U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

COMMISSIONED CORPS INSTRUCTION

CCI 221.02
EFFECTIVE DATE: 30 July 2024

By Order of the Assistant Secretary for Health:

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SUBJECT: Medical Readiness

1. PURPOSE: This Instruction states the medical readiness requirements for officers in the U.S. Public Health Service (USPHS) Commissioned Corps and candidates for a commission in the USPHS Commissioned Corps (hereinafter referred to as "applicants"). It provides policy on the completion, review, and disposition of the medical reports.

2. APPLICABILITY: This Instruction applies to all Regular Corps and Ready Reserve Public Health Service (PHS) officers and to applicants to the USPHS Commissioned Corps. It is not applicable to disability separation/retirement medical examinations (see Commissioned Corps Instruction (CCI) 393.01, "Medical Review Board").

3. AUTHORITY:
   3-1. 42 U.S.C. § 204a, "Deployment Readiness

   3-2. 42 C.F.R. § 21.24, "Physical examinations"

   3-3. 42 C.F.R. § 21.34, "Certification by candidate; requirement of new physical examination"

   3-4. Commissioned Corps Directive (CCD) 128.01, "Medical Fitness for Duty"

   3-5. CCD 111.03, "Conditions of Service"

4. PROPONENT: The proponent of this Instruction is the Assistant Secretary for Health (ASH). The Surgeon General (SG) is responsible for providing supervision of activities relating to the day-to-day operations of the USPHS Commissioned Corps.

5. SUMMARY OF REVISIONS AND UPDATES: This is the fifth issuance of this Instruction in the electronic Commissioned Corps Issuance System (eCCIS) and replaces CCI 221.02, "Medical Readiness," dated 6 November 2023. This version:

   5-1. Moves the appendix, "Medical Retention Standards," from CCI 221.01, "Medical Accession Standards" to this policy.

6. POLICY:

6-1. General.

a. For the purposes of this Instruction the word “medical” used in the context of examination, evaluation, condition, fitness, or readiness refers to physical, dental, and mental health.

b. Active duty PHS officers and officers in the Ready Reserve Corps must be able to perform the duties defined in CCD 111.03, “Conditions of Service,” Section 6-2. In order for the USPHS Commissioned Corps to determine an officer’s medical readiness, all officers must undergo periodic health evaluations and must maintain the required immunizations.

6-2. Physical Examinations.

a. Applicants to the Regular Corps and Ready Reserve Corps.

(1) The USPHS Commissioned Corps uses the examinations of applicants to determine medical qualification for an appointment into the USPHS Commissioned Corps and for baseline documentation of abnormalities existing prior to an appointment to the USPHS Commissioned Corps. Therefore, it is necessary to report every finding of a variance from normal. The SG will determine the specific examination requirements for applicants (see Section 6-3. and Personnel Operations Memorandum (POM) 821.71, “Physical Examination Requirements”).

(2) Commissioned Corps Headquarters (CCHQ) may provide for applicants’ medical examinations through a contracted facility/provider at no expense to the applicants. If the examination is through the contractor, it is the applicants’ responsibility to cooperate with the contractor to ensure that they complete the examination as soon as possible. However, it may be necessary for the applicants to arrange for their own examinations in which case the scheduling and payment of those examinations, as well as the laboratory tests, are the financial responsibility of the applicants.

(3) The SG, or designee, may grant a waiver of the disqualifying condition(s) for an applicant who has a disqualifying medical condition. Medical waivers are initiated by the reviewing Medical Officer in the MAB, CCHQ, who disqualified the applicant or by the Chief, MAB. The applicant must cooperate with the reviewing Medical Officer(s) in order to submit comprehensive/additional documentation and tests related to potentially disqualifying medical conditions so that the reviewing Medical Officer can conduct a complete and accurate review of the applicant’s medical conditions. An applicant may not request a waiver. The decision of the waiver authority is final and is not subject to an appeal by the applicant or any potential hiring authority. (See CCI 221.01, “Medical Accession Standards,” and POM 821.72, “Waiver of a Disqualifying Medical or Dental Condition”.)

(4) Before an appointment and/or before entry on active duty, all applicants to the USPHS Commissioned Corps must notify MAB immediately of any change in health status occurring after submission of any medical information.

(5) Failure to disclose any medical information and/or adhere to the requirements of this Instruction will result in terminating the processing of an application. If CCHQ discovers a failure to disclose information after an appointment, the USPHS Commissioned Corps may terminate an officer's commission in accordance with CCI 341.01, "Probationary Period," CCI 341.02, "Regular Corps Records Review," CCI 382.03, "Involuntary Termination of Commission," or CCD 111.02, "Disciplinary Action," as applicable.

(6) Medical Standards for Appointment. MAB will utilize the following guidance to determine the health qualifications of applicants to the Regular Corps and for applicants to the Ready Reserve Corps:

(a) The USPHS Commissioned Corps' medical retention standards outlined in Appendix A of this Instruction for PHS officers who are transferring from the Regular Corps to the Ready Reserve Corps or who are transferring from the Ready Reserve Corps to the Regular Corps.

(b) The USPHS Commissioned Corps' medical retention standards outlined in Appendix A of this Instruction for applicants who are requesting an inter-service transfer from another uniformed service in accordance with CCI 374.01, "Inter-Service Transfer." If available, such individuals also must provide a copy of the Veterans Affairs examination/disability rating.

(c) The most current version of CCI 221.01, "Medical Accession Standards," Appendix A, for all other applicants to the USPHS Commissioned Corps.

(d) The SG may authorize an abbreviated medical evaluation process for applicants to the Junior Commissioned Officer Student Training and Extern Program (JRCOSTEP). (See Section 4. of POM 821.71.)

b. Examinations of Active-Duty Regular Corps Officers and members of the Ready Reserve Corps.

(1) To ensure deployment readiness, all officers must schedule, complete, and submit a Periodic Health Update (PHU) to document their medical readiness, document service incurred or aggravated conditions, and promote attention to individual health maintenance and disease prevention.

(2) The SG will determine the requirements of the PHU (see POM 821.71). Basic requirements must include:

(a) An updated medical history verified by a healthcare provider;

(b) An annual dental examination;

(c) An annual alcohol/substance abuse screening;

(d) An annual mental health screening for depression, anxiety, and post-traumatic stress disorder (PTSD);

(e) An annual healthcare provider verified weight, height, and, if necessary, determination of percent body fat by "taping"; and

(f) Additional examinations and testing at the discretion of the examining healthcare provider based on the individual needs of the officer and screening examinations recommended by the United States Preventive Services Task Force (USPSTF).

(3) MAB will utilize the USPHS Commissioned Corps' medical retention standards outlined in Appendix A of this Instruction to determine if an officer has a condition that has the potential to impact an officer's medical readiness. If warranted, the USPHS Commissioned Corps may refer an officer to a Medical Review Board (MRB) in accordance with CCI 393.01, "Medical Review Board."

c. Retirement and Separation Examinations. The USPHS Commissioned Corps does not require a retirement or separation examination; however, it is in the officer's best interests to obtain a final examination prior to separating from the USPHS Commissioned Corps in order to document any service-connected conditions. The USPHS Commissioned Corps advises officers to schedule the examinations with sufficient time to obtain the results prior to the effective date of their retirement or separation

(1) Scheduling and obtaining a retirement or separation examination is the officer's responsibility.

(2) Because this is an officer's final physical examination in the USPHS Commissioned Corps, it is important that this examination be thorough and complete. The examining provider should document all conditions and their history and, if not previously investigated, work-up should be completed and recorded. In addition, the provider should transmit copies of pertinent records of any previous evaluations and treatments of significant medical conditions directly to the Medical Evaluations Section, MAB, CCHQ.

(3) If, based on the examination, a question arises as to the officer's fitness to continue to perform the duties of their office and grade if the officer were not separating, the officer must notify the Chief, MAB, in accordance with CCI 393.01, "Medical Review Board."

6-3. Requirements. The SG will determine the specific requirements of the medical examinations, testing, and immunizations including:

a. Testing for Tuberculosis Infection

(1) Applicants. All applicants to the USPHS Commissioned Corps must be tested for evidence of current or latent tuberculosis infection with either a tuberculin skin test (TST) or interferon-gamma releasing assay (IGRA).

(2) Active Duty and Reserve Officers. Since all applicants are now tested for the presence of tuberculosis infection, the USPHS Commissioned Corps does not require routine IGRA testing or TST unless the officer is working at a duty station that is considered high-risk for tuberculosis and the duty station requires regular surveillance or the officer has been deployed to highly endemic area for tuberculosis. If the officer's duty station requires an officer to get routinely tested by TST or IGRA, the officer must submit those results to MAB as part of the officer's PHU.

b. Immunizations. Vaccines are important tools that help protect the health of PHS officers while serving at their assigned duty station and/or while engaging in response activities.

(1) The USPHS Commissioned Corps requires officers to be immunized against: Measles/Mumps/Rubella (MMR), Varicella, Tetanus/Diphtheria, Hepatitis A, Hepatitis B, and influenza (annually). Newly commissioned officers have up to 12 months after commissioning to complete the entire vaccination series for any required immunization.

(2) The USPHS Commissioned Corps requires PHS officers to submit proof of immunizations and boosters to MAB. The information must include: the date and type of vaccine(s) administered; healthcare provider's name, title/rank (if applicable), and signature. The USPHS Commissioned Corps also requires officers to report their immunization information using guidelines provided by MAB on the CCMIS website

(3) Positive antibody titers confirming natural or acquired immunity are acceptable proof of immunity for MMR and Varicella. The officer or applicant must submit accompanying medical documentation MAB for confirmation.

(4) Influenza (annual). The USPHS Commissioned Corps requires PHS officers to obtain an influenza vaccination as soon as the vaccine becomes available during each influenza season. CCHQ will determine compliance with this requirement on 31 December of each year and not on the anniversary date of the officer's last influenza vaccination. Officers who are deployed and/or assigned to the Southern Hemisphere must follow the recommended regional influenza immunization schedule with completion of the immunization by 30 June.

(5) Newly commissioned officers are required to complete a full Hepatitis A vaccine series within their first year of service; however, if otherwise considered basic ready, officers may deploy two weeks after obtaining their first Hepatitis A vaccine shot.

(6) Pregnant officers who are due for a tetanus booster during their first or second trimesters must submit a waiver in order to delay their tetanus/diphtheria/pertussis vaccination until late in their pregnancies.

(7) The SG may require future vaccinations that the USPHS Commissioned Corps needs for deployment environments, health care settings, or as otherwise determined for the efficiency of the service.

(8) The SG or his or her designee can require officers to obtain vaccinations needed for deployment to certain areas of the world.

(9) The USPHS Commissioned Corps encourages officers to obtain other vaccinations recommended in the Centers for Disease Control and Prevention adult recommended immunization schedule.

6-4. Examining Facilities. PHS officers must arrange their PHU through their healthcare provider at the facility where they get their routine healthcare. Applicants who are not examined through CCHQ's contracted facility/provider should get their examinations through their regular healthcare provider at the applicant's expense.

6-5. Medical Readiness for Deployment. In order to fulfill the mission and responsibilities of the USPHS Commissioned Corps, all officers must be able to be deployed to various environments and areas of need. At a minimum, officers must meet medical retention standards (see Appendix A) and be able to

a. Suspend any ongoing professional treatment (e.g. physical therapy, counselling) for the period of the deployment without anticipated adverse health consequences which would render the officer unfit for service;

b. Manage the physical and mental stress of deployment without anticipated adverse health consequences which would render the officer unfit for service; and

c. Manage the dietary and environmental changes encountered during a deployment without anticipated adverse health consequences which would render the officer unfit for service.

d. The SG also may establish additional health standards for officer deployability to environments with limited healthcare and logistic resources.

6-6. Medical Waiver Program for Medical Readiness. There are times when an officer may require a medical waiver due to a medical condition that temporarily affects the officer's health status or personal well-being. Such conditions may pose specific or general physical limitations or restrictions on the officer's ability to reach optimal medical readiness. Therefore, officers may be medically exempt from meeting one or more of the standards for medical readiness and/or Basic level of force readiness when a valid medical reason exists that is supported by appropriate medical documentation.

a. The purpose of the Medical Waiver Program is to assist the USPHS Commissioned Corps in implementing the Department's policy on medical and force readiness, while reducing unintentional injuries due to the inappropriate application of an immunization or physical readiness requirement. This program is administered by MAB within CCHQ.

b. Any officer who, because of a documented medical condition, cannot be deployed or who cannot complete any of the cardiorespiratory endurance exercises of the Annual Physical Fitness Testing (APFT) for 12 consecutive months, or 18 non-consecutive months in a 24 month period, is not eligible for a medical waiver. The Director, CCHQ, must refer such officer to an MRB (see CCI 393.01, "Medical Review Board").

c. The Chief, MAB, or designee, may grant temporary time-limited medical waivers for a documented health condition that is likely to improve within 12 months, or less, from the date that the request was received by MAB.

d. The Chief, MAB, or designee, may grant permanent long-term renewable medical waivers for conditions that are unlikely to improve in the foreseeable future, but that do not prevent an officer from performing, for more than one year, or more than 18 non-consecutive months in a 24 month period, the cardiorespiratory endurance section of the APFT or from being deployed. Examples of this type of waiver are for certain immunizations which are contraindicated in individuals with severe egg allergies or uniform (beard) waivers for individuals with certain chronic dermatologic conditions.

e. Medical waivers are personal exemptions from performing or engaging in one or more of the following activities:

(1) Deploying

(2) Receiving one or more immunization(s)

(3) Performing all or part of the APFT;

(4) Meeting weight standards;

(5) Maintaining uniform requirements (e.g., beard waivers, shoe waivers);

(6) Completing Basic Life Support (BLS) training; or

(7) Fulfilling other requirements necessary for meeting and/or maintaining the Basic level of force readiness.

f. Clarification of Specific Medical Waivers

(1) Deployment. Officers who develop a medical condition that prevents them from safely deploying should request a deployment waiver from MAB within 7 days, but no later than 21 days, after the diagnosis of the condition or after hospital discharge (if applicable), whichever comes later. All officers who are medically unable to deploy must request a deployment waiver regardless of whether the officer is “on call” or “backup” or the SG, or designee, has designated the officer as mission critical. Failure to request a waiver in the designated time period could result in disciplinary action (see CCD 111.02, “Disciplinary Action,” and CCI 241.01, “Readiness and Duty Requirements”)

(2) Pregnancy. Pregnancy waivers are in effect from the time of the receipt in MAB of the documentation of pregnancy until twelve months after the anticipated date of delivery. If the officer is pregnant for less than 20 weeks, the pregnancy waiver will expire six months after the date of the pregnancy termination. Pregnancy waivers automatically cover exemptions for deployment, all sections of the APFT, weight standards, breastfeeding, and obtaining live virus vaccinations. Influenza vaccine is not a live virus and is not waived by the pregnancy waiver. The requirement to submit a PHU is not waived by a pregnancy waiver. The BLS certification requirement is no longer waived as part of the pregnancy waiver. If an officer knows that her BLS will expire, she should get recertified early in her pregnancy. The officer must complete/meet all waived readiness requirements by the end of the month in which her pregnancy waiver expires.

(3) Breastfeeding. Breastfeeding waivers are now included in the pregnancy waiver. Breastfeeding waivers are granted until the baby is one year old. Additional waivers after that time must be accompanied by documentation from the child’s provider that the baby’s health will be jeopardized if breastfeeding (not breast milk, which can be frozen) is terminated for the period of a deployment.

(4) Weight standards. Some medical conditions or treatments can contribute to changes in weight or difficulty gaining or losing weight. When an officer requests a weight standards waiver, the healthcare provider must provide evidence-based data to MAB regarding the effects of the condition or treatment on weight. The officer must also provide a pretreatment weight. If the Chief, MAB, or designee, grants a waiver, the granter must base the

extent of relaxing the standards on the documented effects of the treatment. MAB will utilize evidence-based medical literature to determine the effects of a treatment.

6-7. Command Directed Evaluation (CDE). The ASH, SG, or Director, CCHQ, may authorize a CDE of an officer's medical fitness for service. For purposes of this Section, these individuals are collectively referred to as the "CDE Issuer.

a. The CDE Issuer may direct an officer to undergo such examination, evaluation, or supervision as the CDE Issuer deems necessary if there is reason to believe that the officer:

(1) Has a condition that may impact medical readiness;

(2) Has misrepresented the officer's medical condition; or

(3) Has a condition that could result in the officer not meeting the USPHS Commissioned Corps' medical retention standards.

b. The CDE may include such directives as the CDE Issuer deems are warranted (e.g., specific tests, specific provider, specific facility, how the results are submitted to CCHQ, etc.). If a specific provider or facility is directed and that provider/facility is outside a 75-mile radius of the officer's duty station and/or residence, the Director, CCHQ, or the officer's agency/program may approve travel as authorized in the Joint Travel Regulations (JTR).

c. If the CDE includes a directed psychiatric evaluation, the CDE Issuer must consult with a licensed psychiatrist, a doctoral level clinical psychologist, or other mental health provider to validate the need for such evaluation.

d. A directive to undergo medical or psychiatric treatment, as opposed to examination/evaluation, is not mandatory; however, an MRB or other administrative board may consider failure to comply with directed treatment in their review of the officer's record.

7. RESPONSIBILITIES:

7-1. The Examinee (i.e., officer or applicant).

a. Applicant examinees are responsible for obtaining all examinations and tests in accordance with this Instruction.

b. Officer examinees are responsible for arranging for completion of their PHU through their regular healthcare providers. The officer examinee is responsible for completing a comprehensive medical history, an alcohol abuse questionnaire, a depression screening questionnaire, and a PTSD screening questionnaire prior to the PHU examination and to provide the completed forms to the officer's healthcare provider. The officer examinee is responsible for following all CCHQ instructions regarding the forwarding of examination forms to the appropriate recipient.

7-2. The Examining Healthcare Provider.

a. The healthcare provider examiner is responsible for reviewing the medical history and performing additional testing including a physical examination, additional laboratory testing, other studies, or consultations, as indicated. The dental

examiner is responsible for obtaining an updated dental history and examination.

b. Any provider not authorized to practice independently by virtue of either licensure or facility policy, must have any notes countersigned by a supervising provider who is authorized to practice independently. The examiner must assist the examinee to obtain copies of all PHU documents.

7-3. Medical Affairs, CCHQ. MAB is responsible for the review, evaluation, and maintaining documentation of an active duty officer's latest PHU and for approving medical waivers. In addition, MAB is responsible for determining officers' Medical Readiness Category for deployment and identifying health conditions that have a strong likelihood of negatively affecting their ability to perform the essential functions of their position(s), either permanently or over an extended period of time. MAB is also responsible for the assessment of the health qualifications of all applicants in accordance with the SG's guidance.

7-4. Each officer and applicant is responsible for adhering to the guidelines established in this Instruction and any operational guidelines established by the SG, Director, CCHQ, and Chief, MAB, or their designees. Officers are responsible for observing and promptly obeying the lawful orders of all official superiors, including a CDE.

a. It is the individual's responsibility to be familiar with the published policies that apply to PHS officers and maintain an ongoing awareness of updates and changes to Corps policies.

b. Each officer and applicant must maintain current and updated contact information (e.g., e-mail, phone, address) in CCHQ in order to facilitate the USPHS Commissioned Corps' communication of information.

c. Officers and applicants are responsible for ensuring that all medical document(s) are submitted to MAB within a timely manner, within timeframes outlined in this Instruction, or within the timeframes established by the SG, Director, CCHQ, Chief, MAB, or their designees.

(1) Applicants must notify CCHQ of any change in their medical status after the completion of the examinations, but before their appointment to the USPHS Commissioned Corps.

(2) Officers must promptly inform Medical Affairs of any significant new medical/mental health diagnoses which could potentially affect their long-term health status (i.e., not likely to resolve within one year).

d. Each officer must have a complete record of all of the officer's medical documents in MAB and must ensure that any medical provider submits such documents to MAB. Alternatively, the officer may submit such documents in accordance with guidance provided by the SG, CCHQ, or MAB.

e. Officers are responsible for monitoring their readiness status including due dates for their PHU and required vaccinations and ensuring that they submit all documents by the due dates. Officers are responsible for monitoring their current medical waivers including expiration dates.

f. Officers are responsible for observing and promptly obeying the lawful orders of all official superiors, including a CDE. An officer's failure to do so may result in separation from the USPHS Commissioned Corps.

8. HISTORICAL NOTES: This is the fifth issuance of this Instruction within the eCCIS.

8-1. CCI 221.02, “Medical Readiness,” dated 6 November 2023.

8-2. CCI 221.02, “Medical Readiness,” dated 18 October 2021.

8-3 CCI 221.02, “Medical Readiness,” dated 14 June 2021.

8-4. CCI 221.02, “Medical Readiness,” dated 2 July 2019.

8-5. Commissioned Corps Personnel Manual (CCPM) CC29.3.5, “Medical Examination Requirements,” dated 24 October 1997.

Appendix A

Medical Retention Standards

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Appendix A (continued)

Preamble

1. Application of the Standards. The USPHS Commissioned Corps will consider the conditions in this Appendix as possibly disqualifying for interservice transfer applicants to the USPHS Commissioned Corps or as a justification to initiate a fitness for duty evaluation of Regular Corps officers on active duty or Ready Reserve Corps officers. The conditions listed in this Appendix is not an all-inclusive list. The judgment of the clinical reviewers, applied in a consistent, unbiased, and fair manner, is paramount.

    a. When considering applicants to the USPHS Commissioned Corps, CCHQ will direct requests of a waiver of these standards to the Surgeon General for consideration, when indicated.

    b. If based on these standards, the Director, CCHQ, determines that a fitness for duty evaluation is indicated for a Regular Corps officer on active duty or Ready Reserve Corps officer, the Chief, Medical Affairs Branch will present the officer's medical records to a Medical Review Board (MRB) in accordance with CCI 393.01, "Medical Review Board."

2. The USPHS Commissioned Corps will use the Commissioned Corps Medical Retention Standards in this Appendix as guidelines:

    a. To determine the medical qualification of applicants for interservice transfer into the Regular Corps or Ready Reserve Corps;

    b. To determine medical qualification of officers applying for transfer between the Regular Corps and the Ready Reserve Corps; and

    c. To determine whether Regular Corps officers on active duty or Ready Reserve Corps officers should be recommended to undergo a medical fitness for duty evaluation.

3. Application of the Standards to Interservice Transfers. When considering applicants for an interservice transfer, the USPHS Commissioned Corps will apply the standards on a case-by-case basis with particular focus on whether the applicant will be able to fulfill all conditions of service and whether the course of any pre-existing conditions will, to a reasonable degree of medical certainty (more likely than not), lead to a premature end to the officer's USPHS Commissioned Corps career if commissioned in the USPHS Commissioned Corps.

4. Application of the Standards to Public Health Service Officers. When considering Regular Corps and Ready Reserve Corps officers, the USPHS Commissioned Corps will apply the standards on a case-by-case basis with particular focus on whether the officer can continue to perform their full duty including the ability to deploy and their ability to fulfill all conditions of service.

1. Weight Standards.

a. Body Mass Index (BMI) between 19 and 27.5 kg/m^2.

b. A percent body fat (determined by “taping”) not exceeding:

Age	Male	Female
≤ 28	24%	32%
28-39	26%	35%
40+	28%	38%

c. If BMI is less than 19 kg/m^2, further medical documentation will be requested.

2. Head and Neck.

a. Loss of substance of the skull including face. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms or when interfering with proper wear of personal protective equipment (PPE).

b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

3. 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 compromise of respiratory function 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.

4. 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.

(i) When visual acuity does not meet the standards.

(ii) When the visual field in the better eye is constricted to less than 20°.

(iii) When uncorrectable diplopia exists.

(iv) 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 20°.

c. Corneal Refractive Surgery.

(1) Radial keratotomy (RK), Photorefractive keratectomy (PRK) or Laser Assisted in situ Keratomileusis (LASIK) is not disqualifying if the individual has demonstrated post-surgical refractive stability defined as less than 0.50 diopter changes over two separate exams at least three months apart.

(2) Must meet all vision standards Implantable Contact Lenses (ICL) are not disqualifying if vision standards are met by three months post operatively.

(3) Recommended Wait Times for Activities after Refractive Surgery.

(a) LASIK. The greatest risk after LASIK is flap dislocation. Avoid activities that might cause trauma to the flap.

(b) PRK. The greatest risk after PRK is corneal surface irritation and haze. During the first 3-4 months after surgery, avoid activities that might irritate the surface of your eyes, and avoid exposure to ultraviolet (UV) light by wearing sunglasses when outdoors during the day.

(c) ICL. The greatest risk after ICL is infection inside the eye. Avoid lifting or bending over, trauma to the eye, and avoid activities that increase infection risk such as swimming and gardening.

Recommended Wait Times for Activities after Refractive Surgery

	ICL	LASIK	PRK
Showering or washing face.	No restriction. Notes: You should always avoid getting water in the eyes and pat the eyes dry		
Air travel as a passenger	3 days		5-7 days (after removal of bandage contact lens)
Aerobic activity (walk, run, bike, exercise machines) or weight training. Notes: Avoid getting sweat, dust, or wind in eyes.	2 weeks	As soon as pain and light sensitivity have resolved: 1-2 days.	As soon as pain and light sensitivity have resolved: 3-5 days.
Bending over(toe touches, sit-ups)	2 weeks	No restriction.	
Contact sports: Martial arts, basketball, boxing, wrestling	1 month. Note: There is a lifelong risk of opening surgical wounds with trauma to the eye. If you resume these activities, you must wear eye protection.		1 month.
Exposure to hot tubs, pools, lakes, ocean, river	1 month Note: Risk of infection from contaminated water		
Wearing eye make-up, including camouflage face paint	2 weeks Note: Infection risk from contaminated make-up. When make-up use is resumed, start with new, freshly opened products. Old eye makeup should be discarded.		
Working in a dusty or dirty environment: outdoor rifle range, deploying to the field, gardening	1 month	2 weeks	1 month
CS exposure (gas chamber) or OC spray (pepper spray) exposure	3 months		6 months
Driving an automobile or motorcycle with goggles or face Shield	When you meet the driving vision requirement and feel comfortable.		
Wearing UV protection (sunglasses)	Wear UV protection whenever practical.		Full time first month As much as possible the 2nd-4th months and whenever practical afterwards.

5. 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 duties or require frequent or prolonged medical care.

(6) Otitis Media (chronic or recurrent). 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.

6. Lungs and Chest Wall.

a. Tuberculous (TB) Lesions.

(a) When treatment and return to useful duty will probably require more than 15 months, including an appropriate period of convalescence.

(b) When a Reservist not on active duty has active TB disease 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 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, and may not be placed in the Selected Ready Reserve (SELRES).

b. Non-tuberculous 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.

c. 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 compromise of respiratory function 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.

(17) Obstructive Sleep Apnea. When not correctable by use of CPAP or surgical means.

d. Surgery of the Lungs and Chest. Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

7. Heart and Vascular System.

a. General. Residual of any cardiovascular treatment, including surgery or medication, resulting in symptoms or activity limitations that interfere with satisfactory performance of duty.

b. Heart.

(1) Arrhythmias.

(a) Bradyarrhythmias or tachyarrhythmias not adequately controlled by medication, catheter procedure or device implant if the arrhythmia symptoms (examples: palpitations, presyncope, syncope) or therapy interfere with satisfactory performance of duty.

(b) Uncomplicated pacemaker implantation is not disqualifying.

(c) Arrhythmias that require implantation of an implantable defibrillator (ICD) are disqualifying if:

(i) Associated with ICD shocks (appropriate or inappropriate) that cannot be adequately controlled by programming or medication; or

(ii) If arrhythmia symptoms or therapy interfere with satisfactory performance of duty.

(2) Coronary artery disease. Associated with congestive heart failure or repeated anginal attacks not adequately controlled by medication, catheter procedure or surgery if coronary insufficiency symptoms or therapy interferes with satisfactory performance of duty.

(3) Endocarditis. Resulting in heart failure or valvular insufficiency symptoms or therapy that interfere with satisfactory performance of duty.

(4) Myocarditis, cardiomyopathy (including hypertrophic cardiomyopathy) and heart failure. Persistent symptoms of myocardial insufficiency (examples: dyspnea, loss of energy, syncope) resulting in limitation of physical activity or required therapy that interfere with performance of duty.

(5) Pericardial disease and pericarditis. Associated with persistent symptoms resulting in limitation of physical activity or required therapy that interfere with performance of duty.

(6) Valvular heart disease. Valvular heart disease of any cause, including cardiac and extracardiac rheumatic heart disease associated with persistent symptoms resulting in limitation of physical activity or required therapy that interfere with performance of duty.

c. Vascular System.

(1) Any vascular system disorder associated with persistent symptoms or associated organ compromise resulting in limitation of physical activity or required therapy that interfere with performance of duty, including but not limited to:

(a) Peripheral arterial disease.

(b) Congenital anomalies including aortic coarctation.

(c) Arterial aneurysm.

(d) Raynaud phenomenon.

(e) Periarteritis nodosa.

(f) Chronic venous insufficiency.

(g) Thrombophlebitis.

(h) Peripheral venous insufficiency or varicose veins.

(i) Erythromelalgia.

(2) Hypertension. Including primary or secondary, of any cause, regardless of blood pressure, associated with symptoms, end organ disease or need for therapy that interfere with satisfactory performance of duty.

(3) Recurrent syncope or near syncope. Recurrent syncope or near syncope (including postural orthostatic tachycardia syndrome) that interferes with duty, if no treatable cause is identified or it persists despite conservative therapy.

8. 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 there from.

(5) Erosive esophagitis. Confirmed by gastroscope, chronic with repeated symptomatology, not relieved by medication or surgery.

(6) Gastritis. Severe, chronic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.

(7) 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.

(8) Malabsorption syndrome. When normal nutrition cannot be maintained despite replacement therapy.

(9) Surgical absence of >50% small or large intestine or <50% with inability to maintain normal vigor or nutrition.

(10) Recurrent cholelithiasis. When resulting in bouts of cholecystitis or pancreatitis and failing dietary/medication therapy.

(11) Hernia.

(a) Hiatus hernia. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

(b) Other. If risk for incarceration, if operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

(12) Ileitis, regional (Crohn's disease). Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.

(13) Pancreatitis, chronic. Frequent severe abdominal pain; or steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

(14) Peritoneal adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent hospital admissions.

(15) Proctitis, chronic. Moderate to severe symptoms of bleeding, or painful defecation, tenesmus, and diarrhea, with repeated hospital admissions.

(16) 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, or endoscopic evidence of activity.

(17) Ulcerative colitis. Except when responding well to treatment.

(18) 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 and interferes with performance.

(3) Enterostomy. When permanent.

(4) Gastrectomy.

(a) Total.

(b) Any gastrectomy subtotal, with or without vagotomy, or gastrojejunostomy, when, in spite of good medical management, the individual develops one of the following:

(i) "Dumping syndrome" that persists for 6 months postoperatively.

(ii) Frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively.

(iii) 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.

(iv) 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.

(11) Bariatric Surgery and all other forms of weight loss surgery are not authorized. If an interservice transfer applicant or an Regular Corps officer on active duty or Ready Reserve Corps officer has a remote history of bariatric surgery, has no current implanted devices (e.g. gastric band) and has not manifest any significant problems secondary to the previous procedure for a minimum of five years, the previous bariatric surgery will not be considered disqualifying or grounds for initiating a fitness for duty evaluation.

9. 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. If not adequately controlled by medications (per current American Diabetes Association Standards) or if treatment prevents the officer from being safely deployed.

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 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.

10. 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 1 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, recurrent, 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, ocular fundoscopic 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.

(a) When both ureters are markedly dilated with irreversible changes.

(b) Cutaneous.

(10) 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.

(11) Ureterosigmoidostomy.

(12) Ureterostomy. External or cutaneous.

(13) Urethrostomy. When a satisfactory urethra cannot be restored.

11. Extremities.

a. Upper.

(1) Amputations. Unless close to full function can be achieved with the use of prosthesis, 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.

(a) Shoulder.

(i) Forward elevation to 90°.

(ii) Abduction to 90°.

(b) Elbow.

(i) Flexion to 100°.

(ii) 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.

(i) An active flexor value of combined joint motions of 135° in each of two or more fingers of the same hand.

(ii) An active extensor value of combined joint motions of 75° in each of the same two or more fingers.

(iii) Limitation of motion of the thumb that precludes apposition to at least two fingertips.

(3) Recurrent dislocations of the shoulder. When not repairable or surgery is contraindicated.

b. Lower.

(1) Unless close to full function can be achieved with the use of prosthesis, amputations of part or parts of a lower extremity equal to or greater than any of the following:

(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 official footwear, 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 an official footwear.

(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.

(a) Hip.

(i) Flexion to 90°.

(ii) Extension to 0°.

(b) Knee.

(i) Flexion to 90°.

(ii) Extension to 15°.

(c) Ankle.

(i) Dorsiflexion to 10°.

(ii) 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 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 ankyloses. 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.

12. Spine, Ribs, and Sacroiliac Joints.

a. Spina bifida. Demonstrable signs of moderate symptoms of root or cord involvement.

b. Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated hospitalization or significant assignment limitation.

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

d. 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.

e. Kyphosis. More than moderate, or interfering with function

f. Scoliosis. Severe deformity with over two inches of deviation of tips of spinous processes from the midline.

g. Chronic Lumbosacral spine pain. When unresponsive to therapy, not a surgical candidate, and interfering with performance of duties.

13. 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 duty-related equipment.

b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.

c. Amyloidosis. Generalized.

d. Cysts and tumors. See Section 19 of Appendix B.

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 erythematosus. Chronic with extensive involvement of the skin and mucous membranes or other organ systems and when the condition does not respond to treatment.

s. Neurofibromatosis. If repulsive in appearance, causing gross deformity, 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 significantly interfere with the function of an extremity or interfere with the proper wearing of required clothing, uniform, and duty-related equipment.

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, or not responsive 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 duty or interferes with the proper wearing of required clothing, uniform, and duty-related equipment.

14. 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.) if not 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. Cerebrovascular disease. Manifest by neurologic symptoms, focal or general, degenerative neurological disorders. Manifest by neurologic symptoms, focal or general.

j. Multiple sclerosis.

k. Myasthenia graves.

l. Myelopathy transverse.

m. Narcolepsy, cataplexy, and hypersomnolence.

n. Paralysis, agitans.

o. 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.

p. Syringomyelia.

q. Vertigo. When refractory to treatment or resulting from neoplasm.

r. 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.

15. Psychiatric Disorders.

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, post-traumatic stress disorder or somatoform disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than 12 months. Prophylactic treatment associated with significant medication side effects such as sedation, dizziness, or cognitive changes or requiring frequent follow-up that limit duty options is disqualifying. Prophylactic treatment with medication may continue indefinitely as long as the member remains asymptomatic following initial therapy.

c. Mood disorders. Bipolar disorders or recurrent major depression do not require a 6 month evaluation period prior to initiating a medical board. 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 12 months. Prophylactic treatment associated with significant side effects such as sedation, dizziness, cognitive changes, or frequent follow-up that limit duty options is disqualifying. Prophylactic treatment with medication(s) may continue indefinitely as long as the member remains asymptomatic following initial therapy.

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.

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 performance of duty, are not amenable to treatment, or require prolonged treatment, administrative separation should be recommended.

f. Disorders usually 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 handled like other mental health conditions, 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).

g. Use of non-controlled medications such as Atomoxetine or Buproprion to treat, control, or improve performance for individuals diagnosed with Attention Deficit Disorder (either ADD or ADHD) may be allowed in individuals when a good prognosis is present. Individuals with Attention Deficit Disorder (either ADD or ADHD) that significantly impacts performance despite treatment, or if treatment is refused or due to non-compliance, have a disqualifying condition.

16. Dental Disorders.

a. 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 duty, or deformities that are disfiguring. Personnel must be in a Class 1 or Class 2 (see below) dental status for deployments or overseas duty orders.

b. Dental Classifications. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for Regular Corps officers on active duty and Ready Reserve Corps officers. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.

(1) Class 1 (Oral Health). Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.

(2) Class 2. Patients with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Class 2 are worldwide deployable. Patients in dental class 2 may exhibit the following:

(a) Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient.

(b) Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective cuspal coverage is indicated.

(c) Edentulous areas requiring prostheses but not on an immediate basis.

(d) Periodontium that:

(i) Requires oral prophylaxis.

(ii) Requires maintenance therapy.

(e) Requires treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.

(f) Requires removal of supragingival or mild to moderate sub-gingival calculus.

(g) Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.

(h) Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployment up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.

(i) Temporomandibular disorder patients in remission. The provider anticipates patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance will not interfere with duties.

(3) Class 3. Patients who require urgent or emergent dental treatment. Class 3 patients normally are not considered to be worldwide deployable.

(a) Treatment or follow-up indicated for dental caries, symptomatic tooth fracture or defective restorations that cannot be maintained by the patient.

(b) Interim restorations or prostheses that cannot be maintained for a 12-month period.

(c) Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months.

(i) Acute gingivitis or pericoronitis.

(ii) Active progressive moderate or advanced periodontitis.

(iii) Periodontal abscess.

(iv) Progressive mucogingival condition.

(v) Periodontal manifestations of systemic disease or hormonal disturbances.

(vi) Heavy subgingival calculus.

(vii) Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication, or acceptable esthetics.

(viii) Unerupted, partially erupted, or malposed teeth with historical, clinical or radiographic signs or symptoms of pathosis that are recommended for removal.

(ix) Chronic oral infections or other pathologic lesions.

(x) Pulpal, periapical, or resorptive pathology requiring treatment.

(xi) Lesions requiring biopsy or awaiting biopsy report.

(xii) Emergency situations requiring therapy to relive pain, treat

trauma, treat acute oral infections, or provide timely follow-up care (e.g., drain or suture removal) until resolved.

(xiii) Acute Temporomandibular disorders requiring active treatment that may interfere with duties.

17. 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.

f. Thromboembolic disease.

g. Splenomegaly, chronic.

18. 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) Porphyria Cutanea Tarda.

(5) Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.

(6) 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.

(7) 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 11 of Appendix B.

c. Miscellaneous Conditions or Circumstances.

(1) Chronic Fatigue Syndrome, Fibromyalgia, and Myofascial Syndrome when not controlled by medication or with reliably diagnosed depression.

(2) Unless granted a medical waiver or a religious exception, failure to provide documentation of a required immunization/vaccination (e.g., completed the Hepatitis A and B series, Varicella, Measles/Mumps/Rubella (MMR), Tetanus/Diphtheria). Individuals must also complete any associated boosters in accordance with CDC recommended schedules.

(3) The individual is precluded from a reasonable fulfillment of the purpose of employment in the USPHS Commissioned Corps.

(4) The individual's health or well-being would be compromised if allowed to remain in the USPHS Commissioned Corps.

(5) The individual's retention in the USPHS Commissioned Corps would prejudice the best interests of the Government.

(6) Required chronic and continuous DEA controlled (Class I-V) medications, such as Ritalin, Amphetamine, Cylert, Modafanil is not disqualifying unless the treatment interferes with the ability of the officer to meet all conditions of service including the ability to deploy.

(7) Required chronic anti-coagulant, other than aspirin, such as Coumadin is not disqualifying unless the treatment interferes with the ability of the officer to meet all conditions of service including the ability to deploy.

(8) Chronic (greater than 30 days per year) use of immunosuppressive medications including steroids V is not disqualifying unless the treatment interferes with the ability of the Officer to meet all conditions of service including the ability to deploy.

19. 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 service.

c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness unless not responding to treatment and/or with residual symptoms causing incapacitation or inability to perform required duties. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of duty. However, the following normally render the individual unfit for further service:

(1) Ganglioneuroma.

(2) Meningeal fibroblastoma. When the brain is involved.

20. Sexually Transmitted Infection. Complications or residuals of such chronicity or degree of severity that the individual is incapable of performing useful duty.

21. Human Immunodeficiency Virus (HIV). Officers who demonstrate no evidence of unfitting conditions of immunologic deficiency, neurologic deficiency, and progressive clinical or laboratory abnormalities associated with HIV or AIDS-defining condition shall be retained in the service unless some other reason for separation exists.

22. Transplant recipient. Any organ or tissue except hair or skin.