACU without permethrin.

(13) At 20 weeks of pregnancy, the Soldier is exempt from standing at parade rest or attention for longer than 15 minutes. The Soldier is exempt from participating in swimming qualifications, drown proofing, field duty, and weapons training. The Soldier must not ride in, perform PMCS on, or drive in vehicles larger than light medium tactical vehicles, due to concerns regarding balance, vibrations, and possible hazards from falls.

(14) At 28 weeks of pregnancy, the Soldier must be provided a 15-minute rest period every 2 hours. Her duty week should not exceed 40 hours and the Soldier should not work more than 8 hours in any one day. The 8-hour work day does include the time spent in P3T and the hours worked after reporting to work or work call formation, but does not include the PT hygiene time and travel time to, and from, PT.

*e. Performance of duty.* A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems (for example, pregnancy-induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel assist unit commanders in determining duties.

*f. Sick in quarters.* A pregnant Soldier is not placed sick in quarters solely on the basis of her pregnancy, unless there are complications present that would preclude any type of duty performance.

### 4–10. Stinging insect allergy

*a.* Soldiers are required to carry their prescribed epinephrine autoinjectors and wear appropriate MWT. Profiling officers should prepare P2 profiles for Soldiers who are prescribed epinephrine autoinjectors, in order to inform their supervisors on the potential for use.

*b.* Venom immunotherapy (VIT) that can be supported in a garrison or deployed setting with a maximum interval between maintenance VIT shots every 4 weeks during the first 12 months of VIT, every 8 weeks during the second year, and every 12 weeks for the third year and thereafter, is recommended. Allergists review the servicemember annually for progress to resolution or worsening. Soldiers who decline VIT, should receive a P3 profile and referred to the DES.

*c.* After 3 years of VIT, the allergist determines:

(1) If no additional treatment or epinephrine auto-injector is required, recommend removal of P2 profile.

(2) If additional treatment is recommended, the Soldier may restart venom shots. Soldier may remain fully functional and deployable despite requiring venom allergy shots more than 3 years as long as the appropriate shot intervals are maintained.

(3) Soldiers who do not require further venom allergy shots after 3 years, but are recommended by an allergist-immunologist to carry an epinephrine auto-injector, should maintain a P2 profile without deployment restrictions.

**4–11. Cancer in remission**

*a.* When an oncologist determines a Soldier is in remission after treatment for cancer and that there are no physical residuals, they may issue a P2 profile. The Soldier is considered non-deployable while in surveillance, unless the oncologist deems Soldier deployable after discussing mission requirements with their Commander. If the Soldier remains in a remission up to 5 years, then the P2 profile may expire. Chronic cancers such as chronic lymphocytic leukemia or follicular lymphoma, which have not required treatment over the 5-year interval, may also have an expiration of the P2 profile.

*b.* If at 5 years or sooner, the Soldier experiences relapse or progression of his or her disease that is not expected to return to a prolonged remission, the oncologist writes a P3 profile and refers to the DES.

**4–12. Postpartum profiles**

*a.* Maternity convalescent leave (as prescribed by AR 600–8–10 and Army Directive 2022–06) after delivery, is for a period determined by the attending physician. This is normally for 42 days. If a postpartum Soldier meets the definition of a birth event and service requirements from AD 2022–06, up to six weeks of non-chargeable maternity convalescent leave is authorized by policy. The service requirement is that the postpartum Soldier be either on AD or a RC Soldier, serving on call or ordered to active service, for a continuous period of at least 12 months. Regardless of the Soldier's eligibility for maternity convalescent leave, if there are medical indications for convalescent leave beyond the normal 42-day period, the commanders and profiling providers may grant convalescent leave as warranted.

*b.* Convalescent leave after completion of pregnancy (to include miscarriage) is determined on an individual basis, by the attending physician.

*c.* Prior to commencing convalescent leave, postpartum Soldiers are issued a postpartum profile, starting on the day of discharge, or the completion of the pregnancy if the Soldier is not hospitalized. The post-partum profile allows PT at the Soldier's own pace. Soldiers are encouraged to use the at-home component of Army P3T while on convalescent leave. If a Soldier decides to return early from convalescent leave, the temporary profile remains in effect for the entirety.

*d.* Soldiers receive clearance from the profiling provider to return to full duty.

*e.* All postpartum (any pregnancy that lasts 20 weeks and beyond) Soldiers, in accordance with DoDD 1308.1, are exempt from the ACFT and for record weigh-in for 180 days following completion of pregnancy. After receiving clearance from a profiling provider to resume PRT, postpartum Soldiers take part in the postpartum component of Army P3T. Postpartum Soldiers must receive clearance from a health care provider prior to returning to regular unit PRT if it is before 180 days following pregnancy completion. After receiving clearance from a health care provider to resume PRT, they are expected to use the time in preparation for the ACFT.

*f.* Postpartum and nursing Soldiers are authorized to wear the ACU without permethrin.

*g.* The above guidance is only 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.

**4–13. Concussion profiles**

*a. Significance.* Concussion, also known as traumatic brain injury, is a significant military concern that can adversely affect Soldier health, unit readiness, and mission accomplishment. Extensive research and progress in the recognition, care, and treatment of concussion has led to current policies and clinical practice guidelines for the management of concussions in the garrison and deployed environment. These programs and tools improve recognition, access to care and ultimately, outcomes.

*b. Profiling.* In order to ensure optimal care and reduce variance, profile providers use the appropriate concussion profile template, as required in AR 40–502. These templates also make patient and outcome tracking easier, which supports ongoing improvements in Soldier care in garrison and deployed environments. The limitations associated with repeat brain injuries are different to optimize healing and patient outcomes, and it is essential to communicate this to commanders. The DD Form 689 is not authorized for use for Soldier's diagnosed with a concussion.

## 4–14. Preparation, approval, and disposition of DA Form 3349–SG

*a. Preparation of DA Form 3349–SG.*

(1) A single DA Form 3349–SG is used to record the profiles for both permanent and temporary conditions providing a holistic view of the Soldier's duty limitations.

(2) All DA Form 3349-SGs must be completed in e-Profile for all profiles over 7 days' duration, and using e-Profile for acute conditions lasting for 1–7 days is encouraged, to improve Soldier accountability and unit readiness tracking.

(3) Profiling providers use the various DA Form 3349–SG TSG-approved templates available in e-Profile to use clear, standardized communication in lay terms. The templates align by the reason for profile and severity. For permanent profiles, the profiling providers describe severity with the physical profile functional capacity guide. All templates are thoroughly reviewed and staffed to ensure the highest quality, with clear and accurate communication. Future template suggestions and updates may be sent to the proponent of this policy.

(4) The DA Form 3349–SG is prepared as follows:

*(a) Section 1: items 1–8.* Profiling providers can initiate a profile using the Soldier's name (last, first), DoD ID number, or the Social Security number (SSN). e-Profile pre-populates as much of the section as is available from the available databases and systems of record. The profiling provider completes any unpopulated fields. Table 4–5 displays the current organization (CURORG) list that providers populate, in item five, on DA Form 3349–SG.

**Table 4–5**
**Current organization list**

| | | |
|---|---|---|
| CURORG | A | Active National Guard of the United States |
| CURORG | B | Air National Guard of the United States |
| CURORG | C | Army National Guard (inactive) |
| CURORG | D | United States Marine Corps Reserve |
| CURORG | E | United States Navy, Reserve |
| CURORG | F | United States Coast Guard Reserve |
| CURORG | G | United States Air Force Reserve |
| CURORG | H | United States Army Reserve TPU |
| CURORG | I | USAR Control Group (Individual Mobilization Augmentation (IMA)) |
| CURORG | J | USAR Control Group (active, Guard/Reserve) |
| CURORG | K | USAR Control Group (annual training) |
| CURORG | L | USAR Control Group (reinforcement) |
| CURORG | M | USAR Control Group (officer AD obligor) |
| CURORG | N | USAR Control Group (dual component) |
| CURORG | O | USAR Standby Reserve (active status list) |
| CURORG | P | USAR Standby Reserve (inactive status list) |
| CURORG | R | USAR Retired Reserve |
| CURORG | S | RA Delayed Entry Program |
| CURORG | T | USAR Control Group Reserve Officer Training Corps (ROTC) |
| CURORG | U | Service academy |
| CURORG | V | USAR Delayed Entry Program |
| CURORG | Y | Archived record |
| CURORG | Z | Unknown |
| CURORG | 1 | Regular Army |
| CURORG | 2 | Active Marine Corps |

**Table 4–5**
**Current organization list—Continued**

| | | |
|---|---|---|
| CURORG | 3 | Active Navy |
| CURORG | 4 | Active Coast Guard |
| CURORG | 5 | Active Air Force |
| CURORG | 6 | United States Army retired list |
| CURORG | 7 | Permanent Disability retired list |
| CURORG | 8 | Temporary Disability retired list |
| CURORG | 9 | Army of the United States retired list |

*(b) Section 2: items 9–14.* The profiling provider completes these sections only for permanent conditions. The template describes the reason for profile in lay terms. The profiling provider completes the PULHES and any pertinent profile codes. The profiling provider who initiates the profile is associated with that specific condition. Specific profiling providers (for example, physicians, audiologists, dentists, podiatrists, and so forth) are authorized to be the second signature for permanent conditions with a numerical designator of 2, without a DL physical-category code, within their specialty. Approval authorities may review and approve permanent profiles with a numerical designator of 3 or 4, and profiles with DL physical-category codes. An approval authority may not be both the profiling provider and the approval authority. If an approval authority rewrites a profile, they need to send the profile to either another physician or approval authority (for permanent 2, 3, or 4 profiles) to complete the second signature as described above. The approval authority is encouraged to return the profile, or provide feedback to the profiling provider to improve the process. The digital signature and date is electronically recorded on signing. The MEB physician, State surgeon, USARC surgeon, or their designees, determine whether the Soldier does or does not meet retention standards. A Soldier who enters the DES process secondary to a permanent 3 or 4 profile, indicating that they do not meet retention standards, is initially evaluated by the local or regional MEB. If the appropriate authority determines that the Soldier meets retention standards, then the MEB rewrites the profile to reflect the appropriate limitations. The modified profile accurately reflects the Soldier's limitations with a permanent 2, or a permanent 3, when indicated by policy, and the "S" code applies. The MEB profiling provider documents the circumstances of the process and decision in section 5 on the DA 3349–SG to include the board members: rank, full name; date of MEB final determination; MTF or location. Permanent 3 profiles with an S code are referred to the MAR2 for personnel review. If the Soldier, upon MEB review does not meet retention standards, DES processing continues in accordance with AR 635–40. The S code identifies Soldiers who underwent MEB processing only (not PEB) and were found to meet retention standards with either a permanent 2 or 3 profile. MEBs completed before the S code was introduced in 2011 should be rewritten in e-Profile with an S code, current accurate capabilities and limitations, and considered for modification as described above.

*(c) Section 3: Blocks 15–24.* This section is only for temporary profiles. Temporary profiles are for temporary conditions that are expected to change and improve with treatment. To allow tracking and reflect the fluidity of these conditions, e-Profile displays the "as of date" on the top of section 3. These conditions are selected from the temporary profile taxonomy with the designation of mild, moderate, or severe.

1. Block 15. The profiling provider annotates the reason for the profile in in layman's terms.
2. Block 16. The profiling provider specifies the severity of the injury or illness.
3. Block 17. The profiling provider selects the mechanism of injury. The mechanism of injury is chosen from a drop-down list. The provider's entry is based on Soldier self-report. This is independent and exclusive of any association with the line of duty process.
4. Block 18. The Soldier's duty status.
5. Block 19. The profile expiration date. Profile extensions of expired temporary conditions remain linked to the original profile, to ensure accurate calculation of the number of days on profile for the same condition.
6. Block 20. Annotates the number of days on profile.
7. Block 21. Name of the profiling provider.
8. Block 22. Date the profile was approved.

9. Block 23. e-Profile uses this to calculate the total days on temporary profile in the last 12 months, and 24 months, displaying the as of date for block 23.

10. Block 24. This block documents the Soldier's availability to take a record ACFT for either a permanent or temporary condition. If the condition is temporary, the provider enters the anticipated ACFT availability date. It is important to note, this block is to inform the command of the Soldier's capabilities and limitations and does not require the command to administer an ACFT. There is no longer a prescribed recovery period after a profile; The recovery time is factored into the date authorized to take the ACFT based on the profiling provider's judgment and is not to exceed 90 days (except as directed above in paragraph 4–9*d*(7) for pregnancy). Profiling providers ensure that extensions of expired temporary conditions remain linked to the original profile, to ensure accurate calculation of the number of days. The provider sets the expiration date. The digital signature and date are electronically recorded on signing.

*(d) Section 4: Blocks 25–27.* This section describes the functional activities necessary to perform within retention standards, the additional physical restrictions that guide personnel assignments, and the medical or administrative board referral. An "N" for No documents a Soldier who cannot perform a functional activity in either the P or T columns for permanent or temporary limitations. The additional physical restrictions require more description in weight, time, or pace for permanent and/or temporary conditions. The last block documents the indicated medical or administrative board (if any). All new permanent 3 or 4 profiles require a determination in box 27.

1. Block 25. Describes the functional activities necessary to perform within retention standards, the additional physical restrictions that guide personnel assignments, and the medical or administrative board referral. An "N" for No documents a Soldier who cannot perform a functional activity in either the P or T columns for permanent or temporary limitations.

2. Block 26. The additional physical restrictions require more description in weight, time, or pace for permanent and/or temporary conditions.

3. Block 27. The last block documents the indicated medical or administrative board (if any). All new permanent 3 or 4 profiles require a determination in box 27.

*(e) Section 5: Block 28.* This section documents the medical instructions to the unit commander for mission and duty assignment. These instructions have permanent restrictions listed in bold type and temporary instructions listed in normal type. The medical instructions are written in plain language, clearly, and to encompass the minimal limitations anticipated supporting Soldier health, welfare, and recovery of function. The commander communicates with the profiling provider for any clarification of the instructions. The medical instructions may not be ignored.

*(f) Section 6.* Blocks 29–30. This section describes the ACFT restrictions and alternative options for the aerobic event. A "Yes" or "No" is documented under either the permanent or temporary columns. A Soldier with a permanent condition is referred to the DES process if they cannot complete at least one alternate event, unless prevented by a temporary condition.

1. Block 29. Lists the six core events of the ACFT.

2. Block 30. Lists the alternate cardio events of the ACFT.

*(g) Section 7.* This section describes the Soldier's PRT capabilities for the commander. These should be positive statements to describe what the Soldier can do regarding PT. It is imperative to avoid overlimiting Soldiers which would needlessly impair their ability to train, constraining the Soldier's mission readiness. Conversely, it is important to identify training restrictions that allow a Soldier to heal.

*(h) Section 8.* A profile is a communication tool between the profiling officer and the commander. This can only be effective if the profiling officer generates an accurate, clear, and consistent profile and the unit commander views the profile information to make duty and mission assignments appropriately.

*b. Disposition of DA Form 3349 – SG (temporary and permanent).* The electronic profile displays in the Commander's Portal for command review. The electronic profile displays in the PHA for the health care provider to complete their annual review. An electronic copy of the profile is available in AKO for the Soldier review. The DA Form 3349 – SG is valid when signed by the profiling provider for temporary and permanent 1 and 2 conditions. Permanent 2 profiles are valid from when they are written and the first signature is applied. They remain valid and in a pending status until the appropriate second signature is applied or until the profile automatically expires. The limits of automatic expiration are set in the system of record for Active and Reserve COMPOs. Permanent 3 and 4 profiles, and profiles that assign a deployment-limiting physical-category code are valid when signed by the approval authority. The commander's signature is electronically applied when they view the profile in the Commander's Portal and has no

impact on the validity of the profile. The Soldier may request a printed copy of the DA Form 3349 – SG completed in e-Profile.

**4–15. Responsibility for personnel actions**

*a.* Commanders and personnel officers take necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations.

*b.* Profiles are communication tools between the profiling providers and the commanders. All company level commanders are to review the profiles for the Soldiers under their command through the Commander's Portal. Senior commanders review the medical readiness of their subordinate units and provide guidance and mentorship to ensure accurate readiness reporting.

*c.* If the Soldier's commander believes the Soldier cannot perform within the limits of the permanent profile, or the profile limitations do not address or prevent training that the Soldier can safely complete without aggravating the condition, the commander requests clarification and reconsideration of the profile by the profiling provider. Reconsideration starts with the same profiling provider who seeks to understand the commander's observations and concerns, then either re-writes the profile or revalidates the profile as initially written. This should be a collaborative process to provide the optimal care and employment of the Soldier. In the event that the profiling provider and commander cannot come to an agreement on a temporary or a permanent profile, the commander can request a fitness for duty evaluation with another profiling provider. The second profiling provider has access to the original profile and all applicable notes.

*d.* The commander reviews all new or modified profiles within 14 days for AD, and 30 days for the RCs.

**4–16. Physical profile and the Army Body Composition Program**

AR 600–9, is a personnel program. The DA Form 3349–SG does not excuse Soldiers from the provisions of AR 600–9. The AR 600–9 contains a standard memorandum for completion by a physician if there is an underlying or associated disease process that is the cause of the overweight condition. The inability to perform all ACFT events or the use of certain medications is not generally sufficient medical rationale to exempt a Soldier from AR 600–9.

## Chapter 5
## Medical Examinations—Administrative Procedures

**5–1. General**

This chapter provides—

*a.* General administrative policies relative to military medical examinations.

*b.* Administrative requirements for periodic medical examinations, PHA, Separation History and Physical Examination (SHPE), mobilization, and other medical examinations.

*c.* Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record.

*d.* Policies relative to the scope and recording of medical examinations and assessments accomplished for stated purposes.

**5–2. Application**

The provisions contained in this chapter apply to all medical examinations and assessments accomplished at U.S. Army medical facilities or accomplished for the U.S. Army.

**5–3. Physical fitness**

*a.* Maintenance of physical and medical fitness is an individual military responsibility. Soldiers have an obligation to maintain themselves in a physical condition that enables them to perform Soldier duties efficiently. Soldiers are to seek timely medical care and advice whenever they have a medical condition or physical defect and report any effects on their readiness status. Soldiers are not to wait until their annual PHA to report medical conditions. Soldiers need to provide their military health care provider, unit commander, or medical readiness noncommissioned officer with any civilian health records. The active and

RC Soldier's military health record and/or scanned EHR documents any civilian health records which may impact the Soldier's readiness status.

*b.* Commanders ensure the documentation of a Soldier's readiness and medical status in the personnel systems of record and that the appropriate follow-up action is taken regarding the Soldier's medical or readiness status.

*c.* Commanders ensure that Soldiers complete and maintain all medical readiness requirements.

*d.* Commanders safeguard all protected health information and ensure it is entered into the Soldier's STR and EHR.

**5–4. Consultations**

*a.* AR 40–400 authorizes the referral and use of specialty consultants, either military or civilian.

*b.* The indications for consultation in evaluation of individuals applying for military service, including United States Military Academy (USMA) and Reserve Officers' Training Corps (ROTC), are as follows:

(1) Verification, or establishment, of the exact nature or degree of a given medical condition or physical defect necessary for the determination of the examinee's medical acceptability or unacceptability based on the medical fitness standards prescribed in AR 40–501; or

(2) Consultation assists higher headquarters in the review and resolution of a questionable or borderline case; or

(3) The examining or reviewing profiling provider deems it necessary.

*c.* AD Soldiers receive a consultation, as indicated, to ensure the proper medical care and disposition of the Soldier.

*d.* A medical examiner requesting a consultation routinely furnishes the consultant with—

(1) The purpose or reason for examination; for example, enlistment.

(2) The reason for the consultation.

(3) A brief statement of the desired documentation from the consultant.

(4) Pertinent extracts from available medical records.

*e.* The examining and reviewing entities append the consultation reports to DD Form 2808, DD 2807–1, PHA, and scan the documentation into the Soldier's STR or EHR.

**5–5. Distribution of medical reports**

*a.* The STR, in accordance with AR 40–66, and the designated EHR system, or outpatient treatment record permanently documents copies of the PHA. The DD Form 2766 (Total Force Health Readiness Flowsheet), EHR (as applicable), and MEDPROS are used to document all IMR items. Legible and permanent copies reproduced from signed medical readiness documents are acceptable for any purpose unless specifically prohibited by the applicable regulation. Only authorized personnel or agencies may receive distribution of copies.

*b.* DD Form 2808 and DD Form 2807–1—

(1) All remaining military examinations, to include, examinations to attend special schools, permanent separation from the military, and retirement use the DD Form 2808 and DD Form 2807–1. Medical examinations/histories accomplished in accordance with this chapter are valid. Military medical examinations, other than those conducted at U.S. Military Entrance Processing Command (MEPCOM), do not require the DD Form 2807–2 (Accessions Medical History Report).

(2) When completing DD 2808 and DD 2807–1, the examining facility, and either the Soldier's electronic permanent health record (in accordance with AR 40–66), or outpatient treatment record retains a copy of each document. Legible and permanent copies reproduced from signed copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Only authorized personnel or agencies may receive distribution of copies.

**5–6. Documentary medical evidence**

*a.* Documentary medical evidence can provide a broader understanding of an individual's medical history, level of function and readiness. Examining entities encourage the use of documentary medical evidence to increase clarity and accuracy in the medical examinations. An examiner, or his or her representative, may submit documentary medical records and other documents prepared by physicians or other individuals as evidence of the presence, absence, or treatment of a defect or disease. This evidence receives due consideration by the examiner(s).

*b.* Reports of consultation and medical documentation of special tests are documentary medical evidence.

*c.* The examining or reviewing entities append each piece of documentary medical evidence received to:

(1) Each copy of the DD Form 2808 with annotation in the summary of defects or the originating PHA with annotation in the medical progress note.

(2) Scan into the Soldier's EHR, or STR progress note.

**5–7. Facilities and examiners**

*a.* Physicians, PAs, and nurse practitioners may perform medical examinations of any type except where 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 the aspects of the medical examination within their field and sign the report of medical examination (DD Form 2808) documenting those portions of the examination. In all cases, the profiling provider signs the report of medical examination in block 81 of the DD 2808.

*b.* In general, facilities of the Armed Forces, using military medical officers on Active or Reserve Duty, or full-time or part-time civilian employee physicians, with the assistance of dentists, PAs, nurse practitioners, optometrists, audiologists, and podiatrists complete Army medical examinations and PHAs. Contract agreements with civilian or Department of Veterans Affairs facilities, to perform military medical examinations, PHAs, or SHPEs establish an overseeing Army MTF or Reserve Command. (See table 5–1 for SHPE qualification categories.) This ensures review to assess the contracted medical examinations that uphold medical retention standards in AR 40–501. Military physicians and credentialed health care providers familiar with these standards will make accurate and competent retention determinations. Soldiers have to be medically fit for retention, retirement, or non-DES separation. Profiling providers accurately, clearly, and concisely complete the DA Form 3349–SG to describe the capabilities and any functional limitations identified in the examination. If the Soldier's condition does not meet retention standards, they enter the DES process as described in AR 635–40.

*c.* The DoD Medical Examination Review Board (DODMERB) conducts and coordinates the medical examinations for qualification and admission to the USMA, the U.S. Naval Academy, the U.S. Air Force Academy, and the respective preparatory schools. DODMERB also conducts and coordinates the examinations for the University of Health Sciences. These students may complete their accession lab requirements at their Army medical department Direct Commission Course. All other entities must complete a memorandum of understanding with DHA to describe the process for completing the accession lab requirements.

**Table 5–1**
**Summary of separation history and physical exam qualification categories**

| Soldier | SHPE required | Notes |
|---|---|---|
| **AC or Active Guard and Reserve** | Yes | The SHPE must be completed prior to separation from AD.<br>**Not filing claim**: Complete the SHPE at an MTF or by DoD-contracted services.<br>**Filing claim:** No later than 90 days prior to date of separation from AD, complete the separation exam with the VA when possible. Soldiers who separate from overseas locations should refer to the Services for SHPE location and timing. |
| **RC separating after ≥ 180 days of continuous service on AD orders**<br><br>**or**<br><br>**RC separating with ≥ 30 days of continuous service on AD orders in support of a contingency operation** | Yes | **Not filing claim:** Complete the SHPE at an MTF or by DoD-contracted services prior to separation from AD.<br>**Filing claim:** Complete the separation exam with the VA when possible. The Separation Health Assessment (SHA) must be completed prior to separation from AD. When conducted by the VA, a separation exam up to 180 days prior to the date of separation from AD is acceptable. In accordance with DoDI 6040.46, Paragraph 3.3, a DoD official must review the VA performed exam and make an entry into the STR. The presence of this entry must be validated as current no more than 30 days prior to the date of separation from AD, consistent with separation processing procedures of the military department concerned. |
| **United States Coast Guard** | Yes | Complete SHPE at a cognizant United States Coast Guard , MTF, or VA medical facility. When assigned to Navy, follow Navy procedures. |
| **RC separating after 30 to 179 days of continuous service on AD orders**<br>**or**<br>**RC separating with ≤ 30 days of continuous service on AD orders in support of a contingency operation** | No | Document health status and complete a medical assessment prior to separation from AD. |
| **Potentially unfit for continued military service** | No | Refer to the DES or IDES. DES examinations meet the SHPE requirement. |
| **Other: Not under control of secretaries** (for example, unauthorized absences or civilian incarceration) | No | Commands should request waiver through HRC to HQDA DCS, G–1, or his or her delegee. Memos must include:<br><br>1. "In accordance with DoDI 6040.46, SHPE for the DoD SHA Program, dated 14 April 2016, I hereby request a waiver for the requirement of a SHPE in the separation action pertaining to Rank Name under AR 635–200, paragraph XX."<br><br>2. Brief reason why SHPE is not capable of being done.<br><br>3. Point of contact for this memorandum.<br><br>A copy of this request and the approved waiver must be included in the Soldier's EHR/STR. |

## 5–8. Hospitalization

AR 40–400 authorizes hospitalization if necessary for evaluation in connection with a medical examination or PHA.

## 5–9. Objectives of medical examinations

The objectives of military medical examinations and PHAs are to provide information to:

*a.* Assess the Soldier's medical readiness status and to update the IMR status.

*b.* Review PULHES and update any profiles.

*c.* Inform the individual of modifiable health risks and to identify potential lifestyle modifications.

*d.* Identify an injury or illness that requires treatment or has readiness implications.

*e.* Meet administrative and legal requirements.

*f.* Update information on current medical conditions, medications, readiness, duty, or DL conditions and determine if a Soldier meets medical retention standards.

*g.* Determine an individual Soldier's permanent medical non-deployment status risk and health indicator trends by reviewing the MRAT 24-Month Trend Tool.

**5–10. Scope of medical examinations**

*a.* The scope of a medical examination conforms to the intended use of the examination. The medical examination routine describes each abnormality, whether, or not it affects the examinee's medical fitness to perform military duty. The designated sections on the DD Form 2807–1 and DD Form 2808 annotate all symptoms and diagnoses. DD Form 2807–2 is used in the accessions process. Chapter 6 describes the details of specific examinations and completing the medical examination forms.

*b.* AR 601–270 describes the administrative procedures pertaining to procurement medical examinations conducted at MEPS. DODI 6130.03 and AR 40–501 provide the standards for procurement exams. describes the processes of appointment of commissioned and warrant officers of the Army.

*c.* For procedures pertaining to enrollment in the Army ROTC, see AR 145–1.

*d.* For procedures pertaining to USMA and ROTC Scholarship applicants.

*e.* Medical examinations for airborne qualification on DD Form 2808 are valid for 24 months from the date of medical examination. If the examination is older than 2 years, applicants for airborne school must have a current PHA noting any known change in their medical condition since the last examination. A credentialed profiling provider reviews any clinical changes with duty limitations, to ensure the Soldier meets airborne school medical standards.

*f.* Medical examinations are valid for 24 months from completion date of medical examination until the start date for all U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS) schools. This includes Special Forces (SF) Assessment and Selection; SF, Civil Affairs (CA) and Psychological Operations (PSYOPS) training; Military Free Fall (MFF); SF/Ranger Combat Diver; and Survival, Evasion, Resistance, and Escape (SERE) training. Military Free Fall Jumpmaster, Dive Supervisor, and Diving Medical Technician (DMT) training are not initial qualification courses. As such, these courses only require a current MFF/Combat Diver Qualification Course physical valid for the period specified in 6–3*.* Candidates for DMT, not on dive status, require an initial combat diver physical to attend this school.

*g.* The provisions of paragraphs 5–11 through 5–16 and paragraph 6–2 apply to flying duty medical examinations (FDME), flying duty health screenings (FDHS), and aeromedical summaries for Army aircrew to include unmanned aircraft system (UAS) operators and ATCs. This includes RA, Reserves, ARNG, Department of the Army Civilians (DAC), and contract civilians under employment by the DA or firms under contract to the DA. The FDME and FDHS are performed for occupational and preventive medicine purposes to promote and preserve the fitness, medical readiness, and safety of aviation personnel and resources.

*h.* For all flying classes, evaluation of each disqualifying defect or condition determines if it—

(1) Is progressive.

(2) Is subject to aggravation by military service.

(3) Precludes satisfactory completion of training and/or military service.

(4) Constitutes an undue hazard to the individual or to others.

*i.* Aeromedical health care providers consider the factors involved in the use of medicines (APL, Medications) for treatment of the condition and determine if—

(1) The medication is effective without aeromedically significant side effects.

(2) There is a problem with medication compliance.

(3) The medication is readily available during mobilization.

(4) The medication does not mask symptoms subject to acute incapacitation or complications in the aviation environment.

*j.* The aeromedical health care provider considers whether continued flying duty may—

(1) Compromise personal health.

(2) Pose a risk to aviation safety.

(3) Jeopardize mission completion.

(4) Result in medical limitations that may affect deployment status.

**5–11. Aviation administration definitions**

*a.* AR 600–105 and AR 600–106 provide additional definitions and policies pertaining to aviation duties.

*b.* The term aircrew duties, when used in this chapter, refer to and are interchangeable with, ATC duties, aviation service, flying status, flight status, UAS operator duties, and flying duty.

*c.* The terms aircrew and aircrew member are interchangeable and refer to personnel who are in, or graduated from, corresponding aviation, aeromedical, UAS, or ATC training programs.

*d.* FSs, aeromedical physician assistants (APA), and aviation medicine nurse practitioners (AMNP) are licensed health care providers awarded their respective aeronautical designation after graduation from a basic level U.S. military aviation medicine training program.

*e.* An aerospace medicine specialist is a FS who successfully completed a residency in aerospace medicine, or equivalent as determined by the American Board of Preventive Medicine, American Osteopathic Board of Preventive Medicine, or TSG.

*f.* An Army aeromedical examiner (AME) is a physician with sufficient aeromedical training to allow him or her to independently conduct FDMEs and FDHSs, write aeromedical summaries, and issue DD Form 2992 (Medical Recommendation for Flying or Special Operational Duty). The Dean, School of Army Aviation Medicine (SAAM) or the Director, US Army Aeromedical Agency (USAAMA) validates and approves the aeromedical training. This term is distinct from Federal Aviation Administration (FAA) AMEs. FAA AMEs perform only FAA examinations.

*g.* The Aeromedical Consultants Advisory Panel (ACAP) is a panel of subject matter experts assembled by the USAAMA Director (either physically or virtually) designed to advise the director on such issues as precedent setting cases and policies. It is not a formal medical board such as a MEB or PEB. Its membership may be composed of senior Fort Novosel aviators, senior FSs and medical specialists with various medical specialty credentials and other subject matter experts as necessary.

*h.* An Aeromedical Summary (AMS) is a medical information packet summarizing a case history and requesting waiver or suspension for one or more medical conditions. It is prepared by a FS, APA, AMNP, or AME and once properly reviewed, submitted by a FS or AME via the Aeromedical Electronic Resource Office (AERO) to USAAMA for review and disposition.

*i.* An aeromedical disqualification (DQ) is an unfitting medical condition for aircrew duties as prescribed in the accession and aeromedical standards published in AR 40–501.

*j.* AR 600–105 is central to the administration of rated aviators and FSs and includes definitions and procedures for:

(1) Definitions and procedures for temporary medical suspension.
(2) Medical termination of aviation service.
(3) Aeromedical waivers.
(4) Return to aviation service after termination of aviation service.
(5) Procedures for nonmedical disqualifications for aviation service.
(6) Flying Evaluation Boards (FEB).
(7) In-flight aeromedical evaluations.

*k.* Full flying duties (FFD) is a recommendation of medical fitness permitting aircrew duties as annotated by a FS, APA, AMNP, or AME on a DD Form 2992.

*l.* Duties not including flying (DNIF) is a recommendation of medical unfitness prohibiting flying or ATC duties as annotated by a FS, APA, AMNP, or AME or other health care professional on a DD Form 2992.

*m.* Date of medical incapacitation (DOMI) is the date of definitive disqualifying medical condition determined by history, examination, or testing. This date is the basis for the effective date of medical termination from aviation service and may not always correspond with the date the local FS, APA, AMNP, or AME issued a DNIF on a DD Form 2992.

*n.* The AERO is a web based system for recording and tracking flight physicals and aeromedical summaries. The FS, APA, AMNP, or AME creates and submits FDMEs, FDHSs, and AMSs in AERO. USAAMA dispositions the FDMEs and FDHSs and makes a final recommendation for all AMSs to the aeromedical waiver authority who then grants or denies a waiver, using the AERO system. The AERO system allows servicemembers to view and print their documents contained in the AERO system.

*o.* The Aviation Epidemiology Data Registry (AEDR) is a TSG-directed Aeromedical database that migrates and achieves flight physical and AMS data from the AERO system.

### 5–12. Flying Duty Medical Examinations

*a.* U.S. military or civilian FS, APA, AMNP, or AMEs conduct initial FDMEs. Initial FDMEs meet the Army-specific administrative requirements for completion as outlined in the Aeromedical Technical Bulletins (ATB). The FS, APA, AMNP, or AME applies U.S. Army aeromedical standards from accession and aviation standards published in AR 40–501 and APLs to determine medical fitness for flying duty. The FDME is invalid and incomplete without the electronic or actual signature of a FS, APA, AMNP, or AME on the DD Form 2808 and DD Form 2807–1.

*b.* Trained FS, APA, AMNP, and AMEs conduct comprehensive FDMEs and Interim FDHSs for all Classes, when available. Any military, DAC, contract civilian physician or non-aeromedically trained PA or family nurse practitioner may conduct the FDME when a FS, APA, AMNP, or AME is not available. Only a FS reviews and signs the DD Form 2808, and DD Form 2807–1 (Report of Medical History), or DA Form 4497 (Interim (Abbreviated) Flying Duty Medical Examination), prior to sending (either by mail (Director, USAAMA, Building 110, 6th Avenue, Fort Novosel, AL 36362) or AERO system) to USAAMA for central review. When non-U.S. Army medical facilities perform a FDME, a FS, APA, AMNP, or AME conducts the FDME to meet the administrative requirements of that branch of the U.S. Armed Forces or host allied nation in accordance with STANAG 3526, and AR 12–15. The aeromedical cardiovascular screening program still applies. The FS, APA, AMNP, or AME must apply Army aeromedical standards from accession and aviation standards published in AR 40–501 for the determination of medical fitness for flying duties. If the DD Form 2808 and DD Form 2807–1 are not available when host allied nations perform FDMEs, the allied examiner completes in English the allied documents designed for the same purpose. Include a memorandum for record outlining the unusual circumstances with the FDME.

*c.* DAC or DA contract civilian health care providers with a previous military aeronautical rating of FS, APA, AMNP, or AME practicing in medical specialties other than aviation medicine may complete FDMEs if they meet credentialing requirements. The SAAM provides Army Aviation Medicine refresher training for FS, APA, AMNP, or AMEs to meet credentialing requirements. Other physicians and health care professionals sign the DD Form 2808 for the portions of the examination they accomplish. The FDME is invalid and incomplete without the signature of a FS, APA, AMNP, or AME on the DD Form 2808 and DD Form 2807–1 or DA Form 4497, and the USAAMA final review stamp on the DD Form 2808 or DA Form 4497.

*d.* APAs and AMNPs may conduct FDMEs and FDHSs and sign and submit directly to USAAMA for review and disposition, normal FDMEs and FDHSs meeting aeromedical class standards and FDMEs and FDHSs with existing waivers meeting annual waiver requirements.

*e.* APAs and AMNPs may not submit new disqualifications and those not meeting annual waiver requirements. These require the supervising FS review and co-sign prior to submission. In circumstances when the supervising FS is unavailable, APAs, and AMNPs annotate same on DD Form 2808, Block 73, "Notes" or DA Form 4497 for USAAMA FS staff to assume that role.

*f.* MTFs complete additional tests, procedures, and consultations required to complete initial and annual FDMEs or FDHSs, and AMSs for all aircrew classes, to include civilians, AD, and RC, when possible. MTF commanders or ARNG State Adjutant General's Office may permit supplementary examinations from civilian medical sources to determine fitness for flying duty. These additional tests and consultations are not for the treatment or correction of disqualifying conditions even if such therapeutic interventions may result in the individual being qualified for flight. Conduct additional testing only to the extent required by annual waiver requirements, Aeromedical Policy Letter, or USAAMA Director to determine aeromedical fitness.

*g.* AERO is the primary method for entering and submitting FDME, FDHS, and AMS data.

*h.* Purpose, frequency, and period of validity of FDMEs:

(1) *Initial Flying Duty Medical Examinations (classes 1, 2, 2F/2P, 3, and 4).*

*(a)* Perform Initial FDMEs on applicants to determine aeromedical qualification for initial aviator, ATC, UAS operator or aviation medicine training, other aviation applicants for positions described in AR 600–105, inter-service transfer, transition from AD to RC, for return to AD if the break in service exceeds 12 months, and hiring into the DAC work force.

*(b)* All flight school applicants (class 1 FDMEs) must pass the Selection Instrument for Flight Training before initiating the FDME, and the aviation medicine clinic staff verifies a passing score.

*(c)* The results of Initial FDMEs are recorded on DD Form 2807–1 and DD Form 2808.

*(d)* The initial FDME is valid for a period of 18 months from the date of examination.

*(e)* Repeat initial FDMEs are required if the FDME expires while awaiting selection for or the start of initial aviator, UAS operator, ATC, or aeromedical training. The FDME must be valid and qualified by the Director, USAAMA before the applicant's acceptance into and prior to arrival for any aviator, UAS operator, ATC, or aviation medicine training program.

(2) *Fort Novosel class 1 Flying Duty Medical Examination.* Class 1 aviator training program students must have a valid, approved initial class 1 FDME before acceptance into aviator training programs and upon arriving for flight training at Fort Novosel. Lyster Army Health Clinic will perform a Fort Novosel class 1 FDME before enrolling the student in flight training to revalidate that the student meets class 1 medical standards of fitness for flying duties. Repeat the entire Initial FDME if the Initial FDME is no longer valid.

This physical is valid for up to 24 months to allow completion of the Flight Training programs. Upon graduation and PCS to the next duty station, the aviator completes a FDME or FDHS and birth month realignment, as prescribed in the Aeromedical Technical Bulletins and table 5–2.

(3) *Classes 2, 2F/2P, 3, and 4 validity.* Requirements are:

*(a) General.* Following the initial FDME, subsequent comprehensive FDMEs or interim FDHSs align with the aircrew member's birth month using table 5–2.

*(b) Comprehensive Flying Duty Medical Examination.*

1. Perform a comprehensive FDME on all classes of aircrew if there is no requirement for an Initial FDME or FDHS. Record the results of the Comprehensive FDME on DD Form 2808 and DD Form 2807–1. Report interim changes in medical history on DD Form 2807–1 if not previously documented on an AEDR Medical History Verification Report or AMS. Contract aircrew members (except ATC) are the exception when processed using FAA medical standards and forms. Perform the Comprehensive FDME every 5 years beginning with age 20, or as applicable, at ages 25, 30, 35, 40, and 45. Beginning at age 50, the requirement is for an annual comprehensive FDME.

2. Air crew members complete their FDME within 90 days (two calendar months prior to the birth month plus the birth month) before the end of the birth month. The FDME is valid until the end of the next birth month.

3. Complete and submit a comprehensive FDME after any class A or B mishap.

4. Comprehensive FDMEs are also required for the following: Soldiers requesting a return to aviation service after termination, mishap, FEB, or a disqualifying illness or injury present for more than 365 days. Those terminated from aviation service and requesting a return to aviation service require a comprehensive FDME.

*(c) Interim Flying Duty Medical Examination/Flying Duty Health Screen.*

1. Perform the FDHS on all classes of aircrew if there is no requirement for an initial FDME or comprehensive FDME. Record the results of the FDHS on DA Form 4497 or DD Form 2808 with identified blocks specific for FDHS completion. Report interim changes in medical history on DD Form 2807–1 if not previously documented on an AEDR Medical History Verification Report or AMS.

2. Aircrew members complete their FDHS within 90 days (two calendar months prior to the birth month plus the birth month) before the end of the birth month. The FDHS is valid until the end of the next birth month.

*(d) Rated aviators in aviation service.* AR 600–105 requires rated aviators not performing operational flying duties to complete an annual FDME or FDHS, to the standards of AR 40–501, with issuance of a DD Form 2992.

*(e) Retirement.* If an FDME is required within 90 days of retirement from Federal service, it will be a comprehensive FDME to include all required COMPOs of the SHPE described in chapter 6. The requirement for completion of a SHPE prior to AD separation is all retiring AD Soldiers, and RC Soldiers either on AD orders greater than 180 days or on contingency operations for more than 30 days. Although not otherwise eligible for a SHPE, RC members not on AD and civilian aircrew members eligible for an FDME within 90 days of retirement should have a comprehensive FDME and ensure the evaluation meets all the requirements of a SHPE.

*i.* The requirement to perform FDMEs and FDHSs continues during training exercises or military mobilization unless TSG authorizes a suspension. Requests for authorization to suspend FDMEs proceed through the Director, USAAMA, who coordinates authorization with the TSG aerospace medicine consultant.

*j.* Complete the FDME or FDHS to the extent the MTFs permit when aircrew are on duty or in mobilization at a station OCONUS with limited military medical facilities. Submit in the AERO system as deployed incomplete. If AERO is not available email or attach a cover letter to the FDME or FDHS addressed to Director, USAAMA, explaining the facility limitations. Accomplish the missing portions of the annual FDMEs and FDHSs within 90 days upon return to a station with adequate medical facilities. Align subsequent comprehensive or interim FDHSs with the aircrew member's birth month using table 5–2.

*k.* During certain missions without U.S. or allied military medical officer support (for example, special operations), the commander having custody of the field personnel files may defer the FDME until feasible. Annotate in the remarks section of the DD Form 2992 with an explanation of the deferment.

**Table 5–2**
**Number of months for which a Flying Duty Medical Exam is valid**

| Month in which last FDME was given | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Birth month** | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Jan | 12 | 11 | 10 | 9 | 8 | 7 | 18 | 17 | 16 | 15 | 14 | 13 |
| Feb | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 18 | 17 | 16 | 15 | 14 |
| Mar | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 18 | 17 | 16 | 15 |
| Apr | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 18 | 17 | 16 |
| May | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 18 | 17 |
| Jun | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 18 |
| Jul | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 |
| Aug | 7 | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 |
| Sep | 8 | 7 | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 |
| Oct | 9 | 8 | 7 | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 |
| Nov | 10 | 9 | 8 | 7 | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 |
| Dec | 11 | 10 | 9 | 8 | 7 | 18 | 17 | 16 | 15 | 14 | 13 | 12 |

Note: 1Read down the left column to the examinee's birth month; read across to month of last FDME; intersection number is the maximum validity period. When last FDME was within the 3-month period preceding the end of the birth month, the validity period will normally not exceed 15 months. When the last FDME was for entry into aviation training, for FEB, post-accident, post-hospitalization, pre-appointment (warrant officer candidate) and so forth, the validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with paragraph 6–2f, by 1 month only for completion of an examination begun before the end of the birth month.

### 5–13. Review and disposition of Flying Duty Medical Examinations

*a. Review.* The aeromedical health care provider reviews the individual health record, FDME, and FDHS with, and counsels the examinee, regarding—

(1) Conditions found during the FDME.

(2) Continuing care, including annual waiver requirements, of conditions under treatment and/or waiver.

(3) General preventive health education, including, but not limited to smoking, cholesterol control, weight control, drug, and alcohol abuse, and other high-risk behavior.

(4) Profile status. The PULHES section of the DD Form 2808 and e-Profile will document the examinee's current PULHES profile status. Any changes to the PULHES must be done on a DA Form 3349–SG in e-Profile.

*b. Class 1 and initial classes 2, 2F, 2P, 3, and 4.* Completed FDMEs (originals of DD Form 2807–1, DD Form 2808, and other supporting documents) accomplished for application to aviation and aviation medicine training programs will proceed through the applicant's procurement chain of command, preferably via AERO, to Director, USAAMA for central aeromedical review and disposition. The FS's office must place a copy of the FDME and all enclosures in the electronic medical record or STR and retain a copy in the office for a minimum of 2 years for submissions that did not use AERO. The AERO serves as a repository for the information. In no case does the applicant, or other individuals not in the procurement chain of command, receive the originals. The Director, USAAMA, must make a final recommendation of fitness for flying duties before accepting and assigning initial applicants for aviator, UAS, ATC, and aviation medicine training programs.

*c. Trained classes 2, 2F, 2P, 3, and 4.* Completed FDMEs and FDHSs (DD Form 2808 and DD Form 2807–1 or DA 4497, other supporting documents, and, if applicable, AMS) is forwarded directly to the Director, USAAMA, for central aeromedical review and disposition. The FS's office must place a copy of the FDME or FDHS and all enclosures in the electronic medical record or STR and retain a copy in the office for a minimum of 2 years if submission is not accomplished via AERO. AERO serves as a repository for the information.

*d. Tracking.* The FS tracks FDMEs and FDHSs via AERO from initiation to final recommendation and/or disposition by USAAMA to include disposition by the waiver authority. The AERO report "My

Submissions Stats" and other tools available support flight physical and waiver tracking. If disqualified, the FS and aviation unit take action, per AR 600–105 and AR 600–106.

*e. Distribution of documentation.* Waiver and suspension recommendation letters are documents shared between USAAMA and the waiver authority and do not belong in the flight record. Abbreviated waiver disposition letters generated by the waiver authority are filed in the individual flight record folder HIPAA rules and regulations regarding protected health information are always respected.

**5–14. Temporary medical suspension from aviation service**

*a.* Temporary flying duties pending waiver.

(1) For defects that will not preclude the safe and efficient performance of flying duties nor be aggravated by aviation duty or military mission, the local commander may permit an individual to continue performance of aviation duties pending completion of the formal waiver process and upon favorable recommendation for temporary FFD by the local FS, APA, AMNP, or AME.

(2) When used to recommend temporary flying duties, the remarks section of DD Form 2992 will reflect a limited length of time covered by the issued clearance, for example: "Temporary FFD, 90 days, pending receipt of waiver."

*b.* Temporary medical suspension not pending waiver.

(1) Temporary aeromedical DQs that are minor, self-limited, and likely to result in requalification within 365 days require a temporary medical suspension restricting aircrew from flying duties. Examples include ankle sprain, acute rhinitis, gastroenteritis, and simple closed fracture.

(2) The FS, APA, AMNP, or AME consults a FS at USAAMA, or the major Army command's aviation medicine consultants in the U.S. Army, Europe, or Korea, before issuing a DD Form 2992 in complex or questionable cases, when a temporary FFD is being considered. This includes but is not limited to:

*(a)* Severe coronary artery disease as manifested by angina, infarction, or stroke, or positive treadmill stress test.

*(b)* Seizures, either idiopathic or secondary.

*(c)* Cancer (except for skin).

*(d)* Class 4 drug use.

*(e)* Significant behavioral health disorders including substance use disorders and/or those requiring psychotropic medication.

*(f)* Any other disorder thought by FS to represent excessive aeromedical risk.

(3) The local FS, APA, AMNP, or AME evaluates all aircrew with possible aeromedical DQs identified by the aviator, immediate commander, FS, AMNP, or AME, or USAAMA. The FS, APA, AMNP, or AME follows the established standards of aeromedical care (this regulation, APLs, and ATB series).

(4) The FS, APA, AMNP, or AME recommends a DOMI and recommend DNIF on DD Form 2992. Establishment of the DOMI is important to determine the 365 day period allowable for temporary aeromedical DQs. If the incapacitation persists beyond 365 days, it meets the criteria and requirements of permanent medical suspensions below. The immediate commander sets the DOMI and impose the temporary medical suspension by approving the recommendation on the DD Form 2992.

(5) Aircrew under temporary medical suspension may not be assigned flying/UAS/ATC duties or operate the flight controls of a military aircraft. As an exception, the FS, APA, AMNP, or AME may recommend by DD Form 2992 that the Soldier operate flight simulators, perform ground run-up procedures, and/or undergo an aeromedical consultation with in-flight evaluation as appropriate. (See AR 600–105.)

(6) The immediate commander may remove the temporary medical suspension upon favorable recommendation by a FS, APA, AMNP, or AME by approving the recommendation on the DD Form 2992.

(7) Medical termination from aviation service (see para 5–15) is mandatory if the temporary medical suspension exists for greater than 365 days (AR 600–105). In this case, the temporary medical disqualification (DQ) becomes a permanent medical DQ. The FS, APA, AMNP, or AME notifies the immediate commander by a DD Form 2992 and forward an AMS to Director, USAAMA.

**5–15. Permanent medical suspension from aviation service**

*a.* Aeromedical DQs that are not likely to result in requalification within 365 days require medical termination from aviation service (permanent medical suspension). Issuance of orders for an aeromedical waiver by an aviation service aeromedical waiver authority authorizes continuation of flying duties.

*b.* The local FS, APA, AMNP, and AME thoroughly evaluate the disqualifying condition in accordance with applicable regulations and APLs, and make a preliminary determination of medical fitness for flying duty.

*c.* Upon verification of the condition, the FS, APA, AMNP, or AME will—

(1) Recommend a medical termination from aviation service (permanent medical suspension) on a DD Form 2992 and forward the notification to the immediate commander.

(2) The FS or AME sends an AMS recommending suspension and a DOMI to Director, USAAMA.

*d.* The Director, USAAMA, makes final recommendations to the aviation service aeromedical waiver authority and recommend a—

(1) Date of medical incapacitation.

(2) Final aeromedical disposition.

*(a)* Medical termination from aviation service; or

*(b)* Aeromedical waiver for continuation of aviation service with the permanent aeromedical DQ; or

*(c)* Requalification without aeromedical DQ ("For Information Only").

*e.* In the case of concurrence with USAAMA's suspension recommendation, the aviation service aeromedical waiver authority—

(1) Establishes the DOMI.

(2) Establishes the date of medical termination from aviation service and publish an order (in accordance with AR 600–8–105).

(3) Ensures any referral to the MAR2 or DES processes comply with AR 635–40. DA Civilian personnel regulations govern the management of DAC aircrew, and contract requirements govern the management of contract aircrew, though in both cases the waiver authority initiates personnel actions.

**5–16. Aeromedical waiver and requalification**

*a.* In the case of permanent aeromedical DQ, the aircrew member may request consideration for an aeromedical waiver for continued aviation service through a local FS, APA, AMNP, or AME.

*b.* The FS, APA, AMNP, or AME completes an evaluation within the aeromedical standards of care (this regulation, APLs, and ATB series). The FS, APA, AMNP, or AME prepares an AMS, and the FS or AME reviews and forwards to Director, USAAMA.

*c.* The Chief, Aeromedical Consultation Service—

(1) Reviews the case.

(2) Arranges or requests additional evaluation by aeromedical consultants, medical specialists, or flight evaluations (AR 600–105) as required.

(3) Requests ACAP evaluation if needed.

(4) Refers the case with recommendations to Director, USAAMA.

*d.* The Director, USAAMA—

(1) Determines whether an aeromedical waiver is advisable and if so, defines specific flight restrictions and annual waiver requirements to maintain the waiver.

(2) Forwards final recommendations in the form of a waiver recommendation letter to the aviation service aeromedical waiver authority.

*e.* The aviation service aeromedical waiver authority—

(1) Reviews the aeromedical recommendations and supportive enclosures, considers the needs of the U.S. Army, and makes a final determination to grant or deny an aeromedical waiver.

(2) Issues a waiver disposition letter to the aircrew member, either allowing continuation of aviation service with a waiver, or medically terminating aircrew member from aviation service (permanent medical suspension).

(3) Removes a waiver and all annual waiver requirements, if documentation supports the recommendation from the Director, USAAMA to rescind a waiver.

*f.* The aircrew member acknowledges the waiver and, if applicable, restrictions, and follow-up evaluation, in writing, to the aviation service aeromedical waiver authority. Failure to do so, or declining the waiver, results in a nonmedical disqualification due to dereliction of duty and may result in an FEB (AR 600–105).

*g.* The FS, APA, AMNP, and AME may recommend amendments to the conditions for continuation or removal of waivers in effect, as required, by submitting written justification in an AMS along with supportive documents to the Director, USAAMA.

*h.* Personnel who are dual-status (such as ARNG members and DACs) require a waiver or suspension action from each authority of assignment.

*i.* Aviation service waiver authority contacts:

(1) For all classes of RA and USAR, or international military pilots and flight students of non-NATO or Partnership for Peace (PfP) countries: through Director, USAAMA (MCXY–AER), Fort Novosel, AL 36362–5333; for Commander, Army Human Resources Command, 1600 Spearhead Division Ave., Room 2–1–021, Fort Knox, KY 40122. AERO is used for these transmissions.

(2) All RA or USAR FSs, APAs, and AMNPs: through Director, USAAMA (MCXY–AER), Fort Novosel, AL 36362–5333; for Commander, Army Human Resources Command (AHRC–OPH–C), 1600 Spearhead Division Ave, Dept. 250, Fort Knox, KY 40122. AERO is used for these transmissions.

(3) All classes of ARNG: through Director, USAAMA (MCXY–AER), Fort Novosel, AL 36362–5333; for Chief, NGB (AVN–OP), 111 South George Mason Drive, Arlington, VA 22204–1382. AERO is used for these transmissions.

(4) For all classes of contract civilians falling under Army aeromedical standards and not FAA aeromedical standards for certification: through Director, USAAMA (MCXY–AER), Fort Novosel, AL 36362–5333; through the contracting officer representative, for the commanding general, or the commanding general's designated the waiver authority, of the installation with the da contract (usually the airfield commander or the command aviation officer of the installation with the DA contract; for example, at Fort Novosel, command aviation officer (DPT–AD), Fort Novosel, AL 36362–5333). The Contracting Office and the firm under contract to DA will receive the final determination.

(5) All classes of DAC: through Director, USAAMA (MCXY–AER), Fort Novosel, AL 36362–5333; through aviation unit commander; for the commanding general, or the commanding general's designated waiver authority (usually the airfield commander or command aviation officer; for example, at Fort Novosel, command aviation officer (DPT–AD), Fort Novosel, AL 36362–5333). The local Civilian Personnel Office will receive the final determination.

*j.* An aircrew member with a medical termination (suspension) from aviation service may request aeromedical requalification if the medical DQ resolves or is no longer disqualifying due to policy or standard changes.

*k.* The procedure for requesting requalification is the same as the procedure for requesting an aeromedical waiver. Upon receipt of a favorable recommendation from Director, USAAMA the aviation service aeromedical waiver authority determines if requalification meets the needs of the Army, and if so, the waiver authority—

(1) Publishes orders establishing date of the aeromedical requalification.

(2) Publishes orders of assignment and travel.

(3) Issues an administrative waiver if required.

### 5–17. Active duty for training, Active duty for special work, annual training for Ready Reserves, and in Active duty training

*a.* Individuals on AD for training (ADT)/AD operational support (ADOS; AC, RC, OP) for 30 days or less do not require medical examinations prior to separation unless there is clinical indication.

*b.* TPU/IMA Soldiers on AT for 30 days or less must have a current PHA and dental exam but are not required to undergo a specific medical examination prior to initiating orders unless there is clinical indication for the examination. IRR and Standby Active Soldiers are required to receive a PHA prior to reporting on AT orders. AHRC Surgeon is the waiver authority for the required PHA prior to AT orders for IRR and Standby Active Soldiers.

*c.* An individual on ADT/ADOS (AC, RC, and OP) who incurs an injury during such training that may result in disability, or who alleges medical unfitness or disability, must complete a medical examination.

*d.* The medical retention standards contained in AR 40–501 describe the indications for referral into the DES.

### 5–18. Retiree recalls

A current (within the past 12 months) medical examination to include PHA, SHPE, or retirement medical examination meets requirements.

**5–19. Health records**
Medical examiners review the STR and/or EHR of each examinee, whether an examination is for relief from AD, resignation, retirement, separation from the Service, or any other physical examination; to include exams done for schools, flight duties, and so forth—or as part of a PHA. The examiner notes any significant problems, patient education, and follow-up care on the DD Form 2766, as appropriate.

**5–20. Mobilization of units and members of Reserve Components of the Army**
Mobilization or call-up for war or contingency operations requires a current (within 12 months) PHA and pre-DHAs. See paragraph 6–7 for separation examinations requirements.

**5–21. Frequency of additional and alternate examinations**
*a. Female examinations.* Examinations specific to females are no longer mandatory. Evidence-based women's preventive health services remain important, and Soldiers should follow the clinical guidelines to ensure they receive optimal care. United States Preventative Services Task Force (USPSTF) recommendations include breast and cervical cytology screening examinations (see website for most current guidance: 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 are performed during the birth month. More frequent examinations are scheduled during the birth month and at appropriate intervals thereafter.

**5–22. Deferment of examinations**
*a. Armywide or at specific installations.* In circumstances requiring Armywide or installation deferment of periodic examinations (where conditions preclude doing periodic examinations or PHAs due to resources requirements of other missions—for example, screening for mobilization or contingency operations, heavy casualties, and so on), submit requests for exceptions to policies deferring examinations to TSG (DASG–HCO, G–37, Medical Readiness, USARMY NCR HQDA TSG List Medical Readiness, usarmy.ncr.hqda-otsg.list.medical-readiness@health.mil).
*b. Soldiers in isolated areas.* Commanders of Soldiers stationed in isolated areas (specifically Army attachés, military missions, and military assistance advisory groups (MAAGs)) may delay PHAs, where medical facilities are not available. Soldiers accomplish delayed PHAs at the earliest opportunity in conjunction with leave, temporary duty, or on assignment or attachment to military installation with a medical facility. All health readiness platforms support these readiness requirements regardless of empanelment. 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 PHAs, it may be deferred by direction of the commander having custody of personnel files until such time as its accomplishment becomes feasible. An appropriate entry explaining the deferment is made in the EHR or personnel file when such a situation exists.

**5–23. Promotion**
A complete annual PHA medically qualifies officers, warrant officers, and enlisted personnel, regardless of component, for promotion.

**5–24. Miscellaneous medical examinations**
*a. Special Forces, Civil Affairs, Psychological Operations, Military Free Fall parachutists, Special Forces/Ranger combat divers, survival,* and *Survival, Evasion, Resistance, and Escape medical examinations.* Entrance into SF, CA, PSYOPS, MFF, SF/Ranger Combat Diver, and SERE training is only be accomplished after meeting the medical fitness standards documented by completing the appropriate physical exam.
*b. Certain geographic areas.*
(1) On alert or order for assignment to the system of Army attachés, military missions, MAAGs, or to isolated areas, the commander of the station of assignment refers the individual and his or her dependents, if any, to the medical facility of the command.
(2) The physician of the facility carefully reviews the health records and other available medical records of incoming personnel and dependents. Medical fitness standards and factors to consider in the evaluation are contained in chapter 7 of this DA Pam and in AR 40–501. Reviewing the medical records

and personally interviewing the individuals provides pertinent information about their health. The credentialed health care provider 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.

(3) After review of the clinical records and pertinent discussion, the credentialed health care provider will determine the necessity of a complete medical examination and support accomplishment.

(4) The commander will ensure complete medical evaluations and qualification prior to the individual's departure from his or her home station.

(5) If, as a result of their review of available medical records, discussion with the individual, and findings of the medical examination, the physician finds the individual medically qualified in every respect to include established CCMD guidance, *and* qualified to meet the conditions encountered in the area of contemplated assignment, the physician will complete and sign DA Form 3083 (Medical Examination for Certain Geographical Areas), prior to a PCS. The completing health care providers will ensure documentation of this statement in the health record or outpatient record (AR 40–66), the EHR, and provide a copy to the originating commander.

(6) Screening of all family members will follow the procedures prescribed in AR 608–75. If any family member meets the criteria for enrollment in the Exceptional Family Member Program , assignment coordination with appropriate medical and educational representatives will determine the availability of identified required services. If the projected assignment area cannot meet the medical needs, the medical representative will recommend disapproval of accompanied family travel. The examiner will not disclose the cause of the disqualification of a dependent to the commander without the consent of the dependent, and the parent, if the disqualification relates to a minor. If the Soldier or dependent has a temporary disqualification, the evaluating credentialed health care provider will schedule a reexamination following resolution of the condition and apprise the commander.

(7) If the disqualification of the Soldier is permanent or if it is determined that the disqualifying condition will be present for an extended period of time, the physician must refer the Soldier to an MEB if the Soldier does not meet medical retention standards. The DA Form 3349–SG in e-Profile will be completed outlining specific limitations.

*c. Potential rabies exposure examinations.* The frequency of potential rabies exposure examinations varies according to exposure. Document the examination on the DD Form 2341 (Report of Animal Bite/Scratch–Potential Rabies Exposure) to collect information necessary to record the history and assessment of rabies risk to a person who was potentially exposed to rabies through an animal bite or other route (that is, bat in a bedroom or dormitory), and to record exam observations, animal laboratory findings, disposition results, and follow-up care for that person.

### 5–25. Cardiovascular Screening Program

The Cardiovascular Screening Program (CVSP) required in AR 40–502 may be completed in association with a PHA or routine care. All screening is to be accomplished in accordance with the USPSTF A and B level recommendations for each Solider.

### 5–26. Army Approved Auditory Fitness for Duty Test for H–3 profile Soldiers

*a.* Audiologists at all Army facilities will use the MOHT to assess all Soldiers with projected H–3 profiles to determine actual profile category and to provide recommendations concerning functional hearing limitations that might have negative operational impacts. 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.

*b.* The Soldier's score on the MOHT, along with the audiogram, will be used to determine an appropriate profile category and administrative recommendations based on the procedure in table 4–2.

*c.* The recommendations concerning operational impacts of hearing loss should be made to MAR2 and MEBs and considered when completing the physical profile assignment limitations on DA Form 3349–SG in the EHR. The recommendations provide appropriate information for medical and administrative boards to make a final determination.

## Chapter 6
## Medical Examinations—Forms and Specified Exams

### 6–1. General

*a.* This chapter describes the procedure for ensuring complete and accurate documentation of various medical examinations.

*b.* DD Form 2992 is the outcome of the FDME process and describes the flying duty recommendations to the commander.

*c.* The DD Form 2808 will document the results of a medical examination for most purposes. AR 40–29 describes the use of DODMERB forms for specific accession evaluations.

*d.* The annual PHA is the medical readiness screening tool for all Soldiers. The DoD PHA is completed electronically within the Medical Readiness Portal within MODS.

*e.* SHPE is described in para 6–7.

### 6–2. DD Form 2992 use

*a.* DD Form 2992 is an official, non-medical document used by the aeromedical provider (FS, APA, AMNP, and AME) to communicate with the aviation commander. It reports the aeromedical readiness status of, and recommends aeromedical fitness for, all classes of military and civilian aircrew duties (except contractors using FAA forms).

*b.* Complete the DD Form 2992—

(1) After the completion of an FDME or FDHS.

(2) After an aircraft mishap.

(3) After an FEB.

(4) When reporting to a new duty station or upon assignment to operational flying duty.

(5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military, or civilian), or sick in quarters.

(6) When treated by a health care professional other than a military FS, APA, AMNP, or AME without authorization to issue a DD Form 2992.

(7) Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service.

(8) Other occasions as required by the FS, APA, AMNP, or AME or command.

*c.* AR 600–105 requires rated aviators not performing operational flying duties to complete an annual FDME or FDHS with issuance of a DD Form 2992.

*d.* The aeromedical health care provider completes three copies of the DD Form 2992.

(1) Place the first copy in the outpatient medical record (to include uploading into the EHR).

(2) Forward the second copy to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (TC 3–04.11 para 6–23).

(3) Provide the third copy to the examinee for their records.

*e.* If the local FS, APA, AMNP, or AME finds the examinee qualified for flying duty, in accordance with the accession and aviation standards of AR 40–501, then issuance of the DD Form 2992 will constitute an aeromedical recommendation for flying duty pending final review of the FDME or FDHS by USAAMA. If the examinee requires a waiver, and local FS, APA, AMNP, or AME finds the examinee qualified for flying duty, in accordance with the accession and aviation standards of AR 40–501, then issuance of the DD Form 2992 will constitute an aeromedical recommendation for flying duty pending the approval by the appropriate aviation service aeromedical waiver authority. The aeromedical clearance will expire when the current FDME or FDHS is no longer valid. The unit commander is the approval authority for all aeromedical recommendations on the DD Form 2992.

*f.* During their birth month, the aircrew member may request an extension of the validity period of a current FDME or FDHS for a period of one calendar month after the birth month. The aeromedical provider does not have to support the request, and the commander does not have to authorize an extension. If the extension expires, the aircrew member must complete the FDME or FDHS with one of the following three dispositions:

(1) Found medically qualified and returned to FFD.

(2) Administratively restricted from flying duties if no aeromedical DQ exists and be considered for a non–medical DQ and FEB as described in AR 600–105.

(3) Medically restricted from flying duties if an aeromedical DQ exists. In some cases, temporary flying duties may be recommended on a DD Form 2992.

*g.* Personnel authorized to sign the DD Form 2992 are as follows:

(1) Any physician or health care provider may sign a DD Form 2992 for the purpose of restricting aircrew from aviation duties when an aeromedical DQ exists.

(2) A FS, APA, AMNP, and AME may sign the DD Form 2992 to return aircrew to FFD. Annotate recommended restrictions in the remarks block of a DD Form 2992.

(3) A non-aeromedically trained health care provider under the supervision of a FS may sign the DD Form 2992 to recommend returning aircrew to FFD when a FS is not locally available by obtaining case-by-case telehealth guidance from a FS, documenting the name of the consulted FS on the DD Form 2992, and in the EHR.

*h.* When host allied nations provide aeromedical support and a DD Form 2992 is not available, the Army will accept host or allied nations' forms designed for the same purpose.

*i.* Contract aircrew using FAA for aeromedical certification must possess the applicable FAA Form 8500–9 (Medical Certificate _____ Class), in lieu of a DD Form 2992.

**6–3. DD Form 2808**

*a. Required forms.* The required form for all Army military medical examinations (not used for the PHA) is DD Form 2808. The electronic DD Form 2808 is available to users at https://www.esd.whs.mil/Directives/forms/dd2500_2999/DD2808/, supersedes the paper version of the form, and will be utilized whenever available. The "Laboratory Findings" section of this form may not contain enough space to include all required tests. If additional space is needed, the "Notes" section in box 73 may be used for that purpose. MTFs should use standard overprints, stamps, and so forth, in box 73 for that purpose. Table 6–1 contains model entries and explanatory notes for every box on the DD Form 2808. All examinations do not require all items.

*b. All examinations.* All Army military medical examinations require the following items. Additional items may be clinically indicated. See paragraphs *c* through *g* below for additional items required for special examinations. The box number from the DD Form 2808 that corresponds to the appropriate item to be completed is listed following each item.

(1) *Administrative data.*

*(a)* Date of examination (box 1).

*(b)* SSN and/or DoD ID per direction (box 2).

*(c)* Name of examinee (box 3).

*(d)* Home address; current address, not "home of record" if different (box 4).

*(e)* Home or contact information to include telephone number (box 5).

*(f)* Grade/rank (box 6).

*(g)* Date of birth (box 7).

*(h)* Age (box 8).

*(i)* Sex (box 9).

*(j)* Race and ethnic categories (box 10).

*(k)* Service (box 15a).

*(l)* Component (box 15b).

*(m)* Purpose of exam (box 15c).

*(n)* Name of examining facility (box 16).

*(o)* The Soldier's name, SSN, and/or DoD ID, per direction will also be completed on the top of all pages with entries for this information on the DD Form 2808.

(2) *Clinical evaluation section (boxes 17 through 42*). This includes examination of head, face, neck, scalp, nose, sinuses, mouth, throat, ears (drums), eyes (includes ophthalmoscopy), heart, lungs, vascular system, anus, abdomen, upper, and lower extremities, feet, spine, skin, breast exam, neurologic exam, and testicular exam on males. (All examinations do not require rectal exams, and pelvic exams on females.)

(3) *Dental defects and disease.* This is usually completed by a physician, PA, or nurse practitioner who will be noting any obvious gross abnormalities. This does not replace the dental examination by a dentist required in AR 40–3. The physician, PA, or nurse practitioner may check the box acceptable or unacceptable but are not authorized to attribute a dental class. Only a dentist will assign a dental "class" after a dental examination as described in AR 40–3.

(4) *Notes* section (box 44). Area to explain any abnormalities and to indicate the dental exam is not performed by a dentist.

(5) *Urinalysis for albumin and sugar (boxes 45a and 45b)*.

(6) *Miscellaneous measurements.* Height (box 53), weight (box 54), temperature (box 56), pulse (box 57), blood pressure (box 58a), distant vision (box 61), near vision (box 63), and audiometer results (box 71a).

(7) *Qualification for* service*(box 74a)*. For separation and retirement exams, qualification is based on whether the examinee meets the medical retention standards of chapter 3.

(8) *Physical profile (box 74b).* This section does not replace the requirements for a DA Form 3349–SG in e-Profile as described in chapter 4.

(9) *Summary of defects (box 77).*

(10) *Recommendations (box 78).*

(11) *Name and signatures of examining physician, physician assistant, or nurse practitioner (boxes 81a and 81b), and of examining or approving physician (boxes 82a and 82b or 84a and 84b).*

(12) *Date examination completed.* This is entered in box 85c.

*c. Initial examinations for appointment, enlistment, or induction.* In addition to the items listed for "All Examinations" (paragraph *b* above), the following items are required. (See AR 40–29 for DODMERB exams.)

*Note.* MEPCOM will provide instructions to the MEPS on completion of the required forms for Army applicants. These instructions will include additional items on the DD Form 2808 that are used solely by the MEPS (for example, boxes 75, 79, and 80).

(1) Pregnancy testing on female applicants (box 46).

(2) HIV testing (box 49). See AR 600–110.

(3) Drug and alcohol test. USMA Superintendent and the Cadet Command will develop and maintain their testing policies to complete the DODMERB physical for accession and commissioning (boxes 50 and 51).

(4) Chest x-ray result, if clinically indicated (record in box 73).

(5) Color vision (record results in box 66).

*d. Examinations for the U.S. Army Special Operations Command and U.S. Army John F. Kennedy Special Warfare Center and School to include Special Forces, Civil Affairs, Psychological Operations , Survival, Evasion, Resistance, and Escape, Military Free Fall, Special Forces/Ranger Combat Diver.* In addition to the items listed for "All Examinations" (paragraphs *b*(1), (2), (3), and (4) above), these exams require the following items (laboratory and other studies must be completed within 3 months of the physical examination and the physical examination must be dated within 2 years of the class start date to be valid):

(1) Laboratory tests–

*(a)* Urinalysis for albumin and sugar, all exams (boxes 45a and 45b).

*(b)* Complete blood count (CBC) [Hemoglobin (HGB)/Hematocrit test (HCT) (box 47), white blood cell (WBC), platelet count (box 73)].

*(c)* HIV (box 49).

*(d)* Urine specific gravity and urine microscopic, all exams (record in box 52c).

*(e)* Blood type, *initial exam only; do not repeat*.

*(f)* Sickle Cell Screen, *initial exam only; do not repeat*, must document existing results (record in box 73).

*(g)* Glucose-6-phosphate dehydrogenase*, initial exam only; do not repeat*, may document existing results (record in box 73).

*(h)* Complete cholesterol results to include: total cholesterol, low-density lipoprotein (LDL), High–density lipoprotein (HDL), and Triglycerides (record in box 73).

*(i)* Occult blood, age 40 and older (record in box 73).

*(j)* Prostate Specific Antigen test (PSA) for males age 50 and older (record in box 73).

(2) Miscellaneous measurements–

*(a)* Height (record in box 53).

*(b)* Weight (record in box 54).

*(c)* Pulse (record in box 57).

*(d)* Blood pressure (record in box 58a).

(3) Vision requirements.
*(a)* Distance vision (record in box 61).
*(b)* Near vision (record in box 63).
*(c)* Color vision, *not* required for CA, PSYOPS, and Capstone Training (CST) unless also attending Airborne School (record in boxes 59 and 66).
*(d)* Intraocular pressure measurement (record in box 70).
*(e)* Visual fields (record in box 68).
*(f)* Night vision (record in box 69).
*(g)* Refraction. If vision does not correct to 20/20 in each eye with spectacles or contact lenses, or if uncorrected vision is worse than 20/100 in either eye, not required for SERE (record in box 62).
*(h)* Pre-surgical refraction for anyone who has had photorefractive keratectomy (PRK), laser epithelial keratomileusis (LASEK), or laser-assisted in situ keratomileusis (LASIK) or implantable collamer lens (record in box 73).
(4) Audiometer results (record in box 71a).
(5) Valsalva (record in box 72b.).
(6) Chest x-ray (PA/Lateral) signed by radiologist, *not* required for CA, PSYOPS, unless indicated by current or past clinical history (record in box 73).
(7) Electrocardiogram (ECG) (record in box 73). Include actual ECG with physical examination.
(8) Tuberculin purified protein derivative (PPD) or tuberculin skin test (TST) (record in box 73).
(9) Dental examination by a dentist, *not* required for CA, PSYOPS, and CST unless indication of active clinical dental disease.
(10) "I am informing the examining health care provider of any changes in my health since my last physical examination" (record in box 73).
(11) Cardiac statement: "I have never experienced sudden loss of consciousness due to physical exertion, and I have no family history of sudden cardiac death" (record in box 73).
(12) SERE statement: "I have no fear of heights, depths, dark, or confined spaces" (record in box 73).
(13) Documentation of a neurological examination in block 42 to include mental status, cranial nerves, motor, sensory, coordination, and deep tendon reflexes.
(14) All female candidates to the U.S. Army Special Operations Command (USASOC) and United States Army John F. Kennedy Special Warfare Center and School schools must complete the following *in addition* to the above:
*(a)* Human chorionic gonadotropin is required within 30 days of course attendance.
*(b)* Papanicolaou's (PAP) test within the last 12 months, if over age 21, initial exam only. Frequency of ongoing women's health examinations is in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) guidelines. See current guidelines at https://www.acog.org.
*(c)* Mammogram in accordance with the ACOGguidelines. See current guidelines at https://www.acog.org.
(15) Qualification for service (record in box 74a).
(16) Summary of defects (record in box 77).
(17) Recommendations (record in box 78).
(18) Name and signatures of examining health care provider with date examination completed (record in boxes 81a and 81b).
*e. Examination for Engineer Diving (Military occupational specialty 12D).* In addition to the items listed in "All Examinations" (paragraphs *b*(1), (2), (3), and (4) above), these exams require the following items (complete laboratory, immunizations, and other studies must be within 3 months of the medical examination):
(1) Laboratory tests:
*(a)* Urinalysis for albumin and sugar (boxes 45a and 45b).
*(b)* CBC [HGB/HCT (box 47), WBC, platelet count (box 73)].
*(c)* HIV and Hepatitis C virus(HCV) (box 49).
*(d)* Urine specific gravity, urine microscopic, and dipstick (record in box 52c).
*(e)* Blood type. *Initial exam only; do not repeat.*
*(f)* Sickle Cell Screen. *Initial exam only; do not repeat.* May document existing results (record in box 73).
*(g)* Glucose-6-phosphate dehydrogenase. *Initial exam only; do not repeat.* May document existing results (record in box 73).

*(h)* Complete cholesterol results (fasting lipid panel) to include: total cholesterol, LDL, HDL, and triglycerides (record in box 73).

*(i)* Fasting blood glucose and A1C (record in box 73).

*(j)* Occult blood, age 40 and older (record in box 73).

*(k)* PSA, males age 40 and older (record in box 73).

(2) Miscellaneous measurements.

*(a)* Height (record in box 53).

*(b)* Weight (record in box 54).

*(c)* Pulse (record in box 57).

*(d)* Blood pressure (record in box 58a).

(3) Vision requirements.

*(a)* Distance vision (record in box 61).

*(b)* Near vision (record in box 63).

*(c)* Color vision (record number correctly identified (as applies) and "pass/fail" in boxes 59 and 66).

*(d)* Intraocular pressure measurement (record in box 70).

*(e)* Visual fields (record in box 68).

*(f)* Night vision (record in box 69).

*(g)* Refraction. If vision does not correct to 20/20 in each eye with spectacles or contact lenses, or if uncorrected vision is worse than 20/100 in either eye (not required for SERE) does not qualify (record in box 62).

*(h)* Distant visual acuity that does not correct to 20/20 in both eyes with spectacle lenses does not qualify. Any refractive error in spherical equivalent of worse than plus or minus 8 diopters does not qualify (record in box 62).

*(i)* Pre-surgical refraction for anyone who has had PRK, LASEK, or LASIK (record in box 73).

(4) Audiometer results (record in box 71a).

(5) Valsalva (record in box 72b).

(6) Chest x-ray (PA/Lateral) signed by radiologist (record in box 73).

(7) ECG (record in box 73); include actual ECG with physical examination.

(8) PPD or TST.

(9) Hepatitis A and Hepatitis B complete series or the Hepatitis A/Hepatitis B combined vaccine (Twinrix), unless identified as Medically Immune. All other immunizations must be up to date and documented on the MEDPROS 2766C printout to be included with physical examination (record in box 73).

(10) Dental examination by a dentist or a FS, APA, AMNP, or AME.

(11) Add AR 40–8 statement: "I understand I must be cleared by a FS, APA, AMNP, or AME after hospitalization or sick quarters (in accordance with AR 600–105), or after treatment or activities which may require restriction (in accordance with AR 40–8). I am informing the examining health care provider of any changes in my health since my last physical examination" (record in box 73).

(12) Cardiac statement: "I have never experienced sudden loss of consciousness due to physical exertion, and I have no family history of sudden cardiac death" (record in box 73).

(13) SERE statement: "I have no fear of heights, depths, dark, or confined spaces" (record in box 73).

(14) Documentation of a neurological examination in block 42 to include mental status, cranial nerves, motor, sensory, coordination, and deep tendon reflexes. For engineer divers (MOS 12D), the required neurological examination is outlined in the Navy Dive Manual.

(15) All females must complete the following in addition to the above:

*(a)* PAP test within the last 12 months, if over age 21, *initial exam only*. Frequency of ongoing women's health examinations is in accordance with the ACOG guidelines. See current guidelines at https://www.acog.org/.

*(b)* Mammogram in accordance with the ACOG guidelines. See current guidelines at https://www.acog.org/.

*(c)* Women's health exam may be transcribed. May annotate from medical records.

(16) Qualification for service (record in box 74a).

(17) Summary of defects (record in box 77).

(18) Recommendations (record in box 78).

(19) Name and signatures of examining health care provider with date examination completed (record in boxes 81a and 81b).

*f. Flying duty medical examinations.* See Aeromedical Technical Bulletins, Army Flight Surgeon's Administrative Guide and chapters 5 and 6 of this pamphlet to apply the aeromedical standards in AR 40–501.

*g. Airborne examinations.* In addition to the items listed in "All examinations" (paragraph b(1), (2), (3), and (4) above), the following items are required:

(1) Valsalva (box 72b).

(2) Color vision (boxes 59 and 60).

*h. Examination for Ranger School.* In addition to the items listed in "All Examinations" the following items are required:

(1) *Age 34 and under.* Urinalysis with microscopy (box 52), HCT (box 47); HIV test within 2 years (box 49); Sickle Cell Screen, *initial examination only*, may document existing results (record in box 73). This exam requires an evaluation by a dentist.

(2) *Age 35 and older.* Urinalysis with microscopy (box 52); HCT (box 47); HIV test within 2 years (box 49); Sickle cell screen, *initial examination only*, may document existing results (record in box 73); fasting blood sugar (box 73); CBC (box 52); fasting lipid panel, ECG, occult blood for age 40 and older (record in box 73). This exam requires an evaluation by a dentist. The requirements in paragraph 5–25 for indications of medical follow-up for elevated or abnormal test results should be followed for these exams on applicants 35 and older and the results forwarded with the medical examination to the Ranger School for review.

**6–4. Report of medical history forms**

*a.* Preparation of DD Form 2807–1 (Report of Medical History). DD Form 2807–2 is not required. When the electronic version of the DD Form 2807–1 becomes available, it will supersede the paper form and will be the only one used. The examinee completes this form prior to the examination. The examinee must complete a DD Form 2807–1 in all cases to inform the completion of the DD Form 2808. The DD 2807–1 provides the examining physician with indication of the need for special discussion with the examinee and areas with indications for detailed examination, special tests, or consultation referral. The information entered on this form is confidential and is not for release to unauthorized sources. The examinee should be informed of the confidential nature of his or her entries and comments. Trained enlisted medical service personnel and qualified civilians may inform the examinees of the confidential nature of their entries and comments, instruct, and assist examinees in preparing the DD 2807–1. Trained enlisted medical service personnel and qualified civilians will make no entries on the form other than the date of examination and the examining facility. Prepare the DD Form 2807–1 in an original and one copy with all items complete. Responses will be typewritten or printed in ink. The DD 2807–1 must be dated within 2 years of the class start date to be valid for entrance to USASOC and USAJFKSWCS schools.

*b.* Signature. The examinee will sign the form in black or dark-blue ink or sign electronically when available.

*c.* The physician's summary (or PA's or nurse practitioner's) and elaboration of the examinee's medical history.

(1) The credentialed health care provider (physician, PA, or nurse practitioner) will summarize and elaborate upon the examinee's medical history and in the case of military personnel, the examinee's health record, and cross-referencing their comments by item number. The examiner will clarify all affirmative responses and fully describe all abnormalities noted.

(2) If the examinee is applying for enlistment or appointment and answers reveal that this Soldier was either previously rejected for military service or discharged for medical reasons, ascertain, and record the exact reason.

(3) A facsimile stamp will not be used for signature. Enter the typed and printed name of the physician, PA, or nurse practitioner and the date into the designated blocks. The physician, PA, or nurse practitioner will sign in black or dark-blue ink, or sign electronically when available.

**6–5. Validity times for DD Form 2808**

*a.* Medical examinations are valid for the purpose and periods below, provided there has been no significant change in the individual's medical condition. (Do not complete a DD Form 2808 to document a PHA). The physician completing the final medical evaluation of the individual signs and dates the report in Block 85. The date recorded in Block 85 on the DD Form 2808 will reflect the completion date of the medical examination.

(1) Medical examinations will be valid for 24 months from the date of medical examination to qualify for entrance into USMA, the Uniformed Services University of the Health Sciences (USUHS), ROTC, Officer Candidate School, USMA Preparatory School, induction, enlistment, initial appointment as a commissioned officer or warrant officer (with the exceptions noted in (2) and (3) below). Paragraph 6–7 addresses validity for separation.

(2) At National Advanced Leaders Camp, ROTC Cadets complete a medical screening on DD Form 2807–1, with a focused medical examination as clinically indicated, and laboratory screening tests for DNA, HIV, urinalysis, and drug or alcohol testing. This medical screening and the required laboratory tests are part of the qualification process for a cadet to continue in ROTC and subsequent commissioning.

(3) To qualify a USMA cadet for commissioning complete a DD Form 2807–1, with a focused medical examination as clinically indicated, and the required DNA, HIV, and drug/alcohol tests, if the laboratory tests have not been accomplished during the cadet's tenure.

(4) The entry examination to qualify for PA school serves as the commissioning examination provided there has been no interval change in the student's medical condition as documented on the current PHA.

(5) See paragraph 5–12 for validity periods for FDMEs/FDHSs.

(6) A current DoD PHA within the last 12 months or medical examination, to include documentation of all indicated laboratory tests and consults, for AC Soldiers and ARNGUS and USAR Soldiers will be valid for reenlistment if an individual has been out of the Service for up to 6 months, as well as attendance at Army or civilian schools, ADT, ADOS, and temporary tour of AD tours unless the specific school requires a medical examination or a shorter validity period (for example, SF, diving school, or aviation training). Shorter validity periods for Army Schools must be prescribed by Army regulation or DA pamphlet. The periodic examinations or PHA will be valid only if there has been no change in the Soldier's medical condition since the last complete PHA or medical examination (para 6–6 defines the PHA). See AR 600–110 for specific requirements for HIV testing.

(7) Medical examinations are valid for 18 months for entry into Ranger School, and entry into aviation classes 1, 2, 3, and 4.

*b.* A medical examination conducted for one purpose is valid for any other purpose within the prescribed validity periods, provided the examination is of the proper scope, and using the standards prescribed in AR 40–501. If the examination is deficient in scope, obtain, and record the deficient tests, procedures, and results. The PHA is defined as the DD Form 3024 (Annual Periodic Health Assessment) in the prescribing DoDI.

*c.* The medical examination or PHA for members of the ARNG/ARNGUS and USAR will be valid for the purpose of qualifying for immediate reenlistment in ARNG/ARNGUS and USAR, provided there has been no change in the individual's medical condition since the medical examination or PHA. Paragraph 5–20 describes the administrative requirements for mobilization or contingency operations, and chapter 7 for deployment-specific information. During deployment, the pre-deployment assessment will meet this requirement to support reenlistment during the deployment.

*d.* Medical examinations for engineer divers (MOS 12D):

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

(2) Engineer divers (MOS 12D) must have a full diving medical examination every 5 years. The diving medical officer (DMO)/ undersea medical officer, or FS trained in diving medicine (or has completed a residency in aerospace medicine) performs or reviews the medical examination for engineer divers.

*e.* The DD Form 2808 must be dated within 2 years of the class start date to be valid for entrance to USASOC and USAJFKSWCS schools.

### 6–6. Periodic health assessments

*a. Application.*

(1) An annual PHA is a DoD requirement for all officers, warrant officers, and enlisted personnel of the Army, regardless of component.

(2) The DoD PHA is a medical readiness assessment and public health screening tool and has a different focus than other required examinations. The PHA is a stand-alone assessment that must be completed using the DoD PHA form. A medical exam may not be substituted for a DoD PHA even if a Soldier

undergoes a medical examination within 1 year, the scope of which is equal to or greater than that of the required PHA (such as annual FDME or FDHS).

(3) All RC general officers (grade O7 and above) will complete an annual PHA within the standard 3 calendar months before the end of the general officer's birth month. The PHA may be completed at any military medical facility capable of completing the assessment. If the healthcare provider completing the PHA indicates a need for further evaluation or medical treatment, the general officer will be referred to his/her civilian medical healthcare provider.

(4) General officer (grade O7 and above) PHA completion verification to include date of completion, indication of permanent or temporary profile (with expiration date if applicable) and any duty or deployment limitations will be sent to the following:

*(a)* For AC general officers: mail to 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/.

*(b)* For ARNG general officers: mail to Chief, NGB (GO–AR) Room 2D366, The Pentagon, Washington, DC 20310–2500. For the purpose of requesting clarification email can be used; Contact information for ARNG GO organization: ng.ncr.arng.mbx.gomailbox@mail.mil.

*(c)* For USAR general officers: email to: usarmy.knox.hrc.mbx.gomo-ar-pers@mail.mil.

*b. Procedure.* The PHA consists of three parts—

(1) *Part 1, self-reported health assessment.* A current self-reported health assessment and review completed by the Soldier. The electronic version of the PHA, DD Form 3024 is how to complete the DoD PHA. Handwritten forms will not be accepted. PHAs can be completed with the DHAs. The DoD PHA provides an opportunity for the Soldier to express new health concerns and identify possible impacts to readiness. The Soldier must make an appointment with a healthcare provider to complete the DoD PHA within 60 days after completing the self-reported health status. Whenever possible, the Soldier self-reported health assessment section will be done prior to arrival at the clinic, medical facility, physical exam section, Soldier readiness platform, or local detachment.

(2) *Part 2, medical record review*. A record review will include the Soldier's height and weight, MRAT 24-month trends (AC only), current medical conditions and deployment-related health problems, to include screening for traumatic brain injury exposure, allergies, medications, required immunizations, update of HIV test and DNA specimen, audiology, and visual acuity results. The DD Form 2766 will be updated with the most current information. Medical readiness elements will be documented and/or updated electronically during the record review or encounter. Part 2 of the PHA is conducted, coordinated, and documented by any healthcare provider to include medics, licensed practical nurses, registered nurses or medical providers if needed.

(3) *Part 3, review by a healthcare provider.* A physician, nurse practitioner or PA, preferably the Soldier's primary care team, unit providers, or component providers, will—

*(a)* Review the Soldier's statement of health, any pertinent tests and reports, PULHES, accuracy of DA Form 3349–SG in e-Profile, MRAT 24-month trends (AC only), readiness screening information, and make referrals as indicated. The healthcare provider review will occur within 60 days for Soldiers after completion of the Soldier's self-reported health assessment. See AR 600–110 for specific requirements for HIV testing, documentation, and follow-up.

*(b)* Perform a symptom-focused exam if warranted, to address concerns identified by the Soldier in his/her self-reported health assessment. The PHA will include screening for mental health disorders, behavioral health risks, to include screening for traumatic brain injury exposure, and physical health conditions that may impact mental status or emotional well-being. The provider will make recommendations for referrals to address treatment of medical problems and/or preventive health services as warranted. (Health screening recommendations are to be based on the United States Preventive Task Force Guidelines.)

*(c)* Whenever possible, the PHA will be accomplished in a single appointment. AD TRICARE Prime Remote, ARNG/ARNGUS, and USAR Soldiers may complete the PHA and IMR requirements via the current agencies contracted to provide these medical services.

*(d)* The PHA includes the current DoD Mental Health Assessment (MHA), which is an independent annual requirement. Healthcare providers must complete the one-time DoD MHA training to properly administer this part of the examination.

*(e)* The physician, nurse practitioner or PA will document the Soldier's disposition by assessing their IMR status, DL conditions, dental, immunization, laboratory, and medical equipment as ready or not

ready. This will support an assessment of the Soldier as fully medically ready, partially medically ready, not medically ready, or medically indeterminate.

*(f)* Referrals and recommendations will be documented and orders entered, where applicable, for any required preventative or readiness related medical services not immediately available during the PHA process.

*(g)* The examining physician, nurse practitioner, PA, or record reviewer thoroughly investigates and documents the Soldier's current medical status. A copy of the provider summary and recommendations from the PHA is copied into Armed Forces Health Longitudinal Technology Application (AHLTA (for AD)). A copy of the actual PHA is placed into the health readiness record for RC Soldiers.

*(h)* The PHA status is reported as complete when the credentialed healthcare provider reviews, confirms, and signs the PHA, and it is annotated within the EHR. The credentialed healthcare provider does not have to wait for results of laboratory tests or consults to complete the PHA. The credentialed healthcare provider will sign the PHA on the same day whenever possible but no later than 24 hours after the provider review. Follow-up clinical notes on laboratory tests or consults will be documented in the Soldier's EHR.

*(i)* The DoD PHA may not be completed as part of a DD Form 2795 (Pre-Deployment Health Assessment (Pre-DHA)). DD Form 2796 (Post-Deployment Health Assessment (PDHA)), or DD Form 2900 (Post-Deployment Health Re-Assessment, (PDHA)). The DoD PHA must always be completed on its own and in its entirety despite completion of a DHA.

1. All PHAs are reviewed and signed by a credentialed physician, nurse practitioner or PA.

2. The Soldier is informed of remedial conditions found upon examination. Referrals will be made and/or recommended as indicated (by component) for the purpose of evaluations or care, for general health education matters including, but not limited to nutrition, smoking, alcohol, and drug abuse, and weight control.

3. All personnel with potential hazardous exposures in their work environment, for which medical surveillance examinations are required, will receive information to assure appropriate medical surveillance examinations are conducted. Such occupational health examinations will be specific to job exposure.

*c. Follow-up.* Soldiers of the ARNG/ARNGUS or USAR who are not on AD will be scheduled for follow-up appointment and consultations at Government expense only when appropriate documentation is completed. Treatment of conditions or remediable defects as a result of a PHA screening will be facilitated if authorized through the component process. If individuals are not authorized treatment at government expense, they will be advised to consult a private physician of their own choice at their own expense. (See AR 600–8–4.)

*d. Frequency.* (See paras 5–12 for aircrew, ATCs, and UAS operators.)

(1) SFs, Ranger combat divers, MFF parachutists.

*(a)* Following the initial medical exam, SF/Ranger combat divers and MFF parachutists' subsequent comprehensive exams and PHAs will be aligned with the Soldier's birth month using table 5–2. The medical examination for engineer divers must be performed or reviewed by a DMO or a FS trained in diving medicine. The physical examination for Army MFF must be performed by or reviewed by a FS, DMO, or AME. A DD Form 2992 will be issued annually in conjunction with the medical examination.

*(b)* The comprehensive exam for SF/Ranger combat divers, and MFF parachutists is performed every 5 years beginning at ages 35, 40, 45, and 50. Beginning at age 40, a comprehensive exam will include CVSP, and beginning at age 50 will be an annual requirement. It will be performed within 90 days before the end of the birth month in the year it is due. Comprehensive exams will be completed and submitted after any class A and B mishap.

*(c)* Interim exam SF/Ranger combat divers and MFF parachutists' PHA (a DA Form 4497 may be used) is performed in the interim years when an initial or comprehensive exam is not required. It will be performed within 90 days before the end of the birth month and is valid until the end of the next birth month.

*(d)* SF/Ranger combat divers and MFF parachutists in specialty service are required to maintain a comprehensive or interim Army Special Operations Forces, MFF parachutists, combat divers and divers (MOS 12D) divers exam even when the Soldier is not assigned to operational duty positions.

(2) All other personnel on AD will have a PHA on record no older than 12 months beginning after enlistment or commissioning.

(3) All members of the Selected Reserve will have a PHA at least once every 12 months. Army commanders, the Commander, AHRC, and the Chief Army Reserve, NGB may, at their discretion, direct more

frequent medical assessments or physical examinations in individual cases MEDPROS data will reflect non-compliance if a PHA has not been reported or is older than 15 months.

(4) Members of the IRR have a requirement to promptly report any medical (including mental health) conditions that may affect their readiness to deploy. AHRC will determine what reporting tools the IRR Soldiers (not on AD) will use to meet the annual PHA requirement. For example, an IRR Soldier may be directed to use the DA Form 3725 and virtual muster or the DA Form 7349 (Initial Medical Review - Annual Medical Certificate). The DA Form 7349 is prescribed to collect medical information of sufficient detail for uniformity in medical evaluation for Soldiers who are not required by policy to complete an annual PHA. This form evaluates Soldiers in terms of medical conditions and physical defects which may require medical care or which may require a profile to describe capabilities and limitations. If the Soldier reports any conditions, they are required to provide supporting documentation to AHRC if requested.

### 6–7. Separation History and Physical Exam

SHPE is a joint program to support the evaluation of Soldier disability claims and transition of care to the VA. The SHPE must be completed prior to separation from AD for the eligible population as described in AR 40–502 and table 5–1. There are program requirements, Soldier responsibilities, Command responsibilities, credentialed provider duties, and patient administration duties prescribed in DODI 6040.46.

*a.* The SHPE program requirements includes DoD reporting SHPEs and SHAs completion by component throughout the DoD. To ensure accurate information, these exams will be coded with a joint standardized code in the electronic health record, V70.5_9 “separation / termination / retirement exam”.

*b.* The SHPE program has specific timeline requirements outlined in the SHPE user guide to ensure that the required SHPE exam is complete and validated by 30 days from separation. The requirement for a physical exam within 12 months of separation is fixed; other interval timelines may be adjusted for terminal leave as allowed by DoD and VA policy.

*c.* This assessment is to determine any existing medical condition incurred during AD 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 AD service. File all SHPE associated forms, studies, and laboratory test in the Soldier’s EHR/STR. Any duty limitations are described through the profiling system, and completing a SHPE does not exempt a Soldier from unit PRT, any physical fitness tests, field, or any other type of duty assignment.

*d.* When the Soldier is filing a service connected disability claim, complete the physical examination through the VA, when possible, prior to separation. The VA refers to SHPEs as SHAs.

*e.* The Soldier completes the DD Form 2807–1 and DD Form 2808 in the medical readiness system of record. If the physical is over 6 months (180 days) from retirement and needs to be updated, the DD Form 2697 (Report of Medical Assessment) will also be completed in the medical readiness system of record. The Soldiers who are filing a VA claim will need to adhere to VA policies and procedures, ensure their claim is initiated and their medical records are available to the VA to support their SHPE and any additional exams. The VA will complete the SHPE for Soldiers between 180–90 days from separation.

*f.* Unit commanders ensure Soldiers are preparing and attending appointments and complete the SHPE unless the Servicemember is not under control of the Secretary of a Military Department such as unauthorized absences or civilian incarceration. If a Soldier refuses or fails to comply with the processes necessary to complete the physical exam portion of the SHPE, the unit commander will generate a brief memorandum to document the refusal or non-compliance and provide a copy to the servicing MTF. The memorandum will serve in lieu of the separation report and be documented in the STR to meet the documentation requirements of DODI 6040.46.

*g.* The MTF commander or their designee ensures access and appropriate review to support SHPE requirements. Coordination with the VA will necessitate access and training on the use of the Bidirectional Health Information Exchange.

*h.* Patient Administration provides copies of the STR, supports the transition of care and communication between the DoD, VA, and the Soldier to accomplish the SHPE requirements. The VA providers do not have access to the Army medical readiness system of record and do not use AHLTA, so printed DD Form 2807–1, DD Form 2808, the AHLTA web-print file (or equivalent in future systems), and STR need to be provided. Patient Administration also supports the use of the Bidirectional Health Information Exchange and Joint Legacy Viewer to enhance communication between the DoD and VA systems.

*i.* The SHPE is an individualized health assessment sufficient to evaluate the health of the Soldier at the time of discharge. A SHPE will consist of the following.

(1) DD Form 2807–1, initiated by the Soldier, completed by the Soldier, with comments on all positive responses completed by the healthcare provider performing the SHPE that has that has verified credentials deemed appropriate by the MTF privileging authority to perform such exams, such as a physician, physician's assistant, or nurse practitioner.

(2) A review of the Soldier's DD Form 2807–1 and their medical record will be completed to identify any complaints or potential AD service-related (incurred or aggravated) illness or injury. The health care provider will address and document all concerns related to the subjective input provided by the Soldier. When an allegation of sexual assault arises during an SHPE, the health care provider will ask the Soldier if they have received counseling by a Sexual Assault Response coordinator or victim advocate has been provided, including explanation of the restricted and unrestricted reporting options. If not, the exam will be paused and the Sexual Assault Response Coordinator or Victim Advocate will be contacted. Other parts of the exam may be performed, but the exam and report cannot be completed until the Sexual Assault Response coordinator or victim advocate counseling is provided. Whether the Soldier elects for restricted or unrestricted reporting, per DoD policy documentation of the alleged sexual assault will not be included in the SHPE. Medical documentation will be consistent with the standard provided in DODI 6495.02, Enclosure 7. If completing a SHPE through the VA, follow VA instructions for completing these exams.

(3) DD Form 2808, completed by a credentialed health care provider and a review of medical record and a record of significant medical conditions.

(4) A threshold audiogram completed within the past 6 months, A comprehensive audiology evaluation is necessary abnormal audiograms and referral guidelines per DA Pam 40–501. For RC members, the comprehensive audiogram may be completed after the SHPE, but it must be documented in the STR no later than the final separation from military service to include any subsequent evaluations of a standard to temporary threshold shift.

(5) Optional HCV testing per U.S. Centers for Disease Control guidelines at https://www.cdc.gov/hepatitis/hcv/ and any additional testing appropriate to the Soldier's health status, as determined by the examining credentialed health care provider and in accordance with current DoD and DA policies to include a discussion of the "A" and "B" rated USPSTF recommendations based on the Soldier's age and sex.

(6) An assessment regarding the Soldier's qualification for retention according to AR 40–501.

(7) All occupational health termination examinations required by DoD and DA policy (for example, hearing conservation, radiation medical surveillance) and medical surveillance programs because of hazardous job exposure, must be completed before the SHPE is completed. Ensure currency of any periodic testing required by other issuances (for example, HIV testing in accordance with DODI 6485.01), before referral for SHPE.

*j.* The SHPE may be waived in accordance with DoD and Service guidance. See table 5–1.

*k.* If a full physical examination, with a DD Form 2807–1 and 2808, has been completed in the previous 12 months, a DD Form 2697 may be used to highlight any health changes and be an additional document to the current DD Form 2808. The Soldier must acknowledge with his or her signature in block 19 of DD Form 2697 and DD Form 2808 that the information provided is true and complete.

*l.* In accordance with 10 USC 1145(a)(5), the SHPE occurs immediately before the scheduled separation. With the consent of the Soldier and concurrence of the unit commander, the requirement may be met in any of the ways shown below. No more than 30 days prior to separation, there must be an administrative review and validation of the qualifying SHPE by completing block 85 on the DD Form 2808. When the Soldier has terminal leave, the final out-processing date may be used in lieu of the date of separation from AD for the timeline requirements (other than the 12-month period).

(1) A SHPE up to 30 days prior to the date of separation from AD requires no further documentation.

(2) A SHPE up to 90 days prior to the date of separation from AD must be validated as current not more than 30 days prior to the date of separation. Such validation is an administrative requirement and does not require a separate entry into the STR, though an entry may be made if necessary for tracking purposes.

(3) When conducted by the VA, a separation exam up to 180 days prior to the date of separation from AD is acceptable. In accordance with DODI 6040.46, a DoD official must review the VA performed exam and make an entry into the STR. The presence of this entry must be administratively validated as current no more than 30 days prior to the date of separation from AD.

(4) A DoD physical exam performed between 90 days and 12 months prior to separation from AD if it meets the SHPE minimum standards and is updated with a new medical assessment no more than 30 days prior to separation from AD and documented in the STR.

*m.* When accomplished incident to retirement, discharge, or release from AD, medical examinations, including the SHPE and annual PHA, are valid for a period of 12 months from the date of examination or assessment.

**Table 6–1**
**Recording of medical examination**

| Box no. | Block description | Explanatory notes and model entries<br>(Model entries are in parentheses) Refer to the glossary for abbreviations used |
|---|---|---|
| 1 | (Date of examination) | Enter the date on which the medical examination is accomplished |
| 2 | (SSN) | Examinee's number (SSN 396–38–0699) |
| 3 | (Name) | Record the entire last name, first name, and middle name. When using a suffix, Jr., Sr., or III, it appears after the middle name. (Jackson, Charles John Jr.) |
| 4 | (Home address) | Examinee's current mailing address (not the “home of record “ —if different)<br>(Street number, city, state, Zip code or unit mailing address) |
| 5 | (Telephone number) | Enter telephone number to reach the examinee—home or unit (202–555–1212) |
| 6 | (Grade) | Enter examinee's grade (E8, O4) |
| 7 | (Date of birth) | Record as year, month, day |
| 8 | (Age) | List years of age at the time of examination (28 yr.) |
| 9 | (Sex) | Check female or male |
| 10 | (Race) | Check the applicable block |
| 11 | (Years of Government service) | Not required |
| 12 | (Agency if not DoD) | To be used by other agencies, as appropriate |
| 13 | (Organization unit) | The examinee's current military unit of assignment, Active, or, Reserve. If no current military affiliation, enter a dash (for example, “B Company, 2D Battalion, 325th, Infantry, 82nd Airborne Division, Fort Liberty, NC 28307–5100”) |
| 14a | (Rating or specialty)<br>(Aviators only) | Not required on Army examinations unless directed by USAAMA |
| 14b | Total Flying Time<br>(Aviators only) | Not required on Army examinations unless directed by USAAMA |
| 14c | Last 6 months<br>(Flying Time – Aviators only) | Not required on Army examinations unless directed by USAAMA |
| 15a | (Service) | Check the appropriate service |
| 15b | (Component) | Check the appropriate component |
| 15c | (Purpose of examination) | Check or enter the purpose of the examination |
| 16 | (Name of examining facility) | Name of the examining facility or examiner and address. If an Army post office, include local national location (Military Entrance Processing Station, 310 Gaston Ave., Fairmont, WV 12441–3217) |
| 17[2] | (Head, face, neck, scalp) | Record all swollen glands, deformities, or imperfections of the head or face. If a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face is detected, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If an examiner detects enlarged lymph nodes of the neck describe them in detail with a clinical opinion of the etiology |
| 18 | (Nose) | Record all abnormal findings. Record estimated percent of obstruction to airflow if septal deviation, enlarged turbinates, or spurs are present |
| 19 | (Sinuses) | Record all abnormal findings (“Marked tenderness over left maxillary sinus”) |
| 20 | (Mouth, throat) | Record any abnormal findings, to include enucleated tonsils<br>(Tonsils enucleated) |

**Table 6–1**
**Recording of medical examination—Continued**

| | | |
|---|---|---|
| 21 | (Ears) | If operative scars are noted over the mastoid area, annotate simple or radical mastoidectomy and describe any other clinical findings (for example, “Bilateral severe swelling, injection, and tenderness of both ear canals”) |
| 22 | (Eardrums) | Record all abnormal findings. In the event of scarring of the tympanic membrane, record the percent of involvement of the membrane as well as the mobility of the membrane. If tested, a definite statement will be made as to whether the eardrums move on valsalva maneuver or not and also noted in item 72b |
| 23 | (Eyes) | Record abnormal findings. If an examiner finds ptosis of lids, state the cause and extent of the interference with vision. If an examiner finds pterygium, note: 1. Encroachment on the cornea, in millimeters, 2. Progression, 3. Vascularity<br><br>For example, “Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye, 3 mm encroachment on cornea; nonprogressive, avascular” |
| 24 | (Ophthalmoscope) | Describe opacities of the lens regarding size, progression since last examination, and interference with vision (for example, “Redistribution of pigment, macular, right eye, no loss of visual function. No evidence of active organic disease”) |
| 25 | (Pupils) | Record all abnormal findings |
| 26 | (Ocular motility) | Record all abnormal findings |
| 27 | (Heart) | Describe abnormal heart findings completely to include the time in the cardiac cycle, the intensity, the location, transmission, effect of respiration, or change in the position, and a statement as to whether the murmur is organic or functional. When describing murmurs by grade, indicate basis of grade (for example, “Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. Disappears on exercise and deep inspirations, physiological murmur”) |
| 28 | (Lungs and chest) | Lungs: Describe the cause of any rales and other abnormal sounds detected on exam. The examinee will be evaluated on the basis of the cause of the pulmonary sounds and not simply on the presence of such sounds (for example, “Sibilant and sonorous rales throughout chest. Prolonged expiration”). Breast exam: Note location, size, shape, consistency, discreteness, mobility, tenderness, erythema, dimpling over any mass, in a comprehensive clinical description |
| 29 | (Vascular system) | Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency (for example, “Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency”) |
| 30 | (Anus, rectum)<br>(Prostate if indicated) | Describe surgical scars and the size, number, severity, and location of hemorrhoids. Check fistula, cysts, and other abnormalities (for example, “One small, mild, external hemorrhoid. Digital rectal normal. Stool guaiac negative”). In prostate exam note grade of prostatic enlargement, surface, consistency, shape, size, sensitivity, mobility |
| 31 | (Abdomen, viscera) | Include hernia. Note any abdominal scars and describe the length in inches, location, and direction. If a dilated inguinal ring is found, a statement will be included in item 31 as to the presence or absence of a hernia (2-inch linear diagonal scar, right lower quadrant) |
| 32 | (External genitalia) | Describe any abnormalities. Include results of testicular exam on males |
| 33 | (Upper extremities) | Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as, for example, a history of a broken arm with no significant finding at the time of examination, indicate that no deformity exists and function is normal. Make a positive statement in addition to checking the “normal” column. If an examinee has a history of dislocation, make a statement describing the function, and any limitations at the time of examination (for example, “No weakness, deformity, or limitation of motion, left arm”) |
| 34 | (Lower extremities) | Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the lower extremity, as, for example, a history of a broken leg with no significant finding at the time of examination, indicate that no deformity exists and function is normal. Make a positive statement in addition to checking the “normal” column. If the examinee |

**Table 6–1**
**Recording of medical examination—Continued**

| | | |
|---|---|---|
| | | has a history of dislocation, make a statement describing the function, and any limitations, at the time of examination (for example, “No weakness, deformity, or limitation of motion, left leg”) |
| 35 | (Feet) | Record any abnormality. Describe detected flat feet with the stability of the foot, presence of symptoms, presence of eversion, stable, and bulging of the inner border. Describe pes planus as mild, moderate, or severe (for example, “Flat feet, moderate. Foot asymptomatic, no eversion or bulging; no rotation”). Circle category relating to arch, degree, and symptoms |
| 36 | (Spine, other musculo-skeletal) | Include pelvis, sacroiliac, and lumbosacral joints. Check history. If scoliosis is detected, the amount and location of deviation in inches from the midline will be stated |
| 37 | (Identifying body marks) | Record scars or marks of purely identifying significance and those that interfere with function here. Fully describe tattoos that are obscene or so extensive as to be unsightly (for example, 1-in. vertical scar, dorsum; 3-in. heart-left forearm; shaped tattoo, lateral aspect middle 1/3 left arm) |
| 38 | (Skin) | Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment (for example, “Small discrete angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping”) |
| 39 | (Neurologic) | Record complete description of any abnormality |
| 40 | (Psychiatric) | Record all abnormalities. Before making a psychiatric diagnosis, a minimum psychiatric evaluation will include non-axial diagnosis and clinical criteria for the diagnosis |
| 41 | (Pelvic) | Note type of exam (for example, “bi-manual”). Record any abnormal findings. (See item 52a for pap test.) |
| 42 | (Endocrine) | Describe every abnormality noted |
| 43 | (Dental) | Examining physicians will apply the appropriate standards prescribed in AR 40–501, and indicate “acceptable “ or “non-acceptable. “ This does not replace the required annual dental examination by a dentist or the dentist's determination of the appropriate dental classification |
| 44 | (Notes) | Describe every abnormality noted. Enter pertinent item number before each comment. Continue in item 73 if necessary |
| 45[3] | (Urinalysis)<br>a. Albumin<br>b. Sugar | Record results (For other urine microscopic or specific gravity, record in box 52c.) |
| 46 | (Urine HcG) | Record results |
| 47 | (HGB/hematocrit) | Record results |
| 48 | Blood Type | Record results |
| 49 | (HIV) | Record date, results, add HIV specimen ID label in indicated section |
| 50 | (Drugs) | Record results of Drug Tests, add Drug Test Specimen ID to indicated space |
| 51 | (Alcohol) | Record results of alcohol screen |
| 52 | (Other / results) | 52a (use to record results of pap test)<br>52b (use to record PSA result)<br>52c (use to record urine microscopic or urine specific gravity.) |
| 53 | (Height) | Record in inches to the nearest quarter inch (without shoes). For initial Class 1 FDME: Leg length, sitting height, and functional arm reach will be measured, in accordance with APL, Anthropometrics |
| 54 | (Weight) | Record in pounds to the nearest whole pound (in PT clothes without shoes, or hospital gown) |
| 55 | (Maximal allowable weight) | This item is for accession medical examinations only. This does not replace the official weigh-in for Soldiers in conjunction with the ACFT and AR 600–9 |
| 56 | (Temperature) | Record in degrees Fahrenheit, to the nearest tenth |
| 57 | (Pulse) | Record with arm at heart level |

**Table 6–1**
**Recording of medical examination—Continued**

| | | |
|---|---|---|
| 58 a, b, c | (Blood pressure) | Record Results (for example, 110/76), record repeat readings in 58 b and c if initially elevated |
| 59 | (Red/green vision test) | Record a pass/fail for vivid red/green vision if the examinee fails the color vision test in item 66 |
| 60 | (Other eye or vision test) | For example, results of red lens test |
| 61 | (Distant vision) | Record the English Snellen Linear System (20/20, 20/30, and so forth) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, record the corrected vision of each eye (for example, “Right 20/50 corrected (corr) to 20/20 and Left 20/70 corr to 20/20”) |
| 62 | (Refraction) | Enter the word “manifest” or “cycloplegic,” whichever is acceptable, after refraction. Indicate an emmetropic eye by plano or 0. For corrective lens, record refractive value (for example, “Right By –1.25 S – 0.25 CX 005. Left By –1.75 S – 0.25 CX 175”) |
| 63 | (Near vision) | Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20), enter the corrected vision for each eye and lens value after the word “by” (for example, “Right 20/40 corrected to 20/20 by Same and Left 20/40 corrected to 20/20 by + 0.50”) |
| 64 | (Heterophoria) | Identify the test used; for example, either Maddox Rod or Stereoscope, Vision Testing (SVT), and record results, Prism Divergence not required. All subjective tests will be at 20 feet or at a distance setting of the SVT. Record distance interpupillary distance (PD) in mm (for example, “Esophoria degree 4, Exophoria degree 0, right hyperphoria 0, left hyperphoria 0, PD 63”) |
| 65 | (Accommodation) | Record values without using the word “diopters” or symbols (for example, “Right 10.0; Left 9.5”) |
| 66 | (Color vision) | Record the test used and the number of plates correctly identified over the number of plates tested (for example, PIP, 12/14, pass, or, PIP, 3/14, fail). The Cone Contrast Test and Service approved computer based tests are also acceptable for flight physicals. If the examinee fails a color discrimination test, utilize the Red/Green color naming test and record the result in Block 59 if accepted for the purpose of the exam |
| 67 | (Depth perception) | Record the test used and score in the appropriate space “corrected” or “uncorrected,” as applicable. Enter the best depth perception score achieved by the examinee in seconds of arc (accession standards is 40 seconds of arc) and whether that score equates to pass or fail for the purposes of the examination (for example, RANDOT, 40” arc, pass, or, TITMUS Stereoacuity, 120” arc, fail) |
| 68 | (Field of vision) | Identify the test used and the results. If a vision field defect is found or suspected in the confrontation test, use a more exact perimetric test and a perimeter and/or tangent screen. Record findings on a visual chart and describe them in item 77. Copy of the visual chart must accompany the original DD Form 2808 (for example, “Confrontation test: Normal, full”) |
| 69 | (Night vision) | Test used and Score For aviation, the examiner will record any loss of night vision or report that it is not indicated by history |
| 70 | (Intraocular tension) | Identify type of test used: applanation or non-contact. Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities (for example, “Normal O.D. 18 O.S. 17”) |
| 71a,b | (Audiometer) | Test and record results at 500, 1000, 2000, 3000, 4000, and 6000 Hertz using procedures prescribed in DA Pam 40–501. (use 71b for repeat tests if applicable) |
| 72a | (Read Aloud Test) | Enter RAT satisfactory or unsatisfactory |
| 72b | (Valsalva) | Enter satisfactory or unsatisfactory |
| 73 | (Notes) | Examiner will enter notes on examination about significant medical events in the individual's life, such as major illnesses or injuries and any illness or injury since the last in-service medical examination. The examiner will develop the history by reviewing health record entries and questioning the examinee. Note complications, sequelae, or absence thereof, where appropriate. Comments from other items may also continue into this space if annotated appropriately<br><br>This space is also used for additional tests when there is no specific box for the test on the DD Form 2808. For instance enter the results, if accomplished, of ECGs, chest x–rays, FBS, Fasting lipid profile, cholesterol, occult blood tests, sickle cell screens. Overprints or stamps may be used in this space |
| 74a[4] | (Examinee/applicant qualification) | Indicate is qualified or not qualified for service corresponding to the intent for the exam. Note: the purpose of the examination in item 15c and must check either qualified or unqualified in this section with the purpose of exam (for example, “qualified for accession (chap 2); qualified for retention (chap 3); qualified for separation (chap 3); qualified for retirement (chap 3)”) |
| 74b | (Physical profile) | The physical profile as prescribed in chapter 7 will be recorded. Any permanent profile with above a numerical designator of 1 should have an associated DA Form 3349–SG attached (for example, “111121”) and in e-Profile |

**Table 6–1**
**Recording of medical examination—Continued**

| | | |
|---|---|---|
| 75 | (Signature of examinee) | The examinee will sign the DD Form 2808 if he/she has a disqualifying condition to indicate that he/she has been advised of the disqualifying condition |
| 76 | (Significant or disqualifying defects) | List the significant or disqualifying defects. On accession exams, list the correct ICD code that corresponds to the disqualifying condition. Any medical waivers for accession should also be noted here |
| 77 | (Summary of defects) | Summarize medical and dental defects considered significant. Record all defects considered serious enough to require disqualification, further consideration, such as waiver, or more complete survey. Also record any defect that may be of future significance, such as non-static defects that may become worse. Enter item number followed by a short, concise diagnosis; do not repeat the full description of a defect previously described under the appropriate item. Do not summarize minor, non-significant findings |
| 78 | (Recommendations) | Notation will be made of any indication for further specialized examinations or tests |
| 79 | (MEPS workload) | (MEPS use only) |
| 80 | (Medical inspection date and physicians signature) | Used at the MEPS and includes inspection prior to movement to basic training of height, weight, body fat if applicable, pregnancy test and a note of qualified or unqualified. The physician signature is the physician who has done the inspection and should not be confused with items 83–85 that are the signatures of the medical examiners who accomplished and reviewed the medical examination |
| 81–84 | (Physician or examiner) | Enter the typed or printed names of examiner and signature (physician, PA, or nurse practioner). If examination is not performed by a physician, a physician must co-sign the form in item 82a |
| 85 | Administrative review | Any administrative review should be noted here by the signature of the reviewer, grade, and date. Also indicate the number of attached sheets if applicable |
| 86 | (Waiver granted) | Indicate any waiver outcome. Who granted it, for what medical condition, and the date |
| 87 | (Number of attached sheets) | List the number and type of any attached sheets needed. For example, waivers, specialty consult, DA Form 3349–SG in e-Profile, and so forth |

Notes:

[1] Not all items are required on all examinations. See paragraph 6–3 to determine the scope of the examination based on the purpose of the examination.

[2] Note on the DD Form 2808, items 17 though item 39, the examiner must check normal, abnormal, or not examined. All abnormalities will be described in item 44 and continued in items 73 and 77 if needed.

[3] On page two of the DD Form 2808, re-enter the name and SSN of the examinee in the spaces provided.

[4] On page three of the DD Form 2808, re-enter the name and SSN of the examinee in the spaces provided.

## 6–8. Fitness for Duty Exams

These evaluations will span from profile review and adjudication to a military clinical evaluation to determine if a Soldier has reached MRDP. When a fitness for duty evaluation is for a profile, all original duty limitations remain in effect until the fitness for duty evaluation is completed and the profile is/is not modified.

*a.* MTF commanders, State Surgeons, and the USARC Surgeon will develop processes and procedures to conduct fitness for duty evaluations within their areas of responsibility. These initial fitness for duty evaluations will seek to provide a second review of the Soldier's capabilities and limitations for the command teams.

*b.* Military clinical evaluations to determine a Soldier's capabilities, limitations, and potential retention issues may be requested of the MTF or medical supporting entity. The MTF or medical supporting entity will complete Fit for Duty exams on all AC and RC Soldiers as indicated and/or requested. Completing these exams for RC Soldiers is irrespective of the current duty status, DEERS enrollment status, or line of duty investigation. RC members not enrolled into TRICARE are not entitled to treatment, unless the condition is duty related. For Soldiers who are not eligible for care, the initial civilian evaluations will be submitted with the request. The request will be in memorandum format to the MTF commander or supporting medical authority with the commander's justification, any supporting documentation, and the original profile.

## Chapter 7
## Deployment and Geographical Area Requirements

### 7–1. General instructions and criteria

*a.* Medical readiness and the deployment health assessment programs (DHAP) support the commander's ability to accomplish their unit's designed and assigned missions. Deployable Soldiers are under the direct operational control of the reporting unit, either present or can be present within 72 hours, are in compliance with all required personnel readiness standards, and are not restricted from deploying to perform the unit's core designed and assigned missions. The health care providers will evaluate and report the Soldier's medical readiness. The commander will use this information for their deployability determination. When determining whether a Soldier can deploy with a physical profile, commanders should discuss their questions and concerns with the profiling provider, or request input from the Soldier's medical health care provider.

*b.* Commander reservations and concerns: Any reservations should be based on the commander's personal knowledge and firsthand observations of the Soldier's physical activities. If a profiling provider and commander cannot agree on a Soldier's duty limitations, the commander should request a "fitness for duty" evaluation. Medical instructions described on a physical profile may not be ignored, however. It is the commander's responsibility to counsel the Soldier about physical profiles that may affect their deployment status. In all cases, the role of the commander is to ensure Soldiers do not violate their profiles and are assigned duties that they can perform without undue risk to health and safety. This collaboration will ensure high quality medical care, appropriate duty assignments, and accurate deployability determinations. The DHAP supports sustained readiness.

### 7–2. Deployment, mobilization, and assignment-specific medical requirements

*a. Medical requirements.* AR 40–502 implements individual deployment-specific medical requirements by status described in DoDI 6490.03, DTM 17–004, and DoDI 3020.41. Soldiers and the DoD Civilian expeditionary workforce will maintain a high state of pre-deployment health and medical readiness with a personal commitment to readiness. Deploying unit commanders execute all Army policies and CCMD guidance, regarding deployable personnel medical requirements in accordance with DoDI 6490.03.

(1) Deployable personnel will maintain a high state of pre-deployment health and medical readiness.

(2) Deploying personnel will receive briefings on deployment health threats and are trained and equipped with necessary countermeasures.

(3) FHP prescription products will include a minimum of a 90 day supply of prescription medication. Readiness testing automated neuropsychological assessment metrics, required laboratory studies, and immunizations will be administered as required per DoD, Army, and/or CCMD guidance.

(4) All deployable medical personnel, Soldiers, and DA Civilians will receive training on the signs, symptoms, medical countermeasures, and treatments of exposure to endemic diseases, environmental, occupational, and chemical, biological, radiological, and nuclear health threats.

(5) Deployable individuals' immunization, medical, and dental records will be updated in EHR, STR, and MEDPROS. The custody for these records will be established.

(6) Within 30 days prior to re-deployment inpatient, outpatient medical and dental encounter documentation (including medical and dental treatment records on DoD personnel from allies and coalition partners) will be consolidated and transported back to the deployed Soldiers and/or Civilians home station, to be combined with individuals' permanent medical and dental records.

*b. Assessments.* The DHAP, including the Pre-DHA and PDHA and Post-Deployment Health Reassessment (PDHRA) will be completed by going into AKO, select "My Medical Readiness," under the "Self Service" then select "Deployment Health Assessments" (DHA), and finally, select appropriate DHA within the following timelines:

(1) DD Form 2795 screens for physical and behavioral health readiness and provides the individual the opportunity to correct any health deficiencies prior to deployment and is completed within 120 days of deployment.

(2) DD Form 2796 is completed not earlier than 30 days before redeployment date and not later than 30 days after redeployment, and for RC members, before they are released from AD. The PDHA screens for immediate deployment- related injuries such as physical, mental, or behavioral issues the individual may have sustained during deployment. Soldier responses are compared to the Pre-DHA responses and with documentation of care during deployment found in the deployment health record.

(3) DD Form 2900, PDHRA, is completed within 90–180 days after redeployment, and screens for physical and behavioral health issues that may have evolved over time since the individual's return from deployment.

(4) Within the DHAP timelines all deployable personnel will have a face-to-face interview with a trained health care provider to review their assessments. Medical and dental referrals and follow-up visits for health concerns or issues will be scheduled as appropriate. DHAs are required for all OCONUS deployments greater than 30 days to locations without fixed U.S. MTF and may be required for CONUS deployments at the discretion of the unit commander.

(5) RC Soldiers receive medical and dental care and disability evaluations in accordance with DODI 1241.01 prior to release of RC Soldiers from AD. If the member does not stay on AD, coordination will be made to transition the medical and dental care to the VA.

(6) Mandatory Post-deployment health and risk communications debriefings will be provided to all personnel who have returned or are returning from deployment.

(7) DHAP metrics include compliance (completion of the required assessments in the required timeframe) and completion (completion of the required assessments within or outside the timeframe specified in policy). For example, a Soldier who completes a post-deployment assessment 29 days after returning from deployment is compliant and complete; a Soldier who completes the same assessment at 31 days is not compliant, but complete.

*c. Deployability determinations* When the commander receives an assigned mission, they review the CCMD guidance, medical readiness and deployability determination to determine deployment status for the assigned mission and the need to request any CCMD waiver.

(1) Commanders must make sure all IMR and any specific health deficiencies are corrected prior to individual deployment or assignment to remote locations.

(2) The commander assigns duties that comply with the medical instructions and counsel Soldiers to follow their profiles and perform duties without undue risk to health and safety. If a commander has any questions or concerns regarding the duty limitations described in the profile and their assessment of the Soldier's performance, they are to communicate with the profiling provider for clarification or request a fitness for duty evaluation by another health care provider.

*d. Psychiatric.* Personnel with psychiatric conditions controlled by medication (for over 90 days) are not automatically non-deployable. The commander may consider Soldiers with a psychiatric disorder in remission, or whose residual symptoms do not impair duty performance for deployment duties. The commander makes the ultimate decision whether to deploy the Soldier after consulting with the treating physician or other credentialed health care 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. If there are any questions on the safety of psychiatric medication, consult a psychiatrist. Further information is in Assistant Secretary of Defense (Health Affairs) Memorandum, Clinical Practice Guidance for DL Psychiatric Conditions and Medications, dated October 7, 2013.

*e. Dental.* Oral conditions that require urgent or emergent dental treatment with a risk of progression to a dental emergency within 12 months (DRC 3) are not normally deployable and require correction prior to deployment. A non-DoD civilian dentist will use DD Form 2813 (Department of Defense Active Duty/Reserve/Guard/Civilian Forces Dental Examination), as proof of dental examination (DD Form 2813 is available on the internet at https://www.esd.whs.mil/directives/forms/dd2500_2999/).

### 7–3. Deployment-limiting medical conditions

*a.* Soldiers, DA Civilians and Army contractors having no DL conditions are considered medically qualified to serve in certain geographical areas and theater specific operations.

*b.* CCMDs establish the requirements for their areas of responsibility and any waiver processes. The following medical conditions need careful health care provider review before making a recommendation for deployment into a combat zone or austere isolated area where medical treatment for these conditions may not be readily available.

(1) A history of emotional or mental disorders, including character disorders, of such a degree as to have interfered significantly with adjustment or is likely to require treatment during this tour.

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

(3) Inherent, latent, or incipient medical or dental conditions that are likely to be aggravated by the climate or general living environment prevailing in the area where the Soldier is expected to reside, to such a degree as to preclude acceptable performance of duty.

(4) Of special consideration are Soldiers with a history of chronic cardiovascular, respiratory, or nervous system disorders that are scheduled for assignment and/or residence in an area 6,000 feet or more above sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Columbia; and Addis Ababa, Ethiopia.

(5) Remediable medical, dental, or physical conditions or defects that might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure from CONUS.

**7–4. Special circumstances**

*a. Transition.* Prior to installation clearance for expiration term of service, retirement, separation from the service or transition to IRR, regardless of timeframe, Soldiers are screened for DHAP assessment requirement so that they can be complete even if the timing of their personnel actions preclude them from being compliant with the timeframe specified in policy. Those near or overdue are completed during outprocessing. Soldiers transitioning due to PCS, the Army Reserve, or ARNG are required to complete the PDHRA within the 90–180 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 PDHRA (DD Form 2900). Completing the Pre-DHA (DD Form 2795) within 180 days after returning from a deployment meets the PDHRA requirement.

*c. Warrior Transition Units.* Soldiers assigned or attached to a warrior transition unit (WTU) or Community Care Units (CCU) who deployed for greater than 30 days OCONUS to locations without a fixed Health Readiness Platform will complete all DHAs per DoDI 6490.03. Deployment health activities are required for U.S. military and DoD Civilian individuals deploying for greater than 30 days to OCONUS contingency operations (including Humanitarian and Peacekeeping Operations) in locations without fixed MTFs. Deployment health activities may also be required for individuals deploying for 30 days or less to CONUS or OCONUS locations, based on identified health risks or per the decision of the commander exercising operational control. These assessments are designed to address deployment-related physical and behavioral health needs and concerns of Soldiers within the deployment cycle. Soldiers in care at a WTU or CCU are an important population for this program. Per AR 40–502, there are no exceptions or exemptions regardless of Component for Soldiers in a WTU.

*d. Remote.* Commanders of Soldiers enrolled in AD TPR and TRICARE Prime Remote Overseas administered through the RHRPs will instruct Soldiers to complete the PDHRA (DD form 2900) self-assessment in the medical readiness system of record and coordinate the person to person interview.

*e. During deployment.* Routine medical readiness assessments are deferred during deployment, however a Soldier's MRC can change due to injury, worsening, or development of a medical condition.

## Appendix A

## References

### Section I

### Required Publications

Unless otherwise indicated, DOD publications are available at https://www.esd.whs.mil/dd/dod-issuances/.

**AD 2022–06**
Parenthood, Pregnancy, and Postpartum (Cited in para 4–12*a*.).

**AR 12–15**
Joint Security Cooperation Education and Training (Cited in para 5–12*b*.)

**AR 40–3**
Medical, Dental, and Veterinary Care (Cited in para 3–3*c*.)

**AR 40–8**
Temporary Flying Restrictions Due to Exogenous Factors Affecting Aircrew Efficiency (Cited in para 6–3*e*(11).)

**AR 40–29**
Medical examination of Applicants for United States Service Academies, Reserve Officer Training Corps Scholarship Program and the Uniformed Services University of health Sciences (Cited in para 6–1*c*.)

**AR 40–35**
Preventive Dentistry and Dental Readiness (Cited in para 3–3*c*(4).)

**AR 40–66**
Medical Record Administration and Healthcare Documentation (Cited in para 4–4*d*(3).)

**AR 40–400**
Patient Administration (Cited in 1-8d.)

**AR 40–501**
Standards of Medical Fitness (Cited in para 1–1.)

**AR 40–502**
Medical Readiness (Cited in para 1–1.)

**AR 40–562**
Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases (Cited in para 3–3*d*(1).)

**AR 145–1**
Senior Reserve Officers' Training Corps Program (Cited in para 5–10*c*.)

**AR 220–1**
Army Unit Status Reporting and Force Registration – Consolidated Policies (Cited in para 1–5*a*(1).)

**AR 350–1**
Army Training and Leader Development (Cited in para 4–9*d*(7).)

**AR 600–8–4**
Line of Duty policy, Procedures, and Investigations (Cited in para 6–6*c*.)

**AR 600–8–10**
Leaves and Passes (Cited in para 4–12*a*.)

**AR 600–8–24**
Officer Transfers and Discharges (Cited in para 4–9*b*(3).)

**AR 600–8–105**
Military Orders (Cited in para 5–15*e*(2).)

**AR 600–9**
The Army Body Composition Program (Cited in para 4–9*d*(7).)

**AR 600–105**
Aviation Service of Rated Army Officers (Cited in para 5–11*a*.)

**AR 600–106**
Flying Status for Nonrated Army Aviation Personnel (Cited in para 5–11*a*.)

**AR 600–110**
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (Cited in para 3–3*e*(3).)

**AR 601–270**
Military entrance Processing Station (cited in para 5–10*b*.)

**AR 608–75**
Exceptional Family Member Program (Cited in para 5–24*b*(6).)

**AR 614–30**
Overseas Service (Cited in para 4–9*d*(1).)

**AR 635–40**
Disability Evaluation for Retention, Retirement, or Separation (Cited in para 1–8*d*.)

**AR 635–200**
AD Enlisted Administrative Separations (Cited in para 4–9*b*(3).)

**DA Pam 25–403**
Army Guide to record Keeping (Cited in para 1–4.)

**DA Pam 40–501**
Army Hearing Program (Cited in para 3–3*g*.)

**DA Pam 40–506**
The Army Vision Conservation and Readiness Program (Cited in para 3–3*h.)*

**DA Pam 220–1**
Defense Readiness Reporting System – Army Procedures (Cited in para 1–5*a*(1).)

**DoDD 1308.1**
DoD Physical Fitness and Body Fat Program (Cited in para 4–12*e*.)

**DoDI 1241.01**
Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements (Cited in para 7–2*b*(5).)

**DoDI 3020.41**
Operational Contract Support (OCS) (Cited in para 7–2*a*.)

**DoDI 6025.19**
Individual Medical Readiness (IMR) (Cited in para 2–5*b*.)

**DoDI 6130.03**
Medical Standards for Appointment, Enlistment, or Induction in the Military Services (Cited in para 5–10*b*.)

**DoDI 6485.01**
Human Immunodeficiency Virus (HIV) in Military Service Members (Cited in para 6–7*i*(7).)

**DoDI 6490.03**
Deployment Health (Cited in para 7–2*a*.)

**DoDI 6490.07**
Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees (Cited in para 3–3*c*.)

**DTM 17–004**
Department of Defense Expeditionary Civilian Workforce (cited in para 7–2*a.*)

**FM 7–22**
Army Physical Readiness Training (Cited in para 4–4*b*(4)(*d*).)

**STANAG 3526**
Interchangeability of NATO Aircrew Medical Categories (Cited in para 5–12*b.*)

**Section II**

**Prescribed Forms**
Unless otherwise indicated, DA Forms are available on the Army Publishing Directorate (APD) website (https://armypubs.army.mil).

**DA Form 3349–SG**
Physical Profile Record (Prescribed in para 2–2*b*(3).)

**DA Form 7349**
Initial Medical Review - Annual Medical Certificate (Prescribed in para 6–6*d*(4).)

**DA Form 7809**
Summary of Care by Non-Military Medical Provider (Prescribed in para 2–3*c*.)

## Glossary of Terms

**Active Component**
A Federal force of full-time Soldiers and DACs who make up the operational and institutional organizations engaged in the day-to-day missions of the Army. These Army organizations are designated as force structure component (COMPO) 1. Upon mobilization, ARNGUS/ARNG (COMPO 2) and USAR (COMPO 3) units do not become “AC” organizations; they retain their applicable force structure component designations while on AD. See DA Pam 220–1.

**Applicant**
A person not in a military status who applies for appointment, enlistment, or reenlistment in the USAR.

**Authorized protective eyewear list**
Eyewear that has satisfied all applicable qualification requirements (such as, meets Army standards for ballistic protection) and is listed on Program Executive Office Soldier. Qualified Products List See https://www.peosoldier.army.mil/equipment/eyewear/.

**Candidate**
Any individual under consideration for military status or for a military service program whether voluntary (appointment, enlistment, ROTC) or involuntary (induction).

**Civilian physician**
Any individual who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures in the geographical area concerned.

**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.

**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.

**Health care provider**
Licensed or certified health care personnel (specifically, a physician, PAs, nurse practitioner, dentist, optometrist, physical therapist, chiropractor, occupational therapist, audiologist, podiatrist, nurse midwives, clinical psychologist, clinical social worker, advanced practice nurse, independent duty corpsman, SF 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.

**Integrated Disability Evaluation System**
Procedures that apply in determining whether a Soldier is unfit because of physical disability to reasonably perform the duties of his or her office, grade, rank, or rating. The IDES consists of MEBs (a function of the Army Medical Department), PEBs (elements of the U.S. Army Physical Disability Agency (USAPDA)), and case reviews, when applicable, by USAPDA.

**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 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 (section 4 of DA Form 3349–SG and passing one aerobic AFPT event) and perform the duties required of his or her MOS, grade, or rank.

**Operational Profile Review Board**
A board convened monthly at battalion level and higher to review all temporary profiles of greater than 120 days in length (battalion), greater than 180 days in length (BDE), and greater than 240 days in length (senior command and higher).

**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 a 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.

**Reserve Component**
Applies to ARNGUS, Army National Guard, and USAR units. See DA Pam 220–1.

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

**Separation**
An all-inclusive term that is applied to personnel actions resulting from release from AD, 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 USAR (Selected, Ready, Standby, or Retired) are not considered as separations.