CHAPTER 3

Physical Standards

Section A. Administrative Procedures.

1. Applicability of Physical Standards.
2. Prescribing of Physical Standards.
3. Purpose of Physical Standards.
4. Application of Physical Standards.
5. Interpretation of Physical Standards.
6. Definitions of Terms Used in this Chapter.
7. Required Physical Examinations and Their Time Limitations.
8. Waiver of Physical Standards.
9. Substitution of Physical Examinations.
10. Annual Command Afloat Screening.

Section B. Medical Examination (DD-2808) and Medical History (DD-2807-1).

1. Report of Medical Examination DD-2808.
2. Report of Medical History DD-2807-1.
3. Findings and Recommendations of Report of Medical Examination (DD-2808).
4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.
5. Objection to Assumption of Fitness for Duty at Separation.
6. Separation Not Appropriate by Reason of Physical Disability.
7. Procedures for Physical Defects Found Prior to Separation.

Section C. Medical Examination Techniques and Lab Testing Standards.

1. Scope.
2. Speech Impediment.
3. Head, Face, Neck, and Scalp (Item 17 of DD-2808).
4. Nose, Sinuses, Mouth, and Throat (Item 19, 20 of DD-2808).
5. Ears (General) and Drums (Item 21, 22 of DD-2808).
6. Eyes (General), Ophthalmoscopic, and Pupils (Item 23, 24, 25 of DD-2808).
7. Ocular Motility (Item 26 of DD-2808).
8. Heart and Vascular System (Item 27 of DD-2808).
9. Lungs and Chest (Item 28 of DD-2808).

10. Anus and Rectum (Item 30 of DD-2808).
11. Abdomen and Viscera (Item 31 of DD-2808).
12. Genitourinary System (Item 32 of DD-2808).
13. Extremities (Item 33, 34, 35 of DD-2808).
14. Spine and Other Musculoskeletal (Item 36 of DD-2808).
15. Identifying Body Marks, Scars, and Tattoos (Item 37 of DD-2808).
16. Neurologic (Item 39 of DD-2808).
17. Psychiatric (Item 40 of DD-2808).
18. Endocrine System.
19. Dental (Item 43 of DD-2808).
20. Laboratory Findings.
21. Laboratory Findings.
22. Distant Visual Acuity and Other Eye Tests.
23. Audiometer.
24. Psychological and Psychomotor.

Section D. Medical Standards for Appointment, Enlistment and Induction in the Armed Forces.

1. Scope.
2. Medical Standards.
3. Policy.
4. Responsibilities of Commandant CG-11.
5. Height.
6. Weight.
7. Head.
8. Eyes.
9. Ears.
10. Vision.
11. Hearing.
12. Nose, Sinuses, Mouth and Larynx.
13. Dental.
14. Neck.
15. Lungs, Chest Wall, Pleura, and Mediastinum.

16. Heart.
17. Abdominal Organs and Gastrointestinal System
18. Female Genitalia.
19. Female Genitalia.
20. Urinary System.
21. Spine and Sacroiliac Joints.
22. Upper Extremities Limitation of Motion.
23. Lower Extremities.
24. Miscellaneous Conditions of the Extremities.
25. Vascular System.
26. Skin and Cellular Tissues.
27. Skin and Cellular Tissues.
28. Systemic.
29. Endocrine and Metabolic.
30. Neurologic.
31. Learning Psychiatric and Behavioral.
32. Tumors and Malignancies.
33. Miscellaneous.

Evaluation for Risk OF Head Injury Sequelae.

Classification and Comparative nomenclature of Cervical Smears.

Cells consistent with carcinoma.

Squamous cell carcinoma.

Section E. Physical Standards for Programs Leading to Commission.

1. Appointment as Cadet, United States Coast Guard Academy.
2. Commissioning of Cadets.
3. Enrollment as an Officer Candidate.
4. Commissioning of Officer Candidates.
5. Coast Guard Direct Commission Program.
6. Direct Commission in the Coast Guard Reserve.
7. Direct Commission of Licensed Officers of U. S. Merchant Marine.
8. Appointment to Warrant Grade.

Section F. Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.
2. Use of List of Disqualifying Conditions and Defects.
3. Head and Neck.
4. Esophagus, Nose, Pharynx, Larynx, and Trachea.
5. Eyes.
6. Ears and Hearing.
7. Lungs and Chest Wall.
8. Heart and Vascular System.
9. Abdomen and Gastrointestinal System.
10. Endocrine and Metabolic Conditions (Diseases).
11. Genitourinary System.
12. Extremities.
13. Spine, Scapulae, Ribs, and Sacroiliac Joints.
14. Skin and Cellular Tissues.
15. Neurological Disorders.
16. Psychiatric Disorders. (See section 5-B concerning disposition).
17. Dental.
18. Blood and Blood-Forming Tissue Diseases.
19. Systemic Diseases, General Defects, and Miscellaneous Conditions.
20. Tumors and Malignant Diseases.
21. Sexually Transmitted Disease.
22. Human Immunodeficiency Virus (HIV).
23. Transplant recipient.

Section G. Physical Standards for Aviation.

1. Classification of Aviation Personnel.
2. General Instructions for Aviation Examinations.
3. Restrictions Until Physically Qualified.
4. Standards for Class l.
5. Standards for Class 1R.
6. Candidates for Flight Training.

7. Requirements for Class 2 Flight Officers.
8. Requirements for Class 2 Aircrew.
9. Requirements for Class 2 Medical Personnel.
10. Requirements for Class 2 Technical Observers.
11. Requirements for Class 2 Air Traffic Controllers.
12. Requirements for Landing Signal Officer (LSO).
13. Refractive Surgery.
14. Contact Lenses.

Section H. Physical Examinations and Standards for Diving Duty.

1. Examinations.
2. Standards.

CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section A. Administrative Procedures.

1. Applicability of Physical Standards. 1
2. Prescribing of Physical Standards. 1
3. Purpose of Physical Standards. 1
4. Application of Physical Standards. 1
5. Interpretation of Physical Standards. 2
6. Definitions of Terms Used in this Chapter. 2
7. Required Physical Examinations and Their Time Limitations. 3
8. Waiver of Physical Standards. 9
9. Substitution of Physical Examinations. 11
10. Annual Command Afloat Medical Screening 15

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section A. Administrative Procedures.

1. Applicability of Physical Standards.

   a. Coast Guard standards. The provisions of this chapter apply to all personnel of the Coast Guard and Coast Guard Reserve on active or inactive duty and to commissioned officers of the Public Health Service assigned to active duty with the Coast Guard.

   b. Armed Forces standards. Members of the other Armed Forces assigned to the Coast Guard for duty are governed by the applicable instructions of their parent Service for examination standards and for administrative purposes.

2. Prescribing of Physical Standards.
   Individuals to be enlisted, appointed, or commissioned in the Coast Guard or Coast Guard Reserve must conform to the physical standards prescribed by the Commandant. Separate standards are prescribed for various programs within the Service.

3. Purpose of Physical Standards.
   Physical standards are established for uniformity in procuring and retaining personnel who are physically fit and emotionally adaptable to military life. These standards are subject to change at the Commandant's direction when the needs of the Coast Guard dictate.

4. Application of Physical Standards.

   a. Conformance with Physical Standards Mandatory. To determine physical fitness, the applicant or member shall be physically examined and required to meet the physical standards prescribed in this chapter for the program or specialty and grade or rate involved. An examinee who does not meet the standards shall be disqualified.

   b. Evaluation of Physical Fitness. The applicant's total physical fitness shall be carefully considered in relation to the character of the duties to that the individual may be called upon to perform. Physical profiling is not a Coast Guard policy. Members shall be considered fit for unrestricted worldwide duty when declared physically qualified. The examiner must be aware of the different physical standards for various programs. Care shall be taken to ensure an examinee is not disqualified for minor deviations that are clearly of no future significance with regard to general health, ability to serve, or to cause premature retirement for physical disability. However, conditions that are likely to cause future disability or preclude completing a military career of at least twenty years, whether by natural progression or by recurrences, are also disqualifying. This policy shall be followed when an authentic history of such a condition is established, even though clinical signs may not be evident during the physical examination.

5. Interpretation of Physical Standards.
Examiners are expected to use discretion in evaluating the degree of severity of any defect or disability. They are not authorized to disregard defects or disabilities that are disqualifying in accordance with the standards found in this chapter.

6. Definitions of Terms Used in this Chapter.

   a. Officers. The term "officers" includes commissioned officers, warrant officers, and commissioned officers of the Public Health Service.

   b. Personnel. The term "personnel" includes members of the Coast Guard and Coast Guard Reserve, and the PHS on active duty with the Coast Guard.

   c. Medical and Dental Examiners. Medical and dental examiners are medical and dental officers of the uniformed services, contract physicians and dentists, or civilian physicians or dentists who have been specifically authorized to provide professional services to the Coast Guard. Some USMTFs have qualified enlisted examiners who also conduct medical examinations and their findings require countersignature by a medical officer.

   d. Flight Surgeons, Aviation Medical Officers and Aeromedical Physician Assistants. Officers of a uniformed service who have been so designated because of special training.

   e. Command/Unit. For administrative action required on the Report of Medical Examination (DD-2808), the command/unit level is the unit performing personnel accounting services for the individual being physically examined.

   f. Reviewing / Approving Authority. Commander Coast Guard Personnel Command (CGPC-cm) and MLC (k) are responsible for approval of physical examinations as outlined herein. Clinic Administrators may act as reviewing / approving authority for physical examinations performed in their AOR, including those performed by contract physicians and USMTF's as designated by the cognizant MLC, except for those that are aviation or dive related. Medical Administrators may request physical examination review / approval authority for Clinic Supervisors assigned to their clinic from the cognizant MLC. Reviewing authority shall not be delegated below the HSC level. Upon approval / disapproval of the physical examination, an entry in the comments block of the Medical Readiness System (MRS) will be made stating where the physical was approved or disapproved and the reason for disapproval, if applicable. Medical Administrative Officers (LDO and CWO-Meds) may review physical examinations performed by contract physicians and USMTFs within their AOR.

g. Convening Authority. Convening Authority is an individual authorized to convene a medical board as outlined in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

h. Time Limitation. The time limitation is the period for which the physical examination remains valid to accomplish its required purpose. The time limitation period begins as of the day after the physical examination is conducted.

7. Required Physical Examinations and Their Time Limitations.

a. Enlistment. A physical examination is required for original enlistment in the Coast Guard and the Coast Guard Reserve. This physical examination will usually be performed by Military Entrance Processing Stations (MEPS) and is valid for twenty-four months. Approved MEPS physicals do not require further review. Recommendations noted on separation physical examinations from other services must have been resolved with an indication that the individual meets the standards. A certified copy of that physical examination must be reviewed and endorsed by the reviewing authority Commander (CGRC). The reviewing authority must indicate that the applicant meets the physical standards for enlistment in the USCG.

(1) Recruiters who believe that applicants have been erroneously physically disqualified by MEPS, may submit the DD-2808 and DD-2807-1 (original or clean copies) along with supporting medical records to Commander (CGRC) for review.

(2) Waiver of physical standards for original enlistment may also be submitted as above, and in accordance with paragraph 3-A-8 of this instruction.

(3) Separation physical examinations from any Armed Service may be used for enlistment in the Coast Guard, provided the examination has been performed within the last twelve (12) months. The physical examination must be as complete as a MEPS exam, include an HIV antibody test date (within the last 24 months) and result, and a Type II dental examination. A DD-2807-1 must also be included with elaboration of positive medical history in the remarks section (item #25). Forward all documents for review by Commander (CGRC).

(4) Prior Service enlisted aviation personnel must obtain an aviation physical examination from a currently qualified uniformed services flight surgeon or AMO within the previous 12 months. This physical examination will be submitted with the rate determination package to Commander (CGRC).

(5) Occasionally, applicants for initial entry into the Coast Guard will need to be examined at Coast Guard MTFs. In these cases, the physical examination will be performed per section 3-C. The examining medical officer may defer item #46 of the DD-2808 to the Reviewing Authority. Otherwise, the physical standards for entry (sections 3-D, 3-E and 3-G as appropriate) must be meticulously applied when completing this item. The

completed DD-2808 and DD-2807-1 will be forwarded to the reviewing authority, Commander (CGRC).

b. Pre-Commissioning/Appointments. A physical examination is required within 12 months prior to original appointment as an officer in the Coast Guard or Coast Guard Reserve for personnel in the following categories:

(1) Appointments to Warrant Grade, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office, form CG-9556.

(2) Appointment of a Direct Commission Officer, prior to the date of execution of the Acceptance and Oath of office.

(3) Appointment of a Licensed Officer of the U. S. Merchant Marine as a commissioned officer (examination required within 6 months).

(4) Graduates of the Coast Guard Academy and Officer Candidates School, prior to the execution of the Acceptance and Oath of Office.

c. Separation from Active Duty.

(1) A complete physical examination is required within 12 months for retirement, involuntary separation, or release from any active duty (RELAD) of 30 days or longer into the Ready Reserves (selected drilling or IRR). The physical examination shall follow the guidelines set forth for quinquennial physicals.

(2) Other members separating from the Coast Guard e.g., discharge or transfer to standby reserve (non-drilling) may request a medical and/or dental examination. The medical examination must include: notation of any current problems, a blood pressure measurement, and address items on the preventive medicine stamp. In addition to the above, the practitioner shall ascertain the health needs of the member and undertake measures deemed necessary to meet those needs. The dental examination, if requested, must at least be a Type III exam. These examinations may be annotated on a SF-600, and upon completion, do not require approval.

(3) For members enrolled in the Occupational Medical Surveillance and Evaluation Program (OMSEP), see chapter 12 of this Manual for guidance.

(4) See chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series), for amplification on administrative discharge procedures.

d. Overseas Transfer, Sea Duty Deployment and Port Security Unit (PSU) Health Screening. A modified physical examination, utilizing Figure 3-A-1, is required for all personnel departing for an overseas assignment for 60 consecutive days or greater, PCS transfer to an icebreaker, vessel deployment for 60 consecutive days or more (out of 365), and annually for PSU personnel. This will help

identify and resolve health related issues prior to transfer or deployment, if no significant medical status changes have occurred. Members who are transferring from one overseas assignment to another overseas assignment do not require another overseas physical examination. The completed modified physical examination and a copy of the last completed/approved Report of Physical Examination (DD-2808) and Report of Medical History (DD-2807-1) shall be submitted to the Reviewing Authority. The modified physical examination will include the following:

(1) A health history completed by the evaluee. (The evaluee will certify by signature that all responses are true).

(2) Documentation of the previous approved physical examination to include the status of recommendations and summary of significant health changes.

(3) Review of the health record to ensure routine health maintenance items are up-to-date to include:

(a) Routine gynecologic examinations.

(b) Two pairs of glasses and gas mask inserts for PSU personnel if required to correct refractive error, DNA sampling, G-6-PD screening, immunizations, HIV testing and a Type 2 dental examination.

(4) Review malaria chemoprophylaxis, PPD, and special health concern requirements. Contact the Center for Disease Control and Prevention (CDC) at http://www.cdc.gov or http://www.travel.state.gov for information.

(5) If PCS transferring to a foreign country [refer to 3-C.20.b(7)(b)], HIV antibody test must have been conducted within the past 6 months with results noted prior to transfer.

(6) If an evaluee is enrolled (or will be enrolled based on new assignment) in the Occupational Medical Surveillance and Evaluation Program (OMSEP), ensure appropriate periodic/basic examination is performed.

e. Applicant.

(1) Commissioning Programs. A physical examination is required for applicants for entry into the Coast Guard as follows:

(a) Coast Guard Academy: DODMERB physical examination within 24 months.

(b) Officer Candidate School: MEPS physical within 24 months of entry date, except.

1 Coast Guard personnel on active duty may obtain the physical examination at a USMTF within 24 months of entry date.

2 Members of other Armed Services may submit a physical examination from a USMTF provided the examination has been performed within the past twelve (12) months and is as complete as a MEPS physical examination.

(c) Direct commission: MEPS physical within 24 months of entry date or oath of office for Ready Reserve Direct Commission, except aviation programs, where examination by a uniformed service flight surgeon or AMO is required within 12 months of entry date.

(d) Applicants for service academies, ROTC scholarship programs, and the Uniformed Services University School of Health Sciences (USUHS) are authorized to utilize MTFs for their initial physical examination and additional testing if necessary. (Office of Assistant Secretary of Defense Health Affairs, OASD (HA) policy memo 9900003/Physical Examinations for ROTC Applicants (notal)).

1 Applicants for entry into these program and prospective flight personnel should be treated as mission related priorities with scheduling precedence associated with priority group 1.

2 Scheduling of physical examinations, additional tests and evaluations are to be conducted in a timely manner.

(2) Aviation. An aviation physical examination is required for applicants for training in all categories of aviation specialties. This physical examination is valid for 24 months for Class II applicants and 12 months for pilot applicants.

(3) Diving. A physical examination is required for all applicants for duty involving diving, and is valid for twelve months.

f. Pre-Training Screening Examinations. A screening examination is required within 1 week of reporting to the Coast Guard Academy, Officer Candidate School, Direct Commission Officer orientation, or the Recruit Training Center. This screening examination shall be sufficiently thorough to ensure that the person is free from communicable and infectious diseases, and is physically qualified. The results of this examination shall be recorded on an SF-600 and filed in the health record.

g. Retired Members Recalled to Active Duty. A physical examination is required for retired personnel who are recalled to active duty. This physical examination is valid for twelve months. A physical examination performed for retirement may be used for recall providing the date of recall is within six months of the date of the physical examination.

h. Annual. An annual physical examination is required on all aviation personnel age 50 or older.

i. Biennial.

(1) Biennial physical examination is required every 2 years after initial designation, until age 48, for the following:

(a) All aviation personnel (including air traffic controllers).

(b) All Landing Signal Officers (LSO).

(2) The biennial exam will be performed within 90 days before the end of the birth month. The period of validity of the biennial physical will be aligned with the last day of the service member's birth month. (Example: someone born on 3 October would have August, September, and October in which to accomplish his/her physical. No matter when accomplished in that time frame, the period of validity of that exam is until 31 October two years later).

(3) The requirement to perform a biennial exam will not be suspended in the event of training exercises or deployment. Aircrew with scheduled deployment during their 90 day window to accomplish their biennial exam may accomplish their biennial exam an additional 90 days prior and continue with the same valid end date. This may result in a member having a valid biennial for 30 months. Members unable to accomplish a biennial exam prior to being deployed will be granted an additional 60 days upon return in which to accomplish their physical.

(4) Additionally, a comprehensive physical may be required during a post-mishap investigation, FEB, or as part of a work-up for a medical disqualification.

(5) Personnel designated as aircrew are expected to maintain a biennial exam schedule regardless of current aviation duty status.

j. Triennial. A physical examination is required every three years for all active duty and selected reserve personnel who are 50 years of age or older with the exception of aviation personnel and air traffic controllers. (see 7. h. above)

k. Quinquennial/Quinquennial Diving. A physical examination is required every five (5) years on all active duty and selected reserve personnel, within 30 days of their birth dates starting at age **20** through age **50**, and for all personnel maintaining a current diving qualification (also note "Other" in item #15.c. of DD-2808). Quinquennial physical examinations are also required for:

(1) Reserve officers assigned to the Individual Ready Reserve (IRR) who are on a promotion list.

(2) Officers in 3-A-7.e. (1)(a) and (b) above must have a current approved physical examination documented by PMIS data base entry prior to being promoted (i.e., a quinquennial physical examination within the last 5 years).

l. Occupational Medical Surveillance and Evaluation Program (OMSEP). Those individuals who are occupationally exposed to hazardous substances, physical energies, or employed in designated occupations must undergo physical examinations as required by Chapter 12 of this Manual.

m. Miscellaneous Physical Examinations.

(1) Retention. This examination is done at the direction of the commanding officer when there is substantial doubt as to a member's physical or mental fitness for duty.

(2) Pre-confinement Physical Screening. In general, personnel who are presented for this screening, who do not require acute medical treatment or hospitalization, are fit for confinement. Cases where a member requires more than routine follow-up medical care, or has certain psychiatric conditions, that may make them unfit for confinement, should be discussed with the chief medical officer (or his/her representative) at the confining facility. Personnel requiring detoxification for alcohol or drug dependency are not fit for confinement; however, members that have been detoxified or that may require rehabilitation alone are fit for confinement. This screening shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (DD-2808) and Report of Medical History (DD-2807-1), shall be submitted to the Reviewing Authority.

(3) Post Confinement Physical Examination. Ensure a separation physical examination has been completed prior to the member departing the confining facility. The separation physical shall meet the standards of section 3-F and must be approved by the appropriate MLC (k).

(4) Reservists. A district commander may require any reservist attached to a command within that area to undergo a complete physical examination if reasonable doubt exists as to the reservist's physical or mental fitness for duty.

(5) Non-Fitness for Duty Determination Physical Examinations. The Chief of Health Services retains the authority and responsibility to determine capability and capacity to conduct non-fitness for duty physical examinations for all eligible beneficiaries.

(6) Medical Boards. Medical Boards are convened to evaluate the present state of health and fitness for duty of any active duty/selected reserve member. Chapter 1-16-b.(3)(c) of this Manual outlines required forms for this process.

n. Annual Command Afloat Medical Screening. Officers and enlisted personnel scheduled to assume command afloat shall undergo a medical screening prior to assignment. The initial screening may be conducted by a medical officer where

applicable, or an HS not in the prospective chain of command of the member being screened. Thereafter, all commanding officers and officers-in-charge of afloat units will have an annual command afloat medical screening. This screening will also be performed by a medical officer where available; otherwise, the screening may be performed by a Health Services Technician who IS NOT in the chain of command of the person being screened. The screening process will include a medical history completed by the member, a visual acuity check, blood pressure measurement, and a thorough review of interval history in the member's health record. Results are to be recorded using the format in Figure 3-A-2. The medical screening form (Figure 3-A-2) and a copy of the last approved DD-2808 and DD-2807-1 shall then be forwarded to the appropriate MLC (k) for review. The MLC (k) will approve or disapprove the screening using section 3-F (retention standards) as the guiding directive. If a question arises as to the fitness of the individual, the MLC (k) may request additional information from the examining unit. If the MLC (k) is unable to render a decision as to the fitness for command, the entire command afloat screening package will be forwarded to Commandant (G-WKH) for final action. The reviewed form shall be returned to the member's command for filing in the member's health record.

o. Dental Examinations. Annual Type II dental examinations are required for all active duty assigned to commands collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).

8. Waiver of Physical Standards.

a. Definition of Waiver. A waiver is an authorization to change a physical standard when an individual does not meet the physical standards prescribed for the purpose of the examination.

(1) Normally, a waiver will be granted when it is reasonably expected that the individual will remain fit for duty and the waiver is in the best interests of the Coast Guard. A service member will not be granted a waiver for a physical disability determined to be not fit for duty by a physical evaluation board approved by the Commandant. In these cases, the provisions for retention on active duty contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Personnel Manual, COMDTINST M1000.6 (series) apply.

(2) If a member is under consideration by the physical disability evaluation system, no medical waiver request shall be submitted for physical defects or conditions described in the medical board. All waiver requests received for conditions described in the medical board will be returned to the member's unit without action.

(3) A waiver of a physical standard is not required in a case where a Service member's ability to perform on duty has been reviewed through the physical disability evaluation system and the approved finding of the Commandant is fit for duty.

b. Authority for Waivers. Commander CGPC-epm (enlisted), CGPC-opm (officers), and CGPC-rpm (reserve) have the sole authority to grant waivers. The decision to authorize a waiver is based on many factors, including the recommendations of the Chief, Office of Health and Safety; the best interest of the Service; and the individual's training, experience, and duty performance. Waivers are not normally authorized but shall be reviewed by Commander (CGPC) for the following:

(1) Original enlistment in the regular Coast Guard of personnel without prior military service.

(2) Appointment as a Cadet at the Coast Guard Academy.

(3) Training in any aviation or diving category specialty.

(4) A waiver can be terminated if there is appropriate medical justification.

c. Types of Waivers.

(1) Temporary. A temporary waiver may be authorized when a physical defect or condition is not stabilized and may either progressively increase or decrease in severity. These waivers are authorized for a specific period of time and require medical reevaluation prior to being extended.

(2) Permanent. A permanent waiver may be authorized when a defect or condition is not normally subject to change or progressive deterioration, and it has been clearly demonstrated that the condition does not impair the individual's ability to perform general duty, or the requirements of a particular specialty, grade, or rate.

d. Procedures for Recommending Waivers.

(1) Medical Officer. A medical officer who considers a defect disqualifying by the standards, but not a disability for the purpose for which the physical examination is required, shall:

(a) Enter a detailed description of the defect in Item 77 of the DD-2808.

(b) Indicate that either a temporary or permanent waiver is recommended.

(2) Command/Unit Level. When the command receives a Report of Medical Examination (DD-2808) indicating that an individual is not physically qualified, the command shall inform the individual that he/she is not physically qualified. The individual shall inform the command via letter of his/her intentions to pursue a waiver. The medical officer is required to give a recommendation on whether the waiver is appropriate and if the individual may perform his/her duties with this physical defect. This recommendation shall be completed on an (SF-502) Narrative Summary. A cover letter stating the command's opinion as to the appropriateness of a waiver, the individual's previous performance of duty, special skills, and any other pertinent information, shall accompany the medical officers report. The waiver request package shall be forwarded directly from the

member's unit to Commander CGPC-epm or opm, or Commandant (CGPC-rpm) as appropriate.

e. Command Action on Receipt of a Waiver Authorization. A command receiving authorization from the Commander CGPC-epm/opm/rpm for the waiver of a physical standard shall carefully review the information provided to determine any duty limitation imposed and specific instructions for future medical evaluations. Unless otherwise indicated in the authorization, a waiver applies only to the specific category or purpose for which the physical examination is required. A copy of the waiver authorization shall be retained in both the service and health records for the period for which the waiver is authorized. Copies of future DD-2808's for the same purpose shall be endorsed to indicate a waiver is or was in effect.

9. Substitution of Physical Examinations.

a. Rule for Substitution of Physical Examinations. In certain circumstances, a physical examination performed for one purpose or category may be substituted to meet another requirement provided the following criteria are met:

(1) The examinee was physically qualified for the purpose of the previous examination and all the required tests and recommendations have been completed.

(2) The DD-2808 used for substitution bears an endorsement from the Reviewing Authority or Commandant (CG-112), as appropriate, indicating that the examinee was qualified for the purpose of the previous examination.

(3) There has been no significant change in the examinee's medical status since the previous examination.

(4) A review of the report of the previous examination indicates that the examinee meets the physical standards of the present requirement.

(5) The date of the previous examination is within the validity period of the present requirement.

(6) All additional tests and procedures to meet the requirements of the current physical examination have been completed.

b. No substitutions are authorized for the following physical examinations:

(1) Enlistment.

(2) Pre-training.

(3) Applicants for or designated personnel in special programs (aviation, diving, Academy).

c. Procedures for Reporting Substitution. Substitutions of a physical examination shall be reported by submitting a copy of the DD-2808 and DD-2807-1 being used to meet the present requirements with the endorsement illustrated in

FIGURE 3-A-1, parts A, B, and C. Retain a copy of the substitution endorsement in the health record.

MODIFIED PHYSICAL EXAMINATION FOR:

SUBSTITUTION/OVERSEAS ASSIGNMENT/SEA DUTY/PSU HEALTH SCREENING
This form is subject to the Privacy Act Statement of 1974.

A. EVALUEE DATA

LAST NAME - FIRST NAME - MIDDLE INITIAL SOCIAL	RATE/RANK	SECURITY NUMBER

UNIT	EXAMINING FACILITY

PURPOSE OF EXAMINATION	**TRANSFER/DEPLOYMENT LOCATION**	**DATE**

B. HEALTH HISTORY (completed by examinee)

1. Would you say your health in general is: [ ] Excellent [ ] Good [ ] Fair [ ] Poor
2. Do you have any medical or dental problems or concerns? [ ] No [ ] Yes
3. Do you have any health related duty limitations? [ ] No [ ] Yes
4. Could you be pregnant? (females request HCG if needed) [ ] N/A [ ] Unknown [ ] No [ ] Yes
5. Are you taking prescription medications? (request refills if needed) [ ] No [ ] Yes
6. During the past year, have you sought or required counseling or mental health care? [ ] No [ ] Yes
7. Explain any "fair, poor, yes, or unknown" responses:_____
_____
8. Have you been hospitalized since your last physical? Yes / No. If (Yes) explain._____

I certify that responses above are true: (signature of examinee)_____

C. PHYSICAL EXAMINATION REVIEW (current approved physical examination required)

9. Date and type of current approved physical examination:_____
10. Status of recommendations or further specialist examination:_____
_____
11. Summary of significant health history since last physical examination:_____
_____

D. HEALTH RECORD REVIEW

12. Have routine gynecologic (pap) examinations been completed in past year? (females) [ ] N/A [ ] No [ ] Yes
13. Does examinee have two pair of glasses? (if required to correct refractive error) [ ] N/A [ ] No [ ] Yes
14. Does PSU examinee have a gas mask insert? (if required to correct refractive error) [ ] N/A [ ] No [ ] Yes
15. Has DNA sampling been completed and documented? (once per career) [ ] No [ ] Yes
16. Has G-6-PD screening been completed and documented? (once per career) [ ] No [ ] Yes
17. Are immunizations up-to-date and meet requirements for destination? [ ] No [ ] Yes
18. Has an HIV AB test been drawn in the past 6 months? (foreign country PCS only) [ ] N/A [ ] No [ ] Yes
19. Are malaria chemoprophylaxis, PPD, and special health concern requirements met? [ ] No [ ] Yes
Contact the Center for Disease Control and Prevention at http://www.cdc.gov for information.
20. Has a Type 2 dental examination been completed in the past year and is examinee "Class 1 or 2"? [ ] No [ ] Yes
21. Explain any "no" answers:_____
_____

E. SIGNATURE AND APPROVAL/DISAPPROVAL

Medical Officer signature/stamp:_____ Date:_____

Dental Officer signature/stamp:_____ **Date:**_____

Reviewing/approving authority:_____ **[ ] Approved**

[ ] Disapproved

FIGURE 3-A-2 (revised 2/99)

ANNUAL COMMAND AFLOAT MEDICAL SCREENING

Name:_____ Rank/Grade:_____

SSAN:_____ Date of Birth:_____Work Telephone:_____

Unit OPFAC:_____ Unit Name:_____Date of Screening:_____

To be completed by the member: (use reverse side as needed)

List any significant medical history since your last physical examination or Medical screening (describe any illnesses, injuries, etc.):_____

_____

_____

_____

Have you experienced any significant changes in stress level, mood or family life?

YES NO

If yes, describe_____

_____

_____

_____

Do you have any alcohol-related problems (including DWI)? YES NO

If yes, describe:

_____

_____

_____

Are you presently taking any medication (including over-the-counter)? YES NO

If yes, list:

_____

_____

_____

The information I have provided above is complete and accurate.

_____Date:_____

(Signature of member)

The following section is to be completed by health services personnel:

Review of Health Record performed. Significant findings are:_____
_____

Best Distant Visual Acuity (with correction, if required): R:_____L:_____

Sitting blood pressure:_____ _____

NOTE: ATTACH A COPY OF LAST APPROVED DD-2808 AND DD-2807-1

UNIT: _____Date: _____

(Signature/Title of medical reviewer)

_____Date: _____

(Signature/MLC reviewer)

_____Date:_____

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CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section B. Medical Examination (DD-2808) and Medical History (DD-2807-1).

1. Report of Medical Examination DD-2808 1
2. Report of Medical History DD-2807-1.....1
3. Findings and Recommendations of Report of Medical Examination (DD-2808)...1
4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.....5
5. Objection to Assumption of Fitness for Duty at Separation. 6
6. Separation Not Appropriate by Reason of Physical Disability.....7
7. Procedures for Physical Defects Found Prior to Separation. 7

FIGURE 3-B-1.....8

FIGURE 3-B-2.....9

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section B. Medical Examination (DD-2808) and Medical History (DD-2807-1).

1. Report of Medical Examination DD-2808.

   a. Report of Medical Examination DD-2808. The DD-2808 is the proper form for reporting a complete physical examination. DD-2808 can be obtained from the (CG-1121) Publications and Directives web site athttp://www.uscg.mil/hq/g-w/g-wk/wkh/pubs/index.htm or by http://www.dior.whs.mil/forms/DD2808.PDF directly from the DoD forms web site.

   b. Detailed instructions for the preparation and distribution of this form are contained in section 4-B of this Manual.

2. Report of Medical History DD-2807-1.

   a. Report of Medical History DD-2807-1. The DD-2807-1 is the proper form for reporting a member's medical history. The DD-2807-1 can be obtained from the (CG-1121) Publications and Directives web site at ://www.uscg.mil/hq/g-w/g-wk/wkh/pubs/index.htm or by http://www.dior.whs.mil/forms/DD2807-1.PDF directly from the DoD forms web site.

   b. Detailed instructions on the preparation and distribution of this form are contained in section 4-B of this Manual.

3. Findings and Recommendations of Report of Medical Examination (DD-2808).

   a. Action by the Medical Examiner.

      (1) Review of Findings and Evaluation of Defects. When the results of all tests have been received and evaluated, and all findings recorded, the examiner shall consult the appropriate standards of this chapter to determine if any of the defects noted are disqualifying for the purpose of the physical examination. When physical defects are found that are not listed in the standards as disqualifying, but that, in the examiner's opinion, would preclude the individual from performing military service or the duties of the program for which the physical examination was required, the examiner shall state that opinion on the report indicating reasons. If in the examiner's opinion, a defect listed as disqualifying is not disabling for military service, or a particular program, the examiner shall indicate the basis for this opinion and recommend a waiver in accordance with the provisions of section A of this chapter.

      (2) Remediable Defects. When the physical examination of active duty personnel indicates defects that are remediable or that may become potentially disabling unless a specific medical program is followed, the examiner shall clearly state any recommendations. If the examining facility has the capability of correcting the defect or providing extended outpatient

follow-up or medical care, tentative arrangements for care shall be scheduled, subject to the approval of the examinee's command. If the examining facility does not have the capabilities of providing the necessary care, tentative arrangements for admission or appointment at another facility shall be scheduled, again subject to the approval of the individual's command.

(3) Advising the Examinee. After completing the physical examination, the medical examiner will advise the examinee concerning the findings of the physical examination. At the same time, the examinee shall be informed that the examiner is not an approving authority for the purpose of the examination and that the findings must be approved by proper authorities.

(4) Disposition of Reports. The original DD-2808 and the original DD-2807-1, together with any reports of consultations or special testing reports not entered on the DD-2808 or DD-2807-1, shall be forwarded to the activity that referred the individual for the physical examination.

b. Review and Action on Reports of Physical Examination by Command.

(1) Command Responsibility.

(a) The command has a major responsibility in ensuring the proper performance of physical examinations on personnel assigned and that physical examinations are scheduled sufficiently far in advance to permit the review of the findings and correction of medical defects prior to the effective date of the action for which the examination is required. The command is also responsible to ensure that the individual complies with the examiner's recommendations and to initiate any administrative action required on a Report of Medical Examination.

(b) All DD-2808's shall be reviewed by commanding officers, or their designee, to determine that the prescribed forms were used and that all necessary entries were made.

(c) When the medical examiner recommends further tests or evaluation, or a program of medical treatment (such as hearing conservation, periodic blood pressure readings, etc.), the command will ensure that these tests or examinations are completed or that the individual is directed to and does comply with the recommended program. When a necessary test, evaluation, or program can be completed within a 60 day period, the unit may hold the DD-2808 to permit the forwarding of results. In all cases the command shall endorse the DD-2808 to indicate what action has been taken and forward the report to the reviewing authority if the 60 day period cannot be met or has elapsed.

(d) Disposition of Reports.

1 If a physical examination is accomplished for a purpose for which the command has administrative action, the original DD-2808 and DD-2807-1 and a return self-addressed envelope shall be forwarded to the reviewing authority. No action will be taken to accomplish the purpose for which the physical examination was taken until the endorsed original of the report is returned by the reviewing authority indicating the examinee meets the physical standards for the purpose of the examination.

2 Approved MEPS physicals do not require further review. The original physical (DD-2808 and DD-2807-1) will be carried to the training center by the individual.

3 If the physical examination is for a purpose requiring the consent or approval of the MLC commander, or Commandant, the procedures previously described for command review and action will be accomplished, except rather than forwarding the report of the examination directly to the reviewing authority, it will be included with other supporting documents (letters, recommendations, etc.) and forwarded through the chain of command.

4 Units not using a CGMTF shall send physical examinations to the appropriate CG Clinic (as designated by the cognizant MLC), MLC (k), or CGPC (opm or epm) as appropriate.

c. Action by the Reviewing Authority.

(1) The Commandant is the final reviewing authority for all physical examinations, except for applicants to the Coast Guard Academy.

(2) Administratively, MLC (k) acts as the reviewing authority for physical examinations performed on personnel assigned to their Areas except as in (4) and (5) below.

(3) Another exception to this rule pertains to those flight physicals performed on aviation school students during training that are reviewed and approved by the Navy Operational Medicine Institute (NOMI). NOMI, not MLC (k) will be the approving authority for these physicals. CGPC will remain the waiver approval authority for these physicals, when a waiver is required prior to final approval. Upon completion of flight training and assignment to a Coast Guard unit, the NOMI approved physical will be considered valid until the last day of the member's next birth month. The unit flight surgeon will clear the aviator for all flight related duties based on the NOMI approved flight physical.

(4) Commander, Coast Guard Personnel Command (CGPC-cm) is the reviewing authority for aviator candidate, flight officer candidate, aircrew candidate, and diving candidate physical examinations. Commander,

CGRC shall review disapproved MEPS physicals to ensure proper application of physical standards.

(5) The Department of Defense Medical Examination Review Board (DoDMERB) is the reviewing authority for physical examinations performed on Academy applicants. MEPS is the reviewing authority for physical examinations performed in their facilities.

(6) Each DD-2808 shall be carefully reviewed to determine whether the findings reported indicate the examinee does or does not meet the appropriate physical standards. If further medical evaluation is required to determine that the examinee does meet the standards, or to resolve doubtful findings, the reviewing authority shall direct the commanding officer or recruiting station to obtain the evaluation and shall provide such assistance as may be required.

(7) The reviewing authority shall endorse the original of the DD-2808 indicating whether the examinee does or does not meet the physical standards required. If the examinee does not meet the physical standards, the endorsement shall indicate the particular disqualifying defect or defects. Endorsements can be in the format contained in FIGURE 3-B-1 or use of blocks #74.a, #77 and signature in block #84.a, of the DD-2808.

(8) The endorsed original of the physical examination shall be forwarded to the individual's unit for filing in the member's health record.

(9) Input of physical examination status of personnel into the PMIS system is required. Reviewing Authorities shall collect and submit data regarding all physical examinations/screenings (per paragraph 3-A-7, except subparagraph 3-A-7.f) they review to the appropriate Servicing Personnel Office (SPO) on a monthly basis. Data to be collected for transmittal to the SPO is as follows:

(a) Member's name.

(b) Member's rank/rate.

(c) Member's SSAN.

(d) Member's unit OPFAC.

(e) Date of physical examination.

(f) Purpose of examination.

(g) Date acted upon by Reviewing Authority.

(h) Status code for physical examination. Status codes are as follows:

1 Code A- member qualified for periodic (biennial, quinquennial, etc.) physical examination.

2 Code D- member qualified for RELAD/discharge/retirement.

3 Code O- member qualified for overseas duty.

4 Code N- member not physically qualified.

d. Disposition of Reports.

(1) When the individual meets the appropriate physical standards, forward the physical examination as indicated in FIGURE 3-B-2.

(2) When the individual does not meet the appropriate physical standards and a waiver has been recommended, endorse the physical examination and forward it in accordance with section 3-A-8.

(3) When the individual is not physically qualified for the purpose of the examination and a waiver is not recommended, the reviewing authority will arrange for the examinee to be evaluated by a medical board and provide administrative action as outlined in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.

a. Medical Defects. Before an individual departs for an overseas assignment for 60 consecutive days or greater , to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from its home port for 60 consecutive days or greater, all remediable medical defects, such as hernias, pilonidal cysts or sinuses requiring surgery, etc., must be corrected. Those defects that are not easily corrected will be referred to Commander CGPC for consideration. These procedures also apply to personnel presently assigned to such vessels. In these cases all necessary corrective measures or waivers will be accomplished prior to the sailing date.

b. Dental Defects. All essential dental treatment shall be completed prior to overseas transfer or sea duty deployment except those described in 4-C-3.c. (3)(b). Essential dental treatment constitutes those procedures necessary to prevent disease and disabilities of the jaw, teeth, and related structures. This includes extractions, simple and compound restorations, and treatment for acute oral pathological conditions such as Vincent's stomatitis, acute gingivitis, and similar conditions that could endanger the health of the individual during a tour of duty. Missing teeth are to be replaced when occluding tooth surfaces are so depleted that the individual cannot properly masticate food. Elective dental procedures (those that may be deferred for up to twelve months without jeopardizing the patient's health, i.e., Class II patient need not be completed prior to overseas transfer providing both of the following conditions exist:

(1) Completion of such elective procedures prior to transfer would delay the planned transfer.

(2) Adequate Service dental facilities are available at the overseas base.

c. Vision Defects. A refraction shall be performed on all personnel whose visual acuity is less than 20/20 in either eye (near or distant) or whose present eyewear prescription does not correct their vision to 20/20. All personnel requiring glasses for correction shall have a minimum of two pair prior to overseas transfer or sea duty deployment. All personnel requiring corrective lenses shall wear them for the performance of duty.

5. Objection to Assumption of Fitness for Duty at Separation.

a. Member's responsibilities. Any member undergoing separation from the service that disagrees with the assumption of fitness for duty and claims to have a physical disability as defined in section 2-A-38 of the Physical Disability Evaluation System, COMDTINST M1850.2 (series), shall submit written objections, within 10 days of signing the Chronological Record of Service (CG-4057), to Commander CGPC. Such objections based solely on items of medical history or physical findings will be resolved at the local level. The member is responsible for submitting copies of the following information along with the written objections:

(1) Report of Medical Examination (DD-2808).

(2) Report of Medical History (DD-2807-1).

(3) Signed copy of the Chronological Record of Service (CG-4057).

(4) Appropriate consultations and reports.

(5) "Other pertinent documentation."

(6) The rebuttal is a member's responsibility and command endorsement is not required.

b. Rebuttal package. The package shall contain thorough documentation of the physical examination findings, particularly in those areas relating to the individual's objections. Consultations shall be obtained to thoroughly evaluate all problems or objections the examinee indicates. Consultations obtained at the examinee's own expense from a civilian source shall also be included with the report.

c. Commander (CGPC) responsibility. Commander (CGPC) will evaluate each case and, based upon the information submitted, take one of the following actions:

(1) Find separation appropriate, in which case the individual will be so notified and the normal separation process completed.

(2) Find separation inappropriate, in which case the entire record will be returned and appropriate action recommended.

(3) Request additional documentation before making a determination.

6. Separation Not Appropriate by Reason of Physical Disability.
When a member has an impairment (in accordance with section 3-F of this Manual) an Initial Medical Board shall be convened only if the conditions listed in paragraph 2-C-2.(b), Physical Disability Evaluation System, COMDTINST M1850.2 (series), are also met. Otherwise the member is suitable for separation.

7. Procedures for Physical Defects Found Prior to Separation.

a. Policy. No person shall be separated from the Service with any disease in a communicable state until either rendered noninfectious, or until suitable provisions have been made for necessary treatment after separation.

b. Remediable Non-Disqualifying Defects. Remediable physical defects that would not normally prevent the individual from performing the duties of grade or rate shall be corrected only if there is reasonable assurance of complete recovery and sufficient time remaining prior to separation.

FIGURE 3-B-1

DATE REVIEWERS UNIT _____

Does/does not meet the physical standards for (title or category or purpose of examination), as prescribed in (appropriate section of Medical Manual, COMDTINST M6000.1 (series)).

Disqualifying Defects:

Signature and Title of Reviewer

FIGURE 3-B-2

Physical Exam Purpose	Note:	Original to:	Reviewing Authority:
Aviator Candidate	(1,2)	CGPC-opm	CGPC-cm
Aircrew Candidate	(1,2)	CGPC-epm	CGPC-cm
Diving Candidate	(1,2)	CGPC	CGPC-cm
Physician Assistant Candidate	(1,5)	CGPC-opm	CGPC-cm
Flight Surgeon (FS)		MLC (k)	MLC (k)
FS Candidate	(1)(3)	CG-1121	CG-1121
Aviator	(1)	MLC (k)	MLC (k)
Aircrew	(1)	MLC (k)	MLC (k)
Diving	(1)	MLC (k)	MLC (k)
Flight Officer	(1)	MLC (k)	MLC (k)
Annual	(1)	MLC (k)	MLC (k)
LSO	(1)	or	or
Quinquennial	(1)	Clinic	Clinic
Overseas/Sea Duty	(1)	Administrator	Administrator
Retention	(1)	"	"
Retirement	(1,4)	"	"
Involuntary			
Separation	(1,4)	"	"
RELAD	(1,4)	"	"
Precom /Appts	(1)	"	"
Direct Commission	(1,5)	CGRC	CGRC
OCS	(1,5)	CGRC	CGRC
Enlistment	(2)	CGRC	CGRC

NOTES:
CGRC address: CG Recruiting Command, 4200 Wilson Blvd., Suite 450, Arlington, VA. 22203-1804

(1) The reviewing authority shall review, endorse and return the original to the member's unit for filing in the member's or applicant's health record.

(2) Forward the unendorsed physical to the appropriate Headquarters Office (as listed above) with the application/training request package. That Office will forward the physical to Coast Guard Personnel Command for review.

(3) Forward the original and one copy to Commandant (CG-1121) for review

(4) Ensure that a completed CG-4057 accompanies the completed DD-2808 and DD-2807-1.

(5) Reviewing authority for current USCG or USCGR members only. For all others, Note (2) above applies. Forward a copy of the first/front page of the DD-2808 with endorsement to the appropriate Headquarters office with the application package.

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CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section C. Medical Examination Techniques and Lab Testing Standards.

1. Scope. 1
2. Speech Impediment. 1
3. Head, Face, Neck, and Scalp (Item 17 of DD-2808). 1
4. Nose, Sinuses, Mouth, and Throat (Item 19, 20 of DD-2808). 2
5. Ears (General) and Drums (Item 21, 22 of DD-2808). 2
6. Eyes (General), Ophthalmoscopic, and Pupils (Item 23, 24, 25 of DD-2808). 3
7. Ocular Motility (Item 26 of DD-2808). 5
8. Heart and Vascular System (Item 27 of DD-2808). 5
9. Lungs and Chest (Item 28 of DD-2808). 9
10. Anus and Rectum (Item 30 of DD-2808). 11
11. Abdomen and Viscera (Item 31 of DD-2808). 11
12. Genitourinary System (Item 32 of DD-2808). 11
13. Extremities (Item 33, 34, 35 of DD-2808). 12
14. Spine and Other Musculoskeletal (Item 36 of DD-2808). 14
15. Identifying Body Marks, Scars, and Tattoos (Item 37 of DD-2808). 15
16. Neurologic (Item 39 of DD-2808). 16
17. Psychiatric (Item 40 of DD-2808). 17
18. Endocrine System. 19
19. Dental (Item 43 of DD-2808). 19
20. Laboratory Findings. 19
21. Height, Weight, and Body Build. 28
22. Distant Visual Acuity and Other Eye Tests. 28
23. Audiometer. 32
24. Psychological and Psychomotor. 32

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section C. Medical Examination Techniques and Lab Testing Standards.

1. Scope.
   This section is a medical examination technique guide applicable for all physical examinations.

2. Speech Impediment.
   Administer the "Reading Aloud Test" (RAT) as listed.

   a. Procedure. Have the examinee stand erect, face you across the room and read aloud, as if confronting a class of students.

   b. Pauses. If the individual pauses, even momentarily, on any phrase or word, immediately and sharply say, "What's that?", and require the examinee to start over again with the first sentence of the test.

   c. Second trial. The person who truly stammers usually will halt again at the same word phonetic combination often revealing serious stammering. Examinees who fail to read the test without stammering after three attempts will be disqualified.

   d. Reading aloud test. "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in the winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana Oil.' Grandfather likes to be modern in his language."

3. Head, Face, Neck, and Scalp (Item 17 of DD-2808).

   a. Head and Face. Carefully inspect and palpate the head and face for evidence of injury, deformity, or tumor growth. Record all swollen glands, deformities, or imperfections noted. Inquire into the cause of all scars and deformities. If a defect is detected such as moderate or severe acne, cysts, or scarring, make a statement as to whether this defect will interfere with wearing military clothing and equipment.

   b. Neck. Carefully inspect and palpate for glandular enlargement, deformity, crepitus, limitations of motion, and asymmetry; palpate the parotid and submaxillary regions, the larynx for mobility and position, the thyroid for size and nodules, and the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected describe them in detail with a clinical opinion of their etiology.

   c. Scalp. Examine for deformities such as depressions and exostosis.

4. Nose, Sinuses, Mouth, and Throat (Item 19, 20 of DD-2808).

   a. Nasal or sinus complaints. If there are no nasal or sinus complaints, simple anterior rhinoscopy will suffice, provided that in this examination, the nasal mucous membrane, the septum, and the turbinates appear normal. If the examinee has complaints, a more detailed examination is required. Most commonly, these complaints are external nasal deformity, nasal obstruction, partial or complete on one or both sides; nasal discharge; postnasal discharge; sneezing; nasal bleeding; facial pain; and headaches.

   b. Abnormalities in the mucous membrane. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretions may provide valuable information regarding the type and location of the sinus infection. Evaluate tenderness over the sinuses by transillumination or x-ray. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine if there is any tenderness to percussion beyond the boundaries (as determined by x-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves that may indicate the presence of neoplasm. Note any external swelling of the forehead, orbit, cheek, and alveolar ridge.

   c. Mouth and tongue. Many systemic diseases manifest themselves as lesions of the mouth and tongue; namely leukemia, syphilis, agranulocytosis, pemphigus, erythema multiform, and dermatitis medicamentosa. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of the teeth. Pay particular attention to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.

   d. Throat. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence and position of residual or recurrent lymphoid tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate, ulceration, or evidence of neoplasm on the posterior pharyngeal crypts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall or in the lateral angle of the pharynx and note if there is evidence of swelling that displaces the tonsils, indicating possible neoplasm or abscess. Perform direct or indirect laryngoscopy if the individual complains of hoarseness.

5. Ears (General) and Drums (Item 21, 22 of DD-2808).
   Inspect the auricle, the external canal, and the tympanic membrane using a speculum and good light. Abnormalities (congenital or acquired) in size, shape, or form of the auricles, canals, or tympanic membranes must be noted, evaluated, and recorded.

a. Auricle. Note deformities, lacerations, ulcerations, and skin disease.

b. External canal. Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal, note whether it is normal cerumen, foreign body, or exudate. Determine the source of any exudate in the canal. If this exudate has its origins in the middle ear, record whether it is serous, purulent, sanguinous, or mucoid; whether it is foul smelling; and, whether it is profuse or scanty.

c. Tympanic membrane. Remove all exudate and debris from the canal and tympanic membrane before examination. Unless the canal is of abnormal shape, visualize the entire tympanic membrane and note and record the following points.

(1) List any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.

(2) Note whether the tympanum is air containing.

(3) List any perforations, giving size and position, indicating whether they are marginal or central, which quadrant is involved, and whether it is the flaccid or the tense portion of the membrane that is included.

(4) Attempt, if the tympanic membrane is perforated, to determine the state of the middle ear contents, particularly concerning hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. Do the pathological changes indicate an acute or chronic process? This clinical objective examination should permit evaluating the infectious process in the middle ear and making a reasonably accurate statement regarding the chronicity of the infection; the extent and type of involvement of the mastoid; the prognosis regarding hearing; and, the type of treatment (medical or surgical) that is required.

(5) Note, for all aviation and dive physical examinations, whether the examinee can properly auto insufflate tympanic membrane.

6. Eyes (General), Ophthalmoscopic, and Pupils (Item 23, 24, 25 of DD-2808). External and ophthalmoscopic examinations of the eyes are required on all examinations. Contact lenses shall not be worn during any part of the eye examination, including visual acuity testing. It is essential that such lenses not be worn for 72 hours preceding examination. The strength of the contact that an examinee may possess shall not be accepted as the refraction nor will it be entered as such in Item 60, DD-2808. The general examination shall include the following specific points and checks:

a. General.

(1) Bony abnormality or facial asymmetry.

(2) Position of the eyes.

(3) Exophthalmus.

(4) Manifest deviation of the visual axis.

(5) Epiphora or discharge.

(6) Position of puncta or discharge when pressure exerted over lacrimal sac.

b. Lids.

(1) Ptosis.

(2) Position of lashes, eversion or inversion.

(3) Inflammation of margins.

(4) Cysts or tumors.

c. Conjunctiva. Examine the palpebral and bulbar conjunctiva by:

(1) eversion of upper lid;

(2) depression and eversion of lower lid; and

(3) manually separating both lids.

d. Pupils.

(1) Size.

(2) Shape.

(3) Equality.

(4) Direct, consensual, and accommodative reactions.

e. Directly and obliquely examine the.

(1) Cornea. For clarity, discrete opacities, superficial or deep scarring, pannus, vascularization, pterygium, and the integrity of the epithelium.

(2) Anterior Chamber. For depth, alteration of normal character of the aqueous humor, and retained foreign bodies.

(3) Iris. For abnormalities and pathologic changes.

(4) Crystalline Lens. For clouding or opacities.

f. Ophthalmoscopic.

(1) Media. Examine with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Localize and describe any opacity appearing in the red reflex or direct examination or on eye movement.

(2) Fundus. Examine with the strongest plus or weakest minus lens necessary to bring optic nerve into sharp focus. Pay particular attention

to the color, surface, and margin of the optic nerve, also record any abnormality of the pigmentation or vasculature of the retina.

(3) Macula. Examine for any change.

7. Ocular Motility (Item 26 of DD-2808).

a. Ascertain the motility of the eyeballs by testing for binocular eye movement (ductions and versions) in the cardinal positions of gaze. If any abnormalities are suspected, verify with the cover/uncover test.

b. Observe if the eyes move together and whether there is loss of motion in any direction (paralysis or paresis), or absence of muscle balance, whether latent (heterophoria) or manifest (strabismus / heterotropia). Have the examinee look at a test object and alternately cover and uncover one eye leaving the other uncovered and observe the movement, if any, in each eye. In heterotropia movement occurs only in the eye that is covered and uncovered; on being covered, it deviates and on being uncovered, it swings back into place to take up fixation with the other eye that has remained uncovered.

8. Heart and Vascular System (Item 27 of DD-2808).

a. General. In direct light, have the examinee stand at ease, with arms relaxed and hanging by sides. Do not permit the examinee to move from side to side or twist to assist in the examination, as these maneuvers may distort landmarks: and increase muscular resistance of the chest wall. Examine the heart by the following methods: inspection, palpation, auscultation, and when considered necessary, by mensuration.

b. Inspection. Begin from above and go downward, with special reference to the following:

(1) Any malformation that might change the normal relations of the heart.

(2) Pulsations in the suprasternal notch and in the second interspaces to the right and left of the sternum.

(3) Character of the precordial impulse.

(4) Epigastric pulsations.

c. Palpation. First palpate to detect thrills over the carotids, thyroid glands, suprasternal notch, apex of the heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the examinee stoop and throw the shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and

fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compression of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered.

d. Auscultation. In auscultating the heart, bear in mind the four points where the normal heart sounds are heard with maximum intensity:

(1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.

(2) Tricuspid area, junction of the fifth right rib with the sternum. Here the first sound is distinct.

(3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.

(4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard.

e. Blood Pressure.

(1) Only the sitting blood pressure is required.

(2) Other positions required only if sitting blood pressure exceeds 140/90.

(3) Take the sitting blood pressure with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure.

(4) Personnel recording blood pressure must be familiar with situations that result in spurious elevation. A medical officer shall repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used.

(5) Artificially high blood pressure may be observed as follows.

(a) If the compressive cuff is too loosely applied.

(b) If the compressive cuff is too small for the arm size. Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual, this may require an "oversize" cuff.

(c) If the blood pressure is repetitively taken before complete cuff deflation occurs. Trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure.

(6) At least five minutes of rest should precede the blood pressure recording. Due regard must be given to physiologic effects such as

excitement, recent exercise, smoking or caffeine within the preceding thirty minutes, and illness.

(7) No examinee shall be rejected based on the results of a single recording. If **2** out of the 3 positions exceed 140/90, the disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and averaged. The first determination shall be recorded in Item 58 and the repeat determinations in Item 73 of DD-2808.

(8) While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

f. Blood Pressure Determination.

(1) Use procedures recommended by the American Heart Association.

(2) Take the systolic reading as either the palpatory or auscultatory reading depending on which is higher. In most normal subjects, the auscultatory reading is slightly higher.

(3) Record diastolic pressure as the level at which the cardiac tones disappear by auscultation. In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. In these instances, if the technique is correct and there is no underlying valvular defect, a diastolic reading will be taken at the change in tone.

(4) Note variations of blood pressures with the position change if there is a history of syncope or symptoms to suggest postural hypertension.

(5) Obtain blood pressure in the legs when simultaneous palpation of the pulses in upper and lower extremities reveals a discrepancy in pulse volume.

g. Pulse Rate.

(1) Determine the pulse rate immediately after the blood pressure. Only the sitting position is required.

(2) In the presence of a relevant history, arrhythmia, or a pulse of less than 50 or over 100, an electrocardiogram will be obtained.

h. Interpretation of Abnormal Signs and Symptoms. The excitement of the examination may produce violent and rapid heart action often associated with a transient systolic murmur. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture. Try to recognize the excitable individuals and take measures to eliminate psychic influences from the test.

i. Hypertrophy-Dilitation. An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of cases, should be sought. A horizontal position of the heart must be distinguished from left ventricular enlargement. EKG, ultrasound studies, fluoroscopy, and chest x-ray may be indicated for diagnosis.

j. Physiological Murmurs. Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The discovery of any murmur demands diligent search for other evidence of heart disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection.

(1) Characteristics. The following characteristics of physiological murmurs will help differentiate them from organic murmurs.

(a) They are always systolic in time.

(b) They are usually heard over a small area, the most common place being over the pulmonic valve and mitral valve.

(c) They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.

(d) They are transient in character, frequently disappearing after exercise.

(e) They are usually short, rarely occupying all of the systole, and are soft and of blowing quality.

(f) There is no evidence of heart disease or cardiac enlargement.

(2) Most Common Types. The most common types of physiological murmurs are:

(a) Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly common in individuals with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.

(b) Cardio-respiratory murmurs caused by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration and at times disappear completely when the breath is held.

(c) Prolongations of the apical first sound that are often mistaken for murmurs.

(3) Diagnosis. An EKG, chest x-ray, and echocardiogram are usually indicated to firmly establish the true cause of a murmur and should be done if there is any question of abnormality.

k. Electrocardiograms. Use standard positions for precordial leads when completing electrocardiograms.

9. Lungs and Chest (Item 28 of DD-2808).

a. History and x-ray studies. A thorough examination includes a complete history (DD-2807-1) careful physical examination, and necessary x-ray and laboratory studies. In screening examinations, the history and x-ray studies are the most immediately revealing examination techniques.

b. Exam. Remember that several disqualifying diseases such as tuberculosis and sarcoidosis may not be detectable by physical examination and the absence of abnormal physical signs does not rule out disqualifying pulmonary disease. Such diseases, as well as others (neopasms and fungus infections), may be detected only by chest x-ray.

(1) Conduct the physical examination in a thorough, systematic fashion. Take particular care to detect pectus abnormalities, kyphosis, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis. Any of these findings require additional intensive inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated. The physical examination shall include the following.

(a) Inspection. The examinee should be seated in a comfortable, relaxed position with the direct light falling upon the chest. Careful comparison of the findings elicited over symmetrical areas on the two sides of the chest gives the most accurate information regarding condition of the underlying structures. Observe for asymmetry of the thoracic cage, abnormal pulsation, atrophy of the shoulder girdle or pectoral muscles, limited or lagging expansion on forced inspiration. The large, rounded relatively immobile "barrel" chest suggests pulmonary emphysema.

(b) Palpation.

1 Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, suprasternal notch, and thrills associated with respiration or the cardiac cycle.

2 In addition to the breast examinations with periodic physical examinations, an annual clinical breast examination is required for all active duty females aged 40 and above. Monthly self-examination is recommended for all adult female patients.

(c) Auscultation. Instruct the examinee to breathe freely but deeply through the mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales, or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct the examinee to exhale during this process. Note any rales, paying particular attention to moist rales that "break" with the cough or fine rales heard at the beginning of inspiration immediately after cough.

(2) Do not hesitate to expand the history if abnormalities are detected during examination or in repeating the examination if chest film abnormalities are detected.

c. Asthma bronchiectasis, and tuberculosis. There are three conditions that are most often inadequately evaluated and result in unnecessary and avoidable expense and time loss. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis.

(1) Asthma. In evaluating asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluee's physician, this shall result in rejection even though physical examination is normal. Ask about the use of prescription or over-the-counter bronchodilators.

(2) Bronchiectasis. Individuals who report a history of frequent respiratory infections accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported by a finding of post-tussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings or chest film abnormalities, seek confirmatory opinion from the examinee's personal physician or refer the examinee to the appropriate chest consultant for evaluation and recommendations.

(3) Tuberculosis (TB).

(a) Active TB is often asymptomatic and not accompanied by abnormal physical findings unless the disease is advanced. If only

such manifestations as hemoptysis or draining sinuses are looked for, most cases of TB will be missed.

(b) The most sensitive tool for detecting early TB is the Tuberculin Skin Test (TST).

(c) If positive, evaluate the chest film for any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe. Many tuberculosis lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical lordotic view must be obtained for clarification.

(d) It is neither practical nor possible, in most instances, to determine whether or not a TB lesion is inactive on the basis of a single radiologic examination. Therefore, refer any examinee suspected of TB to a chest consultant or to an appropriate public health clinic for evaluation.

(e) An initial TST is mandatory and shall be made a part of the physical examination for all personnel entering on active duty for a period of 30 days or more.

(f) See Chapter 7 D for complete details of the Tuberculosis Control Program.

10. Anus and Rectum (Item 30 of DD-2808).
All examinations shall include a visual inspection of the anus. Perform a digital rectal examination and test for fecal occult blood on all personnel beginning at age 40 and at any time history or physical exam findings indicate. When anorectal disease is suspected a complete exam should be performed which may include proctosigmoidoscopy as indicated.

11. Abdomen and Viscera (Item 31 of DD-2808).

a. Examination. Examine the abdomen with the examinee supine, as well as standing to detect hernias.

b. Methods. Use appropriate clinical laboratory, radiologic, and endoscopic examinations to confirm a diagnosis.

12. Genitourinary System (Item 32 of DD-2808).

a. General. All physical examinations shall search for evidence of STD or malformation.

b. Instructions for examination according to sex.

(1) Females. The examination shall include:

(a) inspection of the external genitalia;

(b) either a vaginal or rectal bimanual palpation of the pelvic organs; and

(c) Papanicolaou (PAP) testing and visualization of the cervix and vaginal canal by speculum in accordance with 20.f. of this section.

(2) Males. The glans penis and corona will be exposed. The testes and scrotal contents will be palpated and the inguinal lymph nodes will be examined for abnormalities. Palpate the inguinal canals while having the patient perform a valsalva.

13. Extremities (Item 33, 34, 35 of DD-2808).
Carefully examine the extremities for deformities, old fractures and dislocations, amputations, partially flexed or ankylosed joints, impaired functions of any degree, varicose veins, and edema. In general the examination shall include:

a. Elbow. With the examinee holding the upper arms against the body with the forearms extended and fully supinated, observe for the presence of normal carrying angle. Have the examinee flex the elbows to a right angle and keeping the elbows against the body, note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator, and pronator muscles by having the examinee contract these muscles against manual resistance. If indicated, x-rays should include antero-posterior and lateral views.

b. Foot.

(1) Examine the feet for conditions such as flatfoot, corns, ingrown nails, bunions, deformed or missing toes, hyperhidrosis, color changes, and clubfoot.

(2) When any degree of flatfoot is found, test the strength of the feet by requiring the examinee to hop on the toes of each foot for a sufficient time and by requiring the examinee to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, consider the extent, impairment of function, appearance in uniform, and presence or absence of symptoms. Remember, it is usually not the flatfoot condition itself that causes symptoms but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. Report angles of excursion or limitation; comparative measurements; use of orthotics or other supports; and x-ray results if indicated.

c. Hip.

(1) With the examinee standing, observe the symmetry of the buttocks, the intergluteal clefts, and infragluteal fold. Palpate the iliac crest and greater trochanters for symmetry.

(2) If abnormalities are suspected, have the examinee stand first on one foot and then the other, flexing the nonweight bearing hip and knee and observing for ability to balance as well as for instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (non-weight bearing) hip. Such a positive Trendelenburg sign necessitates x-ray evaluation.

(3) While supine have the examinee flex the hip, abduct and adduct the hip and rotate the leg inward. Observe for hesitancy in performing these motions, incomplete range of motion, or facial evidence of pain on motion. Test muscle strength in each position.

(4) With examinee prone, test for ability to extend each leg with knee extended and test for power in each hip in extension.

(5) If abnormalities are detected requiring x-rays, obtain an antero-posterior and a lateral view of each hip for comparison.

d. Knee.

(1) With trousers (skirt/dress), shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature.

(2) Have examinee squat, sitting on heels, and observe for hesitancy, weakness, and presence or absence of pain or crepitus.

(3) With examinee sitting, test for ability to fully extend the knee and test power in extension by applying pressure to the lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness. With examinee still sitting on the table edge, sit and grasp the heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur ("Drawer Sign").

(4) With the examinee supine, mark on each leg a distance of 1 inch above the patella and 6 inches above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.

(5) If there is a history of knee injury assess muscular strength, ligamentous stability, and range of motion. Also look for evidence of inflammatory or degenerative processes.

(6) In the presence of any history of "locking," recurrent effusion, or instability, or when atrophy measured is more than 3/8 inch or when limitation of motion or ligamentous instability is detected, obtain x-rays including an antero-posterior, lateral, and intercondylar view.

(7) An orthopedic evaluation is required on all recruit physicals if there is evidence of any abnormality.

e. Shoulder.

(1) With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry, abnormal configuration, or muscle atrophy.

(2) From the back, with the examinee standing, observe the scapulohumeral rhythm as the arms are elevated from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect.

(3) Test muscle power of abductors, flexors, and extensors of the shoulder, as well as power in internal and external rotation. Have the examinee attempt to lift a heavy weight with arms at the side to establish integrity of the acromioclavicular joint.

f. Wrist and Hand.

(1) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare muscle strength and range of motion, flexion, extension, radial, and ulnar deviation.

(2) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor, indicating possible underlying organic disease.

(3) Have the examinee flex and extend the fingers making sure interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palm.

(4) With the hands pronated, observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves.

(5) With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers against the resistance of the examinee.

(6) If indicated, obtain antero-posterior and lateral x-rays of the wrist, as well as antero-posterior and oblique views of the hand.

14. Spine and Other Musculoskeletal (Item 36 of DD-2808).

Carefully examine for evidence of intervertebral disc syndrome, myositis, and traumatic lesions of the low back (lumbosacral and sacroiliac strains). If there is any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of curvature, obtain orthopedic consultation and x-rays.

a. Examination. With the examinee stripped and standing, note the general configuration of the back, the symmetry of the shoulders, iliac crests and hips, and any abnormal curvature. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating the iliac crests. Have examinee flex and extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the examinee twist to each side as far as possible.

b. Reflexes. With the examinee sitting on the examining table, test patellar and ankle reflexes and fully extend the knee, note complaints of pain (this corresponds to a 90 degree straight leg raising test in supine position).

c. Strength. With the examinee supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on Sl. Flex hip fully on abdomen and knee flexed and determine presence or absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality.

d. Extension. While prone, have the examinee arch the back and test strength in extension by noting the degree to which this is possible.

e. Abnormal findings. If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back x-rays, including pelvis, should be obtained. These should include antero-posterior, lateral, and oblique views.

15. Identifying Body Marks, Scars, and Tattoos (Item 37 of DD-2808).

a. Examination. Carefully inspect the examinee's body, front and rear, on each side of the median line separately, commencing with the scalp and ending at the foot. Record under the "Notes" section on the face of the DD-2808 all body marks, tattoos, and scars useful for identification purposes. Also state if no marks or scars are found.

b. Description of Body Marks, Scars, and Tattoos.

(1) Indicate the size, location, and character of scars, moles, warts, birthmarks, etc.

(2) When recording the location of a tattoo, include narrative description of the design. Tattoo transcriptions of words or initials shall be recorded in capital letters. Describe the size of a tattoo regarding its general dimensions only. A statement relative to color or pigment is not required.

(3) Note amputations and losses of parts of fingers and toes showing the particular digit injured and the extent or level of absence.

c. Abbreviations for Body Marks, Scars, and Tattoos.

(1) The following are authorized abbreviations for the descriptions or conditions indicated:

Amp.-amputation	m. -mole	w. -wart
f. -flat	p. -pitted	VSULA-
fl. fleshy	r. -raised	vaccination scar
s. -scar smooth	l. -linear	upper left arm
v. -vaccination	o. -operative	h. -hairy

(2) Combinations of the above abbreviations are permissible: p.s. 1/2d. - pitted scar 1/2 inch diameter; f.p.s. lxl/2 - flat pitted scar l inch long and 1/2 inch wide; r.h.m. 1/4d. - raised hairy mole 1/4 inch diameter.

(3) Do not use abbreviations when describing tattoos since they are likely to be mistaken as signifying tattooed letters.

16. Neurologic (Item 39 of DD-2808).
Conduct a careful neurological examination being attentive to the following:

a. Gait. The individual shall: walk a straight line at a brisk pace with eyes open, stop, and turn around; (Look for spastic, ataxic, incoordination, or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movement; undue difference in performance with the eyes open and closed.)

(1) stand erect, feet together, arms extended in front; (Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements.)

(2) touch the nose with the right and then the left index finger, with the eyes closed. (Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness.)

b. Pupils. Look for irregularity, inequality, diminished or absent contraction to light or lack of accommodation.

c. Deep Sense (Romberg). Negative, slightly positive, or pronouncedly positive.

d. Deep Reflexes: Patellar, Biceps, etc. Record as absent (o), diminished (-), normal (+), hyperactive (++), and exaggerated (+++).

e. Sensory Disturbances. Examine sensation by lightly pricking each side of the forehead, bridge of the nose, chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists with a tuning fork. With eyes closed, the examinee shall move each heel down the other leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and plantar reflexes. When indicated, perform appropriate laboratory tests and x-ray examinations.

f. Motor Disturbances. Evidence of muscle weakness, paresis, or any other abnormality.

g. Muscular Development. Evidence of atrophy, compensatory hypertrophies, or any other abnormality.

h. Tremors. State whether fine or coarse, intentional or resting, and name parts affected.

i. Tics. Specify parts affected. State whether they are permanent or due to fatigue or nervous tension.

j. Cranial Nerves. Examine carefully for evidence of impaired function or paresis. Remember that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to the cranium.

k. Psychomotor Tension. Test the ability to relax voluntarily by having the examinee rest the forearm upon your palm then test the forearm tendon reflexes with a percussion hammer.

l. Peripheral Circulation. Examine for flushing, mottling, and cyanosis of face, trunk, and extremities. Question as to the presence of localized sweating (armpits and palms) and cold extremities. Carefully study any abnormalities disclosed on the neurological examination and express an opinion as to their cause and significance and whether they are sufficient cause for rejection.

17. Psychiatric (Item 40 of DD-2808).

a. Personality Evaluation. In order to evaluate the adequacy of the examinee's personality for adjustment to the conditions of military service:

(1) Estimate the examinee's capacity coupled with real respect for personality and due consideration for feelings.

(2) Conduct the examination in private to encourage open and honest answers.

(3) Attempt to discover any difficulties that the examinee may have had with interpersonal relationships at work or during leisure activities.

b. Diagnosis of Psychiatric Disorders. The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history, supplemented by information obtained from other sources, such as family, physicians, schools, churches, hospitals, social service or welfare agencies, and courts.

c. Telltale Signs of Psychiatric Disorders. Be watchful for any of the following: inability to understand and execute commands promptly and adequately; lack of normal response; abnormal laughter; instability; seclusiveness; depression; shyness; suspicion; over boisterousness; timidity; personal uncleanliness; stupidity; dullness; resentfulness to discipline; a history of enuresis persisting into late childhood or adolescence; significant nail biting; sleeplessness or night terrors; lack of initiative and ambition; sleep walking; suicidal tendencies, whether bona fide or feigned. Abnormal autonomic nervous system responses (giddiness, fainting, blushing, excessive sweating, shivering or goose flesh, excessive pallor, or cyanosis of the extremities) are also occasionally significant. Note also the lack of responses as might reasonably be expected under the circumstances.

d. Procedures for Psychiatric Examination.

(1) Mental and personality difficulties are most clearly revealed when the examinee feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual's feelings and necessary privacy. Matters of diagnostic significance are often concealed when the examinee feels the examination is being conducted in an impersonal manner or without due concern for privacy.

(2) Pay close attention to the content and implication of everything said and to any other clues, in a “matter-of-fact manner”. Follow-up whatever is not self evident or commonplace.

e. Aviation only.
Although this phase of the examination is routinely performed only on candidates for flight training, it may be made part of any aviation physical examination. The objective is to determine the examinee's basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Report any significant personality change in an experienced aviator. Following the completion of the general examination:

(1) Study carefully the examinee's family history.

(2) Determine the family's attitude towards flying and the examinee's reaction to the stresses of life in general and emotional response and control.

18. Endocrine System.
Evaluate endocrine abnormalities during the general clinical examination. Palpate the thyroid for abnormality and observe the individual for signs of hyperthyroidism or hypothyroidism. Observe general habitus for evidence of endocrine dysfunction.

19. Dental (Item 43 of DD-2808).

a. Who May Conduct Dental Examinations.

(1) For Academy, OCS, and direct commission applicants: a Uniformed Services dental officer.

(3) For all aviation, diving, and overseas/sea duty physical examinations: a Uniformed Services dental officer or a contract dentist.

(4) For all others: a Uniformed Services dental officer, a contract dentist, or a medical examiner if a dentist is unavailable.

b. Procedures for Conducting Dental Examinations.

(1) Applicants for Original Entry. When ever practical, applicants for original entry into the Service shall be given a Type II dental examination. Otherwise, the dental officer shall determine the type of examination that is appropriate for each examinee.

(2) Active Duty Personnel. Members on active duty, who are assigned to locations where Coast Guard, USMTF, or civilian contract dental clinics are available, shall be required to have an annual Type II dental examination.

(3) Reserve Personnel.

(a) Type II dental examination is required for Quinquennial Physical Examinations.

(b) Type II dental examination is required annually for all SELRES.

c. Dental Restorations and Prostheses. The minimum number of serviceable teeth prescribed for entry in various programs of the Service is predicated on having retentive units available to provide for the reception of fixed bridges or partial dentures that may be necessary for satisfactory masticatory or phonetic function. Prostheses already present should be well-designed, functional, and in good condition.

20. Laboratory Findings.

a. Required Tests. Personnel undergoing physical examinations are required to have the following tests performed, except where obtaining them is not possible or expeditious, or incurring charges for them is not authorized. In such cases, these tests shall be obtained at the first duty station where

facilities are available. The normal values listed below are for guidance. Abnormal laboratory values alone are not disqualifying; however, the causative underlying condition may be. Minimal deviations may not require further evaluation and this should be noted as NCD (not considered disqualifying) in item 74 by the examiner. Normal variants should be noted as such.

(1) All Labs must be performed within 180 days of the physical exam or they will be considered out of date.

b. Hematology/Serology.

(1) Hematology. Perform a hematocrit (HCT) or hemoglobin (HGB) on all examinees. Perform other hematological studies only as indicated.

(2) Red Blood Cell Measurements.

(3) Hemoglobin - Males 13-18 gm/100ml

(4) Females 11.7-16 gm/100ml

(5) Hematocrit - Males 40-54%, Females 35-47%

If any of these parameters are abnormal, an RBC and indices shall be done. Normal indices are:

RBC-	Males	4.3 to 6.2 million
	Females	3.8 to 5.4 million
	MCV-	82-92 cubic microns
	MCH-	27-32 picograms
	MCHC -	30-36%

(6) Serological Test for Syphilis (RPR/STS).

(a) Required for all aviation and diving candidate physicals.

(b) Unless there is a documented history of adequately treated syphilis, all examinees testing positive shall have repeat testing three or more days later. Ensure that at the time of obtaining serum the examinee neither has, nor is convalescing from, any acute infectious disease or recent fever. If available at no charge, the facilities of local or state health departments may be used for performing serological tests. Examinees with a history of treated syphilis should have declining or low titer positive reaction.

(c) If the second test is positive then obtain an FTA/ABS. If the FTA/ABS is positive, further evaluation may be required to determine the appropriate therapy.

(d) Several conditions that are known to give false RPR/STS are infectious mononucleosis, malaria, yaws, pinta, chicken pox, infectious hepatitis, immunization, and atypical pneumonia. The cause of a false positive serological test for syphilis should be

explored since many diseases giving a false positive are also disqualifying.

(e) New diagnosis of syphilis requires disease reporting per local governmental requirements and IAW Chapter 7-B-3 of this Manual.

(f) Diagnosis of syphilis requires testing for other sexually transmitted diseases (gonorrhea, chlamydia, HIV and Hepatitis B)

(5) Sickle Cell Preparation Test. Applicants for aviation and diving training shall be tested for sickling phenomenon, if not previously tested. Evaluate positive sickledex results by a quantitative hemoglobin electrophoresis. Greater than 40 percent Hbs is disqualifying for aviation and diving. Once the test has been completed, the results will be filed in the health record and recorded on the Problem Summary List. The test need never be repeated.

(6) Lipid testing.

(a) Routine Screening every 5 years for all members over age 35 with total cholesterol, LDL and HDL as a minimum.

(b) Framingham risk assessment documented every 5 years after age 40.

(c) Screening for all members under age 35 with any of the following cardiac risks:

3 Diabetes mellitus.

4 Tobacco use.

5 Hypertension.

6 Family history of familial hyperlipidemia.

7 Family History of Cardiovascular disease before age 50 in males and age 60 in female relatives.

(d) Decision on intervention for elevated lipids should be made on at least 2 measurements.

(7) HIV Antibody.

(a) The most recent HIV antibody test date will be recorded in item #49 of the Report of Medical Examination (DD-2808), on the Adult Preventive and Chronic Care Flow Sheet (DD 2766) Item 10.h., and under Remarks on the Immunization Record (SF-601). Epidemiological information concerning HIV infection will be

monitored by Commandant (CG-1121) and the policy concerning routine testing will be revised as necessary.

(b) HIV antibody testing is required as follows:

1 All applicants for regular or reserve programs for enlistment, appointment, or entry on active duty.

2 Candidates for officer service (direct commission, OCS, Academy, MORE, etc.,) as part of pre-appointment or pre-contract physical examination.

3 Cadets at the Coast Guard Academy as part of the physical examination prior to commissioning.

4 All Coast Guard members who have not had at least one documented HIV antibody test in the last 2 years.

5 All members with PCS orders to a foreign country, within six months prior to transfer.

6 During the clinical evaluation of the patients being seen for other sexually transmitted or bloodborne diseases (including Hepatitis B) or as part of prenatal examinations.

7 Patients being referred to alcohol/drug treatment programs must be tested for HIV immediately prior to entering such a program. .

8 Newly identified tuberculin reactors.

(c) Accession testing will usually be performed through MEPS examination centers. Other required testing are accomplished through the designated Coast Guard-wide HIV contract with Viromed laboratories. Results for testing done elsewhere will not be available centrally. Therefore, only with the permission of and prior coordination with MLC (k), may Commanding Officers arrange testing with other uniformed services medical treatment facilities (MTF) or qualified local civilian laboratories. Record keeping and reporting requirements must be met regardless of where testing is done.

(d) When Viromed Western Blot results show a member to be HIV antibody positive or indeterminate, the member will be recalled to the clinic. The member will be seen by the medical officer, who will inform the member that:

1 His/her first test was indeterminate or positive, and that a second, confirmatory blood specimen must be drawn. This blood specimen will also be sent to Viromed for expedited analysis.

2 The period of waiting for the results of the confirmatory test may be difficult. The member will be informed where and how to obtain mental health support and counseling

(e) When a member is confirmed HIV antibody positive by the second confirmatory Western Blot, the following will take place.

1 Arrange immediate medical and social services counseling, using available Coast Guard, DoD, or civilian resources to ensure that the member understands the clinical implications of the positive test, the purpose of subsequent medical evaluation, and the policies in this instruction.

2 The member will be referred to a DoD MTF with the capability to perform a complete evaluation. The respective MLC (k) will assist in making arrangements for the evaluation. Ensure that both the medical and dental records accompany the member to the DoD MTF for the evaluation. A narrative summary of this evaluation shall be obtained by the referring medical officer, who shall notify Commandant (CG-1121) via MLC (k) upon receipt. Initiate a Disease Alert Report IAW Chapter 7 of this Manual.

3 The individual's command will order the member to inform all potential or current sexual partners that he/she is HIV positive and always to use condoms when having sex. The member must also be ordered to reveal his/her HIV status to anyone providing him or her with direct medical or dental care.

4 In addition to fulfilling all local health department reporting requirements, the medical officer will report the new infection to the respective MLC (k) medical officer, who will report it to Commandant (CG-1121) HIV program manager.

(f) All information surrounding the individual's physical condition is strictly confidential. Only key personnel, with a verifiable "need to know" such as the individual's commanding officer, should be informed of the HIV status

(g) Coast Guard medical officers requiring a patient to have HIV antibody testing for clinical suspicion should direct the Coast Guard HIV Antibody Testing Center to send a shipment to the Coast Guard-wide contract laboratory immediately. Results should

ordinarily be available within 48 hours via electronic mail or telephone from Commandant (CG-1121).

(h) HIV antibody testing required by members of other uniformed services (active duty or reserve), or by specific agreement with other Federal agencies (e.g., Department of State), must be performed through a Coast Guard HIV Antibody Testing Center.

(i) Voluntary testing and counseling of dependents, retirees, and civilian employees must be performed through a Coast Guard HIV Antibody Testing Center.

c. Chest X-ray (Item 52 of DD-2808).

(1) Will be accomplished as part of the physical examinations for application for aviation or diving programs. Chest X-rays previously performed within eighteen (18) months of application, with normal results, are acceptable if there is no change in clinical presentation.

(2) Will not be performed for routine screening purposes without a prior clinical evaluation and a specific medical indication. The senior medical officer may authorize an exception to this policy when there are obvious medical benefits to be gained by routine screening x-ray examination (e.g., Asbestos Medical Surveillance Program). Such exceptions should be authorized only after careful consideration of the diagnostic yield and radiation risk of the x-ray study, as well as other significant or relevant costs or social factors. X-ray examinations will not be ordered solely for medical-legal reasons.

d. Electrocardiogram (Item 52 of DD-2808).

(1) Electrocardiograms (ECG) shall be accomplished routinely on the following individuals:

(a) Those in whom medical history or clinical findings are suggestive of cardiac abnormalities.

(b) Examinees with a sitting pulse rate of less than 50 or more than 100.

(c) Examinees that are 40 years old or older.

(d) Applicants for aviation and diving training and all designated personnel every four (4) years until age 40, then biennially. For designated aviation personnel on physical examinations where no EKG is required, place the date and results of the last EKG in block #52 (Other) of DD-2808.

(2) All student and designated aviation personnel shall have an ECG on file in their health record.

(3) All tracings will be compared to the baseline reading in the health record, if one is present. If significant changes are present, obtain a cardiac consultation. A report of the consult shall be submitted for review along with the DD-2808. It is imperative then that proper techniques for recording the ECG be followed.

(a) The routine ECG will consist of 12 leads, namely standard leads 1, 2, 3, AVR, AVL, AVF, and the standard precordial leads V1 through V6.

(b) Take care to properly place the precordial electrodes. It is important that the electrodes across the left precordium are not carried along the curve of the rib but are maintained in a straight line. Be particular in placing the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Do not smear electrode paste from one precordial position to another. Include a standardization mark on each recording.

e. Urinalysis. A urinalysis is required on all physical examinations. The urine shall be tested for specific gravity, glucose, protein, blood, leukocyte esterase, and nitrite by an appropriate dipstick method. A microscopic examination is required only if any of these dipstick tests is abnormal.

(1) Specific Gravity. Normal values are 1.005-1.035. Specific gravity varies with fluid intake, time of day, climate, and medication. As a rule, elevation of the specific gravity reflects only the state of hydration, while a low specific gravity may reflect kidney disease. In evaluating abnormalities, a repeat is generally sufficient, provided the factors above are considered and explained to the individual. Where possible, the repeat should be a first morning specimen which is usually the most concentrated.

(2) Glucose. Any positive test is abnormal. A false positive for glucose may occur in individuals who take Vitamin C or drink large quantities of fruit juice. As soon as practical after discovery of the glycosuria, obtain a fasting blood glucose. If glycosuria persists or if the fasting blood glucose exceeds 125 mg/100 ml, evaluate the individual for diabetes.

(3) Protein. A trace positive protein is often associated with a highly concentrated (specific gravity 1.024 or greater) early morning specimen and is considered normal and need not be repeated. A one plus or greater protein, or a trace positive in the presence of a dilute urine, should be evaluated by a 24-hour specimen (normal range 10-200 mg protein/24 hours).

(4) Microscopic.

(a) Normal: 0-5 WBC

0-5 RBC (clean catch specimen)

Occasional epithelial cells (more may be normal in an otherwise normal urinalysis)

No casts occasional bacteria

(b) Pyuria usually indicates an infection or improper collection techniques. Appropriate follow-up is required; including repeat after the infection has cleared.

(c) Hematuria may normally occur following heavy exercise or local trauma and as a false positive in menstruating females. It always requires evaluation with the minimum being a repeat showing no hematuria.

(d) Casts, heavy bacteria, other organisms, and abnormal cells require further evaluation.

f. PAP Test (Item 52 a. of DD-2808).

(1) A PAP test is required at the following times on female members:

(a) On the pre-training physical examination at time of initial entry into the Coast Guard.

(b) Every two years, if on extended active duty.

(c) With quinquennial examinations, for reserves.

(d) Pap tests are no longer required for women who have had a hysterectomy.

(2) PAP tests and pelvic examinations (by civilian or military practitioners) that have been performed within one year of periodic examinations are acceptable. In any case, results of the pelvic examination and PAP test will be recorded in Item 52 a. The practitioner is responsible for communicating the result of the PAP smear (either positive or negative) to the patient.

(3) To reduce false-negative smears, endocervical sampling shall be done using a cytobrush, provided no contraindication is present (as in pregnancy or cervical stenosis). Laboratories to which smears are sent for interpretation must, as a matter of routine, indicate on their reports whether endocervical sampling was adequate. Where endocervical cell sampling is reported as inadequate, the smear shall be repeated.

g. Pulmonary Function Test (PFT). Perform a PFT on all applicable OMSEP examinations and when clinically indicated.

(1) Screening spirometry should not be performed if the subject falls into one of the following catagories:

(a) Is acutely ill from any cause.

(b) Has smoked or used an aerosolized bronchodilator within the past hour.

(c) Has eaten a heavy meal within the previous two hours.

(d) Has experienced an upper or lower respiratory tract infection during the past three weeks.

(e) Administer the PFT by following the manufacturers' instructions.

SPIROMETRIC GUIDELINES

	OBSTRUCTIVE DISEASE **FEV-1/FVC**	**RESTRICTIVE DISEASE FCV%** **FCV PREDICTED**
NORMAL	> 0.69	> .80
MILD TO MODERATE	0.45 -0.69	0.51-0.80
SEVERE	< 0.45	<0.51

h. Special Tests. In some cases, information available should be supplemented by additional tests or diagnostic procedures (eye refractions, x-rays, repeated blood pressure readings, etc.), in order to resolve doubts as to whether the examinee is or is not physically qualified. If facilities are available to perform such tests at no cost, they should be obtained as indicated in individual cases. Otherwise, applicants for original entry in the Service will be required to obtain such tests at their own expense, if they desire further consideration.

i. Laboratory Values (OMSEP). All laboratory values not previously discussed but that accompany a physical examination (e.g., chemistry profiles, etc.,) must have accompanying normals for the laboratory that performed the tests.

j. Mammography. Mammography is required for Coast Guard active duty and reserve females beginning at age 40 and at ages 44, 48, 50, 52, 54, 56, 58, 60, and 62. Clinical findings, family history, and other risk factors may dictate that a mammogram be done at times other than those indicated in

this screening schedule. Results should be documented on the routine physical exams. Mammograms done between the required screening ages can be used to satisfy the periodic requirement. This judgment is left to the practitioner. If mammography is not done at the required ages, the reason must be supplied in item 73 of the DD-2808 and should include date and result of the last mammogram. Practitioners are responsible for communicating mammography results (either positive or negative) to the patient.

k. Glucose-6-Phosphate Dehydrogenase (G-6-PD). Qualitative testing (present or not) for G-6-PD deficiency is required at all accession points (TRACEN Cape May, Academy, RTC Yorktown). All other Coast Guard members with no record of testing shall be tested prior to assignments afloat or to malaria-endemic areas. The results of testing shall be annotated on the DD-2766 Adult Preventive and Chronic Care Flowsheet as well as in MRS. Once testing is accomplished, it need never be repeated.

21. Height, Weight, and Body Build.

a. Height. Measure the examinee's height in both meters and to the nearest inch, without shoes.

b. Weight.

(1) Weights are with underwear/undergarments only.

(2) Weigh the examinee on a standard set of scales calibrated and accurate. Record the weight both kilograms and pounds. Do not record fractions of pounds, such as ounces.

c. Frame Size. Using a cloth tape, measure the wrist of the dominant hand, measure all the way around from lateral to medial styloid process. Measure in centimeters and inches including fraction of inches.

d. Body Fat Percentage. Determined by MEPS.

22. Distant Visual Acuity and Other Eye Tests.

a. Distant Visual Acuity, General. Visual defects are one of the major causes for physical disqualification from the armed services. Methods of testing vision have varied greatly among the armed services and from place to place in each Service. Consequently, visual test results are not always comparable. An examinee presenting for examination at one place might be qualified for visual acuity, while at another place, disqualified. Although this is an undesirable situation, no practical solution, such as prescribing standards for equipment and conditions (room size, ventilation, paint colors, room illumination, etc.), is available to the Coast Guard as the examinations are obtained from various sources over which the Coast Guard has no

control. It is therefore imperative that examiners be especially painstaking to obtain the most accurate results possible.

b. Examination Precautions.

(1) Make every effort to conduct the examination when the examinee is in normal physical condition. Follow the examination routine in the order prescribed in the following instructions. Record the vision for each eye when determined so that errors and omissions will be avoided.

(2) It may be extremely difficult to obtain an accurate measure of visual acuity. Bear in mind those individuals who are anxious to pass visual acuity tests may resort to deception. Similarly, other individuals may attempt to fail a visual acuity test to avoid undesirable duties. Hence, be prepared to cope with either possibility in order to uncover and recognize visual defects without the cooperation of the person being tested.

(3) Refer uncooperative examinees to a medical officer.

c. Examination Procedures.

(1) In order to obtain a more valid evaluation, inform examinees that contact lenses will not be worn during the evaluation and for 72 hours before. Orthokeratotic lenses shall be removed for 14 days or until vision has stabilized for 3 successive examinations.

(2) If the examinee wears glasses, they must be removed before entering the exam room. Test each examinee without unnecessary delay after entering the examining room. In order to prevent personnel from memorizing the charts, permit only one examinee to view the test charts at a time. Ensure other examinees cannot hear the examination.

(3) Follow manufactures instructions on how to conduct a visual acuity test.

(a) Armed Forces Vision Tester (AFVT). Visual acuity may also be determined with the (AFVT). Follow manufactures instruction on how to administer this test.

d. Score recording. Record vision test scores as a fraction in that the upper number is the distance in feet from the chart and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading at a distance of 20 feet, the 30 foot test chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test chart line marked 20. Similarly, 20/200 means a person can read at a distance of 20 feet only the test chart line marked 200.

e. Refraction.

(1) Eye refractions are required:

(a) When applying for flight training (SNA) (This must include cycloplegic.).

(b) When visual acuity falls below 20/20 in either eye (near or distant).

(2) Subsequent refractions are required only if the visual acuity deteriorates further.

(3) If a cycloplegic is used during the course of refraction, then the examinee must wear dark glasses until the effects disappear. The installation of 1 drop into each eye of 1% solution of pilocarpine hydrochloride in distilled water after completing the examination will constrict the pupil and thus relieve the photophobia.

f. Near Vision. Test near vision on all examinees and record results in Item 61 of DD-2808 using Snellen notations. The examinee should be positioned so that the light source is behind him/her and the near vision test card is well illuminated. See manufacturer's instructions on how to administer the test. Record near vision both with and without corrective lenses if glasses are worn or required. Record corrections worn in Item 73. See the chart below for conversion from the various near point letter nomenclatures to Snellen notations.

CONVERSION TABLE FOR VARIOUS NEAR POINT LETTER NOMENCLATURE

Standard Test Chart	Snellen English Linear	Snellen Metric	Jaegar
14/14	20/20	0.50	J-1
14/17.5	20/25	.62	J-2
14/21	20/30	.75	J-4
14/28	20/40	1.00	J-6
14/35	20/50	1.25	J-8
14/49	20/70	1.75	J-12
14/70	20/100	2.25	J-14
14/140	20/200		

g. Heterophoria.

(1) Except for aviation personnel, special tests for heterophoria are not required unless medically indicated.

(2) Heterophoria is a condition of imperfect muscle balance in which the eyes have a constant tendency to deviate and latent deviation is overcome by muscular effort (fusion to maintain binocular single vision). Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the eye deviates toward its fellow, the deviation is known as esophoria; if it deviates away from its fellow, the deviation is known as exophoria; if it deviates up or down, the deviation is known as hyperphoria. The condition of perfect muscle balance (no deviation) is orthophoria.

(3) The vertical and horizontal phorias may be tested with the Phoropter or AFVT.

h. Accommodation. There is no requirement to test accommodation unless medically indicated.

i. Color Perception Tests. Examinees are qualified if they pass either the Pseudoisochromatic Plates (PIP) or the Farnsworth Lantern (FALANT) test. Examinees may be found qualified "on record" if a previous certified physical examination that has a passing PIP or FALANT score is available for review. Examinees who fail the PIP are qualified if they pass the FALANT. See manufacturer's instruction on how to perform these tests.

j. Depth Perception. Required for all aviation personnel and when medically indicated. The AFVT is the most commonly used method of testing depth perception. When this instrument is not available, the Randot (random Dot Circles Test) and the Titmus (Titmus Graded Circles Steroacuity Test) are authorized alternatives to measure depth perception. If the examine fails any of the aforementioned tests, use a Verhoeff Stereopter. Results obtained with the Verhoeff are final in resolving all cases of questionable depth perception. See manufactures instruction on how to perform these tests.

k. Field of Vision. Except for aviation personnel, special tests for field of vision are not required unless medically indicated. Exact procedures on how to perform this test can be obtained from the HS required references.

Night Vision. A test for night vision (dark adaptation) is not required unless indicated for medical or special reasons.

l. Red Lens Test. The red lens test is required on DODMERB examinations and when medically indicated. See manufactures instruction on how to perform this test.

m. Intraocular Tension.

(1) General. Determine intraocular tension each time an eye refraction is performed, during all annual physical examinations, all aviation physicals, and when medically indicated. Above normal tension is a sign of glaucoma; below normal tension of ten exists in degenerated eyeballs or as a normal finding; alterations in tension are sometimes found in cyclitis. Questionable findings on palpation and ophthalmoscopic examination shall be further evaluated.

(2) Testing Intraocular Tension.

(a) General. Routine tonometry shall be performed by a medical officer, optometrist, or a technician who has received instruction in properly performing and interpreting this test.

(b) Instrument. The tonometer estimates the intraocular pressure (IOP) or tension within the eyeball.

(c) Precaution. Determine intraocular tension after all other eye examinations have been completed. Because of corneal denuding by tonometric measurement, a refraction (cycloplegic or manifest) shall not be performed for at least 24 hours following this procedure.

(d) Readings. Intraocular pressure consistently above 21mm Hg in either eye or a difference of 4 or more between the two eyes, shall be referred for ophthalmologic evaluation.

23. Audiometer.

a. An audiometric examination is required on all physical examinations using frequencies 500, 1000, 2000, 3000, 4000, and 6000 hertz.

b. Obtain reference audiograms on all personnel upon initial entry into the Coast Guard at recruit training and all officer accession points (Academy, OCS, Direct Commission, etc.,), and at first duty station for all others.

24. Psychological and Psychomotor.
Psychological and psychomotor testing is not required unless medically indicated.

FIGURE 3-C-1

The following chart enumerates certain conditions, defects, and items of personal history that require thorough evaluation and sets forth the special test, examination, or report desired in each instance.

ITEM:	EXAMINATION AND INFORMATION DESIRED:
ALBUMINURIA, findings of	Repeat test on a second specimen. If still positive do a quantitative 24 hr urine protein.
ASTHMA history of,	Detailed report of asthma and other allergic conditions and a statement from cognizant physician on (1) number and approximate dates of attacks of asthmatic bronchitis or other allergic manifestations; (2) signs, symptoms, and duration of each attack; (3) type and amount of bronchodilating drugs used, and history of any attacks requiring hospitalization.
BACKACHE, back injury	Current orthopedic consultation and report on or wearing of back strength,stability, mobility, and functional brace, history of capacity of back. Report of appropriate x-rays. Transcript of any treatment from cognizant physician.
BLOOD PRESSURE, elevated	Repeat blood pressure (all positions) a.m. and p.m. for 3 consecutive days. Prolonged bed rest shall not precede blood pressure determinations.
CONCUSSIONS	See Head Injury
CONVULSIONS OR SEIZURE	Neurological consultation and electroencephalogram. Transcript of any treatment from cognizant physician.
DIABETES, family history of parent, sibling, or more than one grandparent	Fasting glucose (normal diet with 10-12 but less than 16 hours fast). If elevated, repeat and include 2 hr post prandial.
DIZZINESS or FAINTING SPELLS, history of	Neurological consultation
ENURESIS or history of into late childhood or adolescence (age 12)	Comment on applicant's affirmative reply to question "bed wetting" to include number of past incidents and age at last episode.
FLATFOOT, symptomatic	Current orthopedic consultation with history. Detailed report on strength, stability, mobility, and functional capacity of foot. Report of appropriate x-rays.
GLYCOSURIA, finding or history	See Diabetes.
HAY FEVER, history of	Detailed report of hay fever and other allergic conditions and a statement from personal physician on (1) number, severity, and duration of attacks of hay fever or any other allergic manifestations, and

	(2) type and amount of drugs used in treatment thereof.
HEADACHES, frequent or severe, history of	Neurological consultation.
HEAD INJURY with loss of consciousness in past 5 years, history of	Neurological consultation; clinical abstract of treatment from physician.
HEMATURIA, history of or finding of	Medical consultation with evaluation report, including appropriate laboratory studies and/or complete urological evaluation if indicated.
HEPATITIS, history of	Serum Bilirubin, SGOT, SGPT, SGT, Anti-HCV,and HB_SAg.
JAUNDICE, history of in past 5 years	Serum Bilirubin, SGOT, SGPT, and SGT.
JOINT, KNEE, internal derangement, history of	Current orthopedic consultation and report of strength, stability, mobility, and functional capacity of knee. Report of appropriate x-rays together with comparative measurement of the thighs, knees, and legs.
JOINT, SHOULDER, dislocation, history of	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of shoulder. Report of appropriate x-rays.
MALOCCLUSION, TEETH, history of	Report of examination by a dentist with comment as to whether incisal and masticatory function is sufficient for satisfactory ingestion of the ordinary diet, statement as to presence and degree of facial deformity with jaw in natural position and clarity of speech.
MASTOIDECTOMY, bilateral, history of audiogram.	Current ENT consultation to include
MOTION SICKNESS, history of	Detailed report of all occurrences of motion sickness (such as air, train, sea, swing, carnival-ride), and the age at the time of the last occurrence.
NASAL POLYPS, history of	ENT consultation, with comment as to date polyps removed if no longer present. Detailed report by physician on allergic history and manifestation to include required medication.
SKULL FRACTURE, in past 5 years, history of	See Head Injury.
SLEEPWALKING, beyond childhood, history of (age 12)	Detailed comment by physician. Comment on applicant's affirmative reply to question "been a sleepwalker" to include number of incidents and age at last episode.
SQUINT (cross eyed) Examination	for degree of strabismus and presence of complete and continuous 3rd degree binocular fusion. Request completion of DD-2808 Items 62 and 65 and notation of degree of strabismus.
STUTTERING or STAMMERING,	Report of Reading Aloud Test in Section 3-C-2.

VERTEBRA, fracture or dislocation, history of	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of spine. Report of appropriate x-rays.

FIGURE 3-C-2

HEIGHT STANDARDS		
Category	Minimum (cm/inches)	Maximum (cm/inches)
AVIATION PERSONNEL:		
Candidate for Flight Training	157.4/62	198/78
Class 1 Pilot	157.4/62	198/78
Designated Flight Officer	157.4/62	198/78
Aircrew Candidate	152.5/60	198/78
Designated Aircrew	152.5/60	198/78
ENLISTED PERSONNEL:		
Enlistment in USCG	152.5/60	198/78*
Enlistment in USCG Reserve	152.5/60	198/78*
CANDIDATES FOR:		
USCG Academy	152.5/60	198/78*
Officer Candidate School	152.5/60	198/78*
Appointment of Licensed Officers of U.S. Merchant Marines in the USCG	152.5/60	198/78*
Direct Commission in USCG	152.5/60	198/78*

- MAXIUM HEIGHTS WAIVERABLE TO 203 CM/ 80 INCHES BY COMMANDER COAST PERSONNEL COMMAND (CGPC-adm-1)

NOTES:

1. Heights are without shoes.
2. Metric conversion: 1 inch = 2.54 cm

FIGURE 3-C-3

MINIMUM DISTANT VISUAL ACUITY REQUIREMENTS

CATEGORY	VISION	
A. Aviation Personnel:	Uncorrected	Corrected
1. Candidates for Flight Training	20/50	20/20
2. Pilot, Class	20/200	20/20
3. Pilot, Class 1R	(as waivered)	20/20
4. Designated Flight Officer	20/400	20/20
5. Flight Surgeon, Aviation Medical Examiner or Aviation MEDEVAC Specialist	20/400	20/20
6. Candidate for Aircrew	20/100	20/20
7. Designated Aircrew	20/200	20/20
8. Landing Signal Officer (LSO)	20/200	20/20
9. Air Traffic Controller Candidate	20/100	20/20
10. Designated Air Traffic Controller	20/200	20/20
B. Officers (Note 1):		
1. Commissioned or Warrant in the USCG or USCGR	20/400	20/20
2. Appointment in the USCG of Licensed Officers of the Merchant Marine	20/400	20/20
3. Direct Commission in the USCGR	20/400	20/20
4. Appointment as Cadet	20/400	20/20
5. Precommissioning of Cadets	20/400	20/20
6. OCS Candidates	20/400	20/20
7. Precommissioning of Officer Candidates	20/400	20/20
8. Diving Candidates	20/100	20/20
9. Designated Diver	20/200	20/20
C. Enlisted Personnel:		
1. Enlistment in the USCG or USCGR	See 3.D.13.a	(Note
2. Diving Candidates	(Note 3)	20/20
3. Designated Diver	(Note 3)	20/20

Notes:

1. Refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder) and that astigmatism does not exceed 3.00 diopters and anisometropia does not exceed 3.50 diopters.

2. Corrected vision shall be 20/40 in the better eye and 20/70 in the other or 20/30 in the better eye and 20/100 in the other, or 20/20 in the better and 20/400 in the other. (Note that near visual acuity must correct to at least 20/40 in the better eye.) Refractive error does not exceed plus or minus 8.00 diopters spherical equivalent (sphere + 1/2 cylinder) and ordinary spectacles do not cause discomfort by reason of ghost images, prismatic displacement, etc.; error must not have been corrected by orthokeratology or keratorefractive surgery.

3. 20/100 in the better eye and 20/200 in the worse eye.

CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section D. Medical Standards for Appointment, Enlistment and Induction in the Armed Forces.

1. Scope. 1
2. Medical Standards. 1
3. Policy 2
4. Responsibilities of Commandant CG-11; 2
5. Height 3
6. Weight 3
7. Head 3
8. Eyes 3
9. Vision. 7
10. Ears. 7
11. Hearing 8
12. Nose, Sinuses, Mouth and Larynx 8
13. Dental 10
14. Neck 10
15. Lungs, Chest Wall, Pleura, and Mediastinum 11
16. Heart 12
17. Abdominal Organs and Gastrointestinal System. 13
18. Female Genitalia. 16
19. Male Genitalia 17
20. Urinary System 17
21. Spine and Sacroiliac Joints 18
22. Upper Extremities Limitation of Motion. 20
23. Lower Extremities 21
24. Miscellaneous Conditions of the Extremities 23
25. Vascular System 25
26. Skin and Cellular Tissues 25
27. Blood and Forming Tissues 27

28. Systemic 27
29. Endocrine and Metabolic 29
30. Neurologic.....30
31. Learning Psychiatric and Behavioral 32
32. Tumors and Malignancies.....34
33. Miscellaneous 35
Evaluation for Risk of Head Injury Sequelae 37
Classification and Comparative Nomenclature of Cervical Smears.....38
1. cells consistent with carcinoma 38
2. squamous cell carcinoma 38

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section D. Medical Standards for Appointment, Enlistment and Induction in the Armed Forces.

1. Scope.
   This section applies to the Office of the Secretary of Defense, the Military Departments (including the United States Coast Guard when, by agreement with the Department of Homeland Security, it is not operating as a Military Service in the Department of the Navy), the United States Merchant Marine Academy by agreement with the Secretary of Commerce, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereinafter referred to collectively as the "DoD Components"). The term "Armed Forces," as used herein, refers to the Army, the Navy, the Air Force, the Marine Corps, and the Coast Guard.

2. Medical Standards.
   This section establishes medical standards, which, if not met, are grounds for rejection for military service. Other standards may be prescribed for a mobilization for a national emergency. The medical standards in this section apply to the following personnel:

   a. Applicants for appointment as commissioned or warrant officers in the Active and Reserve components.

   b. Applicants for enlistment in the Armed Forces. For medical conditions or defects predating original enlistment, these standards apply to enlistees' first 6months of active duty.

   c. During training. Applicants for enlistment in the Reserve and federally recognized units or organizations of the National Guard. For medical conditions or defects predating original enlistment, these standards apply during the enlistees' initial period of active duty for training until their return to Reserve or National Guard units.

   d. After 6 months. Applicants for reenlistment in Regular and Reserve components and in federally recognized units or organizations of the National Guard when after a period of more than 6 months have elapsed since discharge.

   e. Schools. Applicants for the Scholarship or Advanced Course Reserve Officers Training Corps (ROTC), and all other Armed Forces' special officer personnel procurement programs.

   f. Retention of cadets and midshipmen at the U.S. Service academies and students enrolled in ROTC scholarship programs.

g. Individuals on the Temporary Disability Retired List (TDRL). Individuals on the Temporary Disability Retired List (TDRL) who have been found fit on reevaluation and wish to return to active duty. The prior disabling condition(s) and any other medical conditions identified before placement on the TDRL, that shall not have prevented reenlistment, are exempt from this Instruction.

h. All individuals being inducted into the Armed Forces.

3. Policy

a. International Classification of Disease (ICD) codes. It is Coast Guard policy, by agreement with DoD Directive 6130 Physical Standard for Appointment, to utilize the International Classification of Disease (ICD) codes in this section, in all records pertaining to a medical condition that results in a personnel action, such as separation or medical waiver. In addition, when a medical condition standard is waived or results in a separation, written clarification of the personnel action should be provided using standard medical terminology.

b. Standards. The standards in this section shall be for the acquisition of personnel in the programs in 3.D.2 of this manual.

c. Disqualifying standards. Unless otherwise stipulated, the conditions listed in this section are those that would be disqualifying by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment or induction into the Armed Forces are classified by the following general systems.

4. Responsibilities of Commandant (CG-11).

a. Review Coast Guard policies. Review Coast Guard policies to conform with the standards contained in DoD Directive 6130.4.

b. Recommend changes. Recommend to the Office of the Assistant Secretary of Defense (Health Affairs) [OASD (HA)] suggested changes in the standards after service coordination has been accomplished.

c. Review all the standards on a quinquennial basis. Review all the standards on a quinquennial basis and recommend changes to the OASD (HA). This review will be initiated and coordinated by the DOD Medical Examination Review Board.

d. Implement standards. Ensure that implementation of the standards in this section are accomplished throughout the U.S. Military Entrance Processing Command.

e. Direct clinics. Under the provisions of DoD Directive 6130.3 "Physical Standards for Appointment, Enlisted or Induction", direct the clinics to apply and uniformly implement the standards contained in this section.

f. Authorize waivers. Authorize waivers if the standards in individual cases for applicable reasons and ensure uniform waiver determinations.

g. Authorize changes in visual standards. Authorize the changes in Service-specific visual standards (particularly for officer accession programs) and establish other standards for special programs. Notification of any proposed changes in standards shall be provided to the ASD (HA) at least 60 days before implementation.

h. Ensure that accurate ICD codes are assigned. Ensure that accurate ICD codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions

i. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the Armed Forces.

5. Height.
The causes for rejection for appointment, enlistment, and induction in relation to height standards are established by each of the military services, Standards for the Coast Guard are:

a. Men: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).

b. Women: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).

6. Weight.
The causes for rejection for appointment, enlistment, and induction in relation to height standards are contained in Weight /Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST 1020.8 (series).

7. Head.

a. Deformities. Uncorrected deformities of the skull, face, or mandible (754.0) of a degree that shall prevent the individual from the proper wearing of a protective mask or military headgear are disqualifying

b. Bone loss. Loss, or absence of the bony substance of the skull (756.0 or 738.1) not successfully corrected by reconstructive materials, or leaving residual defect in excess of one square inch (6.45cm2), or the size of a 25-cent piece is disqualifying.

8. Eyes.

a. Lids.

(1) Current Blepharitis (373.0), chronic or acute, until cured (373.00) is disqualifying.

(2) Current Blepharospasm (333.81) is disqualifying

(3) Current Dacryocystitis, acute or chronic (375.30), is disqualifying.

(4) Deformity of the lids (374.4), complete or extensive lid deformity, sufficient to interfere with vision or impair protection of the eye from exposure is disqualifying.

(5) Current growths or tumors of the eyelid, other than small, non-progressive, asymptomatic, benign lesions, are disqualifying.

b. Conjunctiva.

(1) Current chronic conjunctivitis (372.1), including, but not limited to trachoma (076) and chronic allergic conjunctivitis (372.14), is disqualifying

(2) Current or recurrent Pterygium (372.4) if condition encroaches on the cornea in excess of three millimeters, or interferes with vision, or is a progressive peripheral Pterygium (372.42), or recurring Pterygium after two operative procedures (372.45) is disqualifying.

(3) Current Xerophthalmia (372.53) is disqualifying.

c. Cornea (include surgery).

(1) Current or history of corneal dystrophy of any type (371.5), including, but not limited to keratoconus (371.6) of any degree, is disqualifying.

(2) History of refractive surgery including, but not limited to: Lamellar (P11.7) and/or penetrating keratoplasty (P11.6), Radial Keratotomy and Astigmatic Keratotomy is disqualifying. Refractive surgery performed with an Excimer Laser, including but not limited to, Photorefractive Keratectomy (commonly known as PRK), Laser Epithelial Keratomileusis (commonly known as LASEK) and Laser-Assisted in situ Keratomileusis (commonly known as LASIK)[4] is disqualifying if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded +8.00 to-8.00 diopters.

(b) At least 6 months recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.

(c) There have been complications and / or need for ophthalmic medications.

(d) Post-surgical refraction in each eye is not stable as demonstrated by:

1 At least two separate refractions at least one month apart, the most recent of which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.25 diopters for cylinder vision; and

2 At least 3 months recovery has not occurred between last refractive surgery or augmenting procedure and one of the comparison refractions.

(e) Pre-surgical and post-surgical refractive errors do not meet the standards for the Military Service to which the candidate is applying.

(3) Current keratitis (370), acute or chronic, including, but not limited to recurrent corneal ulcers (370.0), erosions (abrasions), or herpetic ulcers (054.42) is disqualifying.

(4) Current corneal vascularization (370.6), or corneal opacification (371) from any cause that is progressive or reduces vision below the standards prescribed below, is disqualifying

(5) Current or history of Uveitis or Iridocyclitis (364.3) is disqualifying.

d. Retina.

(1) Current or history of retinal defects and dystrophies, Angiomatoses (759.6), retinoschisis and retinal cysts (361.1), phakomas (362.89), and other congenito-retinal hereditary conditions (362.7) that impair visual function or are progressive, are disqualifying.

(2) Current or history of degenerative changes of any part of the retina (362) is disqualifying.

(3) Current or history of detachment of the retina (361), history of surgery for same, or peripheral retinal injury, defect (361.3), or degeneration that may cause retinal detachment is disqualifying.

e. Optic Nerve.

(1) Current or history of optic neuritis (377.3), including, but not limited to Neuroretinitis, secondary optic atrophy, or documented history of retrobulbar neuritis is disqualifying

(2) Current or history of optic atrophy (377.1) or cortical blindness (377.75) is disqualifying.

(3) Current or history of Papilledema (377.0) is disqualifying

f. Lens.

(1) Current Aphakia (379.31), history of lens implant, or current or history of dislocation of a lens is disqualifying.

(2) Current or history of opacities of the lens (366) that interfere with vision or that are considered to be progressive, including cataract (366.9), are disqualifying.

g. Ocular Mobility and Motility.

(1) Current Diplopia (368.2) is disqualifying.

(2) Current nystagmus (379.50) other than physiologic "end-point nystagmus" is disqualifying.

(3) Esotropia (378.0) and hypertropia (378.31): For entrance into Service academies and officer programs, the individual Military Services may set additional requirements. The Military Services shall determine special administrative criteria for assignment to certain specialties.

h. Miscellaneous Defects and Diseases.

(1) Current or history of abnormal visual fields due to diseases of the eye or central nervous system (368.4), or trauma (368.9) is disqualifying.

(2) Absence of an eye, clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.8) is disqualifying.

(3) Current asthenopia (368.13) is disqualifying.

(4) Current unilateral or bilateral non-familial exophthalmoses (376) are disqualifying.

(5) Current or history of glaucoma (365), including, but not limited to primary, secondary, pre-glaucoma as evidenced by intraocular pressure above 21 mmHg, or changes in the optic disc, or visual field loss associated with glaucoma, is disqualifying.

(6) Current loss of normal pupillary reflex, reactions to accommodation (367.5) or light (379.4), including Adie's Syndrome, is disqualifying.

(7) Current night blindness (368.60) is disqualifying.

(8) Current or history of retained intraocular foreign body (360) is disqualifying.

(9) Current or history of any organic disease of the eye (360) or adnexa (376), not specified in paragraph E1.2.1. through subparagraph E1.2.9.8., above, which threatens vision or visual function is disqualifying.

9. Vision.
The Secretaries of the Military Departments shall, under the provisions of DoD Directive 6130.3 "Physical Standard for Appointments", have authority to change Service-specific vision standards and establish other standards for special programs.

a. Distant visual acuity. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367) is disqualifying.

(1) 20/40 in one eye and 20/70 in the other eye.

(2) 20/30 in one eye and 20/ 100 in the other eye.

(3) 20/20 in one eye and 20/400 in the other eye.

b. Near visual acuity. Current near visual acuity of any degree that does not correct to 20/40 in the better eye (367) is disqualifying.

c. Refractive error. Current refractive error [hyperopia (367.0), myopia (367.1), astigmatism (367.2)] or history of refractive error prior to any refractive surgery manifest by any refractive error in spherical equivalent of worse than -8.00 or +8.00 diopters is disqualifying.

d. Cases requiring contact lenses. Current complicated cases requiring contact lenses for adequate correction of vision, such as corneal scars (371) and irregular astigmatism (367.2), are disqualifying.

e. Color vision (368.5). Failure to pass a color vision test is not an automatic disqualification. For entrance into U.S. Service academies and ROTC programs, color vision requirements may be set by the individual Services.

10. Ears.

a. External ear. Current atresia of the external ear (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5), chronic otitis externa (380.2), severe external ear deformity (744.3) that prevents or interferes with the proper wearing of hearing protection is disqualifying.

b. Mastoiditis. Current or history of mastoiditis (383.9), residual with fistula (383.81), chronic drainage or conditions requiring frequent cleaning of the mastoid bone is disqualifying.

c. Ménière's Syndrome. Current or history of Ménière's Syndrome or other chronic diseases of the vestibular system (386) are disqualifying.

d. Inner ear. Current or history of chronic otitis media (382), cholesteatoma (385.3), or history of any inner (P20) or middle (P 19) ear surgery (including cochlear implantation) is disqualifying. Myringotomy or successful tympanoplasty is not disqualifying.

e. Perforation of the tympanic membrane. Current perforation of the tympanic membrane (384.2) or history of surgery to correct perforation during the preceding 120 days (P 19) is disqualifying.

11. Hearing.
All hearing defects are coded with ICD-9 code 389.

a. Audiometric Hearing Levels.

(1) Audiometers calibrated to the International Organization for Standardization (ISO 8253:1 1989) (reference (c)) or the American National Standards Institute (ANSI 1996) (reference (d)) shall be used to test the hearing of all applicants.

(2) Current hearing threshold level in either ear greater than that described below is disqualifying:

(a) Pure tone at 500, 1000, and 2000 cycles per second for each ear of not more than 30 dB on the average with no individual level greater than 35 dB at those frequencies.

(b) Pure tone level not more than 45 dB at 3000 cycles per second or 55 dB at 4000 cycles per second for each ear.

(c) There is no standard for 6000 cycles per second.

b. Current or history of hearing aid use (V53.2) is disqualifying.

12. Nose, Sinuses, Mouth and Larynx.

a. Rhinitis.

(1) Current allergic rhinitis (477.0) due to pollen (477.8) or due to other allergen or cause unspecified (477.9) if not controlled by oral medication or topical corticosteroid medication is disqualifying. History of allergic rhinitis immunotherapy within the previous year is disqualifying.

(2) Current chronic non-allergic rhinitis (472.0) if not controlled by oral medication or topical corticosteroid medication is disqualifying.

b. Cleft lip or palate. Current cleft lip or palate defects (749) not satisfactorily repaired by surgery is disqualifying.

c. Leukoplakia. Current leukoplakia (528.6) is disqualifying.

d. Chronic conditions of larynx. Current chronic conditions of larynx including vocal cord paralysis (478.3), chronic hoarseness, chronic laryngitis, larynx ulceration, polyps, granulation tissue, or other symptomatic disease of larynx, vocal cord dysfunction not elsewhere classified (478.7) are disqualifying.

e. Anosmia or parosmia. Current anosmia or parosmia (781.1) is disqualifying.

f. Epistaxis. History of recurrent epistaxis with greater than one episode per week of bright red blood from the nose occurring over a 3-month period (784.7) is disqualifying.

g. Nasal polyp or history of nasal polyps. Current nasal polyp or history of nasal polyps (471), unless greater than 12 months has elapsed since nasal polypectomy is disqualifying.

h. Perforation of nasal septum. Current perforation of nasal septum (478.1) is disqualifying.

i. Chronic sinusitis. Current chronic sinusitis (473) or current acute sinusitis (461.9) is disqualifying. Such conditions exist when evidenced by chronic purulent discharge, hyperplastic changes of nasal tissue, symptoms requiring frequent medical attention, or x-ray findings.

j. Trachea. Current or history of tracheostomy (V44.0) or tracheal fistula (530.84) is disqualifying.

k. Anomalies of upper alimentary tract. Current or history of deformities, or conditions or anomalies of upper alimentary tract

(750.9), of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing is disqualifying.

l. Pharyngitis. Current chronic pharyngitis (462) and chronic nasopharyngitis (472.2) are disqualifying.

13. Dental.

a. Diseases of the jaw. Current diseases of the jaws or associated tissues that prevent normal functioning are disqualifying. Those diseases include but are not limited to temporomandibular disorders (524.6) and/or myofascial pain that have not been corrected.

b. Severe malocclusion. Current severe malocclusion (524), which interferes with normal mastication or requires early and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement is disqualifying.

c. Insufficient natural healthy teeth. Current insufficient natural healthy teeth (521) or lack of a serviceable prosthesis that prevents adequate incision and mastication of a normal diet and/or includes complex (multiple fixtures) dental implant systems with associated complications are disqualifying. Individuals undergoing enDoDontic care are acceptable for entry in the Delayed Entry Program only if a civilian or military provider provides documentation that active enDoDontic treatment shall be completed prior to being sworn into active duty.

d. Current orthodontic appliances. Current orthodontic appliances for continued treatment (V53.4) are disqualifying. Retainer appliances are permissible, provided all active orthodontic treatment has been satisfactorily completed. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program only if a civilian or military orthodontist provides documentation that active orthodontic treatment shall be completed prior to being sworn into active duty.

14. Neck.

a. Current symptomatic cervical ribs (756.2) are disqualifying.

b. History of congenital cyst(s). Current or history of congenital cyst(s) (744.4) of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts, is disqualifying.

c. Contraction of the neck muscles. Current contraction (723) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent it interferes with the proper wearing of a uniform or military equipment, or is so disfiguring as to interfere with or prevent satisfactory performance of military duty is disqualifying.

15. Lungs, Chest Wall, Pleura, and Mediastinum.

a. Elevation of the diaphragm. Current abnormal elevation of the diaphragm (either side) is disqualifying. Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1), or other thoracic or abdominal organ (793.2) is disqualifying.

b. Current abscess of the lung or mediastinum (513) is disqualifying.

c. Acute infection of the lungs. Current or history of acute infectious processes of the lung, including, but not limited to viral pneumonia (480), pneumococcal pneumonia (481), bacterial pneumonia (482), pneumonia other specified (483), pneumonia infectious disease classified elsewhere (484), bronchopneumonia organism unspecified (485), pneumonia organism unspecified (486), are disqualifying until cured.

d. Asthma. Asthma (493), including reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, reliably diagnosed and symptomatic after the 13th birthday is disqualifying. Reliable diagnostic criteria may include any of the following elements: Substantiated history of cough, wheeze, chest tightness and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 12 months.

(1) Current bronchitis (490), acute or chronic symptoms over 3 months occurring at least twice a year (491), is disqualifying.

(2) Current or history of bronchiectasis (494) is disqualifying.

(3) Current or history of bronchopleural fistula (510), unless resolved with no sequelae is disqualifying.

(4) Current or history of bullous or generalized pulmonary emphysema (492) is disqualifying.

(5) Current chest wall malformation (754), including, but not limited to pectus excavatum (754.81) or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion, is disqualifying.

(6) History of emphysema (510) is disqualifying.

(7) Current pulmonary fibrosis from any cause, producing respiratory symptoms is disqualifying.

(8) Current foreign body in lung, trachea, or bronchus (934) is disqualifying.

(9) History of lobectomy (P32.4) is disqualifying.

(10) Current or history of pleurisy with effusion (511.9) within the previous 2 years is disqualifying.

(11) Current or history of pneumothorax (512) occurring during the year preceding examination if due to trauma or surgery, or occurring during the 3 years preceding examination from spontaneous origin, is disqualifying. Recurrent spontaneous pneumothorax (512) is disqualifying.

(12) History of open or laparoscopic thoracic or chest wall (including breasts) surgery during the preceding 6 months (P54) is disqualifying.

16. Heart.

a. Valvular heart diseases. Current or history of all valvular heart diseases, congenital (746) or acquired (394) including those improved by surgery, are disqualifying. Mitral valve prolapse or bicuspid aortic valve is not disqualifying unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

(1) Current or history of coronary heart disease (410) is disqualifying.

(2) Current or history of symptomatic or electrocardiographic evidence of arrhythmia.

(a) Current or history of supraventricular tachycardia (427.0) or any arrhythmia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation, unless there has been no recurrence during the preceding 2 years while off all medications, is disqualifying. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment, are disqualifying.

(b) Current or history of ventricular arrhythmias (427.1) including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions is disqualifying. Occasional asymptomatic unifocal premature ventricular contractions are not disqualifying.

(c) Current or history of ventricular conduction disorders, including, but not limited to disorders with left bundle branch block (426.2), Mobitz type II second degree AV block (426.12), third degree AV block (426.0), and Lown-Ganong-Levine Syndrome (426.81) associated with an arrhythmia, are disqualifying. Current or history of Wolff-Parkinson-White syndrome (426.7), unless it has been successfully ablated for a period of 2 years without recurrence of arrhythmia and now with a normal electrocardiogram, is disqualifying

(d) Current or history of conduction disturbances, such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4), or Mobitz type I second degree AV block (426.13) are disqualifying when symptomatic or associated with underlying cardiovascular disease.

(3) Current cardiomegaly, hypertrophy, or dilation (429.3) is disqualifying.

(4) Current or history of cardiomyopathy (425), including myocarditis (422) or congestive heart failure (428), is disqualifying.

(5) Current or history of pericarditis (acute nonrheumatic) (420), unless the individual is free of all symptoms for 2 years, and has no evidence of cardiac restriction or persistent pericardial effusion, is disqualifying.

(6) Current persistent tachycardia (785.1) (resting pulse rate of 100 beats per minute or greater) is disqualifying.

(7). Current or history of congenital anomalies of heart and great vessels (746), except for corrected patent ductus arteriosus, are disqualifying

17. Abdominal Organs and Gastrointestinal System.
Current or history of esophageal disease, including, but not limited to ulceration, varices, fistula, achalasia, or Gastro-Esophageal Reflux Disease (GERD) (530.81), or complications from GERD including stricture, or maintenance on acid suppression medication, or other dysmotility disorders; chronic, or recurrent esophagitis (530.1), is disqualifying. Current or history of reactive airway disease associated with GERD is disqualifying. Current or history of dysmotility disorders, chronic, or recurrent esophagitis (530) is disqualifying. History of surgical correction for GERD within six months is disqualifying.

(P42 esophageal correction, P43 stomach correction and P45 intestinal correction.)

a. Stomach and Duodenum.

(1) Current gastritis, chronic or severe (535), or non-ulcerative dyspepsia that requires maintenance medication is disqualifying.

(2) Current ulcer of stomach or duodenum confirmed by x-ray or endoscopy (533) is disqualifying.

(3) History of surgery for peptic ulceration or perforation is disqualifying.

b. Small and Large Intestine.

(1) Current or history of inflammatory bowel disease, including, but not limited to unspecified (558.9), regional enteritis or Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556), is disqualifying.

(2) Current or history of intestinal malabsorption syndromes, including, but not limited to post-surgical and idiopathic (579), is disqualifying. Lactase deficiency is disqualifying only if of sufficient severity to require frequent intervention, or to interfere with normal function.

(3) Current or history of gastrointestinal functional and motility disorders within the past 2 years, including, but not limited to pseudo-obstruction, mega colon, history of volvulus, or chronic constipation and/or diarrhea (787.91), regardless of cause persisting or symptomatic in the past 2 years, is disqualifying.

(4) History of gastrointestinal bleeding (578), including positive occult blood (792.1) if the cause has not been corrected, is disqualifying. Meckel's diverticulum (751.0), if surgically corrected greater than 6 months prior, is not disqualifying.

(5) Current or history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention or to interfere with normal function is disqualifying.

(6) History of bowel resection is disqualifying.

(7) Current symptomatic diverticular disease of the intestine is disqualifying.

c. Hepatic-Biliary Tract.

(1) Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding 6 months, or persistence of symptoms after 6 months, or objective evidence of impairment of liver function is disqualifying.

(2) Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3) is disqualifying.

(3) Current or history of symptomatic cholecystitis, acute or chronic, with or without cholelithiasis (574); postcholecystectomy syndrome, or other disorders of the gallbladder and biliary system (576) is disqualifying. Cholecystectomy is not disqualifying if performed greater than 6 months prior to examination and patient remains asymptomatic. Fiber optic procedure to correct sphincter dysfunction or cholelithiasis if performed greater than 6 months prior to examination and patient remains asymptomatic may not be disqualifying.

(4) Current or history of pancreatitis, acute (577.0) or chronic (577.1), is disqualifying.

(5) Current or history of metabolic liver disease, including, but not limited to hemochromatosis (275.0), Wilson's disease (275.1), alpha-1 anti-trypsin deficiency (277.6), is disqualifying.

(6) Current enlargement of the liver from any cause (789.1) is disqualifying.

d. Anorectal.

(1) Current anal fissure or anal fistula (565) is disqualifying.

(2) Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6) within the last 2 years is disqualifying.

(3) Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last 60 days, is disqualifying.

e. Spleen.

(1) Current splenomegaly (789.2) is disqualifying.

(2) History of splenectomy (P41.5) is disqualifying, except when resulting from trauma.

f. Abdominal Wall.

(1) Current hernia, including, but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553), are disqualifying.

(2) History of open or laparoscopic abdominal surgery during the preceding 6 months (P54) is disqualifying.

(3) History of any gastrointestinal procedure for the control of obesity is disqualifying. Artificial openings, including, but not limited to ostomy (V44), are disqualifying.

18. Female Genitalia.

a. Uterine bleeding. Current or history of abnormal uterine bleeding (626.2), including, but not limited to menorrhagia, metrorrhagia, or polymenorrhea, is disqualifying.

b. Amenorrhea. Current unexplained amenorrhea (626.0) is disqualifying.

c. Dysmenorrhea. Current or history of dysmenorrhea (625.3) that is incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities is disqualifying.

d. Endometriosis. Current or history of endometriosis (617) is disqualifying.

e. Major abnormalities or defects of the genitalia. History of major abnormalities or defects of the genitalia such as change of sex (P64.5), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7) is disqualifying.

f. Ovarian cyst(s). Current or history of ovarian cyst(s) (620.2) when persistent or symptomatic is disqualifying.

g. Pelvic inflammatory disease. Current pelvic inflammatory disease (614) or history of recurrent pelvic inflammatory disease is disqualifying. Current or history of chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9) is disqualifying.

h. Pregnancy. Current pregnancy (V22) is disqualifying until 6 months after the end of the pregnancy.

i. Uterine absence enlargement. History of congenital uterine absence (752.3) is disqualifying. E1.12.10. Current uterine enlargement due to any cause (621.2) is disqualifying.

j. Genital infection or ulceration. Current or history of genital infection or ulceration, including, but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity requiring frequent intervention or to interfere with normal function, is disqualifying.

k Abnormal gynecologic cytology. Currently abnormal gynecologic cytology, including, but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding Human Papilloma Virus (HPV) (079.4) or confirmed Low-Grade Squamous Intraepithelial Lesion (LGSIL) (622.9), is disqualifying. For the purposes of this Instruction, confirmation is by colposcopy or repeat cytology.

19. Male Genitalia.

a. Testicles absent. Current absence of one or both testicles, congenital (752.89) or undescended (752.51), is disqualifying.

b. Epispadias or hypospadias. Current epispadias (752.62) or hypospadias (752.61), when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction, is disqualifying.

c. Testicle enlargement or epididymis. Current enlargement or mass of testicle or epididymis (608.9) is disqualifying.

d. Orchitis or epididymitis. Current orchitis or epididymitis (604.90) is disqualifying.

e. Penis amputation. History of penis amputation (878.0) is disqualifying.

f. Genital infection or ulceration. Current or history of genital infection or ulceration, including, but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11) if of sufficient severity to require frequent intervention or to interfere with normal function, is disqualifying.

g. Prostatitis. Current acute prostatitis (601.0) or chronic prostatitis (601.1) is disqualifying.

h. Hydrocele. Current hydrocele (603), if large or symptomatic, is disqualifying.

(1) Left varicocele (456.4), if symptomatic, or associated with testicular atrophy, or varicocele larger than the testis, is disqualifying.

(2) Any right varicocele is disqualifying.

i. Scrotal pain. Current or history of chronic scrotal pain or unspecified symptoms associated with male genital organs (608.9) is disqualifying.

j. Genitalia abnormalities or defects. History of major abnormalities or defects of the genitalia such as change of sex (P64.5), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7) is disqualifying.

20. Urinary System.

a. Cystitis. Current cystitis or history of chronic or recurrent cystitis (595) is disqualifying.

b. Urethritis. Current urethritis or history of chronic or recurrent urethritis (597.80) is disqualifying.

c. Enuresis. History of enuresis (788.30) or incontinence of urine (788.30) after 13th birthday is disqualifying.

d. Urinary tract disease. Current hematuria (599.7), pyuria, or other findings indicative of urinary tract disease (599) is disqualifying.

e. Urethral stricture or fistula. Current urethral stricture (598) or fistula (599.1) is disqualifying.

f. Kidney.

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73), is disqualifying.

(2) Current pyelonephritis (590.0) (chronic or recurrent), or any other unspecified infections of the kidney (590.9) is disqualifying.

(3) Current or history of polycystic kidney (753.1) is disqualifying.

(4) Current or history of horseshoe kidney (753.3) is disqualifying.

(5) Current or history of hydronephrosis (591) is disqualifying.

(6) Current or history of acute (580) or chronic (582) nephritis of any type is disqualifying.

(7) Current or history of proteinuria (791.0) (greater than 200 mg/24 hours; or a protein to creatinine ratio greater than 0.2 in a random urine sample, if greater than 48 hours after strenuous activity) is disqualifying, unless consultation determines the condition to be benign orthostatic proteinuria.

(8) Current of history of urolithiasis (592) within the preceding 12 months is disqualifying. Recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time is disqualifying.

21. Spine and Sacroiliac Joints.

a. Ankylosing spondylitis. Current or history of ankylosing spondylitis or other inflammatory spondylopathies (720) is disqualifying.

b. Sacroiliac joints. Current or history of any condition, including, but not limited to the spine or sacroiliac joints, with or without objective signs that:

(1) Prevents the individual from successfully following a physically active vocation in civilian life (724), or that is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion is disqualifying.

(2) Requires external support is disqualifying.

(3) Requires limitation of physical activity or frequent treatment is disqualifying.

c. Spine deviation or curvature. Current deviation or curvature of spine (737) from normal alignment, structure, or function is disqualifying if:

(1) It prevents the individual from following a physically active vocation in civilian life.

(2) It interferes with the proper wearing of a uniform or military equipment.

(3) It is symptomatic.

(4) There is lumbar scoliosis greater than 20 degrees, thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 55 degrees when measured by the Cobb Method.

d. Fusion vertebral bodies. History of congenital fusion (756.15) involving more than two vertebral bodies is disqualifying. Any surgical fusion of spinal vertebrae (P81.0) is disqualifying.

e. Vertebra fracture or dislocation. Current or history of fracture or dislocation of the vertebra (805) is disqualifying. A compression fracture involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

f. Epiphysitis. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by x-ray or kyphosis is disqualifying.

g. Herniated nucleus pulposus. Current herniated nucleus pulposus (722) or history of surgery to correct is disqualifying.

h. Spina bifida. Current or history of spina bifida (741) when symptomatic, there is more than one vertebral level involved or with dimpling of the overlying skin is disqualifying. History of surgical repair of spina bifida is disqualifying.

i. Spondylolysis. Current or history of spondylolysis [congenital (756.11), acquired (738.4)] and spondylolisthesis [congenital (756.12) or acquired (738.4)] are disqualifying.

22. Upper Extremities Limitation of Motion.

a. Ranges of motion. Current joint ranges of motion less than the measurements listed in paragraphs below are disqualifying.

(1) Shoulder (726.1)

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3)

(a) Flexion to 100 degrees.

(b) Extension to 15 degrees.

(3) Wrist (726.4). A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.

(4) Hand (726.4)

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb (726.4). Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Finger.

(1) Current absence of the distal phalanx of either thumb (885) is disqualifying.

(2) Current absence of distal and middle phalanx of an index, middle, or ring finger of either hand irrespective of the absence of little finger (886) is disqualifying.

(3) Current absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand (886) is disqualifying.

(4) Current absence of hand or any portion thereof (887) is disqualifying, except for specific absence of fingers, as noted above.

(5) Current polydactyly (755.0) is disqualifying.

(6) Current intrinsic paralysis or weakness of upper limbs, including nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar and radial nerve (354) sufficient to produce physical findings in the hand, such as muscle atrophy and weakness is disqualifying.

c. Current Problems.
Current disease, injury, or congenital condition with residual weakness or symptoms such as to prevent satisfactory performance of duty, including, but not limited to chronic joint pain: shoulder (719.41), upper arm (719.42), forearm (719.43), and hand (719.44), late effect of fracture of the upper extremities (905.2), late effect of sprains without mention of injury (905.7), and late effects of tendon injury (905.8), is disqualifying.

23. Lower Extremities.

a. Limitation of Motion.
Current joint ranges of motion less than the measurements listed in the subparagraphs below are disqualifying.

(1) Hip [due to disease (726.5) or injury (905.2)].

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee [due to disease (726.6) or injury (905.4)].

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle [due to disease (726.7) or injury (905.4) or congenital].

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling five degrees [due to disease (726.7) or injury (905.4) or congenital defect].

b. Foot and Ankle.

(1) Current absence of a foot or any portion thereof (896) is disqualifying.

(2) Current or history of deformities of the toes [acquired (735) or congenital (755.66)], including, but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidicus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), overriding toe(s) (735.8), that prevents the proper wearing of military footwear or impairs walking, marching, running, or jumping, are disqualifying.

(3) Current or history of clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or impairs walking, marching, running, or jumping is disqualifying.

(4) Current symptomatic pes planus [acquired (734), congenital (754.6)] or history of pes planus corrected by prescription or custom orthotics is disqualifying.

(5) Current ingrown toenails (703.0), if infected or symptomatic, are disqualifying.

(6) Current plantar fasciitis (728.71) is disqualifying

(7) Current neuroma (355.6) that is refractory to medical treatment, or impairs walking, marching, running, or jumping, or prevents the proper wearing of military footwear, is disqualifying.

c. Leg, Knee, Thigh, and Hip.

(1) Current loose or foreign body in the knee joint (717.6) is disqualifying.

(2) History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury is disqualifying. History of surgical correction of knee ligaments (P81.4) is disqualifying only if symptomatic or unstable.

(3) Current symptomatic medial and lateral collateral ligament injury is disqualifying.

(4) Current symptomatic medial or lateral meniscal injury is disqualifying.

(5) Current unspecified internal derangement of the knee (717.9) is disqualifying.

(6) Current or history of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Perthes Disease) (732.1), or slipped femoral epiphysis of the hip (732.2) is disqualifying.

(7) Current or history of hip dislocation (835) within 2 years preceding examination is disqualifying.

(8) Current osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4) is disqualifying if symptomatic.

d. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), ankle and/or foot (719.47) that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty, are disqualifying

(2) Current leg-length discrepancy resulting in a limp (736.81) is disqualifying.

24. Miscellaneous Conditions of the Extremities.

a. Chondromalacia. Current or history of chondromalacia (717.7), including, but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome, chronic osteoarthritis (715.3) or traumatic arthritis (716.1), is disqualifying.

b. Dislocations of any major joints. Current joint dislocation if unreduced, or history of recurrent dislocations of any major joint such as shoulder (831), hip (835), elbow (832), knee (836), ankle (837) or instability of any major joint [shoulder (718.81), elbow (718.82), hip (718.85), ankle and foot (718.87) or

multiple sites (718.89)] is disqualifying. History of recurrent instability of the knee or shoulder is disqualifying.

c. Osteoarthritis. Current or history of chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree that has interfered with the following of a physically active vocation in civilian life, or that prevents the satisfactory performance of military duty is disqualifying.

d. Fractures.

(1) Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture) is disqualifying.

(2) Current retained hardware that is symptomatic, interferes with proper wearing of protective equipment or military uniform, and/or is subject to easy trauma, is disqualifying (V53.7). Retained hardware (including plates, pins, rods, wires, or screws used for fixation) is not disqualifying if fractures are healed, ligaments are stable, there is no pain, and it is not subject to easy trauma.

e. Orthopedic implants. Current devices, including, but not limited to silastic or titanium, implanted to correct orthopedic abnormalities (V43), are disqualifying.

f. Bone or joint contusion. Current or history of contusion of bone or joint; an injury of more than a minor nature that shall interfere or prevent performance of military duty, or shall require frequent or prolonged treatment without fracture nerve injury, open wound, crush or dislocation, which occurred in the preceding 6 weeks [upper extremity (923), lower extremity (924), or ribs and clavicle (922)] is disqualifying.

g. Joint replacement. History of joint replacement of any site (V43.6) is disqualifying.

h. Muscular paralysis, contracture, or atrophy. Current or history of muscular paralysis, contracture, or atrophy (728), if progressive or of sufficient degree to interfere with or prevent satisfactory performance of military duty, or shall require frequent or prolonged treatment, is disqualifying.

i. Osteochondromatosis or multiple cartilaginous exostoses. Current or history of osteochondromatosis or multiple cartilaginous exostoses (727.82) are disqualifying.

j. Osteoporosis. Current osteoporosis (733) is disqualifying.

k. Osteomyelitis. Current osteomyelitis (730.0) or history of recurrent osteomyelitis is disqualifying.

l. Osteochondritis desiccans. Current osteochondritis desiccans (732.7) is disqualifying.

25. Vascular System.

a. Arteries and blood vessels. Current or history of abnormalities of the arteries and blood vessels (447), including, but not limited to aneurysms (442), atherosclerosis (440), or arteritis (446), are disqualifying.

b. Vascular disease. Current or history of hypertensive vascular disease (401) is disqualifying. Elevated blood pressure defined as the average of three consecutive sitting blood pressure measurements separated by at least 10 minutes, diastolic greater than 90 mmHg or systolic greater than 140 mmHg, is disqualifying (796.2).

c. Peripheral vascular disease. Current or history of peripheral vascular disease (443), including, but not limited to diseases such as Raynaud's Disease (443.0), is disqualifying.

d. Venous diseases. Current or history of venous diseases, including, but not limited to recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454), is disqualifying.

26. Skin and Cellular Tissues.

a. Sebaceous glands. Current diseases of sebaceous glands to include severe acne (706.1), if extensive involvement of the neck, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of military equipment are disqualifying. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (Accutane(r)), are disqualified until eight weeks after completion o f therapy.

b. Atopic dermatitis. Current or history of atopic dermatitis (691) or eczema (692) after the 9th birthday is disqualifying.

c. Contact dermatitis. Current or history of contact dermatitis (692.4), especially involving materials used in any type of required protective equipment, is disqualifying.

d. Cysts.

1. Current cyst (706.2) (other than pilonidal cyst) of such a size or location as to interfere with the proper wearing of military equipment is disqualifying.

2. Current pilonidal cyst (685) evidenced by the presence of a tumor mass or a discharging sinus is disqualifying. Surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative is disqualifying.

e. Bullous dermatoses. Current or history of bullous dermatoses (694), including, but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa, is disqualifying.

f. Lymphedema. Current chronic lymphedema (457.1) is disqualifying.

g. Furunculosis or carbuncle. Current or history of furunculosis or carbuncle (680) if extensive, recurrent, or chronic is disqualifying.

h. Hyperhidrosis of hands or feet. Current or history of severe hyperhidrosis of hands or feet (780.8) is disqualifying.

i. Skin anomalies congenital or acquired. Current or history of congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation, is disqualifying. History of Dysplastic Nevus Syndrome is disqualifying (232).

j. Keloid formation. Current or history of keloid formation (701.4), if that tendency is marked or interferes with the proper wearing of military equipment, is disqualifying.

k. Lichen planus. Current lichen planus (697.0) is disqualifying.

l. Neurofibromatosis. Current or history of neurofibromatosis (Von Recklinghausen's Disease) (237.7) is disqualifying.

m. Photosensitivity. History of photosensitivity (692.72), including, but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, is disqualifying.

n. Psoriasis, Radiodermatitis, scleroderma. Current or history of psoriasis (696.1) is disqualifying. E1.20.15. Current or history of radiodermatitis (692.82) is disqualifying. E1.20.16. Current or history of extensive scleroderma (710.1) is disqualifying.

o. Urticaria. Current or history of chronic or recurrent urticaria (708.8) is disqualifying.

p. Plantar wart(s). Current symptomatic plantar wart(s) (078.19) is disqualifying.

q. Scars or any other chronic skin disorder. Current scars (709.2) or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of military clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty, is disqualifying.

r. Fungus infections. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties, are disqualifying. For systemic fungal infections, refer to paragraph E 1.22.23.

27. Blood and Forming Tissues.

a. Anemia. Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction, is disqualifying. For the purposes of this Instruction, anemia is defined as a hemoglobin of less than 13.5 for males and less than 12 for females. Use the following ICD-9 codes for diagnosed anemia: hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).

b. Coagulation defects. Current or history of coagulation defects (286) to include, but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), Henoch-Schönlein Purpura (287.0), is disqualifying.

c. Agranulocytosis. and/or leukopenia. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0) is disqualifying.

28. Systemic.

a. Immunodeficiencies. Current or history of disorders involving the immune mechanism including immunodeficiencies (279) is disqualifying. Presence of Human Immunodeficiency Virus or serologic evidence of infection (042) is disqualifying. False positive screening test(s) with ambiguous results on confirmatory immunologic testing is disqualifying.

b. Lupus. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9) is disqualifying.

c. Sclerosis. Current or history of progressive systemic sclerosis (710.1), including CRST Variant, is disqualifying. A single plaque of localized Scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

d. Reiter's disease. Current or history of Reiter's disease (099.3) is disqualifying.

e. Rheumatoid arthritis. Current or history of rheumatoid arthritis (714.0) is disqualifying.

f. Sjögren's syndrome. Current or history of Sjögren's syndrome (710.2) is disqualifying.

g. Vasculitis. Current or history of vasculitis, including, but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegner's granulomatosis (446.4), is disqualifying.

h. Tuberculosis (010).

(1) Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years, is disqualifying.

(2) Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty are disqualifying.

(3) Individuals with a past history of active tuberculosis greater than 2 years before appointment, enlistment, or induction are qualified if they have received a complete course of standard chemotherapy for tuberculosis.

(4) Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest x-ray) (795.5) is disqualifying. Individuals with a tuberculin reaction in accordance with the guidelines of the American Thoracic Society and U.S. Public Health Service (ATS/USPHS), and without evidence of residual disease in pulmonary or non-pulmonary sites are eligible for enlistment, induction, and appointment, provided they have received chemoprophylaxis in accordance with the guidelines of the ATS/USPHS.

i. Syphilis. Current untreated syphilis is disqualifying (097).

j. Anaphylaxis. History of anaphylaxis (995.0), including, but not limited to idiopathic and exercise-induced; anaphylaxis to venom, including stinging insects (989.5); foods or food additives (995.60-69); or to natural rubber latex (989.82), is disqualifying.

k. Tropical fevers. Current residual of tropical fevers, including, but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty, is disqualifying.

l. Sleep disturbances. Current sleep disturbances (780.5), including, but not limited to sleep apneas, is disqualifying.

m. Malignant hyperthermia. History of malignant hyperthermia (995.86) is disqualifying.

n. Industrial solvent or other chemical intoxication. History of industrial solvent or other chemical intoxication (982) with sequelae is disqualifying.

o Motion sickness. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years is disqualifying.

p. Rheumatic fever. History of rheumatic fever (390) is disqualifying.

q. Muscular dystrophies. Current or history of muscular dystrophies (359) or myopathies is disqualifying.

r. Amyloidosis. Current or history of amyloidosis (277.3) is disqualifying.

s. Granuloma. Current or history of eosinophilic granuloma (277.8) is disqualifying. Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, shall not be a cause for disqualification. All other forms of the Histiocytosis (202.3) are disqualifying.

t. Polymyositis /dermatomyositis. Current or history of polymyositis (710.4) /dermatomyositis complex (710.3) with skin involvement is disqualifying.

u. Rhabdomyolysis / Sarcoidosis. History of (728.88) is disqualifying. E1.22.22. Current or history of sarcoidosis (135) is disqualifying.

v. Fungus infections. Current systemic fungus infections (117) are disqualifying. For localized fungal infections, refer to paragraph E1.20.20.

29. Endocrine and Metabolic.

a. Adrenal dysfunction. Current or history of adrenal dysfunction (255) is disqualifying.

b. Diabetes mellitus. Current or history of diabetes mellitus (250) is disqualifying.

c. Pituitary dysfunction. Current or history of pituitary dysfunction (253) is disqualifying.

d. Gout. Current or history of gout (274) is disqualifying.

e. Hyperparathyroidism or hypoparathyroidism. Current or history of hyperparathyroidism (252.0) or hypoparathyroidism (252.1) is disqualifying.

f. Thyroid Disorders.

(1) Current goiter (240) is disqualifying.

(2) Current hypothyroidism (244) uncontrolled by medication is disqualifying.

(3) Current or history of hyperthyroidism (242.9) is disqualifying.

(4) Current thyroiditis (245) is disqualifying.

g. Nutritional deficiency diseases. Current nutritional deficiency diseases, including, but not limited to beriberi (265), pellagra (265.2), and scurvy (267), are disqualifying.

h. Glycosuria. Current persistent Glycosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4), is disqualifying.

i. Acromegaly. Current or history of Acromegaly, including, but not limited to gigantism, or other disorders of pituitary function (253), is disqualifying.

30. Neurologic.

a. Cerebrovascular conditions. Current or history of cerebrovascular conditions, including, but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular insufficiency, aneurysm or arteriovenous malformation (437), are disqualifying.

b. Central nervous system anomalies. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9) is disqualifying.

c. Meninges disorders. Current or history of disorders of meninges, including, but not limited to cysts (349.2), is disqualifying.

d. Hereditodegenerative disorders. Current or history of degenerative and hereditodegenerative disorders, including, but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), or peripheral nerves (337), are disqualifying.

e. Headaches. History of recurrent headaches (784.0), including, but not limited to, migraines (346) and tension headaches (307.81) that interfere with

normal function in the past 3 years, or of such severity to require prescription medications, are disqualifying.

f. Head Injury. (854.0)

(1) History of severe head injury shall be disqualifying if associated with any of the following:

(a) Post-traumatic seizure(s) occurring more than 30 minutes after injury.

(b) Persistent motor or sensory deficits.

(c) Impairment of intellectual function.

(d) Alteration of personality.

(e) Unconsciousness, amnesia, or disorientation of person, place, or time of 24-hours duration or longer post-injury.

(f) Multiple or depressed fractures involving skull or face (804).

(g) Cerebral laceration or contusion (851).

(h) History of epidural, subdural, subarachnoid, or intracerebral hematoma (852).

(i) Associated abscess (326) or meningitis (958.8).

(j) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.

(k) Focal neurologic signs.

(l) Radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

(m) Leptomeningeal cysts or Arteriovenous Fistula.

(2) History of moderate head injury (854.03) is disqualifying. After 2 years post-injury, applicants may be qualified if neurological consultation shows no residual dysfunction or complications. Moderate head injuries are defined as unconsciousness, amnesia, or disorientation of person, place, or time alone or in combination, of more than 1 and less than 24-hours duration post-injury, or linear skull fracture.

(3) History of mild head injury (854.02) is disqualifying. After 1 month post-injury, applicants may be qualified if neurological evaluation shows no residual dysfunction or complications. Mild head injuries are defined

as a period of unconsciousness, amnesia, or disorientation of person, place, or time, alone or in combination of 1 hour or less post-injury.

(4) History of persistent post-traumatic symptoms (310.2) that interfere with normal activities or have duration of greater than 1 month is disqualifying. Such symptoms include, but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

g. Infectious Diseases of the Central Nervous System.

(1) Current or history of acute infectious processes of the central nervous system, including, but not limited to meningitis (322), encephalitis (323), or brain abscess (324), are disqualifying if occurring within 1 year before examination, or if there are residual neurological defects.

(2) History of neurosyphilis (094) of any form, including, but not limited to general paresis, tabes dorsalis, or meningovascular syphilis, is disqualifying.

h. Paralysis, weakness, lack of coordination, chronic pain, or sensory disturbance. Current or history of paralysis, weakness, lack of coordination, chronic pain, or sensory disturbance or other specified paralytic syndromes (344) is disqualifying.

i. Epilepsy. Epilepsy occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal electroencephalogram (EEG) is disqualifying. All such applicants shall have a current neurology consultation with current EEG results (345).

j. Nervous system disorders. Chronic nervous system disorders, including, but not limited to myasthenia gravis (358.0), multiple sclerosis (340), and tic disorders (307.20) [e.g., Tourette's (307.23)] are disqualifying.

k. Central nervous system shunts. Current or history of retained central nervous system shunts of all kinds (V45.2) are disqualifying.

l. Narcolepsy or cataplexy. Current or history of narcolepsy or cataplexy (347) is disqualifying.

31. Learning Psychiatric and Behavioral.

a. Attention Deficit Disorder. Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder (314), or Perceptual/Learning Disorder(s) (315) is disqualifying, unless applicant can demonstrate passing academic

performance and there has been no use of medication(s) in the previous 12 months.

b. Academic skills or perceptual defects. Current or history of academic skills or perceptual defects (315) secondary to organic or functional mental disorders, including, but not limited to dyslexia, that interfere with school or employment, are disqualifying. Applicants demonstrating passing academic and employment performance without utilization or recommendation of academic and/or work accommodations at any time in the previous 12 months may be qualified.

c. Psychotic features. Current or history of disorders with psychotic features such as schizophrenia (295), paranoid disorder (297), other and unspecified psychosis (298) is disqualifying.

d. Mood disorders. Current mood disorders including, but not limited to, major depression (296.2-3), bipolar (296.4-7), affective psychoses (296.8-9), depressive not otherwise specified (311), are disqualifying.

(1) History of mood disorders requiring outpatient care for longer than 6 months by a physician or other mental health professional (V65.40), or inpatient treatment in a hospital or residential facility is disqualifying.

(2) History of symptoms consistent with a mood disorder of a repeated nature that impairs school, social, or work efficiency is disqualifying.

e. Adjustment disorders. Current or history of adjustment disorders (309) within the previous 3 months is disqualifying.

f. Conduct or behavior disorders. Current or history of conduct (312), or behavior (313) disorders is disqualifying. Recurrent encounters with law enforcement agencies, antisocial attitudes or behaviors are tangible evidence of impaired capacity to adapt to military service and as such are disqualifying.

g. Personality disorder. Current or history of personality disorder (301) is disqualifying. History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Armed Forces is disqualifying.

h. Other behavior disorders. Current or history of other behavior disorders is disqualifying, including, but not limited to conditions such as the following:

(1) Enuresis (307.6) or encopresis (307.7) after 13th birthday.

(2) Sleepwalking (307.4) after 13th birthday.

(3) Eating disorders (307.5), anorexia nervosa (307.1), bulimia (307.51), or unspecified disorders of eating (307.59) lasting longer than 3 months and occurring after 13th birthday.

i. Receptive or expressive language disorder. Any current receptive or expressive language disorder, including, but not limited to any speech impediment, stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or to repeat commands, is disqualifying.

j. Suicidal behavior. History of suicidal behavior, including gesture(s) or attempt(s) (300.9), or history of self-mutilation, is disqualifying.

k. Anxiety disorders. Current or history of anxiety disorders [anxiety (300.01), panic (300.2)] agoraphobia (300.21), social phobia (300.23), simple phobias (300.29), obsessive-compulsive (300.3), other acute reactions to stress (308), posttraumatic stress disorder (309.81) are disqualifying.

l. Dissociative disorders. Current or history of dissociative disorders, including, but not limited to hysteria (300.1), depersonalization (300.6), and other (300.8), are disqualifying.

m. Somatoform disorders. Current or history of somatoform disorders, including, but not limited to hypochondriasis (300.7) or chronic pain disorder, are disqualifying.

n. Psychosexual conditions. Current or history of psychosexual conditions (302), including, but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias, are disqualifying.

o. Alcohol dependence, abuse. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305), or other drug abuse (305.2 thru 305.9) is disqualifying.

p. Mental disorders. Current or history of other mental disorders (all 290-319 not listed above) that in the opinion of the civilian or military provider shall interfere with, or prevent satisfactory performance of military duty are disqualifying.

32. Tumors and Malignancies.

a. Tumors. Current benign tumors (M8000) or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome, are disqualifying.

b. Malignant tumors. Current or history of malignant tumors (V10) is disqualifying. Skin cancer (other than malignant melanoma) removed with no residual, is not disqualifying.

33. Miscellaneous.

a. Parasitic diseases. Current or history of parasitic diseases, if symptomatic or carrier state, including, but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), unspecified infectious and parasitic disease (136.9), are disqualifying.

b. Frequent or prolonged treatment. Current or history of other disorders, including, but not limited to cystic fibrosis (277.0), or porphyria (277.1), that prevent satisfactory performance of duty or require frequent or prolonged treatment are disqualifying.

c. Cold-related disorders. Current or history of cold-related disorders, including, but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2), are disqualifying. Current residual effects of cold-related disorders, including, but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache, are disqualifying.

d. Angioedema. History of angioedema, including hereditary angioedema (277.6), is disqualifying.

e. Organ or tissue transplantation. History of receiving organ or tissue transplantation (V42) is disqualifying.

f. Pulmonary or systemic embolization. History of pulmonary (415) or systemic embolization (444) is disqualifying.

g. Metallic poisoning. History of untreated acute or chronic metallic poisoning, including, but not limited to lead, arsenic, silver (985), beryllium, or manganese (985), is disqualifying. Current complications or residual symptoms of such poisoning are disqualifying.

h. Heat pyrexia heatstroke or sunstroke. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0) is disqualifying. History of three or more episodes of heat exhaustion (992.3) is disqualifying. Current or history of a predisposition to heat injuries, including disorders of sweat mechanism, combined with a previous serious episode is disqualifying. Current or history of any unresolved sequelae of heat injury, including, but not limited to nervous, cardiac, hepatic or renal systems, is disqualifying.

i. Interference of performance of duty. Current or history of any condition that in the opinion of the medical officer shall significantly interfere with the

successful performance of military duty or training is disqualifying (should use specific ICD code whenever possible, or 796.9).

j. Pathological conditions. Any current acute pathological condition, including, but not limited to acute communicable diseases, until recovery has occurred without sequelae, is disqualifying.

FIGURE 3-D-1

Evaluation for Risk of Head Injury Sequelae

DEGREE OF HEAD INJURY	MINIMUM REQUIRED WAITING PERIOD	EVALUATION REQUIREMENTS
MILD	ONE MONTH	COMPLETE NEUROLOGICAL EXAMINATION BY A PHYSICIAN
MODERATE	TWO YEARS	COMPLETE NEUROLOGICAL EVALUATION BY A NEUROLOGIST OR INTERNIST CT SCAN
SEVERE	PERMINANT DISQUALIFICATION	COMPLETE NEUROLOGICAL EVALUATION BY NEUROLOGIST OR NEUROSURGEON CT SCAN NEUROPSYCHOLOGICAL EVALUATION

FIGURE 3-D-2

Classification and Comparative Nomenclature of Cervical Smears

Original Classification	CIN System	Bethesda System
Class I: No abnormal cells	Normal smear;	
Class II: Atypical cells present below the level of cervical neoplasia		Atypical squamous cells of undetermined significance
Class III: Smear contains abnormal cells consistent with dysplasia	Mild dysplasia = CIN1 Moderate dysplasia = CIN2	Low-grade SIL (Changes associated with HPV & CIN1)
Class IV Smear contains abnormal cells consistent with carcinoma-in-situ	Severe dysplasia and carcinoma-in-situ = CIN3	High-grade SIL (CIN2, CIN3, and carcinoma-in-situ)
Class V: Smear contains abnormal 1. cells consistent with carcinoma 2. squamous cell carcinoma		Squamous cell carcinoma

Abbreviations: CIN = cervical intraepithelial neoplasia
SIL = squamous intraepithelial lesion

CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section E. Physical Standards for Programs Leading to Commission.

1. Appointment as Cadet, United States Coast Guard Academy. 1
2. Commissioning of Cadets. 2
3. Enrollment as an Officer Candidate. 2
4. Commissioning of Officer Candidates. 3
5. Coast Guard Direct Commission Program. 4
6. Direct Commission in the Coast Guard Reserve. 4
7. Direct Commission of Licensed Officers of U. S. Merchant Marine. 4
8. Appointment to Warrant Grade. 4

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section E. Physical Standards for Programs Leading to Commission.

1. Appointment as Cadet, United States Coast Guard Academy.

   a. Physical Examinations.

      (1) Applicants are encouraged to review the physical standards as published in the Academy Bulletin with their private physician prior to submitting their application for cadet candidate. This review serves to rule out, at this stage of the potential cadet's processing, applicants who obviously will not meet the required physical standards for appointment. In some cases, the physician may recommend a complete physical examination. Inaccuracy in ascertaining defects and determining the candidate's physical status at the time of this review results in unnecessary work for the Coast Guard and disappointment to the candidate when defects are subsequently found during the formal physical examination.

      (2) Candidates and their parents and sponsors are urged to refrain from requesting waivers for medical defects. The Coast Guard bases its decision to disqualify an individual on medical facts revealed in a thorough physical examination. Candidates unable to satisfy the minimum requirements are not suited for commission in the Regular Coast Guard, and consequently are not eligible for training at the Academy. A request for waiver for a medical defect invariably results in disappointment to all concerned.

      (3) Two physical examinations are required:

         (a) Formal physical examination before appointment is tendered.

         (b) Pre-training examination at the time of reporting to the Academy.

      (4) Formal physical examinations prior to accepting of candidates must be performed by a U. S. Public Health Service, Navy, Army, Air Force, or Veteran's Administration medical officer authorized to perform each exam by Department of Defense Medical Examination Review Board (DODMERB). All candidates are instructed where to report for such examinations.

   b. Physical Standards. All candidates for the Coast Guard Academy must meet the physical standards for enrollment as an officer candidate. DODMERB is reviewing authority.

   c. Retention. The standards for retention of a cadet at the Academy are the same as those for enrollment as an officer candidate, except that the Superintendent of the Academy is authorized to establish physical fitness and weight control programs designed to have cadets maintain weight

closer to the ideal than the standards stipulated elsewhere for Service personnel. These stricter goals during cadet years are intended to take advantage of the Academy's unique environment of rigorous physical activity combined with opportunities for diet control and weight monitoring. These programs will instill lifelong behavior patterns to support the Service weight control standards.

2. Commissioning of Cadets.
The pre-appointment physical examination of cadets in the graduating class should be held at least 6 months prior to acceptance of the commission. This physical examination should be conducted to determine physical fitness for commission in the Regular Service (section 3-D and 3-E) with recommendations made accordingly. Cadets should not be summarily disqualified for commissioning merely because they do not meet the standards for appointment as cadets provided that they may reasonably be expected to be physically capable of completing a full and effective Coast Guard career. In general, relatively minor defects that would be disqualifying for original commission direct from civilian life are not disqualifying for commission of a cadet in whom the Government has a considerable investment.

3. Enrollment as an Officer Candidate.

a. Physical Examination. The physical examination for an officer candidate must be conducted by a medical officer and a dentist. Particular care must be exercised during the examination in order that candidates may not be rejected later as a result of reexamination at Officer Candidate School. A complete physical examination is given officer candidates upon arrival at OCS to determine medical fitness and freedom from disease. Physician Assistant Officer Candidates will only receive an initial OCS candidate physical.

b. Physical Standards for Enrollment. The standards contained in section 3-D (section 3-F for enlisted OCS candidates), as modified below, are applicable for enrollment as an officer candidate. Conditions not enumerated, that in the medical examiner's opinion will not permit a full productive career, shall be recorded in detail with appropriate recommendations.

(1) Distant Visual Acuity. Uncorrected visual acuity shall be not worse than20/400 in either eye provided that vision is correctable to 20/20 and that refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder), astigmatism does not exceed 3.00 diopters, and anisometropia does not exceed 3.50 diopters. Eyes must be free from any disfiguring or incapacitating abnormality and from acute or chronic disease. All personnel requiring corrective lenses shall wear them for the performance of duty.

(2) Near visual acuity of any degree that does not correct to 20/40 in the better eye.

(3) Normal color perception.

(4) Teeth.

(a) All candidates shall be given a Type II dental examination by a dental officer, as part of the pre-training physical examination.

(b) Caries. No more than four teeth may exhibit multi-surface caries.

(c) Endodontics. The need for endodontic intervention on seven or more canals is disqualifying.

(d) Maxillary and Mandibular Bones. Malunited fractures of maxillary or mandibular bones and deformities of maxillary or mandibular bones interfering with mastication or speech are disqualifying. The presences of extensive necrosis or osseous lesions requiring surgical intervention are also disqualifying.

(e) Oral Tissues. Extensive loss of oral tissues that would prevent the replacement of missing teeth with a satisfactory prosthetic appliance is disqualifying. Unresolved oral inflammatory diseases are disqualifying. Hypertrophic, hyperplastic, or leukoplakic conditions of the soft tissue of the oral cavity may be disqualifying and will be considered on a case-by-case basis.

(f) Periodontal Disease. The presence of advanced periodontal disease is disqualifying.

(g) Serviceable Teeth. A sufficient number of teeth, natural or artificial, in functional occlusion to assure satisfactory incision, mastication, and phonation are required. The minimum requirement is edentulous upper and lower jaws corrected by full dentures. A requirement for placement of a prosthesis to meet the above requirements is disqualifying.

(h) Temporomandibular Joint. Current symptoms and/or history of chronic temporomandibular joint dysfunction is disqualifying (see also section 3-D-16.b).

4. Commissioning of Officer Candidates.

a. The physical examination given upon arrival at OCS precludes the need for a commissioning physical examination providing there has been no intervening change in physical status and a visual acuity and color perception examination are given prior to actual commissioning.

b. The physical standards for commissioning are the same as for enrollment as an officer candidate. Final determination as to physical fitness for commissioning is made by the Commandant.

5. Coast Guard Direct Commission Program.
Physical standards for Coast Guard active duty member's (CWO's, enlisted) that apply for the Direct Commission program are the same as for retention of officers in the regular Coast Guard. (refer to Section F of this Manual for the standards). Physical standards for all other applicants are the same as for enrollment of officer candidates.

6. Direct Commission in the Coast Guard Reserve.

   a. Non-aviator. The physical examination and standards for direct commission in the Reserve are the same for enrollment of officer candidates, except that Ready Reserve Direct Commission (RRDC) examinations must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).

   b. Aviator. Candidates for direct commission in the Reserve as aviators must obtain an aviation physical examination from a currently qualified uniformed services flight surgeon or AMO within the last 12 months. The candidate must meet the standards for Class I, contained in section 3-G.

7. Direct Commission of Licensed Officers of U. S. Merchant Marine.

   a. Physical Examination. Two physical examinations are required: a preliminary physical at the time of the written examination; and a pre-appointment physical examination taken by successful candidates within six months of actual commission. The physical examination must be conducted by a medical officer of the uniformed services on active duty. Final determination of physical fitness will be made by the Commandant.

   b. Physical Standards. The physical standards for direct commission of Licensed Officers of the U. S. Merchant Marine are the same as for enrollment of officer candidates. All these standards must be met without waiver.

8. Appointment to Warrant Grade.

   a. Physical Examination. A complete physical examination is required within 12 months prior to appointment to Warrant Officer, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).

   b. Physical Requirements. The physical standards for appointment of Coast Guard members to Warrant Officer are the same as for retention of officers in the regular Coast Guard. (refer to Section 3-F of this Manual for the standards). Physical standards for all other applicants are the same as for enrollment of officer candidates.

CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section F. Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions. 1
2. Use of List of Disqualifying Conditions and Defects. 1
3. Head and Neck. 1
4. Esophagus, Nose, Pharynx, Larynx, and Trachea. 2
5. Eyes. 2
6. Ears and Hearing. 4
7. Lungs and Chest Wall. 5
8. Heart and Vascular System. 6
9. Abdomen and Gastrointestinal System. 9
10. Endocrine and Metabolic Conditions (Diseases). 11
11. Genitourinary System. 11
12. Extremities. 13
13. Spine, Scapulae, Ribs, and Sacroiliac Joints 17
14. Skin and Cellular Tissues 17
15. Neurological Disorders. 19
16. Psychiatric Disorders. (see section 5-B concerning disposition) 20
17. Dental. 21
18. Blood and Blood-Forming Tissue Diseases. 21
19. Systemic Diseases, General Defects, and Miscellaneous Conditions 21
20. Tumors and Malignant Diseases. 23
21. Sexually Transmitted Disease. 23
22. Human Immunodeficiency Virus (HIV). 23
23. Transplant recipient. 23

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section F. Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.

   a. Scope. This section establishes specific physical standards applicable to all personnel (regular and reserve) for:

      (1) Enlistment/reenlistment of prior service USCG personnel within 6 months of discharge from active duty in the Regular Coast Guard.

      (2) Retention.

      (3) Overseas duty.

      (4) Sea duty.

   b. Physical Examinations. Physical examinations should be conducted by at least one medical and one dental officer of the uniformed services or by contract physician/dentist.

   c. Fitness for Duty. Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Active duty or reserves on extended active duty considered permanently unfit for duty shall be referred to an Initial Medical Board for appropriate disposition. Reservists in any status not found 'fit for duty' six months after incurring/aggravating an injury or illness, or reservists who are unlikely to be found 'fit for duty' within six months after incurring/aggravating an injury or illness shall be referred to an Initial Medical Board. See Personnel Manual COMDTINST M1001.28 (series), Chapter 6, "Reserve Incapacitation System".

2. Use of List of Disqualifying Conditions and Defects.
   This section lists certain medical conditions and defects that are normally disqualifying. However, it is not an all-inclusive list. Its major objective is to achieve uniform disposition of cases arising under the law, but it is not a mandate that possession of one or more of the listed conditions or physical defects (and any other not listed) means automatic retirement or separation. If the member's condition is disqualifying but he/she can perform his/her duty, a waiver request could be submitted in lieu of immediate referral to an Initial Medical Board. If the request is denied, then an Initial Medical Board is required. The only exception is HIV infection, which may not require waiver or referral to IMB if the member continues to fully perform duties. (see Chapter 3- F-22 of this Manual).

3. Head and Neck.

a. Loss of substance of the skull. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms.

b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

4. Esophagus, Nose, Pharynx, Larynx, and Trachea.

a. Esophagus.

(1) Achalasia. Manifested by dysphagia (not controlled by dilation), frequent discomfort, inability to maintain normal vigor and nutrition, or requiring frequent treatment.

(2) Esophagitis. Persistent and severe.

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

(4) Stricture of the esophagus. Of such a degree as to almost restrict diet to liquids, require frequent dilation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

(1) Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.

(2) Stenosis of the larynx. Causing respiratory embarrassment upon more than minimal exertion.

(3) Obstruction edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

c. Nose, Pharynx, Trachea.

(1) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and concomitant severe headaches.

(2) Sinusitis. Severe and chronic that is suppurative, complicated by polyps, and does not respond to treatment.

(3) Trachea. Stenosis of trachea that compromises airflow to more than a mild degree.

5. Eyes.

a. Diseases and Conditions.

(1) Active eye disease or any progressive organic disease regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual field so that the member fits into one of the following:

(a) Distant visual acuity does not meet the standards.

(b) The diameter of the field of vision in the better eye is less than 20°.

(2) Aphakia, bilateral. Regardless of lens implant(s).

(3) Atrophy of optic nerve.

(4) Glaucoma. If resistant to treatment, or affecting visual fields, or if side effects of required medications are functionally incapacitating.

(5) Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.

(6) Ocular manifestations of endocrine or metabolic disorders. Not disqualifying, per se; however, residuals or complications, or the underlying disease may be disqualifying.

(7) Residuals or complications of injury. When progressive or when reduced visual acuity or fields do not meet the standards.

(8) Retina, detachment of.

(a) Unilateral.

1 When visual acuity does not meet the standards.

2 When the visual field in the better eye is constricted to less than 20°.

3 When uncorrectable diplopia exists.

4 When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(b) Bilateral. Regardless of etiology or results of corrective surgery.

b. Vision.

(1) Aniseikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.

(2) Binocular diplopia. Which is severe, constant, and in zone less than 20° from the primary position.

(3) Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally disqualifying.

(4) Night blindness. Of such a degree that the individual requires assistance in any travel at night.

(5) Visual Acuity.

(a) Visual acuity that cannot be corrected to at least 20/50 in the better eye.

(b) Complete blindness or enucleation of an eye.

(c) When vision is correctable only by the use of contact lenses or other corrective device (telescope lenses, etc.).

(6) Visual Fields. When the visual field in the better eye is constricted to less than 20o.

(7) Color Perception. Normal color perception is required for retention of commissioned officers (certain warrant officer specialties do not require normal color perception) and selected ratings [See the Personnel Manual, COMDTINST M1000.6 (series) and Chapter 5-B]. Retesting for color perception is not required if results of previous tests are documented in the health record, and there has been no history of a change in color vision.

c. Corneal Refractive Surgery.

(1) The refractive surgery procedures radial keratotomy (RK), and intracorneal rings (ICR) are disqualifying and not waiverable.

(2) Corneal Refractive Surgery for aviation personnel and candidates is discussed in Chapter 3. Section G.13 of this manual.

(3) Photorefractive keratectomy (PRK) or Laser Assisted in situ Keratomileusis (LASIK) is not disqualifying for non-aviation members, including diving personnel, and does not require a waiver if the following conditions are met:

(a) Must follow guidelines for elective health care contained in 2.A.6.

(b) There must be post surgical refractive stability defined as less than 0.50 diopter changes over two separate exams at least three months apart.

(c) Must meet all vision standards in 3-F.5.b (divers must meet vision standards in 3-H.2.h). If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2 (series).

6. Ears and Hearing.

a. Ears.

(1) Infections of the external auditory canal. Chronic and severe, resulting in thickening and excoriation of the canal, or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

(2) Malfunction of the acoustic nerve. Evaluate hearing impairment.

(3) Mastoiditis, chronic. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.

(4) Mastoidectomy. Followed by chronic infection with constant or recurrent drainage requiring frequent or prolonged medical care.

(5) Meniere's syndrome. Recurring attacks of sufficient frequency and severity as to interfere with satisfactory performance of military duty, or require frequent or prolonged medical care.

(6) Otitis Media. Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent or prolonged medical care.

b. Hearing. Retention will be determined on the basis of ability to perform duties of grade or rating.

7. Lungs and Chest Wall.

a. Tuberculous Lesions. See chapter 7 of this Manual.

(1) Pulmonary tuberculosis.

(a) When an active duty member's disease is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months, including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)

(b) When a Reservist not on active duty has TB that will probably require treatment for more that 12 to 15 months including an appropriate period of convalescence before being able to perform full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

b. Nontuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by measurements that must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity. Many of the conditions listed below may coexist and in combination may produce unfitness.

(1) Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications that require repeated hospitalization.

(2) Bronchial Asthma. Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks not controlled by inhaled or oral medications, or requiring oral corticosteroids more than twice a year.

(3) Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications that require repeated hospitalization.

(4) Bronchitis. Chronic, severe persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications that require repeated hospitalization.

(5) Cystic disease of the lung, congenital. Involving more than one lobe of a lung.

(6) Diaphragm, congenital defect. Symptomatic.

(7) Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight, or marked restriction of respiratory excursion and chest deformity, or marked weakness and fatigability on slight exertion.

(8) Histoplasmosis. Chronic and not responding to treatment.

(9) Pleurisy, chronic or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

(10) Pneumothorax, spontaneous. Repeated episodes of pneumothorax not correctable by surgery.

(11) Pneumoconiosis. Severe with dyspnea on mild exertion.

(12) Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

(13) Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(14) Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals that cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(15) Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.

(16) Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.

c. Surgery of the Lungs and Chest. Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

8. Heart and Vascular System.

a. Heart.

(1) Arrhythmias. Associated with organic heart disease, or if not adequately controlled by medication or if they interfere with satisfactory performance of duty.

(2) Arteriosclerotic disease. Associated with congestive heart failure, repeated anginal attacks, or objective evidence of myocardial infarction.

(3) Endocarditis. Bacterial endocarditis resulting in myocardial insufficiency or associated with valvular heart disease.

(4) Heart block. Associated with other symptoms of organic heart disease or syncope (Stokes-Adams Syndrome).

(5) Myocarditis and degeneration of the myocardium. Myocardial insufficiency resulting in slight limitation of physical activity.

(6) Pericarditis.

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

(b) Chronic serous pericarditis.

(7) Rheumatic valvulitis and valvular heart disease. Cardiac insufficiency at functional capacity and therapeutic level of class IIC or worse, American Heart Association. A diagnosis made during the initial period of service or enlistment that is determined to be a residual of a condition that existed prior to entry in the service is disqualifying regardless of severity.

b. Vascular System.

(1) Arteriosclerosis obliterans. When any of the following pertain:

(a) Intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest.

(b) Objective evidence of arterial disease with symptoms of claudication, ischemic chest pain at rest, or with gangrenous or permanent ulcerative skin changes in the distal extremity.

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

(2) Congenital anomalies. Coarctation of aorta and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.

(3) Aneurysms. Aneurysm of any vessel not correctable by surgery and producing limiting symptomatic conditions precluding satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions that preclude satisfactory performance of duty.

(a) Satisfactory performance of duty is precluded because of underlying recurring or progressive disease producing pain, dyspnea, or similar symptomatic limiting conditions.

1 Reconstructive surgery including grafts, when prosthetic devices are attached to or implanted in the heart.

2 Unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision.

(4) Periarteritis nodosa. With definite evidence of functional impairment.

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

(6) Raynaud's phenomenon. Manifested by trophic changes of the involved part characterized by scarring of the skin or ulceration.

(7) Thrombophlebitis. When repeated attacks require such frequent treatment as to interfere with satisfactory performance of duty.

(8) Varicose veins. Severe and symptomatic despite therapy.

(9) Any condition requiring anti-thrombotic medication other than aspirin.

c. Miscellaneous.

(1) Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.

(2) Hypertensive cardiovascular disease and hypertensive vascular disease.

(a) Diastolic pressure consistently more than 90 mm Hg following an adequate period of therapy on an ambulatory status; or

(b) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

1 Cerebrovascular symptoms.

2 Arteriosclerotic heart disease if symptomatic and requiring treatment.

3 Kidney involvement, manifested by unequivocal impairment of renal function.

4 Grade III (Keith-Wagener-Barker) changes in the fundi.

(3) Rheumatic fever, active, with or without heart damage. Recurrent attacks.

(4) Residual of surgery of the heart, pericardium, or vascular system under one or more of the following circumstances:

(a) When surgery of the heart, pericardium, or vascular system results in inability of the individual to perform duties without discomfort or dyspnea.

(b) When the surgery involves insertion of a pacemaker, reconstructive vascular surgery employing exogenous grafting material.

(c) Similar newly developed techniques or prostheses, the individual is unfit.

9. Abdomen and Gastrointestinal System.

a. Defects and Diseases.

(1) Achalasia. Manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

(2) Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

(3) Biliary dyskinesia. Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

(4) Cirrhosis of the liver. Recurrent jaundice or ascites; or demonstrable esophageal varices or history of bleeding therefrom.

(5) Gastritis. Severe, chronic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.

(6) Hepatitis, chronic. When, after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impaired liver function.

(7) Hernia.

(a) Hiatus hernia. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

(b) Other. If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

(8) Ileitis, regional. (Crohn's disease); Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.

(9) Pancreatitis, chronic. Frequent severe abdominal pain; or steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

(10) Peritoneal adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent hospital admissions.

(11) Proctitis, chronic. Moderate to severe symptoms of bleeding, or painful defecation, tenesmus, and diarrhea, with repeated hospital admissions.

(12) Ulcer, peptic, duodenal, or gastric. Repeated incapacitation or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory, x-ray, and endoscopic evidence of activity.

(13) Ulcerative colitis. Except when responding well to ordinary treatment.

(14) Rectum, stricture of. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

b. Surgery.

(1) Colectomy, partial. When more than mild symptoms of diarrhea remain or if complicated by colostomy.

(2) Colostomy. When permanent.

(3) Enterostomy. When permanent.

(4) Gastrectomy.

(a) Total.

(b) Subtotal, with or without vagotomy, or gastrojejunostomy, when, in spite of good medical management, the individual develops one of the following:

1 "Dumping syndrome" that persists for 6 months postoperatively.

2 Frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively.

3 Continues to demonstrate significant weight loss 6 months postoperatively. Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.

4 Not to be confused with "dumping syndrome," and not ordinarily considered as representative of unfitness are: postoperative symptoms such as moderate feeling of fullness after eating; the need to avoid or restrict ingestion of high carbohydrate foods; the need for daily schedule of a number of small meals with or without additional "snacks."

(5) Gastrostomy. When permanent.

(6) Ileostomy. When permanent.

(7) Pancreatectomy.

(8) Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy. Followed by more than mild symptoms of digestive disturbance, or requiring insulin.

(9) Proctectomy.

(10) Proctopexy, proctoplasty, proctorrhaphy, or proctotomy. If fecal incontinence remains after appropriate treatment.

10. Endocrine and Metabolic Conditions (Diseases).

a. Acromegaly. With function impairment.

b. Adrenal hyperfunction. That does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.

c. Adrenal hypofunction. Requiring medication for control.

d. Diabetes Insipidus. Unless mild, with good response to treatment.

e. Diabetes Mellitus. When requiring insulin or not controlled by oral medications.

f. Goiter. With symptoms of breathing obstruction with increased activity, unless correctable.

g. Gout. With frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

h. Hyperinsulinism. When caused by a malignant tumor, or when the condition is not readily controlled.

i. Hyperparathyroidism. When residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.

j. Hyperthyroidism. Severe symptoms, with or without evidence of goiter, that do not respond to treatment.

k. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.

l. Hypothyroidism. With objective evidence and severe symptoms not controlled by medication.

m. Osteomalacia. When residuals after therapy preclude satisfactory performance of duty.

11. Genitourinary System.

a. Genitourinary conditions.

(1) Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

(2) Dysmenorrhea. Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than l day/month.

(3) Endometriosis. Symptomatic and incapacitating to degree that necessitates recurrent absences of more than 1 day/month.

(4) Hypospadias. Accompanied by chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings, and the condition is not amenable to treatment.

(5) Incontinence of urine. Due to disease or defect not amenable to treatment and so severe as to necessitate recurrent absences from duty.

(6) Menopausal syndrome, physiologic or artificial. With more than mild mental and constitutional symptoms.

(7) Strictures of the urethra or ureter. Severe and not amenable to treatment.

(8) Urethritis, chronic. Not responsive to treatment and necessitating frequent absences from duty.

b. Kidney.

(1) Calculus in kidney. Bilateral or symptomatic and not responsive to treatment.

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

(3) Cystic kidney (polycystic kidney). When symptomatic and renal function is impaired, or if the focus of frequent infection.

(4) Glomerulonephritis, chronic.

(5) Hydronephrosis. More than mild, or bilateral, or causing continuous or frequent symptoms.

(6) Hypoplasia of the kidney. Associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) Nephritis, chronic.

(8) Nephrosis.

(9) Perirenal abscess. With residuals that preclude satisfactory performance of duty.

(10) Pyelonephritis or pyelitis. Chronic, that has not responded to medical or surgical treatment, with evidence of persistent hypertension, eyeground changes, or cardiac abnormalities.

(11) Pyonephrosis. Not responding to treatment.

c. Genitourinary and Gynecological Surgery.

(1) Cystectomy.

(2) Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.

(3) Nephrectomy. When, after treatment, there is infection or pathology in the remaining kidney.

(4) Nephrostomy. If drainage persists.

(5) Oophorectomy. When, following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

(6) Penis, amputation of.

(7) Pyelostomy. If drainage persists.

(8) Ureterocolostomy.

(9) Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

(10) Ureterocystostomy, cutaneous.

(11) Ureteroplasty.

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

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

(12) Ureterosigmoidostomy.

(13) Ureterostomy. External or cutaneous.

(14) Urethrostomy. When a satisfactory urethra cannot be restored.

12. Extremities.

a. Upper.

(1) Amputations. Amputation of part or parts of an upper extremity equal to or greater than any of the following:

(a) A thumb proximal to the interphalangeal joints.

(b) Two fingers of one hand.

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

(2) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 1.

(a) Shoulder.

1 Forward elevation to 90° .

2 Abduction to 90° .

(b) Elbow

1 Flexion to 100° .

2 Extension to 60° .

(c) Wrist. A total range, extension plus flexion, of 15°

(d) Hand. For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints.

1 An active flexor value of combined joint motions of 135° in each of two or more fingers of the same hand.

2 An active extensor value of combined joint motions of 75° in each of the same two or more fingers.

3 Limitation of motion of the thumb that precludes apposition to at least two finger tips.

(3) Recurrent dislocations of the shoulder. When not repairable or surgery is contraindicated.

b. Lower.

(1) Amputations.

(a) Loss of a toe or toes that precludes the ability to run, or walk without a perceptible limp, or to engage in fairly strenuous jobs.

(b) Any loss greater than that specified above to include foot, leg, or thigh.

(2) Feet.

(a) Hallux valgus. When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(b) Pes Planus. Symptomatic more than moderate, with pronation on weight bearing that prevents wearing military shoes, or when associated with vascular changes.

(c) Talipes cavus. When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or that prevents wearing a military shoe.

(3) Internal derangement of the knee. Residual instability following remedial measures, if more than moderate; or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

(4) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 2.

(a) Hip.

1 Flexion to 90° .

2 Extension to 0 .

(b) Knee.

1 Flexion to 90° .

2 Extension to 15°.

(c) Ankle.

1 Dorsiflexion to 10°.

2 Plantar Flexion to 10°.

(5) Shortening of an extremity, which exceeds two inches.

c. Miscellaneous.

(1) Arthritis.

(a) Due to infection. Associated with persistent pain and marked loss of function with x-ray evidence and documented history of recurring incapacity for prolonged periods.

(b) Due to trauma. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint that precludes satisfactory performance of duty.

(c) Osteoarthritis. Severe symptoms associated with impaired function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

(d) Rheumatoid arthritis or rheumatoid myositis. Substantiated history of frequent incapacitating and prolonged periods supported by objective and subjective findings.

(e) Seronegative Spondylarthropaties. Severe symptoms associated with impaired function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(2) Chondromalacia or Osteochondritis Dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

(3) Fractures.

(a) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or more than moderate loss of function.

(b) Nonunion. When, after an appropriate healing period, the nonunion precludes satisfactory performance of military duty.

(c) Bone fusion defect. When manifested by more than moderate pain or loss of function.

(d) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

(4) Joints.

(a) Arthroplasty. With severe pain, limitation of motion and function.

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

(c) Contracture of joint. Marked loss of function and the condition is not remediable by surgery.

(d) Loose bodies within a joint. Marked functional impairment complicated by arthritis that precludes favorable treatment or not remediable by surgery.

(5) Muscles.

(a) Flaccid paralysis of one or more muscles, producing loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(b) Spastic paralysis of one or more muscles producing loss of function that precludes satisfactory performance of duty.

(6) Myotonia congenita.

(7) Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

(8) Osteoarthropathy, hypertrophic, secondary. Moderately severe to severe pain present with joint effusion occurring intermittently in one or multiple joints and with at least moderate loss of function.

(9) Osteomyelitis, chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree that interferes with stability and function.

(10) Tendon transplant. Fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

13. Spine, Scapulae, Ribs, and Sacroiliac Joints.

a. Congenital anomalies.

(1) Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.

(2) Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated hospitalization or significant assignment limitation.

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

c. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

d. Kyphosis. More than moderate, or interfering with function, or causing unmilitary appearance.

e. Scoliosis. Severe deformity with over two inches of deviation of tips of spinous processes from the midline.

14. Skin and Cellular Tissues.

a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.

c. Amyloidosis. Generalized.

d. Cysts and tumors. See section 3-F-20.

e. Dermatitis herpetiformis. If fails to respond to therapy.

f. Dermatomyositis.

g. Dermographism. Interfering with satisfactory performance of duty.

h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

i. Elephantiasis or chronic lymphedema. Not responsive to treatment.

j. Epidermolysis bullosa.

k. Erythema multiforme. More than moderate and chronic or recurrent.

l. Exfoliative dermatitis. Chronic.

m. Fungus infections, superficial or systemic. If not responsive to therapy and interfering with the satisfactory performance of duty.

n. Hidradenitis suppurative and folliculitis decalvans.

o. Hyperhydrosis. Of the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

p. Leukemia cutis and mycosis fungoides.

q. Lichen planus. Generalized and not responsive to treatment.

r. Lupus erythematous. Chronic with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

s. Neurofibromatosis. If repulsive in appearance or when interfering with satisfactory performance of duty.

t. Panniculitis. Relapsing febrile, nodular.

u. Parapsoriasis. Extensive and not controlled by treatment.

v. Pemphigus. Not responsive to treatment, and with moderate constitutional or systemic symptoms, or interfering with satisfactory performance of duty.

w. Psoriasis. Extensive and not controllable by treatment.

x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.

y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity.

z. Scleroderma. Generalized, or of the linear type that seriously interferes with the function of an extremity or organ.

aa. Ulcers of the skin. Not responsive to treatment after an appropriate period of time or if interfering with satisfactory performance of duty.

bb. Urticaria. Chronic, severe, and not amenable to treatment.

cc. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.

dd. Other skin disorders. If chronic, or of a nature that requires frequent medical care or interferes with satisfactory performance of military duty.

15. Neurological Disorders.

a. Amyotrophic sclerosis, lateral.

b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.

c. Atrophy, muscular. Progressive muscular atrophy.

d. Chorea. Chronic and progressive.

e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) Following a seizure, the member is NFFD, and will remain unfit until he/she is controlled with medications with no seizures for twelve months. A medical board is not required if the convulsive disorder is well controlled.

f. Friedreich's ataxia.

g. Hepatolenticular degeneration.

h. Migraine. Manifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.

i. Multiple sclerosis.

j. Myelopathy transverse.

k. Narcolepsy, cataplexy, and hypersomnolence.

l. Obstructive Sleep Apnea. when not correctable by use of CPAP or surgical means.

m. Paralysis, agitans.

n. Peripheral nerve conditions.

(1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.

(2) Neuritis. When manifested by more than moderate, permanent functional impairment.

o. Syringomyelia.

p. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance loss of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

16. Psychiatric Disorders. (see Chapter 5 Section B of this manual concerning disposition)

a. Disorders with Psychotic Features. Recurrent psychotic episodes, existing symptoms or residuals thereof, or recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.

b. Affective disorders; anxiety, somatoform, or dissociative disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than 6 months. Regardless of the length of treatment, any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance".

c. Mood disorders. Bipolar disorders or recurrent major depression. All other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization, or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months. Prophylactic treatment requiring more than one drug, or associated with significant side effects (such as sedation, dizziness or cognitive changes) or frequent follow-up that limit duty options. (Prophylactic treatment with medication may continue indefinitely as long as the member remains asymptomatic following initial therapy). Any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance."

d. Personality; sexual; factitious; psychoactive substance use disorders; personality trait(s); disorders of impulse control not elsewhere classified. These conditions may render an individual administratively unfit rather than unfit because of a physical impairment. Interference with performance of effective duty will be dealt with through appropriate administrative channels (see section 5-B).

e. Adjustment Disorders. Transient, situational maladjustment due to acute or special stress does not render an individual unfit because of physical impairment. However, if these conditions are recurrent and interfere with military duty, are not

amenable to treatment, or require prolonged treatment, administrative separation should be recommended (see Section 5-B).

f. Disorders usually first evident in infancy, childhood, or adolescence, disorders of intelligence. These disorders, to include developmental disorders, may render an individual administratively unfit rather than unfit because of a physical impairment. Anorexia Nervosa and Bulimia are processed through PDES, while the remaining are handled administratively, if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and/or safety). See section 5-B of this Manual and Chapter 12 of the personnel manual for further guidance.

17. Dental.
Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residual conditions that are incapacitating or interfere with the individual's satisfactory performance of military duty, or deformities that are disfiguring. Personnel must be in a Class 1 or Class 2 (see Chapter 4. Section C.3.c.(3)) dental status to execute sea duty or overseas duty orders. Prior service personnel must meet the enlistment dental standards contained in section 3-D.

18. Blood and Blood-Forming Tissue Diseases.
When response to therapy is unsatisfactory, or when therapy requires prolonged, intensive medical supervision.

a. Anemia.

b. Hemolytic disease, chronic and symptomatic.

c. Leukemia, chronic.

d. Polycythemia.

e. Purpura and other bleeding diseases. Any condition requiring long-term coumadin.

f. Thromboembolic disease.

g. Splenomegaly, chronic.

19. Systemic Diseases, General Defects, and Miscellaneous Conditions.

a. Systemic Diseases.

(1) Blastomycosis.

(2) Brucellosis. Chronic with substantiated recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.

(3) Leprosy. Any type.

(4) Myasthenia gravis.

(5) Porphyria Cutanea Tarda.

(6) Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.

(7) Tuberculosis (TB).

(a) Meningitis, tuberculosis.

(b) Pulmonary TB, tuberculous empyema, and tuberculous pleurisy.

(c) TB of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(d) TB of the female genitalia.

(e) TB of the kidney.

(f) TB of the larynx.

(g) TB of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals, and complications.

(8) Symptomatic neurosyphilis. In any form.

b. General Defects.

(1) Visceral, abdominal, or cerebral allergy. Severe or not responsive to therapy.

(2) Cold injury. Evaluate on severity and extent of residuals, or loss of parts as outlined in section 3-F-12.

c. Miscellaneous Conditions or circumstances.

(1) Chronic Fatigue Syndrome, Fibromyalgia , and Myofascial Syndrome when not controlled by medication or with reliably diagnosed depression.

(2) The individual is precluded from a reasonable fulfillment of the purpose of employment in the military service.

(3) The individual's health or well-being would be compromised if allowed to remain in the military service.

(4) The individual's retention in the military service would prejudice the best interests of the Government.

(5) Required chronic and continuous DEA controlled (Class I-V) medications, such as Ritalin, Amphetamine, Cylert, Modafanil.

(6) Required chronic anti-coagulant, other than aspirin, such as Coumadin.

20. Tumors and Malignant Diseases.

    a. Malignant Neoplasms. If they are unresponsive to therapy or when the residuals of treatment are in themselves disqualifying under other provisions of this section or in individuals on active duty when they preclude satisfactory performance of duty.

    b. Neoplastic Conditions of Lymphoid and Blood Forming Tissues. Render an individual unfit for further military service.

    c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of military duty. However, the following normally render the individual unfit for further military service:

        (1) Ganglioneuroma.

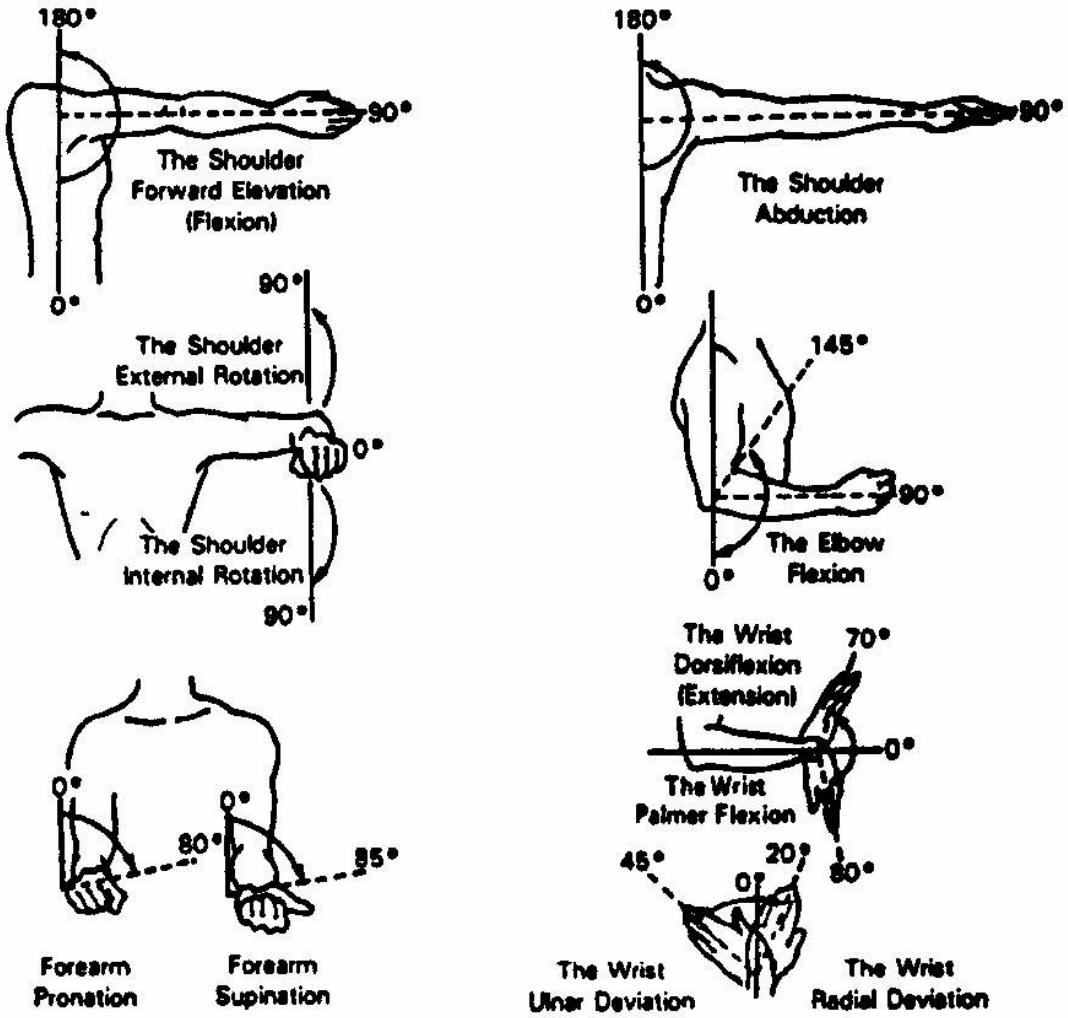
        (2) Meningeal fibroblastoma. When the brain is involved.

21. Sexually Transmitted Disease.
    Complications or residuals of such chronicity or degree of severity that the individual is incapable of performing useful duty.

22. Human Immunodeficiency Virus (HIV).
    A member who is discovered to be HIV positive (infected with HIV) by confirmatory testing is not world-wide deployable. An HIV positive member who continues to fully perform his duties is fit for duty ashore. After the member has been initially evaluated at the appropriate DoD MTF per Chapter 3, Section C of this manual, the supporting medical officer shall obtain a copy of the written narrative detailing the member's medical condition and forward it to Commandant CG-1121 via the cognizant MLC (k). The Narrative shall be marked confidential. Commandant CG-1121 will advise CGPC that the member is not worldwide deployable but will not forward information as to the members diagnosis. Determination of duty assignments shall then be made by CGPC Assignments Officers cognizant of the member’s duty restriction. The member's supporting medical officer shall obtain copies of the BIANNUAL medical evaluation narratives from the appropriate DoD MTF and submit them (marked as confidential) to Commandant CG-1121 via MLC (k). A medical board shall be initiated when progression of the disease adversely impacts the member's ability to perform his duties. Taking medication for HIV disease is not necessarily in itself reason to initiate a medical board.

23. Transplant recipient.
    Any organ or tissue except hair or skin.

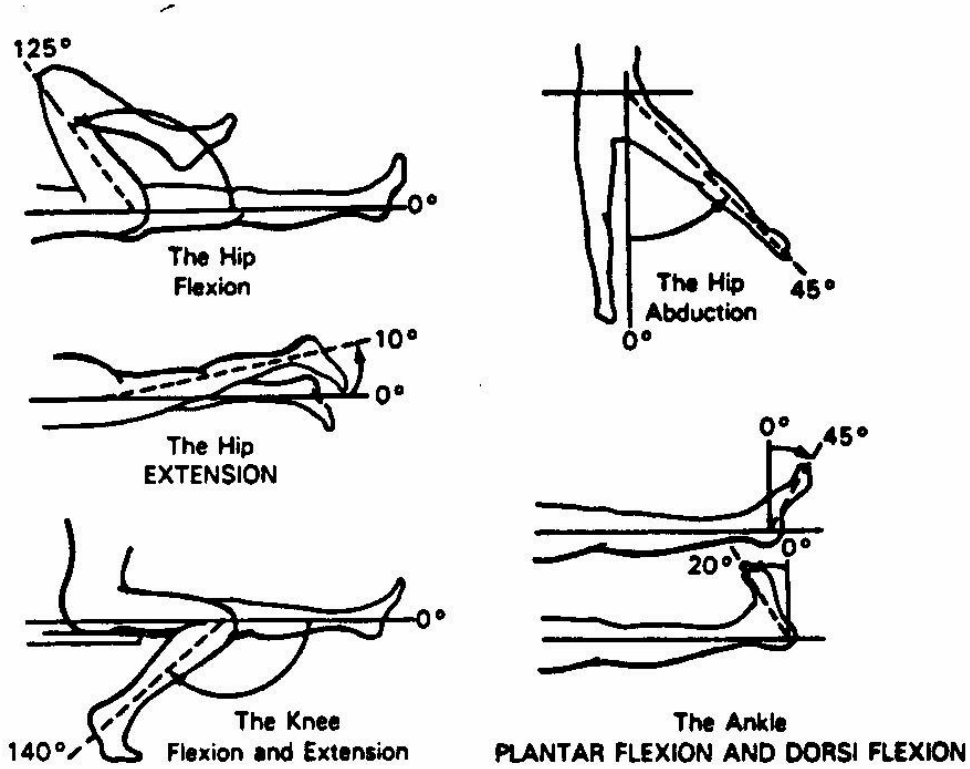
3-F — EXHIBIT 1
MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
UPPER EXTREMITIES



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid position (0°) between pronation and supination when the thumb is uppermost.

CH-10

3-F — EXHIBIT 2
MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
LOWER EXTREMITIES



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.

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CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section G. Physical Standards for Aviation.

1. Classification of Aviation Personnel. 1
2. General Instructions for Aviation Examinations. 1
3. Restrictions Until Physically Qualified. 4
4. Standards for Class l. 4
5. Standards for Class 1R. 6
6. Candidates for Flight Training. 7
7. Requirements for Class 2 Flight Officers. 9
8. Requirements for Class 2 Aircrew. 9
9. Requirements for Class 2 Medical Personnel. 10
10. Requirements for Class 2 Technical Observers. 10
11. Requirements for Class 2 Air Traffic Controllers. 10
12. Requirements for Landing Signal Officer (LSO). 11
13. Refractive Surgery. 11
14. Contact Lenses. 12

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATIONS

Section G. Physical Standards for Aviation.

1. Classification of Aviation Personnel.

   a. Aviation Personnel in General. Classification of Coast Guard aviation personnel is similar to that prescribed for Navy aviation personnel. The term "aviation personnel" includes all individuals who, in the performance of their duty, are required to make frequent aerial flights. Aviation personnel are divided into two classes: Class 1 and Class 2.

   b. Class 1. Class 1 consists of aviation personnel engaged in actual control of aircraft, which includes aviators, student aviators, and student flight surgeons that are chosen to perform solo flights.

   c. Class 1R. Class 1R consists of aviation personnel engaged in actual control of aircraft who:

      (1) meet Class 1 standards but are age 50 or over; or

      (2) have a waiver (temporary or permanent) of physical standards which forbids unrestricted flight. The flight restriction(s) to which the Class 1R pilot is subject will be defined by the waiver authority. In all cases, however, Class 1R aviators will fly as a dual pilot with a Class 1 aviator.

   d. Changing Classes. Except for changes in class due solely to age, individuals requiring a change in their classification for more than two months must submit the following to Commander CGPC:

      (1) SF-502, Narrative Summary, completed by a flight surgeon/aviation medical officer stating the need for the class change and whether a permanent or temporary change is requested; and

      (2) command endorsement.

   e. Class 2. Class 2 consists of aviation personnel not engaged in actual control of aircraft. This includes aviation observers, technical observers, flight surgeons, aviation medical officers, aviation MEDEVAC specialists, flight officers, aircrew members, air traffic controllers, and other persons ordered to duty involving flying.

2. General Instructions for Aviation Examinations.

   a. Object of Aviation Physical Examinations.

      (1) The examination for flying shall be limited to members of the aeronautical organization and authorized candidates. The object of an aviation physical examination is to ensure individuals involved in aviation are physically and mentally qualified for such duty, and to

remove from aviation those who are temporarily or permanently unfit because of physical or mental defect.

(2) The main objective in examining candidates for flight training is selecting individuals who can fly safely and continue to do so for at least 20 years.

(3) For designated aviators, the objective is to determine if the individual can fly safely during the next 24 months.

b. Performance of Aviation Physical Examinations. To promote safety and to provide uniformity and completeness, an aviation physical examination must be performed by a currently qualified Flight Surgeon (FS)/Aviation Medical Officer (AMO)/Aeromedical Physician Assistant (APA) authorized by the Commandant. Only physicians or physician assistants who have successfully passed a course at a school of aviation medicine of the U. S. Armed Forces leading to the designation of “Flight Surgeon”, “Aviation Medical Officer” or “Aeromedical Physician Assistant” are so authorized. Civilian physicians who were military flight surgeons and who are currently certified by the Federal Aviation Administration as aviation medical examiners may also be authorized.

c. Scope of Aviation Physical Examination. In addition to the general service requirements specified in section 3-D, certain special requirements must be met by the various categories of individuals concerned with aviation. The extent of the examination and the physical standards vary for the several categories of aviation personnel. The term "flight or aviation physical examination" is therefore incomplete unless the character of the duty that the examinee is to perform is specified--this incomplete term shall not be used in item #16 of DD-2808 (rev Jul-01) as the purpose of the examination. Examiners shall conduct aviation physical examinations in accordance with the general procedures specified in this section and in section 3-C.

d. Required Aviation Physical Examinations. Each individual in the Service who is assigned to duty requiring performance of frequent aerial flights, regardless of classification, must have passed an aviation physical within the preceding 24 months. In some cases, more frequent examinations are required. Aviation physical examinations are required as indicated in this section. They may also be ordered whenever needed to determine an individual's physical fitness for the type aviation duty to which assigned.

(1) Entry on Active Duty. Reserve aviation personnel who perform frequent aerial flights must have passed an aviation physical examination, commensurate with the type of duty to be performed, within the 24 months preceding active duty or active duty for training. Aviators who are not members of aviation reserve units must have

satisfactorily passed an aviation physical examination within six months immediately preceding the actual control of aircraft.

(2) Biennial. All aviation personnel, including Reservists on inactive duty for training, who will actually control aircraft or perform frequent aerial flights must obtain a biennial aviation physical examination commensurate with the type of duty to be performed. The examination is required every two (2) years after initial designation. Upon reaching age 50, the examinations become annual.

(3) Direct Commission. An aviation physical examination is required prior to direct commissioning of aviators in the Reserve. The aviator is required to meet Class I standards.

(4) Candidates for Designation as Class 1. All candidates for flight training, whether or not they are already in the Service, must pass a physical examination for flight training duty. The examination date must not precede the application date by more than 12 months.

(5) Candidates for Designation as Class 2. An approved aviation physical examination less than 24 months old is required both when applying for a Class 2 aviation training program and prior to a Class 2 designation.

(6) FAA Airmen Medical Certificate. After receiving Federal Aviation Administration (FAA) Aviation Medical Examiner (AME) training, Coast Guard flight surgeons/AMOs may request authorization from Commandant (CG-1121) to perform Second and Third Class physical examinations and issue FAA Medical Certificates to all military personnel on active duty including active duty for training. The FAA Administrator furnishes AME's with the necessary instructions, guides, and forms required for this purpose. Except in those instances where there is a military requirement for FAA certification, examination and issuance of medical certificates shall not interfere with the flight surgeon's primary duties. Whenever possible, certificates should be obtained in conjunction with a required aviation physical examination.

(7) Aircraft Accidents. Any Coast Guard member involved in a Class A or B aircraft mishap in which damage to the aircraft or injury to any crewmember occurs shall undergo a complete aviation physical examination as part of the mishap investigation. Examinations after other mishaps are left to the discretion of the flight surgeon/AMO.

(8) Quinquennial. The quinquennial examination of a Reserve aviation special duty officer must be an aviation physical examination.

(9) Separation. An aviation physical examination is not required of aviation personnel being separated from active duty. The requirements for examination are the same as those for the separation from active duty of non-aviation personnel.

e. Boards. Assignment to and continuation of duty involving flying is an administrative process. Except for enlisted personnel in aviation ratings, fitness to perform aviation duties is a determination independent of the determination of fitness for continued service. The process regarding physical disqualifications and waivers for aviation personnel is outlined in the Aviation Medicine Manual, COMDTINST 6410.3.

f. Reporting Fitness for Flying Duties. The process for reporting fitness for duty for aviation personnel is outlined in the Aviation Medicine Manual, COMDTINST 6410.3 (series).

g. Reporting Aviation Physical Examinations. The process for reporting Aviation Physical Examinations for aviation personnel is outlined in the Aviation Medicine Manual, COMDTINST 6410.3 (series).

3. Restrictions Until Physically Qualified.
The process regarding restrictions until physically qualified for aviation personnel is outlined in the Aviation Medicine Manual, COMDTINST 6410.3(series).

4. Standards for Class l.

a. General. The physical examination and physical standards for Class 1 are the same as those prescribed in sections 3-C and 3-D of this Manual, as modified by the following subparagraphs.

b. History.

(1) History of any of the following is disqualifying: seizures, isolated or repetitive (grand mal, petit mal, psychomotor, or Jacksonian); head injury complicated by unconsciousness in excess of 12 hours or post traumatic amnesia or impaired judgment exceeding 48 hours; malaria, until adequate therapy has been completed and there are no symptoms while off all medication for 3 months.

(2) For persons already in the Coast Guard a complete review of their health record is most important. Flight surgeons are authorized to postpone the examination of persons who fail to present their health record at the time of examination. In exercising this prerogative, due consideration must be made in cases where access to the individual's health record is administratively impracticable.

c. Therapeutics and General Fitness. Note on the DD-2808 if the individual received medication or other therapeutic procedures within 24 hours of the examination. In general, individuals requiring therapeutics or who have observed lowering of general fitness (dietary, rest, emotional, etc.,) which might affect their flying proficiency shall not be found qualified for duty involving flying.

d. Each aviation physical will have a Valsalva, SBT (Self Balancing Test), and AA (Aeronautical Adaptability) performed and noted.

e. Height. Minimum 157.4 cm (62 inches). Maximum 198 cm (78 inches).

f. Chest. Any condition that serves to impair respiratory function may be cause for rejection. Pulmonary function tests are recommended to evaluate individuals with a history of significant respiratory system problems.

g. Cardiovascular System. Cardiac arrhythmia, heart murmur, or other evidence of cardiovascular abnormalities shall be carefully studied. Evidence of organic heart disease, rhythm disturbances or vascular diseases, if considered to impair the performance of flying duties, is cause for rejection.

h. Teeth. The following are disqualifying:

(1) Any carious teeth that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.

(2) Any dental defect that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.

(3) Fixed active orthodontic appliances require a waiver from CGPC (opm or epm). (fixed retainers are exempts).

(4) Routine crown and temporary dental work is not disqualifying for aviation missions. Recommend that temporary crowns be cemented with permanent cement like polycarboxylate or zinc oxyphosphate cement until the permanent crown is delivered. Recommend temporary grounding of 6-12 hours after procedures. Such work may be disqualifying for deployment.

i. Distant Visual Acuity. Distant visual acuity shall be not less than 20/200 in either eye and if less than 20/20 must be correctable to 20/20 with standard lenses. When the visual acuity of either eye is less than 20/20 correction shall be worn at all times while flying.

j. Oculomotor Balance. The following are disqualifying:

(1) esophoria greater than 10 prism diopters;

(2) exophoria greater than 10 prism diopters;

(3) hyperphoria greater than 1.5 prism diopters;

(4) prism divergence at 20 feet and 13 inches is optional. These tests shall be accomplished only on designated aviators who have sustained significant head injury, central nervous system disease, or who have demonstrated a change in their phorias.

k. Eyes. Any pathologic condition that may become worse or interfere with proper eye function under the environmental and operational conditions of flying disqualifies. History of radial keratotomy is disqualifying.

l. Near Visual Acuity. Uncorrected near vision (both eyes) shall be not less than 20/200 correctable to 20/20, with correction worn in multivision lenses while flying if uncorrected near vision is less than 20/40 in either eye.

m. Color Vision. Normal color perception is required.

n. Depth Perception. Normal depth perception is required. When any correction is required for normal depth perception it must be worn at all times.

o. Field of Vision. The field of vision for each eye shall be normal as determined by the finger fixation test. When there is evidence of abnormal contraction of the field of vision in either eye, the examinee shall be subjected to perimetric study for form. Any contraction of the form field of 15o or more in any meridian is disqualifying.

p. Refraction. There are no refractive limits.

q. Ophthalmoscopic Examination. Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function is disqualifying. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.

r. Ear. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. A perforation or evidence of present inflammation is disqualifying. The presence of a small scar with no hearing deficiency and no evidence of inflammation, does not disqualify. Perforation, or marked retraction of a drum membrane associated with chronic ear disease, is disqualifying.

s. Sickle Cell Preparation Test. Quantitative hemoglobin electrophoreses greater than 40% HGs is disqualifying.

5. Standards for Class 1R.
Physical requirements for service are the same as for Class 1, except:

a. Age 50 or older, or

b. Have a waiver (temporary or permanent) of physical standards that forbids unrestricted flight.

6. Candidates for Flight Training.

a. Standards. Candidates for flight training shall meet all the requirements of Class 1, with the following additions or limitations:

(1) Cardiovascular.

(a) Candidates with accessory conduction pathways (Wolff-Parkinson-White (WPW), other ventricular pre-excitation patterns) are CD. No waiver is recommended for candidates with this condition.

(b) Candidates with WPW Syndrome who have had definitive treatment via Radio Frequency (RF) ablation with demonstrable non-conduction on follow-up Electrophysiologic Studies (EPS) are considered for waiver on a case-by-case basis.

(c) Asymptomatic candidates: When incidentally noted accessory bypass tracts, proven incapable of sustained rapid conduction as demonstrated by EPS, is discovered in a candidate, the candidate (if asymptomatic), will be considered qualified. In general, EPS is not recommended in asymptomatic individuals.

(2) Height. Candidates for Class I training must also satisfy the following anthropometric requirements: Refer to figure 3-G-1 through figure 3-G-4 for guidelines on measurements.

(a) sitting height: 33 inches to 40.9 inches. Record in parentheses in Item 73, DD-2808 (SH_____), see figure 3-G-1 for proper measurements;

(b) sitting eye height: 28.5 inches or greater. Record in parentheses in Item 73, DD-2808 (SEH_____), see figure 3-G-2 for proper measurements;

(c) thumb tip reach: 28.5 inches or greater. Record in parentheses in Item 73, DD-2808 (TTR____), see figure 3-G-3 for proper measurements;

(d) buttock-knee length: 21 inches to 27.9 inches. Record in parentheses in Item 73, DD-2808 (BKL____), see figure 3-G-3 for proper measurements;

(e) add: sitting eye height (SEH) and thumb tip reach (TTR), 57 inches or greater. Record in parentheses in Item 73, (SEH + TTR =____).

(3) Uncorrected distant visual acuity must be not less than 20/50 each eye and correctable 20/20 each eye. Uncorrected near visual acuity must be not less than 20/20 each eye (may be waiverable).

(4) While under the effects of a cycloplegic, the candidate must read 20/20 each eye. The following are disqualifying:

(a) total myopia greater than (minus) -2.00 diopters in any meridian;

(b) total hyperopia greater than (plus) +3.00 diopters in any meridian;

(c) astigmatism greater than (minus) -0.75 diopters; (Report the astigmatic correction in terms of the negative cylinder required.)

(d) the purpose of this cycloplegic examination is to detect large latent refractive errors that could result in a change of classes during an aviation career. Therefore, the maximum correction tolerated at an acuity of 20/20 shall be reported. Cycloplegics reported as any other acuity, e.g., 20/15 will be returned.

(5) The Coast Guard will consider sending candidates to Navy Flight School who have had photorefractive keratectomy, (anterior corneal stromal surface laser ablation with no stromal flap), and meet all of the enrollment criteria. Candidates must have demonstrated refractive stability as confirmed by clinical records. Neither the spherical or cylindrical portion of the refraction may have changed more than 0.50 diopters during the two most recent postoperative manifest refractions separated by at least one month. The final manifest shall be performed no sooner than the end of the minimum waiting period (3 or 6 months depending on the degree of preoperative refractive error). The member must have postoperative uncorrected visual acuity of at least 20/50 correctable with spectacles to at least 20/20 for near and distance vision. Detailed enrollment criteria may be obtained by contacting CGPC-opm-2.

(6) Hearing. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

FREQUENCY	500	1000	2000	3000	4000
EITHER EAR	30	25	25	45	55

(7) Personality. Must demonstrate, in an interview with the flight surgeon, a personality make-up of such traits and reaction that will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of flying.

(8) Chest x-ray. Aviation trainees must have had a chest x-ray within the past three years.

(9) Report of Medical History (DD-2807-1). In addition to the normal completion of the DD-2807-1, the following statement shall be typed in block 29 and signed by the applicant: "I certify that I do not now use, nor have I ever used, contact lens for any purpose, and that I am not aware that my uncorrected vision has ever been less than 20/50." If the applicant cannot sign this statement, include a full explanation by the examining flight surgeon, and an ophthalmology consultation.

b. Reporting.

(1) The importance of the physical examination of a candidate should be recognized not only by the examining flight surgeon but also by health services personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination cannot be completed in one working day, seek the commanding officer's help in making it possible for the candidate to remain available for a second working day. Careful planning should keep such cases to a minimum. If a report, upon reaching Commandant (CG-112), is found to be incomplete and must be returned, the candidate will suffer undue delay in receiving orders and in some cases will be completely lost to the Coast Guard as a candidate. The preparation of the DD-2808 in the case of a candidate requires extreme care by all concerned.

(2) In a report of the examination of a candidate, rigid adherence to set standards is expected. The examining officers are encouraged to use freely that portion of the report that provides for "remarks" or "notes." Comments made under "remarks" are the examiner's opinion. Information from any source may be molded into an expression of professional opinion. A final recommendation of the examiner must be made. When such recommendation is not consistent with standards set by Commandant (CG-11) the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation made. When space on an DD-2808 is inadequate, use a Continuation Sheet (SF-507).

7. Requirements for Class 2 Flight Officers.

a. Flight Officer Candidates. Flight officer candidates shall meet the standards for Class 1 except that depth perception is not required.

b. Designated Flight Officers. Flight officers shall meet the standards for flight officer candidate except that uncorrected distant visual acuity must be not less than 20/400 in either eye and shall be correctable to 20/20.

8. Requirements for Class 2 Aircrew.

a. Aircrew Candidates. Unless otherwise directed by Commander CGPC-epm, personnel will not be permitted to undergo training leading to the designation of aircrewmen unless a flight surgeon/aviation medical officer

has found them physically qualified for such training. Should it be desirable, for exceptional reasons, to place in training a candidate who does not meet the prescribed physical standards, the commanding officer may submit a request for a waiver, with the DD-2808 and DD-2807-1, to Commandant (CGPC), justifying the request. Aircrew candidates shall meet the standards for Class 1, except that minimum height is 152.5 cm/60 inches and uncorrected distant visual acuity must be not less than 20/100 each eye, correctable to 20/20 each eye. Cycloplegic refraction and anthropometric measurements are not indicated. A chest x-ray is required within the previous 3 years.

b. Designated Aircrew. Aircrew shall meet the standards for Class 1, except the minimum height is 152.5 cm/60 inches.

9. Requirements for Class 2 Medical Personnel.

a. Flight Surgeon (FS)/Aviation Medical Officer (AMO)/Aeromedical Physician Assistants (APA), FS Candidates. While assigned to a Duty Involving Flight Operations billet, FS/AMOs/APAs shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

b. Aviation MEDEVAC Specialists (AMS)/AMS Candidates. Aviation MEDEVAC Specialists (Health Services technicians (HS) who are assigned to flight orders), shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

10. Requirements for Class 2 Technical Observers.
The term "technical observer" is applied to personnel who do not possess an aviation designation but who are detailed to duty involving flying. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. They shall meet the standards prescribed for general duty. These personnel are not required to undergo a physical examination for flying provided a complete physical examination, for any purpose, has been passed within the preceding 60 months and intervening medical history is not significant. The physical examination need not be conducted by an FS/AMO. Technical observers who are required to undergo egress training must have a current (general purpose) physical examination and a status profile chit indicating "OK DIF/Dunker/Chamber."

11. Requirements for Class 2 Air Traffic Controllers.
Air traffic controllers, tower controllers, and ground control approach operators shall meet the general physical standards for Class 1, except:

a. Articulation. Must speak clearly and distinctly without accent or impediment of speech that would interfere with radio communication. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidence of speech impediments that become manifest or aggravated under excitement are disqualifying.

b. Height. Same as general service.

c. Visual Acuity.

(1) Candidate's visual acuity shall be no worse than 20/100 for each eye correctable to 20/20 each eye and the correction shall be worn while on duty.

(2) Personnel already designated shall have distant visual acuity no worse than 20/200 each eye correctable to 20/20 each eye and the correction shall be worn while on duty.

(3) Air traffic controllers whose vision becomes worse than 20/200 either eye may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their rating.

d. Depth Perception. Normal depth perception is required.

e. Heterophoria. The following are disqualifying:

(1) esophoria or exophoria greater than 6 prism diopters; and

(2) hyperphoria greater than 1 prism diopter.

12. Requirements for Landing Signal Officer (LSO).

a. Physical Examinations for Landing Signal Officer (LSO).

(1) Candidates. Officer and enlisted candidates for training as LSO's shall have a physical examination prior to the training leading to qualification. LSO duties for flight deck require stricter visual acuity standards than those for general duty in the Coast Guard. Examination by a FS/AMO is not required.

(2) Reexamination. Biennial reexamination is required of all currently qualified LSO's.

b. Physical Standards for LSO's. In addition to the physical standards required for officer and enlisted personnel, the following standards apply:

(1) Distant Visual Acuity. The uncorrected distant visual acuity shall be no worse than 20/200 in each eye and must be correctable to 20/20 in each eye. If the uncorrected distant visual acuity is less than 20/20 in either eye, corrective lenses must be worn while performing LSO duties.

(2) Depth Perception. Normal depth perception is required.

(3) Color Vision. Normal color perception is required.

13. Refractive Surgery.

a PRK is waiverable for Class 2 Aviation Personnel and Landing Signal Officers if the following guidelines are met:

(1) The PRK procedure must be performed at a MTF. No waivers will be granted for PRK performed by a civilian provider.

(2) Pre-surgical refractive error must be in the range of minus 8 to plus 6 diopters with no more than 3 diopters or cylinder in either eye.

(3) If refractive stability is demonstrated as evidenced by less than a 0.50 diopters change over two separate exams at least four weeks apart, then the member can apply to CGPC for a waiver 3 months after surgery.

(4) All pre-operative, operative and post operative medical records must be submitted for review by the waiver authority.

(5) The member must not have any visual complaints post operatively per the quality of vision questionnaire which is to be included in the waiver package. This form can be found on the Commandant (CG-112) Web Site.

(6) Post operatively the member must meet all aviation visual standards in this section.

(7) A quality of vision questionnaire and visual acuity check is to be done every three months for one year after the surgery. This information is to be noted in the member's medical record and reviewed by the flight surgeon.

b LASIK and LASEK are disqualifying for aviation duty and landing signal officer duty.

14. Contact Lenses.

a. Class 1 personnel may be authorized by their local flight surgeon to wear contact lenses while flying, provided the following conditions are met:

(1) Only gas permeable disposable soft lenses may be used.

(2) The lenses are to be removed during the hours of sleep.

(3) The lenses are disposed of after 2 weeks of use.

(4) All prescribed optometry follow-up visits are adhered to. After routine safe use has been established and documented by the prescribing optometric authority, an annual optometric recheck is the minimum required. A copy of the record of any visit to an eye care professional will be furnished by the member to the local flight surgeon for review and placement in the member's health record.

(5) Following any change in the refractive power of the contact lens, the member must be checked on the AFVT to ensure that Coast Guard

Class I standards for acuity and depth perception are met. In addition, the flight surgeon shall document that there is no lens displacement, when user moves his/her eyes through all 8 extreme ranges of gaze.

(6) Contact lens case, saline for eye use, and an appropriate pair of eyeglasses are readily accessible (within reach) to the lens wearer while in-flight.

(7) Contact lens candidate submits request to the command agreeing to abide the above conditions.

(8) The flight surgeon authorizes use of contact lenses after ensuring that such use is safe and the user fully understands the conditions of use. This authorization expires after one year. Initial and any annual re-authorizations shall be documented by an entry in the health record.

(9) Contact lens use is not a requirement for aviation operations. The decision to apply for authorization is an individual option. Accordingly, lens procurement and routine optometric care related to contact lens use at government expense are not authorized.

b. The optional wearing of contact lenses by Class 2 personnel performing duty involving flying and by air control personnel in the actual performance of their duties is authorized under the following circumstances:

(1) Individuals are fully acclimated to wearing contact lenses and visual acuity is fully corrected by such lenses;

(2) Individuals wearing contact lenses while performing flight or air control duties have on their person, at all times, an appropriate pair of spectacles;

(3) A flight surgeon has specifically authorized the wearing of contact lenses while performing flight or air control duties (An entry shall be made on SF-600 in the individual's health record authorizing wearing of contact lenses.); and

(4) Wearing contact lenses while performing aviation duties is an individual option. Accordingly, procuring contact lenses at government expense is not authorized.

Sitting Height

Purpose

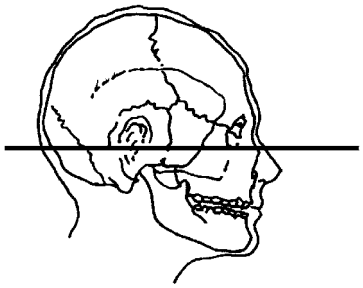
This measurement is important in the design and layout of work stations occupied by Navy personnel. Controls must be placed in numerous locations, and the minimum acceptable space between the helmet and the canopy of cockpits must be considered.

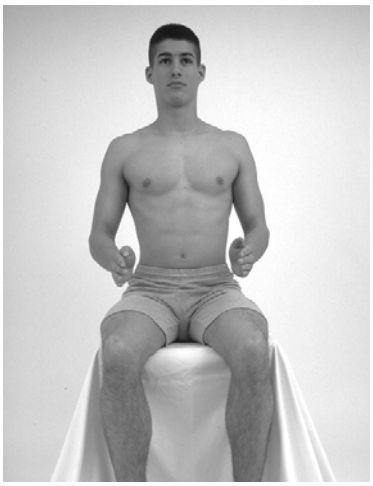
Equipment Required

Anthropometer

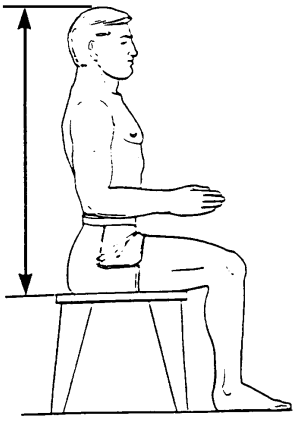
Measurement Procedure

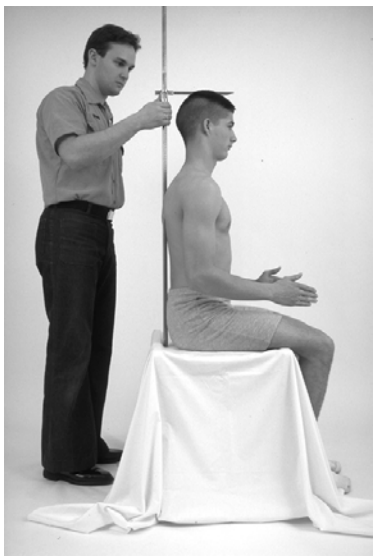
1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel, and the knees are flexed 90° with the feet in line with the thighs.





2. Measure the vertical distance between the sitting surface and the top of the head with an anthropometer. The shoulders and upper extremities should be relaxed. Measure at the maximum point of quiet respiration.





NOTE: *Measurements are to be taken to the nearest eighth of an inch. The measurement should be taken at least twice. If there is a large variation between the two measurements, recheck the body position and repeat measurements.*

Eye Height, Sitting

Purpose

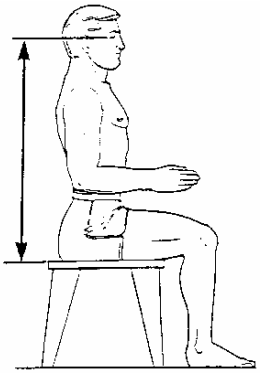
Sitting Eye Height plays a decisive role in instrument panel layout, viewing angles, and seat adjustment, since the pilot must have optimum vision both inside and outside of the cockpit.

Equipment Required

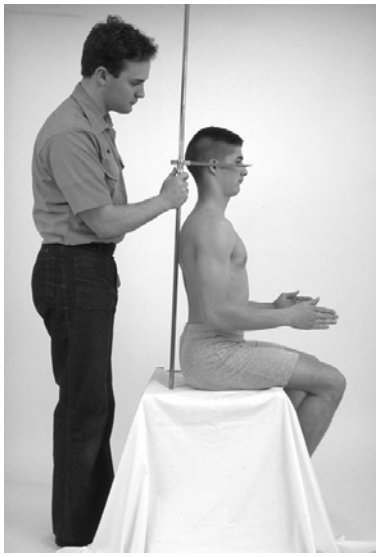
Anthropometer

Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the corner or angle formed by the meeting of the eyelids on the outer corner of the right eye with an anthropometer.



NOTE: *Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

Thumbtip Reach

Purpose

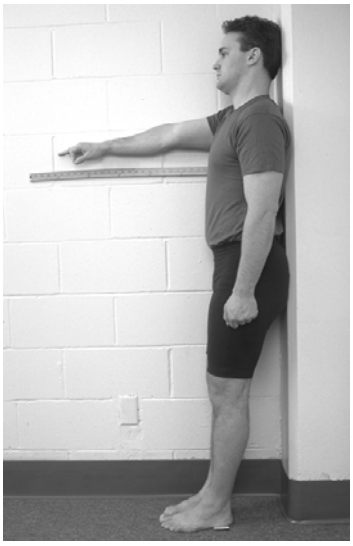
This measurement is important in the design and layout of work stations occupied or used by Navy personnel. Thumbtip reach is particularly useful for the placement of controls in various locations within cockpits.

Equipment Required

Wall--mounted linear scale.

Measurement Procedure

1. The subject stands erect in a corner looking straight ahead with the feet together and heels 7.87 inhes (20 cm) from the back wall.
2. With the buttocks and shoulder placed against the wall, the right arm and hand (palm down) are stretched horizontally along the scale while the thumb continues along the horizontal line of the arm with the index finger curving around to touch the pad at end of the thumb.



3. The subject's right shoulder is held against the rear wall. The horizontal distance from the back wall to the tip of the right thumb is measured.

NOTE 1*: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

Buttock-Knee Length

Purpose

This measurement is usually associated with ejection seat clearance and threshold values between the knee and the glare shield (or canopy bow).

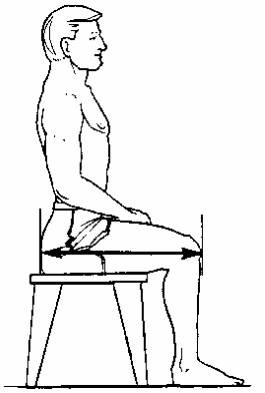
Equipment Required

Anthropometer

Measurement Procedure

1. While the subject sits erect, draw a landmark on the bottom tip of the right knee cap. The subject's thighs should be parallel, with the knees flexed at 90°. The feet should be in line with the thighs, and lying flat on the surface of a footrest or the floor.

2. The anthropometer is placed flush against the buttock plate at the most posterior point on either buttock, and the anterior point to the right knee is measured with an anthropometer.



CHAPTER 3

PHYSICAL STANDARDS AND EXAMINATION

Section H. Physical Examinations and Standards for Diving Duty.

1. Examinations.....1
2. Standards.....1

CHAPTER 3 PHYSICAL STANDARDS AND EXAMINATION

Section H. Physical Examinations and Standards for Diving Duty.

1. Examinations.

   a. Candidates. Acceptable candidates for duty that involves diving or underwater swimming must conform to the physical standards contained in section 3-D except as modified below.

   b. Reexamination. Reexamination of all divers shall be conducted every five (5) years after designation until age 48.

   c. Examination Just Prior to Age 40. Qualified divers who desire to continue in that specialty and are about to reach age 40 must be examined by a medical officer. The DD-2808 and DD-2807-1, along with the examiner's recommendation as to whether the individual is or is not physically qualified to continue as a diver shall be forwarded to CG Personnel Command (adm-1) for final decision and in time to reach Headquarters before the individual attains age 40. A certain latitude may be allowed for a diver of long experience and a high degree of efficiency in diving. The individual must be free from any diseases of the cardiovascular, respiratory, genitourinary, and gastrointestinal systems, and of the ear. The individual's ability to equalize air pressure must be maintained.

   d. Examination Prior to Dives. Divers should ordinarily be examined prior to each unusually hazardous dive and prior to extensive operations when practicable to do so. Medical officers available during extensive diving operations should make observations, by personal interview if possible, of all divers prior to their initial dive each day.

2. Standards.

   a. Disqualifying History. Any of the following is disqualifying:

      (1) Tuberculosis, asthma, chronic pulmonary disease.

      (2) Chronic or recurrent sinusitis, otitis media, otitis externa.

      (3) Chronic or recurrent orthopedic pathology.

      (4) Chronic or recurrent gastrointestinal disorder.

   b. Age Requirements. Candidates beyond the age of **35** shall not be considered for initial training in diving, the most favorable age being 20 to 30. For officers undergoing training in deep sea diving for the specific purpose of becoming diving supervisors or salvage officers, the upper age limit is 39 years.

   c. Nose, Sinuses, Mouth, and Throat. Obstruction to breathing or chronic hypertrophic or atrophic rhinitis is disqualifying. Septal deviation is not disqualifying in the presence of adequate ventilation. Chronically diseased

tonsils are disqualifying pending tonsillectomy. Presence or history of chronic or recurrent sinusitis is cause for rejection.

d. Ears (General) and Drums.

(1) Acute or chronic disease of the auditory canal, membrane tympani, middle or internal ear is disqualifying. Perforation or marked scarring or thickening of the drum is disqualifying. The eustachian tubes must be freely patent for equalization of pressure changes.

(2) All candidates shall be subjected in a recompression chamber to a pressure of 50 pounds per square inch to determine their ability to clear their ears effectively and otherwise to withstand the effects of pressure.

e. Skin and Lymphatics. There shall be no active acute or chronic disease of the skin characterized by infectiveness and/or offensiveness in close working conditions and interchange of diving apparel.

f. Psychiatric. The special nature of diving duties requires a careful appraisal of the candidate's emotional, temperamental, and intellectual fitness. Past or recurrent symptoms of neuropsychiatric disorder or organic disease of the nervous system are disqualifying. No individual with a history of personality disorder shall be accepted. Neurotic trends, emotional immaturity or instability and antisocial traits, if of sufficient degree to militate against satisfactory adjustment are disqualifying. Stammering or other speech impediment that might become manifest under excitement is disqualifying.

g. Dental. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral disease and generally unserviceable teeth are cause for rejection. Candidates with moderate malocclusion, or extensive restorations and replacements by bridges, may be accepted, if such do not interfere with effective use of self-contained underwater breathing apparatus (scuba). Fixed active orthodontic appliances require a waiver from CGPC-opm or epm (fixed retainers are exempt).

h. Distant Visual Acuity. Diving candidates and designated divers shall have a minimum uncorrected distant visual acuity of 20/200 or better, must be correctable to 20/20. Waiver considerations will be on a case-by-case basis. Emphasis on the ability to perform previous diving duties/recreational diving, if any, should be elaborated on in the applicant's letter requesting a waiver of the physical standards.

i. Hearing Standards. Maximum requirement for hearing standards are:

(1) 1000Hz -30dB, 2000Hz-35dB, 3000Hz- 45dB, 4000Hz-55dB

(2) Results greater than the above listed dB require a waiver.

j. Required Labs. Serology, CBC with Diff, Lipid panel, HIV, G6PD, Sickle Cell and Blood type.