IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

RICHARD ROE; VICTOR VOE; and OUTSERVE-SLDN, INC., Plaintiffs, v. PATRICK M. SHANAHAN, in his official capacity as Acting Secretary of Defense; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; and the UNITED STATES DEPARTMENT OF DEFENSE, Defendants.	)	No. 1:18-cv-1565-LMB-IDD

MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS AND DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

INTRODUCTION

Plaintiffs Richard Roe and Victor Voe challenge their discharges from the United States Air Force. The Plaintiffs were discharged on the ground that their infection with the Human Immunodeficiency Virus (HIV) likely precludes their deployment to the United States Central Command ("CENTCOM") area of operation. After review of their cases by four boards comprising the Air Force's disability evaluation system, the Secretary of the Air determined that Roe and Voe would be unable to reasonably perform the duties of their office, grade, rank, or rating. Plaintiffs Roe and Voe, together with Plaintiff OutServe-SLDN, Inc., challenge the Secretary's discharge decisions, as well as the Department of Defense ("DOD") and Air Force regulations that were applied in those decisions, under the Equal Protection Clause and the Administrative Procedure Act.

The Court lacks subject matter jurisdiction to consider Plaintiffs' claims for several reasons. First, Plaintiffs have not yet exhausted all avenues of administrative relief, including an appeal to the Air Force Board of the Correction of Military Records. *See infra* part I.A. Moreover, even if Plaintiffs had exhausted their administrative remedies, the Court also lacks jurisdiction because Plaintiffs' claims raise a non-justiciable military controversy, *see infra* part I.B, and because Plaintiffs do not possess standing to bring those claims, *see infra* part I.C.

Even if this Court had jurisdiction over Plaintiffs' claims, Plaintiffs cannot clearly establish even one of the four elements required to permit this Court to grant preliminary relief. *See infra* part II. It is well-established that federal employees have no entitlement to their positions and must make an extraordinary showing to justify injunctive relief preventing their termination from federal employment. The burden is even heavier in cases of military discharge in light of the significant deference courts must give to military decision making. Plaintiffs come nowhere close

to making this elevated showing, and otherwise have not met the necessary prerequisite of demonstrating a irreparable harm. Therefore, if this Court does exercise jurisdiction here, it should nonetheless deny Plaintiffs' motion for preliminary injunction.

BACKGROUND

I. Regulatory Background

Department of Defense Instruction ("DoDI") 1332.18 governs the discharge of service members with medical conditions. Air Force Instruction ("AFI") 10-203, *Duty Limiting Conditions*, implements DoDI 1332.18 and establishes procedures for the administrative management of airmen with injuries or illnesses that affect their ability to perform military duties. A104.[1] These procedures ensure maximum utilization and readiness of personnel, while preserving airmen's health and minimizing risk of further injury or illness. *Id.*

DoD has also promulgated detailed instructions to the Military Services governing the management of service members with laboratory evidence of HIV infection. DoDI 6485.01 directs the Services to (1) periodically screen all service members, A84, (2) provide medical care for all service members with laboratory evidence of HIV, (3) establish "aggressive disease surveillance and health education programs" for service members, and if necessary, (4) refer a service member with laboratory evidence of HIV for "a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses. . . ." A85.

Consistent with this guidance, the Air Force directed its personnel center to conduct medical evaluations of "fitness for continued service for asymptomatic HIV Airmen . . . in the same manner as any Airman with a chronic and/or progressive disease." A338. The Air Force further directed that "[a]symptomatic HIV alone is not unfitting for continued service." A338-

[1] Citations to the appendix filed with this brief are abbreviated A___.

339. Airmen with asymptomatic HIV would not be referred to the disability evaluation system ("DES") unless they satisfied the requirements of DoDI 1332.18. *Id.* The Air Force also explained that the decision to retain or separate airmen with asymptomatic HIV would be made on a case by case basis. A339.

The Air Force uses a tiered disability review process. An airman's case is first evaluated by the Air Force Personnel Center's Medical Retention Standards Office. A415. If this office determines that an airman has (1) one or more medical conditions that may prevent the airman from reasonably performing the duties of his office, grade, rank, or rating, (2) a medical condition that represents an obvious medical risk to the health of the member or to the health and safety of others, or (3) a medical condition that imposes unreasonable requirements on the military to maintain or protect the airman, then the airman is referred to the DES. *Id.* If none of these conditions are present, the airman is returned to duty (called IRILO). A105, A127. An airman referred to DES first undergoes a Medical Evaluation Board ("MEB"). A129. A MEB is composed of two or more licensed physicians, and it prepares a narrative summary of the airman's duty limiting condition. A416. After evaluating an airman's case, the MEB can return the airman to duty or forward the case to a Physical Evaluation Board ("PEB"). A416-417. If the case is forwarded to a PEB, the airman is given an opportunity to make a written rebuttal and is provided an impartial medical review, if requested. A417.

Every case at this level is reviewed by an informal PEB ("IPEB"). A417. The IPEB prepares a narrative summary after considering the airman's medical records, the airman's written rebuttal, and the recommendation of the airman's commander. *Id.* Applying the standards in DoDI 1332.18, the IPEB prepares a written recommendation whether to discharge or return the airman to duty. A418. An airman may appeal an IPEB decision to a formal PEB ("FPEB"). A419. On

appeal, airmen receive representation and an opportunity for an in-person hearing before the FPEB. *Id.* The FPEB also applies the standards in DoDI 1332.18 and prepares a written recommendation whether to discharge or return the airman to duty. A419-420. An airman who receives a discharge recommendation from the FPEB may then appeal to the Secretary of the Air Force Personnel Council ("SAFPC"). *Id.* The SAFPC reviews the case, applies the standards in DoDI 1332.18, and makes a recommendation whether to discharge or return an airman to duty. A420.

Even if the SAFPC decides to separate an airman, the airman still has significant intra-service administrative remedies available to alter or overturn the separation. *See Guerra v. Scruggs*, 942 F.2d 270, 272-73 (4th Cir. 1991). The airman may seek review of the separation decision by the Air Force Board for Correction of Military Records ("AFBCMR"), which has broad authority to correct any error or injustice in an airman's military record. *See* 10 U.S.C. § 1552; 32 C.F.R. § 581.3; AFI 36-2603. The AFBCMR has authority to consider claims of constitutional, statutory, and regulatory violations in the rendering of personnel decisions. *See Guerra*, 942 F.2d at 273. It serves as the "highest administrative body in the [Air Force's] own appellate system" and may offer the Air Force's definitive interpretation of its own regulations. *Navas v. Gonzalez Vales*, 752 F.2d 765, 770-71 (1st Cir. 1985). The AFBCMR is not limited to just correcting military records; the Secretary of the Air Force, acting through or upon recommendation of the AFBCMR, possesses plenary authority to afford relief to airmen injured by adverse personnel actions including, but not limited to, reversing involuntary separations, removing adverse information from personnel files, and awarding back pay and allowances. *See* 10 U.S.C. §§ 1552(a), (c), (d).

An airman aggrieved by a decision of the AFBCMR may generally seek judicial review of that final decision. *See Randall v. United States*, 95 F.3d 339, 348 (4th Cir. 1996). If an airman

seeks back pay in connection with a military record change, he may bring a Tucker Act claim before the Court of Federal Claims. *Id.* Where the airman does not seek monetary relief, then the AFBCMR's decision may generally be reviewed by the district courts under the Administrative Procedure Act. *Id.*

II. Roe And Voe's Separation Decisions

Roe and Voe's separation decisions were processed in the same manner as cases involving other chronic medical conditions. In accordance with DoDi 6485.01, the MEB determined that Plaintiffs' diagnoses made their qualifications for worldwide duty questionable and referred their cases to the IPEB. A554 (Roe), A761 (Voe). The IPEB determined that Plaintiffs would be unable to reasonably perform the duties of their office, grade, rank, or rating because of their inability to deploy and potential medical complications. A550 (Roe), A758 (Voe). The IPEB determinations acknowledge that Plaintiffs are asymptomatic, otherwise physically fit, and able to perform in-garrison duties. *Id.*

On appeal, the FPEB in both cases determined that, although Roe and Voe were asymptomatic, plaintiffs should be separated because they were subject to significant deployment restrictions in career fields with high likelihoods of deployment. A468 (Roe), A756 (Voe). Both plaintiffs sought SAFPC review, and in both cases, the SAFPC concluded that Plaintiffs belonged to career fields with high deployment tempos but were subject to deployment restrictions, including ineligibility to deploy to the CENTCOM area, where the majority of the Air Force is expected to deploy, and were therefore unfit for continued service. A460 (Roe), A747 (Voe).

Following the SAFPC's decisions, both Roe and Voe received separation papers. A666 (Roe), A942 (Voe). Roe is scheduled to be honorably discharged in March 2019, and Voe is scheduled to be honorably discharged in February 2019. *Id.* Neither Roe nor Voe have sought

review of their discharges before the AFBCMR. A420.

STANDARD OF REVIEW

Defendants bring a factual challenge to the Court's subject matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1). In a factual challenge, "the defendant argues 'that the jurisdictional allegations of the complaint [are] not true,' providing the trial court the discretion to 'go beyond the allegations of the complaint and in an evidentiary hearing determine if there are facts to support the jurisdictional allegations.'" *Beck v. McDonald*, 848 F.3d 262, 270 (4th Cir. 2017) (quoting *Kerns v. United States* 585 F.3d 187, 192 (4th Cir. 2009)). Because the Court may consider facts outside of the pleadings to determine if it in fact possesses jurisdiction to consider the case, "the presumption of truthfulness normally accorded a complaint's allegations does not apply." *Id.* "When, as here, a defendant challenges the existence of subject matter jurisdiction in fact, the plaintiff bears the burden of proving the truth of such facts by a preponderance of the evidence." *Unites States ex re. Vuyyuru v. Jadhav*, 555 F.3d 337, 347 (4th Cir. 2009).

A party seeking a preliminary injunction bears the burden of establishing that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Each of these four factors must be satisfied to obtain preliminary injunctive relief. *Henderson v. Bluefield Hosp. Co.*, 902 F.3d 432, 439 (4th Cir. 2018). Consequently, if the party seeking the injunction fails to make a clear showing of any one of the four factors, the Court need not consider the remaining factors and must deny the preliminary injunction. *See id.* at 438-39.

ARGUMENT

The Court must dismiss Plaintiffs' complaint for lack of subject matter jurisdiction because

the claims are premature, *see infra* part I.A, the claims raise a non-justiciable military controversy, *see infra* part I.B, and because Plaintiffs do not possess standing to bring these claims, *see infra* part II. Each of these grounds is independently sufficient to require jurisdictional dismissal. Even if this Court did possess jurisdiction over Plaintiffs' claims, Plaintiffs cannot clearly establish any of the four elements required to permit the Court to grant preliminary relief and their motion for preliminary injunction must be denied. *See infra* part III. Finally, even if this Court were to grant preliminary relief, such relief should be limited to the individual Plaintiffs. *See infra* part IV.

I. This Court Lacks Subject Matter Jurisdiction To Consider Plaintiffs' Claims.

A. Plaintiffs Roe And Voe's Claims Must Be Dismissed As Premature.

"[A] court should not review internal military affairs 'in the absence of (a) an allegation of the deprivation of a constitutional right, or an allegation that the military has acted in violation of applicable statutes or its own regulations, and (b) exhaustion of available intraservice corrective measures.'" *Williams v. Wilson*, 762 F.2d 327, 359 (4th Cir. 1985) (quoting *Mindes v. Seaman*, 453 F.2d 197, 201 (5th Cir. 1971)); *see also Downey v. U.S. Dep't of the Army*, 685 F. App'x 184, 192-83 (4th Cir. 2017). Failure to exhaust all available intra-service remedies renders any federal court claim (and any request for immediate injunctive relief sought along with that claim) "a nonjusticiable military controversy," requiring a district court to dismiss the claim "without prejudice as premature." *Williams*, 762 F.2d at 359-60; *see also Guerra*, 942 F.2d at 276-77. Despite its application here, Plaintiffs do not even acknowledge this binding precedent.

Plaintiffs seek to bypass the well-established intra-service remedies available to them, including review at the AFBCMR, to obtain premature review in federal court. The AFBCMR has authority to consider the very arguments that Plaintiffs present here, and thereafter alter any discharge, order back pay and allowances, and recommend reinstatement into the Air Force. *See*

10 U.S.C. § 1552.

The Fourth Circuit (and other circuits) has held that service members must exhaust their intra-service remedies before seeking relief in federal court. *See, e.g.*, *Williams*, 762 F.2d at 360; *Guerra*, 942 F.2d at 273; *Wilt v. Gilmore*, 62 F. App'x 484, 487-88 (4th Cir. 2003); *see also, e.g.*, *Navas*, 752 F.2d at 769-70; *Thornton v. Coffey*, 618 F.2d 686, 692 (10th Cir. 1980); *Hodges v. Callaway*, 499 F.2d 417 (5th Cir. 1974). This is so even when, unlike here, the AFBCMR cannot afford full relief to the service member. *See Guerra*, 942 F.2d at 272; *Wilt*, 62 F. App'x at 488. A decision of the AFBCMR "might completely obviate the need for judicial review" or, at the very least, provide the Court with "a definitive interpretation of the [applicable] regulation and an explication of the relevant facts from the highest administrative body in the [service's] own appellate system." *Navas,* 752 F.2d at 770-71 (quoting *Hodges*, 499 F.2d at 422). Further, under a "consistent and unambiguous line of cases," the Fourth Circuit has "reject[ed] the contention that constitutional claims should be exempt from exhaustion requirements." *Nationsbank Corp. v. Herman*, 174 F.3d 424, 429 (4th Cir. 1999).

Plaintiffs are entitled to present all of their arguments to the AFBCMR. There is no reason for this Court to weigh in on the meaning of the challenged regulations (or the proper application of those regulations to Plaintiffs) before the Air Force itself has had an opportunity to offer a definitive interpretation. Indeed, Plaintiffs could ultimately prevail in the administrative proceedings. In any event, this action is premature.

Plaintiffs' claims are materially indistinguishable from *Williams*, where the plaintiff alleged that the military failed to follow its own regulations during his separation proceeding and sought immediate injunctive relief from a federal district court before any actual discharge could take place. *See Williams*, 762 F.2d at 360. The Fourth Circuit held unequivocally that because

the plaintiff had not exhausted all of his intra-service remedies, including review at the applicable BCMR, the lawsuit was a "nonjusticiable military controversy," and dismissed the case without prejudice as premature. *Id.* Under this binding Fourth Circuit precedent, Plaintiffs' action, including their claims that the Air Force failed to follow its own regulations, is premature and must be dismissed without prejudice so that Plaintiffs may exhaust all intra-service remedies.

B. Even If Plaintiffs Roe and Voe Had Properly Exhausted Their Available Intra-service Remedies, Their Claims Raise A Non-Justiciable Military Controversy.

Even if Plaintiffs' claims satisfied the threshold requirements of the *Williams/Mindes* analysis, the Court would be required to balance four factors to determine if it could properly consider the case:

(1) the nature and strength of the plaintiff's challenge to the military determination;
(2) the potential injury to the plaintiff if review is refused;
(3) the type and degree of anticipated interference with the military function; and
(4) the extent to which the exercise of military expertise or discretion is involved.

Williams, 762 F.2d at 359 (quoting *Mindes*, 453 F.2d at 201-02). In this case, none of these factors weigh in favor of this Court taking jurisdiction over Plaintiffs' claims.

First, Plaintiffs' Equal Protection and APA challenges are weak. In addition to being premature, plaintiff's only constitutional claim, an Equal Protection challenge, is subject to a highly deferential standard of review. The conduct challenged by Plaintiffs does not "impinge[] upon a fundamental right or involve[] a suspect classification, [therefore] a minimal level of scrutiny is applied under the rational basis test." *Guerra*, 942 F.2d at 279. Under the rational basis standard, "a regulation need only bear some rational relationship to legitimate governmental purposes," and the "deference afforded to government . . . is so deferential that even if the government's actual purpose in creating classifications is not rational, a court can uphold the regulation if the court can envision some rational basis for the classification." *Id.* Plaintiffs'

arguments to the contrary are without merit. The Fourth Circuit has squarely held that claims of discrimination on the basis of HIV status are subject to rational basis review only. *See Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1267 (4th Cir. 1995); *see also Constantine v. Rectors & Visitors of George Mason Univ.*, 411 F.3d 474, 486 (4th Cir. 2005) ("classifications based on disability are subject to minimal scrutiny.").

"[R]ational-basis review of an equal protection claim in the context of agency action is similar to that under the APA . . . . In such a case, the equal-protection argument is folded into the APA argument, since no suspect class is involved and the only question is whether the defendants' treatment of [Plaintiff] was rational (i.e., not arbitrary and capricious)." *Cooper Hosp./Univ. Med. Ctr. v. Burwell*, 179 F. Supp. 3d 31, 47 (D.D.C. 2016) (internal citations omitted), *aff'd sub nom. Cooper Hosp. Univ. Med. Ctr. v. Price*, 688 F. App'x 11 (D.C. Cir. 2017); *see also Nazareth Hosp. v. Sec'y of HHS*, 747 F.3d 172, 180 (3d Cir. 2014); *Ursack, Inc. v. Sierra Interagency Black Bear Grp.*, 639 F.3d 949, 955 (9th Cir. 2011). In other words, because Plaintiffs' challenges are to an agency action, the equal-protection challenge is subsumed within the APA challenge. *See* 179 F. Supp. 3d at 47. Defendants have set forth the justifications for their HIV policies in two reports to Congress. A364 (2014 Report), A380 (2018 Report). As discussed in more detail *infra*, these justifications are sufficient to survive rational basis review.

Plaintiffs' challenges to the Air Force's implementation of regulations are also weak.[2] In

[2] If the Court concludes that Plaintiffs' challenges to the Air Force's application of the challenged regulations are justiciable because they are procedural in nature, *see Allphin v. United States*, 758 F.3d 1336, 1342 (Fed. Cir. 2014), it must nevertheless refuse to consider Plaintiffs' challenges to the substance of the Air Force's decisions. In military discharge cases "merit-based challenges are nonjusticiable . . . [t]he merits of a military staffing decision are committed wholly to the discretion of the military." *Id.* at 1341 (internal citation omitted). The Air Force "has wide discretion to manage its workforce, and its decisions to institute [review boards] and honorably discharge its [airmen] are unquestionably beyond the competence of the judiciary to review." *Id.* (internal citation omitted). For procedural challenges to agency action, the appropriate relief is remand.

reviewing agency actions, the Court must "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Fort Sumter Tours, Inc. v. Babbitt*, 66 F.3d 1324, 1335 (4th Cir. 1995) (quotation omitted); *see Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). "The APA confines judicial review of executive branch decisions to the administrative record of proceedings before the pertinent agency." *Downey v. U.S. Dep't of the Army*, 110 F. Supp. 3d 676, 685–86 (E.D. Va. 2015), *aff'd* 685 F. App'x 184 (4th Cir. 2017) (internal quotation marks, citations, and alterations omitted).

The Air Force applied the provisions in DoDI 6485.01 and AFI 44-178, and referred Roe and Voe's cases to the DES in the same manner as any service member with a chronic or progressive illnesses. A85, A299. Plaintiffs were provided the full opportunity in the DES process to present their case to multiple boards and appeal, before final separation decisions were made by the Air Force. The administrative record demonstrates that each board recommended separation because both Plaintiffs faced deployment restrictions, and the SAFPC concluded that Plaintiffs were in career fields likely to deploy to the CENTCOM area of operations (the area to which a majority of Air Force deployments are currently sent), and Plaintiffs would likely be unable to deploy to CENTCOM. A460 (Roe). A747 (Voe); A419 (Decl.).

Second, Plaintiffs will not suffer significant injury if their claims are dismissed. Roe and Voe have both completed their terms of enlistment. Compl. ¶¶ 75, 88 (Dkt. 1). It is beyond question that there is no right to reenlist in the military, and therefore no injury if reenlistment is denied, at the conclusion of a service member's term of enlistment. *Williams v. United States*, 541 F. Supp. 1187, 1191-92 (E.D.N.C. 1982); *see also, e.g.*, *Guerra*, 942 F.2d at 278 ([E]ven if we found that Guerra had a property interest at one time, we note that he would no longer have a

property interest because his term of enlistment has now expired."); *Dodson v. U.S. Army,* 988 F.2d 1199, 1203-04 (Fed. Cir. 1993) ("[N]o one has a right to enlist or reenlist in the armed forces, unless specially given one by statute or regulation."); *Montiel v. United States*, 40 Fed. Cl. 67, 72 (Fed. Cl. 1998) ("servicemembers have no right to reenlist at the expiration of their terms."); *West v. Brown*, 558 F.2d 757, 760 (5th Cir. 1977); *Simmons v. Brown*, 497 F. Supp. 173, 178 (D. Md. 1980) ("[A] serviceman has no property interest or entitlement in continued military service"). Moreover, both Roe and Voe will receive honorable discharges, A666 (Roe), A942 (Voe), and it is well-settled that such discharges do not give rise to reputational injury. *See Guerra*, 942 F.2d at 274; *Chilcott v. Orr*, 747 F.2d 29, 34 (1st Cir. 1984); *McBride v. West*, 940 F. Supp. 893, 896 (E.D.N.C. 1996) (holding that an honorable discharge did not constitute irreparable harm); *Simmons*, 497 F. Supp. at 179 ("[A] liberty interest is not impinged by the mere fact of discharge from military service unless stigmatizing information is likely to be disseminated to the public at large or to prospective employers.").[3]

The third and fourth prongs of the *Mindes* balancing are substantially intertwined, and both weigh in favor of the Court declining jurisdiction in this case. Plaintiffs' claims strike at the core of military discretion and expertise, and the Court's second-guessing of those decisions would result in a substantial interference with military functions. Whether and how individuals may serve in the military is a central strategic calculation for which the Court has no expertise. Defendants' policies regarding deployability and retention of military members deemed to be non-deployable

[3] Furthermore, Plaintiffs' discharges cannot create stigma because the circumstances of the discharges are confidential unless Plaintiffs themselves choose to release them. *See Sims v. Fox*, 505 F.2d 857, 862-63 (5th Cir. 1974) ("The mere presence of derogatory information in *confidential* files is not an infringement of 'liberty'." (emphasis added)).

stem from the military's goal of "maximiz[ing] the lethality and readiness of the joint force" and the military's judgment that "all Service members [should be] expected to be deployable." *See* A62. Decisions about which Service members are fit—including medically fit— to meet the needs of the military and whether those members should be deployed are precisely the "complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force" that the Supreme Court has said are "essentially professional military judgments." *Winter*, 555 U.S. at 24 (quoting *Gilligan v. Morgan*, 413 U.S. 1, 10 (1973)); *see also Heisig v. United States*, 719 F.2d 1153, 1156 (Fed. Cir. 1983). Courts consistently refuse to interfere with such professional military judgments. Indeed, earlier this month the Court of Appeals for the District of Columbia Circuit vacated a preliminary injunction entered against another military personnel policy, noting that "it is 'difficult to think of a clearer example of the type of governmental action that was intended by the Constitution to be left to the political branches directly responsible—as the Judicial Branch is not—to the electoral process.'" *Doe 2 v. Shanahan*, No. 18-5257, 2019 WL 102309, at *2 (D.C. Cir. Jan. 4, 2019) (quoting *Gilligan v. Morgan*, 413 U.S. 1, 10 (1973)); *see also, e.g.*, *Thomassen v. Perry*, 80 F.3d 915, 925-26 (4th Cir. 1996).

Accordingly, none of the four *Williams/Mindes* factors weigh in favor of considering Plaintiffs' claims, which the Court should dismiss as non-justiciable.

C. Plaintiffs Lack Standing To Bring Their Claims.

This case should also be dismissed because Plaintiffs lack standing. For an individual to demonstrate Article III standing, he must show that "(1) []he suffered an actual or threatened injury that is concrete, particularized, and not conjectural; (2) the injury is fairly traceable to the challenged conduct; and (3) the injury is likely to be redressed by a favorable decision." *Doe v. Va. Dep't of State Police*, 713 F.3d 745, 753 (4th Cir. 2013).

Plaintiffs Roe and Voe allege that they have been injured because they have been prevented from continuing to serve in the Air Force. Plaintiffs cannot show, however, that they have a "legally protected interest" in continued service beyond their current terms of enlistment. *See Hutton v. Nat'l Bd. of Examiners in Optometry, Inc.*, 892 F.3d 613, 621 (4th Cir. 2018) (noting that, to satisfy the first prong of the standing analysis, a plaintiff must show that he "suffered an invasion of a legally protected interest" (internal quotation omitted)). Both Plaintiffs concede that their terms of enlistment have expired. Compl. ¶¶ 74, 88. Thus, Plaintiffs must reenlist to continue serving in the Air Force. It is well-established that "a citizen enjoys no constitutionally protected right to join the military," and consequently that there is "no substantive protection for reenlistment." *Williams*, 541 F. Supp. at 1191-92. There is also no statutory or regulatory right to reenlist in the Air Force. *See* 10 U.S.C. §§ 505, 508(b); A173, A211. Because Plaintiffs have alleged no legally protected interest they have not met their burden to demonstrate standing.

Even if Plaintiffs could demonstrate that a legally protected interest was injured, they still would not possess standing because their alleged injury is not likely to be redressed by a favorable decision on their claims. "An injury is redressable if it is likely as opposed to merely speculative that the injury will be redressed by a favorable decision." *Doe*, 713 F.3d at 755 (internal citations omitted). And Fourth Circuit "precedent declin[es] to find redressability where an additional, unchallenged rule could prevent a plaintiff from having [his] injury cured." *Id. at* 757. Although deployability and discharge determinations may inform the Secretary's reenlistment decisions, reenlistment is a separate process independent of both the medical evaluation and the underlying regulations challenged by the Plaintiffs. *See generally* A159. Enlistment and reenlistment decisions are in the sole discretion of the Secretary of the Air Force. *See* 10 U.S.C. §§ 505, 508(b). No statute or regulation creates an entitlement to reenlistment for enlisted members of the Air

Force. *See* A211 ("Reenlistment in the Regular Air Force . . . is a command prerogative and is not an inherent right of any individual."). Even if Roe and Voe were to prevail on their claims, they would be required to engage in the reenlistment process, and could be denied reenlistment on unrelated grounds. *See* A173 ("Airmen *may be considered* for reenlistment . . . if they . . . 1. Meet eligibility requirements . . . 2. Have qualities essential for continued service . . . 3. Can perform duty in a career field in which the Air Force has a specific need.") (emphasis added). Plaintiffs do not challenge the reenlistment regulations and those regulations plainly could prevent them from obtaining their desired relief.[4] Thus, the individual Plaintiffs have not met their burden to demonstrate standing.

The sole organizational plaintiff, OutServe-SLDN, has likewise failed to demonstrate standing to bring its claims. An organization "can assert standing either in its own right or as a representative of its members." *S. Walk at Broadlands Homeowner's Ass'n v. Openband at Broadlands*, LLC, 713 F.3d 175, 182 (4th Cir. 2013). Here, Outserve has not alleged any injury to itself and therefore "'can establish standing only as [a] representative[] of [its] members who have been injured in fact, and thus could have brought suit in their own right.'" *Id.* at 183-83 (quoting *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 40 (1976)). An organizational plaintiff must satisfy three prongs to establish representational standing:

> (1) Its own members would have standing to sue in their own right;
> (2) the interests the organization seeks to protect are germane to the organization's purpose; and
> (3) neither the claim nor the relief sought requires the participation of individual members in the lawsuit.

Id. at 184 (quoting *Md. Highway Contractor's Ass'n*, 933 F.2d 1246, 1251 (4th Cir. 1991)).

[4] Although Plaintiffs request that the Court order Defendants to reenlist them directly, that power is not within the Court's inherent authority and infringes on the separation of powers.

At the first prong of this test, "to show that its members would have standing, an organization must 'make specific allegations establishing that at least one *identified member* had suffered or would suffer harm.'" *Id.* (quoting *Summers v. Earth Island Inst.*, 555 U.S. 488, 498 (2009) (emphasis in original)). The only individual members of Outserve identified by the complaint are Plaintiffs Roe and Voe.[5] As discussed above, neither Roe nor Voe have standing to bring the claims in the present case. Therefore, Outserve has failed to establish that it has standing to bring claims in this case.

II. Plaintiffs Cannot Demonstrate Entitlement To Preliminary Injunctive Relief.

A preliminary injunction is an "extraordinary and drastic remedy." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997). Plaintiffs have not met their burden to make a clear showing that they are entitled to preliminary relief. To succeed on their motion, Plaintiffs must clearly demonstrate each of four elements: (1) they are "likely to suffer irreparable harm in the absence of preliminary relief;" (2) they are "likely to succeed on the merits;" (3) "that the balance of equities tips in [their] favor;" and (4) "that an injunction is in the public interest." *Winter*, 555 U.S. at 20. "*Winter* ma[kes] clear that *each* of these four factors must be satisfied to obtain preliminary injunctive relief." *Henderson*, 902 F.3d 439. Consequently, if Plaintiffs fail to make a clear showing of any one of the four factors the Court need not consider the remaining factors and must deny the preliminary injunction. *See id.* at 438-39. Plaintiffs have not established any of these elements, let alone all four of them. Accordingly, their motion must be denied.

[5] Plaintiffs reference four additional members in an attachment to their Motion for Preliminary Injunction. However, even if those individuals could be shown to have standing, they are not, identified in the complaint, and "[i]t is well-established that parties cannot amend their complaints through briefing or oral advocacy." *S. Walk*, 713 F.3d at 184.

A. Fourth Circuit Authority Precludes Plaintiffs From Establishing Irreparable Harm.

Plaintiffs' motion for a preliminary injunction must be denied because they cannot make a "clear showing" of likely irreparable harm. *See Winter*, 555 U.S. at 22. In cases involving military personnel decisions, courts require the moving party to make a much stronger showing of irreparable harm than the ordinary standard for injunctive relief. *See Guerra*, 942 F.2d at 274; *see also Hartikka v. United States*, 754 F.2d 1516, 1518 (9th Cir. 1985).

The Supreme Court has recognized that where federal civilian employees seek immediate injunctive relief from termination, the employee must make an extraordinary showing of irreparable harm beyond the traditional evidence necessary to sustain preliminary injunctive relief. *Sampson v. Murray*, 415 U.S. 61, 91-92 (1974). The *Sampson* Court specifically rejected the same allegations of harm on which Plaintiffs premise their motion, Pls.' Mem. (Dkt. 34) at 27-28, as insufficient:

> Assuming for the purpose of discussion that respondent had made a satisfactory showing of loss of income and had supported the claim that her reputation would be damaged as a result of the challenged agency action, we think the showing falls far short of the type of irreparable injury which is a necessary predicate to the issuance of a temporary injunction in this type of case.

Sampson, 415 U.S. at 91-92; *see also id.* at 84. Moreover, Plaintiffs claims arise in the military personnel context, where courts have provided extraordinary deference. *See, e.g.*, *Orloff v. Willoughby*, 345 U.S. 83, 93-94 (1953); *Hartikka*, 754 F.2d at 1518; *Chilcott*, 747 F.2d at 33 ("[M]ilitary discharge proceedings should be enjoined only in exceptional circumstances."). The Fourth Circuit has held "that *Sampson*'s higher requirement of irreparable injury should be applied in the military context given the federal courts' traditional reluctance to interfere with military matters." *Guerra*, 942 F.2d at 274.

In *Guerra*, the Fourth Circuit applied this heightened standard to a nearly identical set of circumstances—an enlisted National Guard soldier seeking immediate injunctive relief to preclude his forthcoming separation based on conclusory allegations of reputational loss and pay—and held that the soldier simply could not demonstrate the necessary irreparable harm. *Id.* at 274-75. Courts have not hesitated to reject claims of stigma or reputational injury from service members who received discharges less favorable than Plaintiffs' honorable discharges. *See id.* at 274 (holding that even a "general discharge under honorable conditions is not an injury of sufficient magnitude to warrant an injunction."); *Chilcott*, 747 F.2d at 34; *McBride*, 940 F. Supp. at 896.[6]

Even in the absence of this precedent, Plaintiffs' injuries are simply not irreparable. Plaintiffs can obtain review from the AFBCMR, which is empowered to "correct any military record . . . when the Secretary considers it necessary to correct an error or remove an injustice," 10 U.S.C. § 1552(a), and may (in conjunction with the Secretary of the Air Force) order Plaintiffs' reinstatement and backpay.[7] In the event that the AFBCMR denies their requests for relief, Plaintiffs have an alternate course of recovery in either the Court of Federal Claims (which can

[6] Plaintiffs rely on an out-of-circuit district court decision to the contrary, Pls.' Mem. at 28 (citing *Elzie v. Aspin*, 841 F. Supp. 439, 443 (D.D.C. 1993); however, the Fourth Circuit was clear in *Guerra* that the damage to a plaintiff's reputation from the time of discharge to the decision of the AFBCMR does not rise to the level of irreparable injury, and that decision is binding. 942 F.2d at 274-75.

[7] In this respect, Plaintiffs are entitled to greater remedies from the AFBCMR than were the Plaintiffs in *Williams* and *Guerra*. As the Fourth Circuit noted in both of those cases, because of the unique federalism issues applicable to National Guardsmen, the applicable BCMR could not order the reinstatement of either of those Plaintiffs; nevertheless, the Fourth Circuit held that those Plaintiffs were still required to complete BCMR review before seeking federal court relief. *See Guerra*, 942 F.2d at 276-77; *Williams*, 762 F.2d at 359-60. As members of the regular Air Force, the AFBCMR, in conjunction with the Secretary of the Air Force, can order Plaintiffs' reinstatement.

"provide an entire remedy" under the Tucker Act, *Mitchell v. United States*, 930 F.2d 893, 896-97 (Fed. Cir. 1991)) or this Court (under the APA).

Further, Plaintiffs point to no "dire consequences" that would excuse requiring Roe and Voe from exhausting their administrative remedies. *Guerra*, 942 F.2d at 277. To be sure, Plaintiffs' rely on *Karnoski* to allege that "denial of timely health care" is an irreparable injury. Pls.' Mem. At 27-28 (citing *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *9 (W.D. Wash. Dec. 11, 2017). But the Supreme Court has stayed the injunction in *Karnoski*. *See Trump v. Karnoski*, No. 18A625, 2019 WL 271944, at *1 (U.S. Jan. 22, 2019). And Plaintiffs here were not denied medical care here. The Secretary determined that they should be discharged. In any event, both Roe and Voe are entitled to receive medical benefits from the Department of Veterans Affairs, 38 C.F.R. § 17.37(b), that are not subject to any copayment or income eligibility requirement, 38 C.F.R. §§ 17.108(d)(1), (e)(1), 17.110(c)(2), 17.111(f)(1).

Plaintiffs' reliance on the fact that they assert a constitutional violation to establish irreparable injury is also misplaced. Pls.' Mem. at 28 Although courts have recognized that there is a strong presumption of harm where a plaintiff alleges a loss of First Amendment rights, *see Legend Night Club v. Miller*, 637 F.3d 291, 302 (4th Cir. 2011), this authority does not apply with the same force in cases not involving First or Fourth Amendment claims. *See Vaqueria Tres Monjitas, Inc. v. Irizarry*, 587 F.3d 464, 484-85 (1st Cir. 2009) (noting that an automatic finding of irreparable harm for a constitutional violation has been generally reserved for "infringements of free speech, association, privacy or other rights as to which temporary deprivation is viewed of such qualitative importance as to be irremediable by any subsequent relief" and that "it cannot be said that violations of Plaintiffs' rights to due process and equal protection automatically result in irreparable harm" (citation and emphasis omitted)); *Siegel v. LePore*, 234 F.3d 1163, 1177 (11th

Cir. 2000); *Hohe v. Casey*, 868 F.2d 69, 73 (3d Cir. 1989). Thus, the fact that Plaintiffs have alleged an equal protection violation cannot by itself establish that they will be irreparably harmed absent an injunction.

In sum, because Plaintiffs cannot establish the necessary irreparable harm to justify preliminary injunctive relief, this Court should deny Plaintiffs' motion without addressing the other *Winter* factors. *See Henderson*, 902 F.3d at 438-39.

B. Plaintiffs Have Not Clearly Demonstrated That They Are Likely To Succeed On The Merits.

Even if, despite Fourth Circuit authority to the contrary, Plaintiffs could somehow establish the necessary irreparable harm in the absence of preliminary injunctive relief, they cannot demonstrate that they will likely succeed on the merits. Plaintiffs' challenges to Defendants' policies are unlikely to succeed because those policies need only be rationally related to military needs. Plaintiffs' challenges to the Air Force's decisions to separate Roe and Voe are also unlikely to succeed because the Air Force properly and consistently applied its regulations.

1. Plaintiffs Have No Likelihood of Success on the Merits Because Their Claims are Non-Justiciable.

Fourth Circuit precedent is clear that, when a case that cannot be heard because the Court lacks subject matter jurisdiction, Plaintiffs have "no likelihood of success on the merits." *Guerra*, 942 F.2d at 277. As explained above, *see supra* Part I, review is unavailable here for several reasons, including Plaintiffs failure to exhaust their intra-service remedies. *Id.* at 276-77; *see also Williams*, 762 F.2d at 359. Plaintiffs therefore must obtain review of their separation decisions through the AFBCMR before coming to this Court. *See Williams*, 762 F.2d at 360 ("The ABCMR is better equipped than the courts. . . . The ABCMR has far greater experience that this court in deciphering the content and effect of military regulations and should be permitted to exercise its

expertise." (citing *Navas*, 752 F.2d at 769-70)). For this reason alone, Plaintiffs cannot demonstrate that they are likely to succeed on the merits.

2. Even If Plaintiffs Claims Are Justiciable, They Are Unlikely to Succeed on the Merits of Their Challenges to Defendants' Policies Because Those Policies Are Rational.

As explained *supra* in part I.B, Plaintiffs' constitutional claims are subject to rational basis review only and analysis of those claims is subsumed within the APA analysis. *See Cooper Hosp.*, 179 F. Supp. 3d at 47. Plaintiffs concede that military readiness, "building and maintaining an effective military," and protecting the health and safety of services members are legitimate government interests. Pls.' Mem. at 13. As such, the Court must "uphold the polic[ies] so long as [they] can reasonably be understood to result from a justification independent of unconstitutional grounds." *Trump*, 138 S. Ct. at 2420.

DoD and the Air Force have provided sufficient justifications for their policies. A369-379 (2014 Report), A380-413 (2018 Report). As explained in DoD's 2014 Report to Congress, HIV infection has the potential to undermine a Service member's medical fitness and the readiness of the force. A376. As Plaintiffs concede, in the best case scenario, individuals who are HIV positive must take daily action to ensure that their viral loads stay suppressed in order to remain healthy and minimize the risk that they will infect others. *See* Compl. ¶¶ 51-55, 59, 80. This need for regular treatment and monitoring could impair the ability of an HIV-positive Service member to serve worldwide. A384. As a May 2018 report from the Centers for Disease Control and Prevention ("CDC") noted, "[c]linical, pharmacy, and laboratory services are limited in some deployment settings" and "access to expedited laboratory testing for HIV infection" as well as the three-site [sexually transmitted infections] testing recommended by the CDC "is either unavailable or not easily accessible at many smaller medical facilities in the United States." A437.

Additionally, "because some pharmacies have insufficient stock of medication for use for [HIV treatment,] not every service member" who needs the medication can obtain it, and the recommended follow-up evaluations every three months "can be difficult in light of the often unpredictable training and mission schedules." *Id.* Moreover, despite the development of successful treatment strategies, current treatments do not cure HIV and, if treatment is interrupted, it is thought that "the vast majority of, if not all, infected individuals receiving [antiretroviral therapy (ART)] will experience plasma viral rebound regardless of the level of HIV . . . at the time of discontinuation of ART." A444. In these circumstances, DoD and the Air Force's regulations governing the discharge of service members are rational.

Plaintiffs contend that Defendants' regulations governing military service for service members with laboratory evidence of HIV are not rationally related to military effectiveness because service members who receive successful treatment are physically fit. Pls.' Mem. at 13-15. This argument misconstrues the regulations applicable to their Air Force separation decisions. The Air Force did not apply DoDI 1332.45, but rather heeded the direction of DoDI 6485.01 to refer service members with laboratory evidence of HIV to the DES in the same manner as a Service member with other chronic or progressive illnesses. A414-416; *see also* A229, A329. And while a service member cannot be separated solely on the basis of being infected, a service member whose condition otherwise interferes with their ability to perform their military occupation successfully may be referred to the DES. A392, A294-337. The DES process is regulated by DoDI 1332.18, which provides reasonable procedures for the assessment of service members with deployment limiting conditions. In short, the regulations require a service member to be declared unfit if the evidence "establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating . . . ." A27.

To determine whether a service member can reasonably perform his duties, DoDI 1332.18 directs the services to consider: (1) whether the service member can perform the common military tasks required for the Service member's office, grade, rank, or rating; (2) whether the service member is capable of taking the required physical fitness test; (3) whether the service member is "deployable individually or as part of a unit, with or without prior notification, to any vessel or location specified by" the service; and (4) for service members whose conditions disqualify them for specialized duties, whether the specialized duties constitute the member's current assignment, if the member has an alternative specialty, or if reclassification of the member is feasible. A31. Thus, a fitness determination does not turn solely on a service member's physical fitness. Rather, it is a more inclusive review of a service member's ability to reasonably perform duties of his or her office, grade, rank, or rating.

Plaintiffs further contend that the military should be able to provide necessary medical care to deployed service members. Pls.' Mem. at 15-17. But this argument is nothing more than the substitution of conclusory assertions and Plaintiffs' opinions for the military's professional judgment, which this Court cannot allow. *See Goldman v. Weinberger*, 475 U.S. 503, 507 (1986) (explaining that "courts must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest"); *see also, e.g., Doe 2 v. Shanahan*, No. 18-5257, 2019 WL 102309 at *2 (D.D.C. Jan. 4, 2019); *Thomassen*, 80 F.3d at 925-26. Besides ignoring the risks of interruption of medical care, Plaintiffs' arguments also misconstrue the purpose of forward-deployed military medical assets. Those assets are not intended to care for service members' chronic medical needs, but rather the exigent and emerging needs of the deployed force. A397, A425-426. And contrary to Plaintiffs' argument, the military may consider the added burden of providing medical care to deployed service members,

particularly where, as noted above, the law of this Circuit is that HIV diagnosis is not a suspect classification and that claims of discrimination on the basis of HIV status are subject to rational basis review. *Doe*, 50 F.3d at 1267; *see also Rostker v. Goldberg*, 453 U.S. 57, 81-82 (1981) (noting that the courts should not dismiss "added burdens" and "administrative burdens" in challenges to military policies).

Plaintiffs also attempt to minimize the risk of a transmission of HIV on the battlefield, because there are no documented cases of such transmission. But this argument presumes the best outcome for a deployed service member—continued access to treatment and complete viral suppression—when the military must weigh the risks of the worst outcome—the interruption of treatment, subsequent rebound of HIV, and potential to transmitted the virus to others. As the waiver authority for CENTCOM explains, when deciding whether to deploy a service member the military considers how a service member would be impacted by reasonably anticipated contingencies, such as loss, theft, or destruction of medication. A427-428.

DoD's deployment regulations are also rational. DoD policy places the responsibility to decide whether to grant a waiver to a service member with laboratory evidence of HIV to deploy to a certain country to the combatant commander responsible for that geographic region. A88-89. (DoDI 6490.07). Though Plaintiffs singularly focus on the success and relative ease of modern antiretroviral treatments, the DoD considers a broader range of issues associated with deployment, including risks to the service members health and the risk to his or her unit. As the waiver authority for CENTCOM explains in his declaration, when deciding whether to deploy a service member the military conducts an individual assessment of each condition, occupation, as well as the timing and location of the deployment. A427. The military also considers how a service member would be impacted by reasonably anticipated contingencies, how their condition will impact the

evaluation of routine medical issues, what secondary effects their treatment may have, and how their condition will influence, and be influenced by, operational activities within active combat zones. *Id.* Not only is such a risk calculation rational, but it is also fundamentally a professional military judgment that is not subject to judicial review. *See Winter*, 555 U.S. at 24; *see also Harkness v. Sec'y of Navy*, 858 F.3d 437, 444 (6th Cir. 2017) (explaining that duty assignments "lie at the heart of military expertise and discretion" and such decisions are therefore non-justiciable).

Plaintiffs also discount the likelihood that a battlefield blood transfusion, and transmission of HIV because of a blood transfusion, would occur. But battlefield transfusions do occur, and the safety of such transfusions has long been a concern. A429 (explaining that screening for HIV began in 1986, in part, for this reason). The military's clinical guidelines for battlefield transfusions warn military physicians that there is a known and documented risk of a transfusion-transmitted infection. A1025-1026. And while the probability of transmission of HIV by battlefield blood transfusion may be "relatively low . . . the potential impact is high." A431. In fact, there are documented cases of the transmission of infectious agents as the result of battlefield transfusions. *See* A450 (HTLV, a retrovirus like HIV), A1025-1026 (reporting the transmission of Hepatitis C Virus and HTLV to service members who received battlefield transfusions).

3. Even If Plaintiffs' Claims Are Justiciable, Plaintiffs Cannot Demonstrate That The Air Force Violated Its Regulations.

Plaintiffs APA claims also fail because they cannot demonstrate that the Air Force violated either the DoD's or its own regulations. Judicial review of an agency action under the APA is confined "to the administrative record of proceedings before the pertinent agency."[8] *Downey*, 110

[8] For this reason, the Court should not permit discovery to proceed in this case.

F. 3d at 685-86. The administrative record here demonstrates that the Air Force properly considered Roe and Voe's treatment by acknowledging that Plaintiffs were asymptomatic, that they were on a one or two pill per day regimen, that they could pass their physical assessments, and that they were physically able to perform their in garrison duties. A460, A468, A550 (Roe), A474, A756, A758 (Voe).

At each level of review, the board applied 1332.18, and the administrative record explains the reasoning that, despite Plaintiffs' asymptomatic condition, Roe and Voe should be separated because they would likely not be able to perform the duties of their military specialties, both of which were subject to high deployment tempos to the CENTCOM area of responsibility. A460 (Roe); A747 (Voe).

The boards' recommendations were not arbitrary and capricious, and the record demonstrates a connection between the facts and the conclusion that Air Force reached. The conclusion that Plaintiffs likely would not be permitted to deploy is supported by the declaration of CENTCOM's designated waiver authority, who notes that, although a deployment waiver for a service member is possible, it is not likely. A427-428. The boards' recommendations are also supported by the fact that the overwhelming majority of deployments of Air Force personnel have been to the CENTCOM area of responsibility. A419. And the Air Force's choice to emphasize a particular area of operations is consistent with DoDI 1332.18's instruction that a Service may consider whether a service member is deployable "to any vessel or location specified by the Military Department." A31. Far from Plaintiffs' arguments that Roe and Voe were being discharged for HIV "alone," they were in fact discharged for a combination of having HIV and being in a career field where they would have a high deployment tempo to CENTCOM, rendering

it impossible for them to fully perform their duties. The Air Force therefore reasonably applied the applicable regulations to the separation decisions here.

Plaintiffs rely on *Wilson v. Office of Civilian Health & Med. Program of Uniformed Servs. (CHAMPUS),* 866 F. Supp. 931, 936 (E.D. Va. 1994), to support their argument that failure to use updated medical information makes a decision arbitrary and capricious. Pls.' Mem. at 23-24. In *Wilson*, the court held that the DoD was arbitrary and capricious when it relied on an outdated and non-authoritative news article for medical information rather than that of a board-certified oncologist, both of which were in the record. 866 F. Supp. at 936. No such circumstances exist here. The concerns reflected in the challenged policies are not outdated. A380-413, A423-28. And Plaintiffs here ask the court to substitute the opinion of their expert for DoD's professional military and medical judgment, an approach rejected by the Supreme Court in *Winter*. 555 U.S. at 28.

4. Even If Plaintiffs' Claims Are Justiciable, Plaintiffs Cannot Demonstrate that The Air Force Failed to Apply Its Regulations Uniformly.

Plaintiffs' allegation that the Air Force is not applying DoD's or its regulations consistently is also without merit. Pls. Mtn at 22. Plaintiffs base this argument on the incorrect assumption that all service members with asymptomatic HIV are similarly situated. They are not. DoD and Air Force regulations require weighing considerations other than a service member's medical condition, such as deployability. A31.

Of the ten appeals by airmen with laboratory evidence of HIV decided in October of 2018, the SAFPC returned four airmen to duty and recommended the discharge of six airmen. A420. The SAFPC recommended discharge for one airman because his medical condition was unstable. *Id.* It recommended discharge for two airmen because their medical conditions disqualified them

for specialized duties. *Id.* The SAFPC recommended discharge for three airmen, including Roe and Doe, because those airmen were employed in career fields with a high rate of deployment from 2015 to 2017. *Id.* By contrast, the four airmen who were returned to duty were each employed in career fields with low rates of deployment. *Id.* Thus, rather than demonstrating inconsistent treatment, an overall review of the SAFPC's recommendations show that the Air Force is applying the standards set forth in DoDI 1332.18.

C. The Remaining Equitable Factors Do Not Favor Preliminary Injunctive Relief.

The remaining equitable factors—which merge when the government is a party, *Nken v. Holder*, 556 U.S. 418, 435 (2009)—do not favor preliminary injunctive relief. Plaintiffs contend that the loss of their positions (which is potentially temporary, pending review by the AFBCMR) outweighs the loss the Air Force would suffer. Pls.' Mem. at 28-29. But the Fourth Circuit rejected this casual view towards the presumed harm to the military from the entry of preliminary injunctive relief in *Guerra*, noting that the harm "is greater than it first appears." 942 F.2d at 275. This is so because "injunctions would be routinely sought in . . . discharge cases" and "[t]he result would be judicial second-guessing of a kind that courts have been reluctant to engage in." *Id*.

The same is true here. If this Court were to grant preliminary relief, each and every service member with a chronic medical condition facing separation would be able to seek similar relief in the federal courts before the services could evaluate the service member's arguments for retention, issue a decision on separation, and provide review from the services' BCMRs. A preliminary injunction would also entangle the Court in "professional military judgments,"—"complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force," *Winter*, 555 U.S. at 24 (citations omitted)—in a way that would interfere "with the subordinate decisions of military authorities" and "frustrate[] the national security goals that the

democratic branches have sought to achieve," *Thomassen*, 80 F.3d at 926. The Court "cannot predict the effect" on the Air Force of retaining airmen who have been determined to be not fit for duty. *Guerra*, 942 F.2d at 275. The Air Force's discretionary decision, if second-guessed, that "would be a disruptive force as to affairs peculiarly within the jurisdiction of the military authorities." *Orloff*, 345 U.S. at 95. Additionally, an injunction establishing a new policy concerning the deployability or retention of HIV-positive Service members would deprive the military of its ability to determine the appropriate makeup and distribution of its forces, a judgment call for which the military is uniquely situated. *See Winter*, 555 U.S. at 24

The public interest would also not be served by ordering the Air Force to stop processing Plaintiffs' separations. *See Guerra*, 942 F.2d at 280 (holding that the public interest did not weigh in favor of immediate injunctive relief to preclude military member's discharge based on same analysis as the balancing of harms). Indeed, in the context of personnel actions, it is in the public interest to "allow[] the military, in an orderly fashion, to fully adjudicate claims on the part of its own personnel, free of unnecessary interference by the federal courts." *McBride*, 940 F. Supp. at 897. Permitting court involvement prior to the exhaustion of administrative remedies is a drastic change to precedent that simultaneously undermines the trust placed in the military to regulate its own actions and results in judicial second guessing of military actions prior to their completion.

Thus, the final two factors weigh in Defendants' favor, not Plaintiffs'. For these reasons, Plaintiffs cannot clearly establish any of the preliminary injunction factors on this record, let alone all four of them. Their motion must therefore be denied. *See Henderson*, 902 F.3d at 439.

III. Even If Plaintiffs' Prevail, The Appropriate Remedy Is Remand Or An Injunction Limited To Plaintiffs Roe And Voe.

If the Court rules in Plaintiffs' favor, any injunction should be no broader than necessary to provide Plaintiffs complete relief, and should therefore be limited to the individual Plaintiffs

before this Court. *See Lewis v. Casey*, 518 U.S. 343, 357 (1996). If the Court finds merit in Plaintiffs' APA claims, then the appropriate remedy is a remand to the Air Force for a better explanation of its decisions. *See Fla. Power & Light*, 470 U.S. 729, 744 ("[T]he proper course, except in rare circumstances, is to remand to the agency for additional investigation or explanation.").

As for Plaintiffs' constitutional claims, Plaintiffs fail to show that a nationwide injunction is necessary to redress any injury to them. *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018) (noting that "[a] plaintiff's remedy must be tailored to redress the plaintiff's particular injury."); *California v. Azar*, 911 F.3d 558, 582 (9th Cir. 2018). Plaintiffs' facial challenges do not provide this basis. The Supreme Court has stayed a nationwide injunction against a military policy to the extent it swept beyond the parties to the case. *See United States Dep't of Def. v. Meinhold*, 510 U.S. 939 (1993). *Meinhold* involved a facial constitutional challenge by a discharged Navy service member to DoD's "then-existing policy regarding homosexuals." *Meinhold v. United States Dep't of Def.*, 34 F.3d 1469, 1473 (9th Cir. 1994). After the district court enjoined DoD from "taking any actions against gay or lesbian servicemembers based on their sexual orientation" nationwide, the Supreme Court stayed that order "to the extent it conferred relief on persons other than Meinhold." *Meinhold*, 510 U.S. at 939. The Supreme Court's grant of a stay in *Meinhold* reflects the principle that injunctive relief should not extend beyond the parties to the case.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court dismiss Plaintiffs' claims and deny their motion for a preliminary injunction.

DATE: January 25, 2019

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Department of Defense
INSTRUCTION

NUMBER 1332.18
August 5, 2014
Incorporating Change 1, Effective May 17, 2018

USD(P&R)

SUBJECT: Disability Evaluation System (DES)

References: See Enclosure 1

1. PURPOSE. This instruction:

a. Reissues DoD Directive (DoDD) 1332.18 (Reference (a)) as a DoD instruction (DoDI) in accordance with the authority in DoDD 5124.02 (Reference (b)).

b. Establishes policy, assigns responsibilities, and provides procedures for referral, evaluation, return to duty, separation, or retirement of Service members for disability in accordance with Title 10, United States Code (U.S.C.) (Reference (c)); and related determinations pursuant to sections ~~3501,~~ 6303, 8332, and 8411 of Title 5, U.S.C. (Reference (d)); section 104 of Title 26, U.S.C. (Reference (e)); and section 2082 of Title 50, U.S.C. (Reference (f)).

c. Incorporates and cancels DoDI 1332.38 (Reference (g)) and the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Memorandums (References (h) through (o)).

2. APPLICABILITY. This instruction applies to the OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. POLICY. It is DoD policy that:

a. The DES will be the mechanism for determining ~~return to~~ *fitness for* duty, separation, or retirement of Service members because of disability in accordance with Reference (c).

b. Service members will proceed through one of ~~three~~ *the* DES processes: the Legacy Disability Evaluation System (LDES), *or* the Integrated Disability Evaluation System (IDES)~~, or the Expedited Disability Evaluation System (EDES).~~ DoD's objective in all DES processes is to

collaborate with the Department of Veterans Affairs (VA) to ensure continuity of care, timely processing, and seamless transition of the Service member from DoD to VA in cases of disability separation or retirement. *It is DoD policy for Service members to process through the IDES unless a compelling and individualized reason for process through the LDES is approved by the Secretary of the Military Department.*

c. The standards for all determinations related to disability evaluation will be consistently and equitably applied, in accordance with Reference (c), to all Service members, and be uniform within the components of the Military Departments.

d. Reserve Component (RC) Service members who are not on a call to active duty of more than 30 days and who are pending separation for non-duty related medical conditions may enter the DES for a determination of fitness and whether the condition is duty related.

e. In determining a Service member's disability rating, the Military Department will consider all medical conditions, whether individually or collectively, that render the Service member unfit to perform the duties of the member's office, grade, rank, or rating.

f. Service members who are pending permanent or temporary disability retirement and who are eligible for a length of service retirement at the time of their disability evaluation may elect to be retired for disability or for length of service. However, when retirement for length of service is elected, the member's retirement date must occur within the time frame that a disability retirement is expected to occur.

g. A Service member may not be discharged or released from active duty because of a disability until he or she has made a claim for compensation, pension, or hospitalization with the VA or has signed a statement that his or her right to make such a claim has been explained, or has refused to sign such a statement. The Secretaries of the Military Departments may not deny a Service member who refuses to sign such a claim any privileges within DES policy as noted in this instruction.

h. RC Service members on active duty orders specifying a period of more than 30 days will, with their consent, be kept on active duty for disability evaluation processing until final disposition by the Secretary of the Military Department concerned. *In accordance with DoDI 1241.01 (Reference (p)), RC Service members may elect to be released from active duty before completion of DES processing. These Service members may receive legal counseling in accordance with the regulations of the Military Department concerned.*

i. The Secretaries of the Military Departments may authorize separation on the basis of congenital or developmental defects not being compensable under the Veterans Affairs Schedule for Rating Disabilities (VASRD) if defects, circumstances or conditions interfere with assignment to or performance of duty. ~~These Service members will not be referred to the DES.~~ *The basis for separation will be appropriately documented following guidelines and criteria in accordance with DoDI 6040.42 (Reference (q)). These Service members will not be referred to the DES unless the defect was subject to super imposed disease or injury during military service, or other potentially unfitting conditions exist that may have been incurred or aggravated by*

military service.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3 of this instruction. Additional procedural guidance for the LDES is included in DoD Manual (DoDM) 1332.18, Volume 1 (Reference ~~(p)~~*(r)*). Additional procedural guidance for the IDES is included in DoDM 1332.18, Volume 2 (Reference ~~(q)~~*(s)*). ~~Procedural guidance for EDES will be published in a separate DoD issuance.~~

6. INFORMATION COLLECTION REQUIREMENTS

a. The DES Annual Report, referred to in paragraphs ~~1d(6)(a)~~ *1.d.(6)(a)*, ~~1d(6)(b)~~ *1.d.(6)(a)*, and ~~1e(4)~~ *1.e.(4)* of Enclosure 2 of this instruction, has been assigned report control symbol DD-HA(A,Q)2547 in accordance with the procedures in Volume 1 of DoD Manual 8910.01 (Reference ~~(r)~~*(t)*).

b. The DES quarterly data submission, referred to in paragraphs ~~1d(6)(b)~~ *1.d.(6)(b)* and ~~1d(4)~~ *1.d.(4)* of Enclosure 2 of this instruction, has been assigned report control symbol DD-HA(A,Q)2547 in accordance with the procedures in Reference ~~(r)~~*(t)*.

7. RELEASABILITY. **Cleared for public release**. This instruction is available on ~~the Internet from~~ the DoD Issuances Website at ~~http://www/dtic/mil/whs/directives~~ *http://www.esd.whs.mil/DD*.

8. EFFECTIVE DATE. This instruction *is effective August 5, 2014.*~~:~~

~~a. Is effective August 5, 2014.~~

~~b. Will expire effective August 5, 2024 if it hasn't been reissued or cancelled before this date in accordance with DoDI 5025.01 (Reference (s).~~

Jessica L. Wright
Under Secretary of Defense for
Personnel and Readiness

Enclosures

1. References
2. Responsibilities
3. Operational Standards for the DES

Glossary

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 1332.18, "Separation or Retirement for Physical Disability," November 4, 1996 (hereby cancelled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) Title 10, United States Code
(d) Title 5, United States Code
(e) Section 104 of Title 26, United States Code
(f) Section 2082 of Title 50, United States Code
(g) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as amended (hereby cancelled)
(h) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Guidance for the Disability Evaluation System and Establishment of Recurring Directive-Type Memoranda," May 3, 2007 (hereby cancelled)
(i) Under Secretary of Defense for Personnel and Readiness Memorandum, "Directive-Type Memoranda (DTM) on Standards for Determining Unfitness Due to Medical Impairment (Deployability)," December 19, 2007 (hereby cancelled)
(j) Under Secretary of Defense for Personnel and Readiness Memorandum, "Directive-Type Memorandum (DTM) on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub. L. 110-181)," March 13, 2008 (hereby cancelled)
(k) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub. L. 110-181)," October 14, 2008 (hereby cancelled)
(l) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy and Procedural Memorandum for the DES Pilot Program," November 21, 2007 (hereby cancelled)
(m) Under Secretary of Defense for Personnel and Readiness Memorandum "Policy and Procedural Update for the Disability Evaluation System (DES) Pilot Program," December 11, 2008 (hereby cancelled)
(n) Under Secretary of Defense for Personnel and Readiness Memorandum "Cross Service Support and Service Organization Role at Disability Evaluation System (DES) Pilot Locations," March 29, 2010 (hereby cancelled)
(o) Under Secretary of Defense for Personnel and Readiness Memorandum, "Directive-Type Memorandum – Integrated Disability Evaluation System," December 19, 2011 (hereby cancelled)
~~(p) DoD Manual 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014~~
(p) DoD Instruction 1241.01, "Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements," April 19, 2016

~~(q) DoD Manual 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014~~

(q) DoD Instruction 6040.42, "Management Standards for Medical Coding of DoD Health Records," June 8, 2016

(~~p~~*r*) DoD Manual 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014

(~~q~~*s*) DoD Manual 1332.18, Volume 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System," August 5, 2014

~~(s) DoD Instruction 5025.01, "DoD Issuances Program," June 6, 2014~~

(~~r~~*t*) DoD Manual 8910.01, Volume 1, "DoD Information Collections Manual: Procedures for DoD Internal Information Collections," June 30, 2014*, as amended*

~~(t) Title 38, Code of Federal Regulations, Part 4 (part 4 is also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)")~~

(u) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended

~~(u) Under Secretary of Defense for Personnel and Readiness Memorandum, "Expedited DES Process for Members with Catastrophic Conditions and Combat-Related Causes," January 6, 2009~~

(~~t~~*v*) Title 38, Code of Federal Regulations, Part 4 (part 4 is also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)")

(~~v~~*w*) Memorandum of Agreement Between the Department of Defense and Department of Veterans Affairs, January 16, 2009

(~~w~~*x*) Memorandum of Agreement Between the Department of Defense and Department of Veterans Affairs, June 16, 2010

(~~x~~*y*) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007

~~(y) Section 1612 of Public Law 110-181, "National Defense Authorization Act for Fiscal Year 2008," January 28, 2008~~

~~(z) Joint Federal Travel Regulations, Volume 1, "Uniformed Service Members," current edition~~

~~(aa) Joint Federal Travel Regulations, Volume 2, "Department of Defense Civilian Personnel," current edition~~

~~(ab) DoD Directive 1332.27, "Survivor Annuity Programs for the Uniformed Services," June 26, 2003~~

(z) DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014

(aa) DoD Instruction 1000.30, "Reduction of Social Security Number (SSN) Use Within DoD," August 1, 2012

(ab) Administrative Instruction 15, "OSD Records and Information Management Program," May 3, 2013, as amended

(ac) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

(~~y~~*ad*) Section 1612 of Public Law 110-181, "National Defense Authorization Act for Fiscal Year 2008," January 28, 2008

(~~z~~*ae*) Joint Federal Travel Regulations, Volume 1, "Uniformed Service Members," current edition

(~~aa~~*af*) Joint ~~Federal~~ Travel Regulations, Volume 2, "Department of Defense Civilian Personnel," current edition

(~~ab~~*ag*) DoD Directive 1332.27, "Survivor Annuity Programs for the Uniformed Services," June 26, 2003

~~(ac) DoD Directive 1332.35, "Transition Assistance for Military Personnel," December 9, 1993~~

(ah) DoD Instruction 1332.35, "Transition Assistance Program (TAP) for Military Personnel," February 29, 2016

(~~ad~~*ai*) DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014*, as amended*

(~~ae~~*aj*) Section 115 of Title 32, United States Code

(~~af~~*ak*) Title 37, United States Code

(~~ag~~*al*) Title 38, United States Code

~~(ah) DoD Instruction 1332.30, "Separation of Regular and Reserve Commissioned Officers," November 25, 2013~~

(am) DoD Instruction 1332.30, "Commissioned Officer Administration Separations," May 11, 2018

~~(ai) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition~~

(an) Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition

ENCLOSURE 2

RESPONSIBILITIES

1. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Oversees the Director, Defense Health Agency (DHA), in the execution of programmatic and operational responsibilities in accordance with DoDD 5136.01 (Reference (u)).

~~a~~*b*. Establishes the Disability Advisory Council (DAC) to advise and recommend improvement of the DES and designates its chair.

~~b~~*c*. Monitors the performance of the DES and recommends improvements in DES policy.

~~c~~*d*. Reviews DES policies, including those proposed by the Military Departments.

~~d~~*e*. Through the Deputy Assistant Secretary of Defense for ~~Warrior Care Policy (DASD)(WCP))~~ *Health Services Policy and Oversight (DASD(HSP&O))*:

(1) In coordination with the ~~Assistant Secretary of Defense for Reserve Affairs (ASD(RA))~~ *Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&RA))* and the Secretaries of the Military Departments, oversees, assesses, and reports on the performance of the DES and recommends to the ASD(HA) changes in policy, procedure, or resources to improve DES performance.

(2) Monitors changes to military personnel, ~~and~~ compensation statutes and DoD policy, and other pertinent authorities, to assess their impact on disability evaluation, RC medical disqualification, and related benefits.

(3) Reviews Military Departments' policies and procedures for disability evaluation that affect the uniformity of standards for separation or retirement for unfitness because of disability, or separation of RC members for medical disqualification.

(4) Develops quality assurance procedures to ensure that policies are applied fairly and consistently and reports to ASD(HA) the results of Military Department DES quality control programs.

(5) Develops and executes a strategic communications plan for the DES in coordination with:

(a) Assistant *to the* Secretary of Defense for Public Affairs

(b) Secretaries of the Military Departments

(c) Under Secretary for Benefits, Veterans Benefits Administration, VA

(d) Under Secretary for Health, Veterans Health Administration, VA

(6) Establishes reporting requirements necessary to monitor and assess the performance of the DES and compliance of the Military Departments with this instruction.

(a) Not later than July 1 of each year, publishes the information the Military Departments must include in the DES Annual Report.

(b) Analyzes quarterly data submitted by the Military Departments and provides the DES Annual Report to the ASD(HA).

(c) Analyzes monthly DES data to assess trends that might inform policy adjustments.

~~e. Through the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight:~~

(~~1~~*7*) Reviews Military Departments' policies and procedures for disability evaluation that affect the uniformity of standards for separation or retirement for unfitness because of disability or separation of RC members for medical disqualification.

(~~2~~*8*) Monitors changes to the laws, and regulations of the VA to assess their impact on the DoD's application of the VASRD (Reference (~~t~~*u*)) to Service members determined unfit because of disability, and recommends timely guidance to the ASD(HA).

(~~3~~*9*) Recommends guidance and performance monitoring necessary to implement this instruction, including recommending performance metrics and areas of emphasis.

(*1*0) ~~DASD(WCP) advises~~ *Advises* on the accurateness and completeness of the DES Annual Report and DES quarterly data submitted by the Military Departments to propose improvements to the DES based upon the submitted performance data.

(~~5~~*11*) In conjuction with the Secretaries of the Military Departments and the Director, ~~Defense Health Agency~~ *DHA,* develops program planning, allocation, and use of healthcare resources for activities within the DoD related to the DES.

(~~6~~*12*) In coordination with the Military Departments *and DHA* information technology (IT) offices, ensures IT support and access to programs used at the military treatment facilities (MTFs) and other related systems for medical record input and retrieval are available to each Military Department physical evaluation board (PEB).

(~~7~~*13*) Provides grade O-6 or civilian equivalent representation with a sufficient understanding of the DES to the DAC.

2. ~~ASD(RA)~~ *ASD(M&RA)*. Under the authority, direction, and control of the USD(P&R), the ~~ASD(RA)~~ *ASD(M&RA)*:

a. In coordination with the ASD(HA) and the Secretaries of the Military Departments, ensures that policies for the DES are applied for RC personnel consistent with those established for Active Component (AC) personnel and reflect the needs of RC members as required by Reference (c).

b. Provides O-6 level or civilian-equivalent representation with sufficient understanding of the DES to the DAC.

c. Reviews annual DES performance and recommends improvements to ASD(HA) to ensure process efficiency and equity for members of the RC.

3. GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE (GC DoD). In consultation with the General Counsels and the Judge Advocates General of the Military Departments, the GC DoD provides policy guidance on legal matters relating to DES policy, issuances, proposed exceptions to policy, legislative proposals, and provide legal representation for the DAC as set forth in Enclosure 7 of Reference (~~p~~*r*).

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Comply with chapter 61 of Reference (c), this instruction, and any implementing guidance.

b. Implement the DES in accordance with this instruction.

c. Manage the temporary disability retired list (TDRL) in accordance with Appendix 4 of Enclosure 3 of this instruction.

d. Staff and provide resources to meet DES performance goals, without reducing Service members' access to due process consistent with Reference (~~p~~*r*).

e. Establish procedures to develop and implement standardized training programs, guidelines, and curricula for Military Department personnel who administer DES processes, including physical evaluation board liaison officers (PEBLOs), non-medical case managers, and personnel assigned to the medical evaluation board (MEB), the PEB, and appellate review authorities.

f. Establish and execute agreements to support the disability processing of members who receive medical care from another Military Department.

g. Establish procedures to ensure Service members who are hospitalized or receiving treatment at a VA or a non-governmental facility are referred, processed, and counseled in a manner similar to their peers.

h. In consultation with their respective Judge Advocates General, establish policy, training and procedures for the provision of legal counsel to Service members in the DES.

i. Establish a quality assurance process to:

(1) Ensure policies and procedures established by this instruction are fairly and consistently implemented.

(2) Establish procedures to ensure the accuracy and consistency of MEB and PEB determinations and decisions.

(3) Establish procedures to monitor and sustain proper performance of the duties of MEBs, PEBs, and PEBLOs.

j. Prepare and forward data submissions for the DES Annual Report to the ~~DASD(WCP)~~ *DASD(HSP&O).*

k. Through their respective Inspectors General, review compliance with the requirements contained in Enclosure 3 of this instruction every 3 fiscal years for the preceding 3-fiscal-year period. Forward a copy of their final Inspectors General compliance reports to the USD(P&R).

l. Investigate all matters of potential fraud pertaining to the DES and resolve as appropriate.

m. Provide grade O-6 or civilian-equivalent representation with a sufficient understanding of the DES to the DAC.

~~n. Comply with USD(P&R) Memorandum (Reference (u)).~~

~~o~~*n*. Comply with the Memorandums of Agreement between the DoD and the VA pertaining to the IDES (References (~~v~~*w*) and (~~w~~*x*)).

~~p~~*o*. Comply with the *privacy* procedures outlined in DoD 5400.11-R (Reference (~~x~~*y*)), *DoDD 5400.11 (Reference (z)), DoDI 1000.30 (Reference (aa)), Administrative Instruction 15 (Reference (ab)), and DoD 6025.18-R (Reference (ac))*.

~~q~~*p*. Establish procedures to ensure that, with the consent of the Service member, the address and contact information of the Service member are transmitted to the department or agency for other appropriate veterans affairs of the State in which the Service member intends to reside after retirement or separation.

~~r~~*q*. Establish procedures to provide, with consent of the Service member, notification of the hospitalization of a Service member under their jurisdiction evacuated from a theater of combat

and admitted to an MTF within the United States to the Senators representing the State, and the Member, Delegate or Resident Commissioner of the House of Representatives representing the district, that includes the Service member's home ~~or~~ *of* record or a different location as provided by the Service member.

~~s~~*r*. Before demobilizing or separating an RC member who incurred an injury or illness while on active duty, provide to the Service member information on:

(1) The availability of care and administrative processing through military-affiliated or community support services.

(2) The location of the support services, whether military-affiliated or community, located nearest to the permanent place of residence of the Service member.

ENCLOSURE 3

OPERATIONAL STANDARDS FOR THE DES

1. OVERVIEW OF THE DES

a. Under the supervision of the Secretary of the Military Department concerned, the DES consists of:

(1) Medical evaluation to include the MEB, impartial medical reviews, and rebuttal.

(2) Disability evaluation to include the PEB and appellate review, counseling, case management, and final disposition.

b. The Secretaries of the Military Departments:

~~(1) Will use the LDES process for non-duty related disability cases and for Service members who entered the DES prior to the IDES being implemented at a given MTF.~~

~~(2) Subject to the written approval of the USD(P&R), may also use the LDES process for Service members who are in initial entry training status, including trainees, recruits, cadets, and midshipmen. Secretaries of the Military Departments who enroll initial entry trainees, recruits, cadets, and midshipmen in the LDES must offer to enroll these Service members in the VA Benefits Delivery at Discharge or Quick Start programs.~~

~~(3) Will use the EDES process for consenting Service members designated with a catastrophic illness or injury incurred in the line of duty.~~

~~(4) May designate a Service member's condition as catastrophic if he or she has a permanent and severely disabling injury or illness that compromises the ability to carry out the activities of daily living. Guidance for procedures unique to the EDES is available in Reference (u).~~

~~c. Except for initial entry trainees, Military Academy cadets, and midshipmen entered into the LDES and catastrophically ill or injured Service members entered in the EDES, will use the IDES process for all newly initiated cases referred under the duty-related process (see Glossary). Guidance for procedures unique to the IDES is available in Reference (q).~~

(1) Will use the IDES process for all newly initiated cases referred under the duty-related process except for Service members approved for the LDES process.

(2) For cases initiated on or after May 17, 2018, may either:

(a) Authorize, if requested by a Service member (to include initial entry trainees, Military Academy cadets, and midshipmen), processing through the LDES rather than the IDES.

Before the Secretary concerned approves such a request, the Service member must acknowledge, in writing, that he or she was offered the opportunity to receive a legal briefing regarding the procedural differences between the LDES and the IDES;

(b) Enroll Service members into the LDES after providing information to these Service members about the VA Benefits Delivery at Discharge program before enrollment; or

(c) Use the LDES process for consenting Service members designated with a catastrophic illness or injury incurred in the line of duty.

~~d.~~*c. LDES and* IDES disability examinations will include a general medical examination and any other applicable medical examinations performed to VA compensation and pension standards. Collectively, the *LDES and IDES* examinations will be sufficient to assess the Service member's referred and claimed condition(s), assist VA in ratings determinations and assist Military Departments to determine if the medical conditions, individually or collectively, prevent the Service member from performing the duties of his office, grade, rank, or rating.

2. MEB

a. Purpose. An MEB *reviews all available medical evidence, to include any examinations completed as a part of DES processing, and* documents the medical status and duty limitations of Service members who meet referral eligibility criteria in Appendix 1 to this enclosure.

b. Composition. The MEB will be comprised of two or more physicians (civilian employee or military). One of these physicians must have detailed knowledge of the standards pertaining to medical ~~fitness~~ *retention standards*, the disposition of patients, and disability separation processing. Any MEB listing a behavioral health diagnosis must contain a thorough behavioral health evaluation and include the signature of at least one psychiatrist or psychologist with a doctorate in psychology.

c. Resourcing. The Secretary of the Military Department concerned will develop standards on the maximum number of MEB cases that are pending before a MEB at any one time.

d. Referral to PEB. The MEB documents whether the Service member has ~~a~~ medical condition*s, whether singularly, collectively or through combined effect,* that will prevent them from reasonably performing the duties of their office, grade, rank, or rating. If the Service member cannot perform the duties of his office, grade, rank, or rating, the MEB refers the case to the PEB.

e. Service Member Medical Evaluations

(1) Medical Evaluations. An MEB will evaluate the medical status and duty limitations of:

(a) Service members referred into the DES who incurred or aggravated an illness or injury while under order to active duty specifying a period of more than 30 days.

(b) RC members referred for a duty-related determination.

(2) MEB Exemptions. An MEB is not required:

(a) For Service members temporarily retired for disabilities who are due for a periodic physical medical examination.

(b) When an RC member *who is not on active duty* is referred for ~~impairments~~ *conditions* unrelated to military status and performance of duty (see Glossary for the definition of non-duty-related ~~impairments~~ *condition*).

(3) MEB Prerequisites. A Service member will not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury.

(4) Impartial Medical Reviews. Consistent with section 1612 of Public Law 110-181 (Reference (~~y~~*ad*)), the Secretary of the Military Department concerned will, upon request of the Service member, assign an impartial physician or other appropriate health care professional who is independent of the MEB to:

(a) Serve as an independent source of review of the MEB findings and recommendations.

(b) Advise and counsel the Service member regarding the findings and recommendations of the MEB.

(c) Advise the Service member on whether the MEB findings adequately reflect the complete spectrum of the Service member's injuries and illnesses.

(5) MEB Rebuttal. Service members referred into the DES will upon request be permitted to at least one rebuttal of the MEB findings.

f. Content

(1) Medical information used in the DES must be sufficiently recent to substantiate the existence or severity of potentially unfitting conditions. The Secretaries of the Military Departments will not perform additional medical exams or diagnostic tests if more current information would not substantially affect identification of the existence or severity of potentially unfitting conditions.

(2) MEBs will confirm the medical diagnosis for and document the full clinical information, including history, treatment status, and potential for recovery of the Service member's medical conditions that, individually or collectively *or through combined effect,* ~~may~~

will prevent the Service member from performing the duties of his office, grade, rank, or rating and state whether each condition is cause for referral to a PEB.

g. Competency. When the Service member's ability to handle his or her financial affairs is unclear, the MEB or TDRL packet will include the results of a competency board.

h. Medical Documentation for RC Members with Non-duty Related Conditions. The medical documentation for RC members with non-duty related conditions referred for disability evaluation must provide clear and adequate written description of the medical condition(s) that, individually or collectively, may prevent the RC member from performing the duties of his office, grade, rank, or rating.

i. Non-medical Documentation. The MTF will forward the cases of Service members with a duty-related determination to the PEB with the MEB documentation and:

(1) The line of duty (LOD) determination, when required by section 6 of Appendix 3 of this enclosure.

(2) Except in cases in which the illness or injury is so severe that return to duty is not likely, a statement from the Service member's immediate commanding officer describing the impact of the member's medical condition on the ability to perform his or her normal military duties.

(3) An official document identifying the next of kin, court-appointed guardian, or trustee when a Service member is determined incompetent to manage his or her financial affairs.

3. DISABILITY EVALUATION

a. Purpose. PEBs determine the fitness of Service members with medical conditions to perform their military duties and, for members determined unfit because of duty-related ~~impairments~~ *conditions*, their eligibility for benefits pursuant to chapter 61 of Reference (c). Service members may appeal the decision of the PEB. The PEB process includes the informal physical evaluation board (IPEB), formal physical evaluation board (FPEB) and appellate review of PEB results.

b. IPEB. The IPEB reviews the case file to make initial findings and recommendations without the Service member present. The Service member may accept the finding, rebut the finding, or request a FPEB. The Secretary of the Military Department concerned will allow the Service member a minimum of 10 calendar days from receipt of the informal findings to rebut the findings of the IPEB or request an FPEB. In addition to this timeline, Military Departments must publish timelines for presentation and consideration of cases.

c. FPEB. In accordance with section 1214 of Reference (c), Service members who are found unfit are entitled to a formal hearing, an FPEB, to contest their IPEB findings. The PEBLO will document the Service member's declination of an FPEB. If the Secretary of the Military

Department concerned changes those findings or determinations following a Service member's concurrence, the Service member will be entitled to a formal hearing to contest the changes.

d. Composition

(1) The IPEB will be comprised of at least two military personnel at field grade or civilian equivalent or higher. In cases of a split opinion, a third voting member will be assigned to provide the majority vote.

(2) The FPEB must be comprised of at least three members and may be comprised of military and civilian personnel representatives. A majority of the FPEB members could not have participated in the adjudication process of the same case at the Informal Physical Evaluation Board.

(a) The FPEB will consist of at least a president, who should be a military ~~O-6~~ *O-6*, or civilian equivalent; a medical officer; and a line officer (or non-commissioned officer at the E-9 level for enlisted cases) familiar with duty assignments.

(b) The physician cannot be the Service member's physician, cannot have served on the Service member's MEB, and cannot have participated in a TDRL re-examination of the Service member.

(c) In the case of RC members, Secretaries of the Military Departments will ensure RC representation on the PEBs is consistent with section 12643 of Reference (c) and related policies. Secretaries of the Military Departments may adjust member composition of the FPEB to enhance the adjudication process consistent with applicable laws and regulations.

(d) Contract personnel may not serve as PEB adjudicators or PEB appellate review members.

e. Eligibility. Service members determined unfit and TDRL members determined fit may demand, and are entitled to, an FPEB. At its discretion, the Military Department may grant a formal hearing to Service members who are determined fit but are not on the TDRL.

f. Resourcing. The Secretary of the Military Department concerned will direct the allocation of additional personnel to the PEB process if deemed appropriate for proper and expeditious adjudication of case load.

g. Issues. At the FPEB, the Service member will be entitled to address issues pertaining to his or her fitness, the percentage of disability, degree or stability of disability, administrative determinations, or a determination that his or her injury or disease was non-duty related.

h. Hearing Rights. Service members will have, at a minimum, the following rights before the FPEB:

(1) To have their case considered by board members, a majority of whom were not voting members of their IPEB.

(2) To appear personally, through a designated representative, by videoconference, or by any other means determined practical by the Secretary of the Military Department concerned. Unless the Secretary of the Military Department directs the FPEB to fund the personal travel and other expenses, RC members with non-duty related determinations are responsible for their personal travel and other expenses.

(3) To be represented by Government appointed counsel provided by the Military Department. Service members may choose their own civilian counsel at no expense to the Government. The PEB president should notify the Secretary of the Military Department concerned if the lack of Government appointed counsel affects timely PEB caseload adjudication.

(4) To make a sworn or an unsworn statement. A Service member will not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury.

(5) To remain silent. When the Service member exercises this right, the member may not selectively respond, but must remain silent throughout the hearing.

(6) To introduce witnesses, depositions, documents, sworn or unsworn statements, declarations, or other evidence in the Service member's behalf and to question all witnesses who testify at the hearing. The FPEB president determines whether witnesses are essential. If the FPEB president determines witnesses essential, travel expenses and per diem may be reimbursed or paid in accordance with the Joint ~~Federal~~ Travel Regulation, Volumes 1 and 2 (References (~~z~~*ae*) and (~~aa~~*af*)). Witnesses not deemed essential by the FPEB president may attend formal hearings at no expense to the Government.

(7) To access all records and information received by the PEB before, during, and after the formal hearing.

i. Record of Proceedings. ~~Upon a Service member's written request, the~~ *The* Military Department will provide the Service member a record of the PEB proceedings. The PEB record of proceedings must convey the PEB findings and conclusions in an orderly and itemized fashion, with specific attention to each issue presented by the Service member regarding his or her case, and the basis for applying total or extra-schedular ratings or unemployability determinations, as applicable.

j. Duty-related Determinations. The record of proceedings for active duty Service members and RC members referred for duty-related determinations will document, at a minimum:

(1) The determination of fit or unfit.

(2) The code and percentage rating assigned an unfitting and compensable disability based on the VASRD. The standards for determining compensable disabilities are specified in Appendix 3 of this enclosure.

(3) The reason an unfitting condition is not compensable.

(a) The specific accepted medical principle, as stated in Appendix 3 of this enclosure, for overcoming the presumption of service aggravation for all cases with a finding of preexisting condition without service aggravation.

(b) The accepted medical principle justifying findings that an RC member performing inactive duty training (IDT), active duty training, or on active duty of 30 days or less, has a preexisting disability that was not permanently aggravated by service.

(c) The rationale justifying findings that a disability that was incurred in the LOD prior to September 24, 1996, and that was not permanently service aggravated since September 23, 1996, was not the proximate result of military service.

(4) For Service members being placed on the TDRL or permanently retired, the nature of the disability and the stability and permanency of the disability.

(5) Administrative determinations made consistent with Appendix 5 of this enclosure.

(6) The record of all proceedings for PEB evaluation including the evidence used to overcome a presumption listed in this instruction and changes made as a result of review by subsequent reviewing authority will include a written explanation in support of each finding and recommendation. If applicable, the basis for applying or not applying total or extra-schedular ratings or unemployability determinations.

k. Non-duty Related Determinations. For RC members referred for non-duty related determinations, the record of proceedings will document only:

(1) The fitness determination.

(2) For RC members determined fit, a determination of whether the member is deployable, if Service regulations require such a determination.

l. Appellate Review. The Military Department will review the findings and recommendations of the FPEB when requested by the Service member or designated representative or as required by the regulations of the Military Department concerned. The Military Department will also provide to the Service member a written response to an FPEB appeal that specifically addresses each issue presented in the appeal.

m. Quality Assurance. Each Military Department will establish and publish quality review procedures particular to the PEB and conduct quality assurance reviews in accordance with the laws, directives, and regulations governing disability evaluation.

4. COUNSELING

a. Purpose. Service members undergoing evaluation by the DES must be advised of the significance and consequences of the determinations being made and their associated rights, benefits, and entitlements. Each Military Department will publish and provide standard information booklets that contain specific information on the MEB and PEB processes. These publications must include the rights and responsibilities of the Service member while navigating through the DES. The information will be made available at the servicing MTFs and PEBs.

b. Topics

(1) PEBLOs will inform Service members of the:

(a) Sequence and nature of the steps in the disability process.

(b) Statutory rights and requirements but will not provide legal advice.

(c) Effect of findings and recommendations.

(d) Process to submit rebuttals.

(e) Probable retired grade.

(f) Estimated timeframe for completing the DES at their installation.

(2) PEBLOs will inform Service members or refer them to the appropriate subject matter experts on:

(a) Potential veterans' benefits.

(b) Post-retirement insurance programs and the Survivor Benefit Plan in accordance with DoDD 1332.27 (Reference (~~ab~~*ag*)), if appropriate.

(c) Applicable transition benefits, in accordance with ~~DoDD~~ *DoDI* 1332.35 (Reference (~~ac~~*ah*)).

(d) Applicable standards detailed in the VASRD, which would have to be recognized to increase the percentage of disability, prior to acting on a Service member's request for a formal PEB.

(e) Services provided by military, veteran, or national service organizations.

(f) Electronic resources for ill and injured Service members such as National Resource Directory, eBenefits, etc.

(g) Availability and processes for obtaining legal counsel to assist in rebutting or appealing MEB and PEB findings.

(h) The appropriate Defense Finance and Accounting Service finance representative for payment calculations for severance pay or retirement pay.

c. Incompetent Service Members. When a Service member has been determined incompetent by a competency board, his or her designated representative (e.g., court appointed guardian, trustee, or primary next of kin) will be counseled and afforded the opportunity to assert the rights granted to the Service member, unless prohibited by law.

d. Pre-separation Counseling. Service members on orders to active duty for more than 30 days will not be separated or retired because of disability before completing pre-separation counseling pursuant to Reference (~~a~~*ah*).

5. CASE MANAGEMENT

a. Service members undergoing evaluation by the DES must be advised on the status of their case, issues that must be resolved for their case to progress, and expected time frame for completing DES at their installation.

b. PEBLOs will contact Service members undergoing disability evaluation at least monthly and provide any necessary DES assistance.

6. FINAL DISPOSITION. After adjudicating all appeals, the personnel authorities specified in Appendix 6 to this enclosure will:

a. Issue orders and instructions to implement the determination of the respective Service's final reviewing authority.

b. Consider Service member requests to continue on active duty or in the RC in a permanent limited duty status if the member is determined unfit.

7. ADMINISTRATIVE DECISIONS

a. The Secretary of the Military Department concerned may:

(1) Direct the PEB to reevaluate any Service member determined to be unsuitable for continued military service.

(2) Retire or separate for disability any Service member determined upon re-evaluation to be unfit to perform the duties of the member's office, grade, rank, or rating.

b. The Secretary of the Military Department concerned may not:

(1) Authorize the involuntary administrative separation of a member based on a determination that the member is unsuitable for deployment or worldwide assignment after a PEB has found the member fit for the same medical condition; or

(2) Deny the member's request to reenlist based on a determination that the member is unsuitable for deployment or worldwide assignment after a PEB has found the member fit for the same medical condition.

c. Consistent with DoDI 1332.14 (Reference (~~ad~~*ai*)), any Service member found fit for duty by the PEB but determined unsuitable for continued service by the Secretary of the Military Department concerned for the same medical condition considered by the PEB may appeal to the Secretary of Defense, who is the final authority.

8. TRAINING AND EDUCATION

a. Assignment of Personnel to the DES. The Secretaries of the Military Departments will certify annually that the following personnel assigned to or impacting the DES were formally trained prior to being assigned to performing DES duties.

(1) Medical officers.

(2) PEBLOs.

(3) Patient administration officers.

(4) PEB adjudicators.

(5) PEB appellate review members.

(6) Judge advocates.

(7) Military Department civilian attorneys.

b. Training. Training programs for all personnel assigned to the DES must be formal and documented. At a minimum, training curricula will consist of:

(1) An overview of the statutory and policy requirements of the DES, the electronic and paper recordkeeping policies of the Military Department, customer service philosophies, and VA processes, services and benefits.

(2) Familiarization with medical administration processes.

(3) Knowledge of online and other resources pertaining to the DES and DoD and VA services, the chain of supervision and command, and the Military Department Inspectors General hotlines for resolution of issues.

c. Mentoring. Individuals assigned for duty as PEBLOs must receive at least 1 week of on-the-job training with an experienced PEBLO.

Appendixes

1. DES Referral
2. Standards for Determining Unfitness Due to Disability or Medical Disqualification
3. Standards for Determining Compensable Disabilities
4. TDRL Management
5. Administrative Determinations
6. Final Disposition

APPENDIX 1 TO ENCLOSURE 3

DES REFERRAL

1. GENERAL. The Secretary of the Military Department concerned will refer Service members who meet the criteria for disability evaluation regardless of eligibility for disability compensation.

2. CRITERIA FOR REFERRAL

a. When the course of further recovery is relatively predictable or within 1 year of diagnosis, whichever is sooner, medical authorities will refer eligible Service members into the DES who:

(1) Have one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating including those duties remaining on a Reserve obligation for more than 1 year after diagnosis;

(2) Have a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

(3) Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

b. In all cases, competent medical authorities will refer into the DES eligible Service members who meet the criteria in paragraph ~~2a~~ *2.a. of this appendix* within 1 year of diagnosis.

3. ELIGIBILITY FOR REFERRAL

a. Duty-related Determinations. Except as provided in section 4 of this appendix, the following categories of Service members who meet the criteria in section 2 of this appendix are eligible for referral to the DES for duty-related determinations:

(1) Service members on active duty or in the RC who are on orders to active duty specifying a period of more than 30 days.

(2) RC members who are not on orders to active duty specifying a period of more than 30 days but who incurred or aggravated a medical condition while the member was ordered to active duty for more than 30 days.

(3) Cadets at the United States Military Academy, the United States Air Force Academy, or Midshipmen of the United States Naval Academy.

(4) Service members previously determined unfit, serving in a permanent limited duty status, and for whom the period of continuation has expired.

(5) Other Service members who are on orders to active duty specifying a period of 30 days or less if they have a medical condition that was incurred or aggravated in the LOD while the Service member was:

(a) Performing active duty or IDT.

(b) Traveling directly to or from the place at which such duty is performed.

(c) Remaining overnight immediately before the commencement of IDT or while remaining overnight between successive periods of IDT at or in the vicinity of the site of the IDT.

(d) Serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Title 32, U.S.C. (Reference (~~ae~~*aj*)) while the Service member was traveling to or from the place at which the member was to serve; or while the member remained overnight at or in the vicinity of that place immediately before serving.

(6) Service members with duty-related determinations, as described in paragraph 3.a. of this appendix, will be referred into the DES for a determination of fitness. If found unfit, a determination will be made as to the Service member's entitlement to separation or retirement for disability with benefits pursuant to chapter 61 of Reference (c) and administrative determinations in accordance with Appendix 5 to this enclosure.

(7) A member of a*n* RC who is ordered to active duty for a period of more than 30 days and is released from active duty within 30 days of commencing such period of active duty for failure to meet physical standards for retention due to a pre-existing condition not aggravated during the period of active duty or medical or dental standards for deployment due to a pre-existing condition not aggravated during the period of active duty will be considered to have been serving under an order to active duty for a period of 30 days or less.

b. Non-duty Related Determinations. Members of the RC with non-duty related determinations, who are otherwise eligible as described in section 2 of this appendix, will be referred solely for a fitness for duty determination when one of the following exist:

(1) The RC member does not qualify under paragraph ~~3a~~ *3.a.* of this appendix.

(2) The RC member requests referral for a fitness determination upon being notified that they do not meet medical retention standards.

(3) Service regulations direct the RC member be referred to the DES for a determination of fitness before being separated by the Reserve for not meeting medical retention standards.

4. INELIGIBILITY FOR REFERRAL

a. Service members are ineligible for referral to the disability evaluation process when:

(1) The Service member has a condition, circumstance, or defect of a developmental nature, not constituting a physical disability, as described in paragraph ~~3i.~~ *3.i.* above the signature of this instruction, that interferes with assignment to or performance of duty and that was not service aggravated.

(2) The Service member is pending an approved, unsuspended punitive discharge or dismissal, except as provided by Service regulations.

(3) The Service member is pending separation under provisions that authorize a characterization of service of under other than honorable conditions, except as provided by Service regulations. This restriction is based on the provisions upon which the member is being separated and not on the actual characterization the member receives.

(4) The Service member is not physically present or accounted for.

(5) Disability results from intentional misconduct or willful neglect or was incurred during a period of unauthorized absence or excess leave.

b. However, the Secretaries of the Military Departments should normally evaluate for disability those Service members who would be ineligible for referral to the DES due to paragraphs ~~4a(2)~~ *4.a.(2)* and ~~4a(3)~~ *4.a.(3)* of this appendix when the medical ~~impairment~~ *condition* or disability evaluation is warranted as a matter of equity or good conscience.

5. SERVICE MEMBERS WITH MEDICAL WAIVERS

a. Provided no permanent aggravation has occurred, Service members who enter the military with a medical waiver may be separated without disability evaluation when the responsible medical authority designated by Service regulations determines within 6 months of the member's entry into active service that the waivered condition represents a risk to the member or prejudices the best interests of the Government.

b. Once 6 months have elapsed the Secretary of the Military Department concerned will refer the Service member for disability evaluation when the Service member meets the criteria in section 2 of this appendix and is eligible for referral in accordance with section 3 of this appendix.

c. Members who entered the Service with a medical waiver for a pre-existing condition and who are subsequently determined unfit for the condition will not be entitled to disability separation or retired pay unless military service permanently aggravated the condition. Members granted medical waivers will be advised of this provision at the time of waiver application and when it is granted.

6. WAIVER OF PEB EVALUATION. Except as prohibited by section 7 of this appendix, Service members may waive referral to the PEB with the approval of the Secretary of the Military Department concerned.

a. The Service member must be counseled on the DES process, the right to a PEB, and the potential benefits of remaining in an active duty or active reserve status to complete evaluation by the DES.

b. The Service member must request a waiver in writing and such request or an affidavit must attest that the member has received the counseling described and declines referral to the PEB.

7. PROHIBITION FROM WAIVING DISABILITY EVALUATION. A Service member approved for voluntary early separation from active duty who incurs a Reserve obligation and who has conditions that are cause for referral into the DES cannot waive disability evaluation.

8. REFERRAL IMPLICATIONS. Neither referral into the DES nor a finding of unfitness constitutes entitlement to disability benefits.

APPENDIX 2 TO ENCLOSURE 3

STANDARDS FOR DETERMINING UNFITNESS DUE TO DISABILITY OR MEDICAL DISQUALIFICATION

1. UNIFORMITY OF STANDARDS. The standards listed in this instruction for determining unfitness due to disability will be followed unless the USD(P&R) approves exceptions on the basis of the unique needs of the respective Military Department.

2. GENERAL CRITERIA FOR MAKING UNFITNESS DETERMINATIONS

a. A Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation.

b. A Service member may also be considered unfit when the evidence establishes that:

(1) The Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or

(2) The Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

3. RELEVANT EVIDENCE. The Secretaries of the Military Departments will consider all relevant evidence in assessing Service member fitness, including the circumstances of referral. To reach a finding of unfit, the PEB must be satisfied that the evidence supports that finding.

a. Referral Following Illness or Injury. When referral for disability evaluation immediately follows acute, grave illness or injury, the medical evaluation may stand alone, particularly if medical evidence establishes that continued service would be harmful to the member's health or is not in the best interest of the respective Service.

b. Referral for Chronic ~~Impairment~~ *Condition*. When a Service member is referred for disability evaluation under circumstances other than as described in paragraph ~~3a~~ *3.a.* of this appendix, an evaluation of the Service member's performance of duty by supervisors may more accurately reflect the capacity to perform. Supervisors may include letters, efficiency reports, credential reports, status of physician medical privileges, or personal testimony of the Service member's performance of duty to provide evidence of the Service member's ability to perform his or her duties.

c. Cause-and-effect Relationship. Regardless of the presence of illness or injury, inadequate performance of duty, by itself, will not be considered evidence of unfitness due to disability, unless a cause-and-effect relationship is established between the two factors.

4. REASONABLE PERFORMANCE OF DUTIES

a. Considerations. Determining whether a Service member can reasonably perform his or her duties includes consideration of:

(1) Common Military Tasks. Whether the Service member can perform the common military tasks required for the Service member's office, grade, rank, or rating including those during a remaining period of Reserve obligation. Examples include routinely firing a weapon, performing field duty, or wearing load-bearing equipment or protective gear.

(2) Physical Fitness Test. Whether the Service member is medically prohibited from taking the respective Service's required physical fitness test. When an individual has been found fit by a PEB for a condition that prevents the member from taking the Service physical fitness test, the inability to take the physical fitness test will not form the basis for an adverse personnel action against the member.

(3) Deployability. Whether the Service member is deployable individually or as part of a unit, with or without prior notification, to any vessel or location specified by the Military Department. When deployability is used by a Service as a consideration in determining fitness, the standard must be applied uniformly to both the AC and RC of that Service.

(4) Special Qualifications. For Service members whose medical condition disqualifies them for specialized duties, whether the specialized duties constitute the member's current duty assignment; the member has an alternate branch or specialty; or reclassification or reassignment is feasible.

b. General, Flag, and Medical Officers. An officer in pay grade O-7 or higher, or a medical officer in any grade, being processed for retirement by reason of age or length of service, will not be determined unfit unless the determination of the Secretary of the Military Department concerned with respect to unfitness is approved by the USD(P&R) on the recommendation of the ASD(HA).

c. Service Members on Permanent Limited Duty. A Service member previously determined unfit and continued in a permanent limited duty status or otherwise continued on active duty will normally be found unfit at the expiration of his or her period of continuation. However, the Service member may be determined fit when the condition has healed or improved such that the Service member would be capable of performing his or her duties in other than a limited-duty status.

d. Combined Effect. A Service member may be determined unfit as a result of the combined effect of two or more ~~impairments~~ *conditions* even though each of them, standing alone, would not cause the Service member to be referred into the DES or be found unfit because of disability. *The PEB will include in its official findings, in cases where two or more medical conditions (referred or claimed) are present in the service treatment record, that the combined effect was*

considered in the fitness determination as referred by the MEB. Combined effect includes the pairing of a singularly unfitting condition with a condition that standing alone would not be unfitting.

5. PRESUMPTION OF FITNESS

a. Application. The DES compensates disabilities when they cause or contribute to career termination. Service members who are pending retirement at the time they are referred for disability evaluation are presumed fit for military service.

(1) Service members may overcome this presumption by presenting a preponderance of evidence that he or she is unfit for military service. The presumption of fitness may be overcome when:

(a) An illness or injury occurs within the presumptive period that would prevent the Service member from performing further duty if they were not retiring.

(b) A serious deterioration of a previously diagnosed condition, including a chronic one, occurs within the presumptive period, and the deterioration would preclude further duty if the Service member were not retiring.

(c) The condition for which the Service member is referred is a chronic condition and a preponderance of evidence establishes that the Service member was not performing duties befitting either his or her experience in the office, grade, rank, or rating before entering the presumptive period because of the condition.

(2) Service members are not presumed fit for military service in these instances of a pending retirement:

(a) The disability is one for which a Service member was previously determined unfit and continued in a permanent limited duty status. The presumption of fitness will be applied to other medical ~~impairments~~ *conditions* unless the medical evidence establishes they were impacted by the original unfitting disabilities.

(b) Selected Reserve members who are eligible to qualify for non-regular retirement pursuant to the provisions of section 12731b of Reference (c).

(c) RC members referred for non-duty-related determinations.

b. Presumptive Period. The Secretaries of the Military Departments will presume Service members are pending retirement when the ~~preparation of the Service member's MEB narrative summary~~ *Service member's referral into the DES* occurs after any of these circumstances:

(1) A Service member's request for voluntary retirement has been approved. Revocation of voluntary retirement orders for purposes of referral into the DES does not negate application of the presumption.

(2) An officer has been approved for selective early retirement or is within 12 months of mandatory retirement due to age or length of service.

(3) An enlisted member is within 12 months of his or her retention control point or expiration of active obligated service, but will be eligible for retirement at his or her retention control point or expiration of active obligated service.

(4) An RC member is within 12 months of mandatory retirement or removal date and qualifies for a 20-year letter at the time of referral for disability evaluation.

(5) A retiree is recalled, to include those who transferred to the Retired Reserve, with eligibility to draw retired pay upon reaching the age prescribed by statute unless the recalled retiree incurred or aggravated the medical condition while on their current active duty orders and overcomes the presumption of fitness.

6. EVIDENTIARY STANDARDS FOR DETERMINING UNFITNESS BECAUSE OF DISABILITY

a. Objective Evidence

(1) The Secretary of the Military Department concerned must cite objective evidence in the record, as distinguished from personal opinion, speculation, or conjecture, to determine a Service member is unfit because of disability.

(2) Doubt that cannot be resolved with evidence will be resolved in favor of the Service member's fitness through the presumption that the Service member desires to be found fit for duty.

b. Preponderance of Evidence. With the exception of presumption of fitness cases, the Secretary of the Military Department concerned will determine fitness or unfitness for military service on the basis of the preponderance of the objective evidence in the record.

APPENDIX 3 TO ENCLOSURE 3

STANDARDS FOR DETERMINING COMPENSABLE DISABILITIES

1. OVERVIEW OF DISABILITY COMPENSATION CRITERIA. Service members who are determined unfit to perform the duties of the member's office, grade, rank, or rating because of disability in accordance with Appendix 2 of this enclosure may be eligible for disability benefits when:

a. The disability is not the result of the member's intentional misconduct or willful neglect and was not incurred during unauthorized absence or excess leave.

b. The Service member incurred or aggravated the disability while he or she was:

(1) A member of a regular component of the Military Services entitled to basic pay;

(2) A member of the Military Services entitled to basic pay, called or ordered to active duty (other than for training pursuant to section 10148 of Reference (c)) for a period of more than 30 days;

(3) A member of the Military Services on active duty for a period greater than 30 days but not entitled to basic pay pursuant to section 502(b) of Title 37, U.S.C. (Reference (~~af~~*ak*)) due to authorized absence to participate in an educational program or for an emergency purpose, as determined by the Secretary of the Military Department concerned;

(4) A cadet at the United States Military Academy or the United States Air Force Academy or a midshipman of the United States Naval Academy after October 28, 2004; or

(5) A member of the Military Services called or ordered to active duty for a period of 30 days or less, performing IDT or traveling directly to or from the place of IDT, to funeral honors duty, or for training pursuant to section 10148 of Reference (c).

2. DISABILITY RETIREMENT CRITERIA FOR REGULAR COMPONENT MEMBERS AND MEMBERS ON ACTIVE DUTY FOR MORE THAN 30 DAYS. Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(1)~~ *1.b.(1)* through ~~1b(4)~~ *1.b.(4)* of this appendix will be retired with disability benefits when:

a. The disability is permanent and stable.

b. The member has:

(1) At least 20 years of service computed in accordance with section 1208 of Reference (c); or

(2) A disability of at least 30 percent, pursuant to Reference (~~t~~*v*), and that disability:

(a) Was not noted at the time of the member's entrance on active duty unless the Secretary of the Military Department concerned demonstrates with clear and unmistakable evidence that the disability existed before the member's entrance on active duty and was not aggravated by active military service;

(b) Is the proximate result of performing active duty;

(c) Was incurred in the LOD in time of war or national emergency; or

(d) Was incurred in the LOD after September 14, 1978.

3. DISABILITY RETIREMENT CRITERIA FOR MEMBERS ON ACTIVE DUTY FOR 30 DAYS OR LESS, ON IDT, FUNERAL HONORS DUTY, OR TRAINING PURSUANT TO SECTION 10148 OF REFERENCE (C). Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(5)~~ *1.b.(5)* of this appendix will be retired with disability benefits when:

a. The disability is permanent and stable.

b. The Service member has:

(1) At least 20 years of service computed in accordance with section 1208 of Reference (c); or

(2) A disability of at least 30 percent, pursuant to Reference (~~t~~*u*), and that disability meets at least one of the following criteria:

(a) The disability was incurred or aggravated before September 24, 1996, as the proximate result of:

1. Performing active duty or IDT;

2. Traveling directly to or from the place of active duty or IDT; or

3. An injury, illness, or disease incurred or aggravated immediately before the commencement of IDT or while remaining overnight, between successive periods of IDT, at or in the vicinity of the site of the IDT, if the site of the IDT is outside reasonable commuting distance of the Service member's residence.

(b) The disability is a result of injury, illness, or disease that was incurred or aggravated in the LOD after September 23, 1996:

1. While performing active duty or IDT;

2. While traveling directly to or from the place of active duty or IDT;

3. While remaining overnight immediately before the commencement of IDT; or

4. While remaining overnight between successive periods of IDT at or in the vicinity of the site of the IDT.

(c) The disability is a result of an injury, illness, or disease incurred or aggravated in the LOD:

1. While serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Reference (~~ae~~*aj*);

2. While the Service member was traveling to or from the place at which the member was to serve; or

3. While the Service member remained overnight at or in the vicinity of that place immediately before serving, if it is outside reasonable commuting distance from the member's residence.

4. DISABILITY SEPARATION CRITERIA FOR REGULAR COMPONENT MEMBERS AND MEMBERS ON ACTIVE DUTY FOR MORE THAN 30 DAYS. Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(1)~~ *1.b.(1)* through ~~1b(4)~~ *1.b.(4)* of this appendix will be separated with disability benefits when:

a. The Service member has less than 20 years of service.

b. The disability meets one of the following criteria:

(1) Is or may be permanent and less than 30 percent, pursuant to Reference (~~t~~*v*), and:

(a) Is the proximate result of performing active duty;

(b) Was incurred in the LOD in time of war or national emergency; or

(c) Was incurred in the LOD after September 14, 1978.

(2) Is less than 30 percent, pursuant to Reference (~~t~~*v*), at the time of the determination and was not noted at the time of the Service member's entrance on active duty (unless clear and unmistakable evidence demonstrates the disability existed before the Service member's entrance on active duty and was not aggravated by active military service).

(3) Is at least 30 percent, pursuant to Reference (~~t~~*v*), and at the time of the determination, the disability was neither:

(a) The proximate result of performing active duty;

(b) Incurred in the LOD in time of war or national emergency; nor

(c) Incurred in the LOD after September 14, 1978, and the Service member had less than 8 years of service computed pursuant to section 1208 of Reference (c) on the date when he or she:

1. Would otherwise be retired pursuant to section 1201 of Reference (c); or

2. Was placed on the TDRL pursuant to section 1202 of Reference (c).

5. DISABILITY SEPARATION CRITERIA FOR MEMBERS ON ACTIVE DUTY FOR 30 DAYS OR LESS, ON IDT, FUNERAL HONORS DUTY, OR TRAINING PURSUANT TO SECTION 10148 OF REFERENCE (C)

a. Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(5)~~ *1.b.(5)* of this appendix will be separated with disability benefits when:

(1) The Service member has less than 20 years of service.

(2) The disability meets one of the following criteria:

(a) Is or may be permanent.

(b) Is the result of an injury, illness, or disease incurred or aggravated in line of duty while:

1. Performing active duty or IDT;

2. Traveling directly to or from the place of active duty;

3. Remaining overnight immediately before the commencement of IDT, between successive periods of IDT, at or in the vicinity of the site of the IDT if the site is outside reasonable commuting distance of the Service member's residence; or

4. Serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Reference (~~ae~~*ai*) while the Service member was traveling to or from the place at which he or she was to serve; or while the Service member remained overnight at or in the vicinity of that place immediately before serving.

(c) Is less than 30 percent under the VASRD at the time of the determination and, in the case of a disability incurred before October 5, 1999, was the proximate result of performing active duty or IDT or of traveling directly to or from the place at which such duty is performed.

b. If the Service member is eligible for transfer to the inactive status list pursuant to section 1209 of Reference (c) and chooses to, he or she may be transferred to that list instead of being separated.

6. LOD REQUIREMENTS. In the DES, LOD determinations assist the PEB and appellate review authority in meeting the statutory requirements under chapter 61 of Reference (c) for separation or retirement for disability.

a. Relationship of LOD Findings to DES Determinations

(1) LOD determinations will be made in accordance with the regulations of the respective Military Department. When an LOD determination is required, the DES will consider the finding made for those issues mutually applicable to LOD and DES determinations. These issues include whether a condition is pre-existing and whether it is aggravated by military service and any issues of misconduct or negligence.

(2) When the PEB has reasonable cause to believe an LOD finding appears to be contrary to the evidence, disability evaluation will be suspended for a review of the LOD determination in accordance with Service regulations. The PEB will forward the case to the final LOD reviewing authority designated by the Secretary of the Military Department concerned with a memorandum documenting the reasons for questioning the LOD finding.

b. Referral Requirement. When an LOD determination is required, it will be done before sending a Service member's case to the PEB.

c. Presumptive Determinations. The determination is presumed to be in the LOD without an investigation in the case of:

(1) Disease, except as described in paragraphs ~~6e(1) to 6e(6)~~ *6.d.(1) to 6.d.(6)* of this appendix.

(2) Injuries clearly incurred as a result of enemy action or attack by terrorists.

(3) Injuries while a passenger in a common commercial or military carrier.

d. Required Determinations. At a minimum, LOD determinations will be required in these circumstances.

(1) Injury, disease, or medical condition that may be due to the Service member's intentional misconduct or willful negligence, such as a motor vehicle accident.

(2) Injury involving the abuse of alcohol or other drugs.

(3) Self-inflicted injury.

(4) Injury or disease possibly incurred during a period of unauthorized absence.

(5) Injury or disease apparently incurred during a course of conduct for which charges have been preferred.

(6) Injury, illness, or disease of RC members on orders specifying a period of active duty of 30 days or less while:

(a) Performing active duty or IDT;

(b) Traveling directly to or from the place of active duty;

(c) Remaining overnight immediately before the commencement of IDT, between successive periods of IDT, at or in the vicinity of the site of the IDT if the site is outside reasonable commuting distance of the Service member's residence; or

(d) Serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Reference (~~ae~~*ai*) while the Service member was traveling to or from the place at which he or she was to serve; or while the Service member remained overnight at or in the vicinity of that place immediately before serving.

7. EVIDENTIARY STANDARDS FOR DETERMINING COMPENSABILITY OF UNFITTING CONDITIONS

a. Misconduct and Negligence. LOD determinations concerning intentional misconduct and willful negligence will be judged by the evidentiary standards established by the Secretary of the Military Department concerned.

b. Presumption of Sound Condition for Members on Continuous Orders to Active Duty Specifying a Period of More Than 30 Days

(1) The Secretaries of the Military Departments will presume Service members, including RC members and recalled retirees, on continuous orders to active duty specifying a period of more than 30 days entered their current period of military service in sound condition when the disability was not noted at the time of the Service member's entrance to the current period of active duty.

(2) The Secretaries of the Military Departments may overcome this presumption if clear and unmistakable evidence demonstrates that the disability existed before the Service member's entrance on their current period of active duty and was not aggravated by their current period of military service. Absent such clear and unmistakable evidence, the Secretary of the Military Department concerned will conclude that the disability was incurred or aggravated during their current period of military service.

(3) The Secretary of the Military Department concerned must base a finding that the Service member's condition was not incurred in or aggravated by their current period of military service on objective evidence in the record, as distinguished from personal opinion, speculation, or conjecture. When the evidence is unclear concerning whether the condition existed prior to their current period of military service or if the evidence is equivocal, the presumption of sound condition at entry to the current period of military service has not been rebutted and the Secretary of the Military Department concerned will find the Service member's condition was incurred in or aggravated by military service.

(4) Any hereditary or genetic disease will be evaluated to determine whether clear and unmistakable evidence demonstrates the disability existed before the Service member's entrance on active duty and was not aggravated by their current period of military service. However, even if the disability is determined to have been incurred prior to entry on their current period of active duty, any aggravation of that disease, incurred during the Service member's current period of active duty, beyond that determined to be due to natural progression will be determined to be service-aggravated.

(5) There is no presumption of sound condition for RC members serving on orders of 30 days or less.

c. Presumption of Incurrence or Aggravation in the LOD for Members on Continuous Orders to Active Duty Specifying a Period of More Than 30 Days

(1) The Secretaries of the Military Departments will presume that diseases or injuries incurred by Service members on continuous orders to active duty specifying a period of more than 30 days were incurred or aggravated in the LOD unless the disease or injury was noted at time of entry into service. The Secretaries of the Military Departments may overcome the presumption that a disease or injury was incurred or aggravated in the LOD only when clear and unmistakable evidence indicates the disease or injury existed prior to their current period of military service and was not aggravated by their current period of military service.

~~(2) There is no presumption of incurrence or aggravation in the LOD for RC members serving on orders of 30 days or less.~~

(~~3~~*2*) Pursuant to the provisions of sections 1206(a) and 1207(a) of Reference (c), a preexisting condition is deemed to have been incurred while entitled to basic pay and will be considered for purposes of determining whether the disability was incurred in the LOD when:

(a) The Service member was ordered to active duty for more than 30 days (other than for training pursuant to section 10148(a) of Reference (c)) when the disease or injury was determined to be unfitting as subsequently determined by the PEB.

(b) The Service member was not a member of the RC released within 30 days of his or her orders to active duty in accordance with section 1206a of Reference (c) due to the identification of a preexisting condition not aggravated by the current call to duty.

(c) The Service member will have a career total of at least 8 years of active service at the time of separation.

(d) The disability was not the result of intentional misconduct or willful neglect or was incurred during a period of unauthorized absence.

d. RC Members Serving on Orders of 30 Days or Less~~.~~

(1) The Secretary of the Military Department concerned will determine if injuries and diseases to RC members serving on orders of 30 days or less were incurred or aggravated in the LOD as described in section 4 of this appendix.

(2) For RC members being examined in accordance with section 3 of this appendix, aggravation must constitute the worsening of a preexisting medical condition as a direct result of military duty and over and above the natural progression of the condition.

(3) There is no presumption of incurrence or aggravation in the LOD for RC Service members serving on orders of 30 days or less.

e. Prior Service ~~Impairment~~ *Condition*. Any medical condition incurred or aggravated during one period of active service or authorized training in any of the Military Services that recurs, is aggravated, or otherwise causes the member to be unfit, should be considered incurred in the LOD, provided the origin of such ~~impairment~~ *condition* or its current state is not due to the Service member's misconduct or willful negligence, or progressed to unfitness as the result of intervening events when the Service member was not in a duty status.

f. Medical Waivers

(1) Service members who entered the Military Service with a medical waiver for a preexisting condition and are subsequently determined unfit for the condition will not be entitled to disability separation or retired pay unless:

(a) Military service permanently aggravated the condition or hastened the condition's rate of natural progression; or

(b) The member will have 8 years of active service at the time of separation.

(2) Service members granted medical waivers will be advised of the waiver application process when applying for a waiver and when it is granted.

g. Treatment of Pre-existing Conditions. Generally recognized risks associated with treating preexisting conditions will not be considered service aggravation. Unexpected adverse events, over and above known hazards, directly attributable to treatment, anesthetic, or operation performed or administered for a medical condition existing before entry on active duty, may be considered service aggravation.

h. Elective Surgery or Treatment. A Service member choosing to have elective surgery or treatment done at his or her own expense will not be eligible for compensation in accordance with the provisions of this instruction for any adverse residual effect resulting from the elected treatment, unless it can be shown that such election was reasonable or resulted from a significant impairment of judgment that is the product of a ratable medical condition.

i. Rating Disabilities. When a disability is established as compensable, it will be rated in accordance with Reference (~~t~~*v*). When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability, such doubt will be resolved in favor of the Service member.

APPENDIX 4 TO ENCLOSURE 3

TDRL MANAGEMENT

1. INITIAL PLACEMENT ON THE TDRL

a. A Service member will be placed on the TDRL when the member meets the requirements for permanent disability retirement except that the disability is not determined to be stable but may be permanent. A disability will be determined stable when the preponderance of medical evidence indicates the severity of the condition will probably not change enough within the next ~~5~~ *3* years to increase or decrease the disability rating percentage*, pursuant to section 1210 of Reference (c)*.

b. Service members with unstable conditions rated at a minimum of 80 percent that are not expected to improve to less than an 80 percent rating will be permanently retired.

2. TDRL RE-EVALUATION. The TDRL will be managed to meet the requirements for periodic disability examination, suspension of retired pay, and prompt removal from the TDRL pursuant to chapter 61 of Reference (c), including the reexamination of temporary retirees at least once every 18 months to determine whether there has been a change in the disability for which the member was temporarily retired.

a. Initiating the TDRL Re-evaluation Process. No later than 16 months after temporarily retiring a Service member for disability or after his or her previous re-evaluation, the Military Department will obtain and review available DoD medical treatment documentation and VA or veteran-provided medical treatment, or disability examination that occurred within 16 months of being placed on the TDRL, and rating documentation. If the documents reviewed are deemed sufficient and consistent with the requirements of chapter 61, of Reference (c), the Military Department may rely on that documentation to determine whether there has been a change in disability for which the Service member was temporarily retired. The PEB will review the available evidence to determine if the documentation is sufficient to:

(1) Fully describe each disability that the Secretary of the Military Department concerned determined was unfitting and may be permanent but was unstable at the time the Service member was placed on the TDRL, the current status of such disabilities, the progress of the disability and a suggested time frame (not to exceed 18 months) for the next examination.

(2) Fully describe, including treatment and etiology, any new disability that was caused by or directly related to the treatment of a disability for which the Service member was previously placed on the TDRL.

b. Conduct of Disability Re-examinations. If the Military Department determines the available medical records and examination reports, including those available from VA, do not meet the requirements in paragraphs ~~2a(1)~~ *2.a.(1)* and ~~2a(2)~~ *2.a.(2)* of this appendix, the Military

Department will comply with their responsibilities in chapter 61 of Reference (c) regarding the TDRL, to include performing TDRL examinations that meet the requirements of paragraph ~~2a(1)~~ *2.a.(1)* and ~~2a(2)~~ *2.a.(2)* of this appendix.

c. PEB Re-adjudication. The Military Department will request that VA provide their most current rating and medical evidence upon which the most current rating was based for the condition for which the veteran was placed on the TDRL. The PEB ~~may use~~ *will consider* the future examination requirements set by the disability rating activity site (D-RAS) as an indicator of stability when making the recommendations of stability determinations and case disposition to the Secretary of the Military Department. If the PEB decides to continue a Service member on temporary retirement for disability for which the D-RAS has not scheduled a future examination, the Military Department will execute required TDRL examinations and ratings in accordance with chapter 61 of Reference (c).

d. PEB Disposition

(1) If the PEB finds the veteran fit for duty for the condition(s) for which he or she was placed on the TDRL; that the condition(s) is now stable; and the veteran wishes to return to active duty, the Military Department will administer any additional examinations required to evaluate whether the veteran is otherwise fit for duty in accordance with the Military Department's regulations and the guidance in this instruction. The Military Department will administer other dispositions in accordance with the guidance in this instruction.

(2) If upon re-evaluation while on the TDRL, the Service member is still found unfit ~~for~~ *due to* the unstable condition for which he or she was placed on the TDRL, evaluation of other conditions is not required. If the Service member is no longer found unfit for the unstable condition for which he or she was placed on the TDRL, an assessment will be made as to whether any other condition exists that would prevent a return to duty. If other conditions exist that render the Service member unfit, a determination will be made that the condition is unfitting but not compensable in the DES.

e. Cases on VA Appeal. When a Service member who was temporarily retired for disability has appealed a VA decision and the appeal resides with the Board of Veterans Appeals or Court of Appeals for Veterans' Claims, the Military Department will obtain from the VA a copy of the most current rating and medical evidence available.

(1) The Military Department will obtain and review the available DoD and the VA medical treatment and disability examination documentation available for the condition for which the Service member was placed on the TDRL.

(2) The Military Department will review the available medical evidence to determine if the documentation is sufficient to conduct the TDRL re-evaluation process without a disability examination of the Service member.

(3) If the PEB determines that the Service member requires an additional disability examination, the PEB will coordinate the actions needed to meet the statutory, 18-month

examination requirement in chapter 61 of Reference (c). Upon receipt of all necessary medical evidence, the PEB will adjudicate the case.

f. Administrative Finality. During TDRL re-evaluation, as described in paragraph ~~2a~~ *2.a.* of this appendix, previous determinations concerning application of any presumption established by this instruction, LOD, misconduct, and whether a medical ~~impairment~~ *condition* was permanent, service-incurred, or preexisting and aggravated will be considered administratively final for conditions for which the Service member was placed on the TDRL unless there is:

(1) Evidence of fraud.

(2) A change of diagnosis that warrants the application of accepted medical principles for a preexisting condition.

(3) A correction of error in favor of the Service member.

g. Required Determinations. The Secretary of the Military Department concerned will determine whether the conditions for which the Service member was placed on the TDRL are unfitting and compensable. When, upon re-evaluation, a temporarily retired veteran is determined fit for the conditions for which he or she was placed on the TDRL and has no other DoD compensable disabilities, the veteran will be separated from the TDRL without entitlement to DoD disability benefits.

h. Service Member Medical Records. The Service member will provide to the examining physician, for submission to the PEB, copies of all his or her medical records (e.g., civilian, VA, and military) documenting treatment since the last TDRL re-evaluation.

i. Compensability of New Diagnoses. Conditions newly diagnosed during temporary retirement will be compensable when:

(1) The condition is unfitting and;

(2) The condition was caused by or directly related to the treatment of a condition for which the Service member was previously placed on the TDRL.

(3) To correct an error in favor of the Service member, the Secretary of the Military Department concerned determines the condition was unfitting and compensable at the time the member was placed on the TDRL.

j. Current Physical Examination. Service members on the TDRL are not entitled to permanent retirement or separation with disability severance pay without a current periodic physical examination acceptable to the Secretary of the Military Department concerned as required by chapter 61 of Reference (c).

k. Refusal or Failure to Report. In accordance with chapter 61 of Reference (c), when a Service member on the TDRL refuses or fails to report for a required periodic physical

examination or provide his or her medical records in accordance with paragraph ~~2h~~ *2.h.* of this appendix, disability retired pay will be suspended.

(1) If the Service member later reports for the physical examination, retired pay will be resumed effective on the date the examination was actually performed.

(2) If the Service member subsequently shows just cause for failure to report, disability retired pay may be paid retroactively for a period not to exceed 1 year prior to the actual performance of the physical examination.

(3) If the Service member does not undergo a periodic physical examination after disability retired pay has been suspended, he or she will be administratively removed from the TDRL on the ~~fifth~~ *third* anniversary of the original placement on the list.

l. Priority. TDRL examinations, including hospitalization in connection with the conduct of the examination, will be furnished with the same priority given to active duty members.

m. Reports From Non-MTFs. MTFs designated to conduct TDRL periodic physical examinations may use disability examination reports from any medical facility or physician. The designated MTF remains responsible for the adequacy of the examination and the completeness of the report. The report must include the competency information specified in paragraph ~~2e~~*2.e.* of this appendix.

n. Incarcerated Members. A report of disability examination will be requested from the appropriate authorities in the case of a Service member imprisoned by civil authorities. In the event no report, or an inadequate report, is received, documented efforts will be made to obtain an acceptable report. If an examination is not received, disposition of the case will be in accordance with paragraph ~~2k~~ *2.k.* of this appendix. The Service member will be advised of the disposition and that remedy rests with the respective Military Department Board for Correction of Military Records.

APPENDIX 5 TO ENCLOSURE 3

ADMINISTRATIVE DETERMINATIONS

1. ADMINISTRATIVE DETERMINATIONS FOR PURPOSES OF EMPLOYMENT UNDER FEDERAL CIVIL SERVICE

a. The PEB renders a final decision on whether an injury or disease that makes the Service member unfit or that contributes to unfitness was incurred in combat with an enemy of the United States, was the result of armed conflict, or was caused by an instrumentality of war during war.

b. These determinations pertain to whether a military retiree later employed in federal civil service is entitled to credit of military service toward a federal civil service retirement in accordance with sections 8332 and 8411 of Reference (d); in accordance with section 2082 of Reference (f); ~~retention preference in accordance with section 3501 of Reference (d);~~ credit of military service for civil service annual leave accrual in accordance with section 6303 of Reference (d); and exclusion of federal income taxation in accordance with section 104 of Reference (e).

(1) Incurred in Combat with an Enemy of the United States. The disease or injury was incurred in the LOD in combat with an enemy of the United States.

(2) Armed Conflict. The disease or injury was incurred in the LOD as a direct result of armed conflict (see Glossary) in accordance with section~~s 3501 and~~ 6303 of Reference (d). The fact that a Service member may have incurred a disability during a period of war, in an area of armed conflict, or while participating in combat operations is not sufficient to support this finding. There must be a definite causal relationship between the armed conflict and the resulting unfitting disability.

(3) Instrumentality of War During a Period of War. The injury or disease was caused by an instrumentality of war, incurred in the LOD during a period of war as defined in sections 101 and 302 of Title 38, U.S.C. (Reference (~~ag~~*al*)), and makes the Service member unfit in accordance with section~~s 3501 and~~ 6303 of Reference (d). Applicable periods are:

(a) World War II. The period beginning December 7, 1941, and ending December 31, 1946; and any period of continuous service performed after December 31, 1946, and before July 26, 1947, if such period began before January 1, 1947.

(b) Korean Conflict. The period beginning June 27, 1950, and ending January 31, 1955.

(c) Vietnam Era. The period beginning August 5, 1964, and ending May 7, 1975.

(d) Persian Gulf. The period beginning August 2, 1990, through date to be prescribed by Presidential proclamation or law.

2. DETERMINATIONS FOR FEDERAL TAX BENEFITS. Disability evaluation includes a determination and supporting documentation on whether the Service member's disability compensation is excluded from federal gross income in accordance with Reference (e). For compensation to be excluded, the Service member must meet the criteria in either paragraph ~~2a~~ *2.a.* or ~~2b~~ *2.b.* of this appendix.

a. Status. On September 24, 1975, the individual was a military Service member, including the RC, or was under binding written agreement to become a Service member.

(1) A Service member who was a member of an armed force of another country on that date is entitled to the exclusion.

(2) A Service member who was a contracted cadet of the Reserve Officers Training Corps on that date is entitled to the exclusion.

(3) A Service member who separates from the Military Service after that date and incurs a disability during a subsequent enlistment is entitled to the exclusion.

b. Combat Related. This standard covers injuries and diseases attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict. A disability is considered combat-related if it makes the Service member unfit or contributes to unfitness and the preponderance of evidence shows it was incurred under any of the following circumstances.

(1) As a Direct Result of Armed Conflict. The criteria are the same as those in paragraph 1.b. of this appendix.

(2) While Engaged in Hazardous Service. Such service includes, but is not limited to, aerial flight duty, parachute duty, demolition duty, experimental stress duty, and diving duty.

(3) Under Conditions Simulating War. In general, this covers disabilities resulting from military training, such as war games, practice alerts, tactical exercises, airborne operations, and leadership reaction courses; grenade and live fire weapons practice; bayonet training; hand-to-hand combat training; rappelling; and negotiation of combat confidence and obstacle courses. It does not include physical training activities, such as calisthenics and jogging or formation running and supervised sports.

(4) Caused by an Instrumentality of War. Occurrence during a period of war is not a requirement to qualify. If the disability was incurred during any period of service as a result of wounds caused by a military weapon, accidents involving a military combat vehicle, injury or sickness caused by fumes, gases, or explosion of military ordnance, vehicles, or material, the criteria are met. However, there must be a direct causal relationship between the instrumentality

of war and the disability. For example, an injury resulting from a Service member falling on the deck of a ship while participating in a sports activity would not normally be considered an injury caused by an instrumentality of war (the ship) since the sports activity and not the ship caused the fall. The exception occurs if the operation of the ship caused the fall.

3. RECOUPMENT OF BENEFITS. In accordance with sections 303a and 373 of Reference (~~af~~*ak*), when a Service member is retired, separated or dies as a result of a combat-related disability and has received a bonus, incentive pay, or similar benefit, the Secretary of the Military Department concerned:

a. Will not require repayment by the Service member or his or her family of the unearned portion of any bonus, incentive pay, or similar benefit previously paid to the Service member.

b. Will require the payment to the Service member or his or her family of the remainder of any bonus, incentive pay, or similar benefit that was not yet paid to the member, but to which he or she was entitled immediately before the death, retirement, or separation.

c. Will not apply paragraphs ~~3a~~ *3.a.* and ~~3b~~ *3.b.* of this appendix if the death or disability was the result of the Service member's misconduct.

4. DETERMINATION FOR RC MEMBERS WHO ARE TECHNICIANS AND DETERMINED UNFIT BY THE DES. In accordance with section 10216(g) of Reference (c), the record of proceedings for RC members who are technicians and determined unfit by the DES must include whether the member was determined unfit due to a combat-related event.

APPENDIX 6 TO ENCLOSURE 3

FINAL DISPOSITION

1. FINAL DECISION AUTHORITY

a. Secretary of Defense. The Secretary of Defense, after considering the recommendation of the USD(P&R), approves or disapproves the appeal of any Service member found fit for duty by the PEB but determined unsuitable for continued service by the Secretary of the Military Department concerned for the same medical condition considered by the PEB.

b. USD(P&R). The USD(P&R), after considering the recommendation of the ASD(HA), approves or disapproves the disability retirement of any general or flag officer or medical officer being processed for, scheduled for, or receiving non-disability retirement for age or length of service.

c. Secretaries of the Military Departments. Except as stated in paragraphs ~~1a~~ *1.a.* and ~~b~~ *b* of this appendix, the Secretary of the Military Department concerned has the authority to make all determinations in accordance with this instruction regarding unfitness, disability percentage, and entitlement to disability severance and retired pay.

2. GENERAL RULES REGARDING DISPOSITION

a. Retirement

(1) Except for Service members approved for permanent limited duty consistent with section 3 of this appendix, any Service member on active duty or in the RC who is found to be unfit will be retired, if eligible, or separated. This general rule does not prevent disciplinary or other administrative separations from the Military Services.

(2) Selected Reserve members with at least 15 but no more than 20 years of qualifying service pursuant to section 12732 of Reference (c) who are to be separated, may elect either separation for disability or early qualification for retired pay at age 60 pursuant to sections 12731 and ~~12731(b)~~ *12731b* of Reference (c). However, the separation or retirement for disability cannot be due to the member's intentional misconduct, willful failure to comply with standards and qualifications for retention, or willful neglect, and cannot have been incurred during a period of unauthorized absence or excess leave.

b. Removal From the TDRL. Service members determined fit as a result of TDRL re-evaluation will be processed as:

(1) Appointment and/or Enlistment. Upon the Service member's request, and provided he or she is otherwise eligible, the Secretary of the Military Department concerned will appoint

or enlist the Service member in the applicable grade and component as outlined in section 1211 of Reference (c).

(2) Recall to Active Duty

(a) Regular Officers and Enlisted Members. Subject to their consent, regular officers and enlisted members will be recalled to duty, if they are otherwise eligible and were not separated in accordance with law or regulation at the time they were placed on the TDRL. They will be deemed medically qualified for those conditions on which a finding of fit was determined. Any new condition arising between DES evaluation and recall must meet the respective Military Service's medical standards for retention.

(b) RC. Subject to their consent, RC officers, warrant officers, and enlisted members will be reappointed or reenlisted as a Reserve for service in their respective RC in accordance with section 1211 of Reference (c). RC members determined fit by TDRL re-evaluation will not be involuntarily assigned to the Individual Ready Reserve.

(3) Separation. In accordance with section 1210(f) of Reference (c), Service members required to be separated or retired for non-disability reasons at the time they were referred for disability evaluation and placed on the TDRL, if determined fit, will be separated or retired, as applicable.

(4) Termination of TDRL Status. TDRL status and retired pay will terminate upon discharge, recall, reappointment, or reenlistment, as outlined in section 1211 of Reference (c).

(5) Right to Apply for VA Benefits. A Service member may not be discharged or released from active duty due to a disability until he or she has been counseled on their right to make a claim for compensation, pension, or hospitalization with the VA.

3. CONTINUANCE OF UNFIT SERVICE MEMBERS ON ACTIVE DUTY OR IN THE RESERVES. Upon the request of the Service member or upon the exercise of discretion based on the needs of the Military Departments, the Secretary of the Military Department concerned may allow unfit Service members to continue in a permanent limited-duty status, either active or reserve duty in the same or different rating or occupational specialty. Such continuation may be justified by the Service member's service obligation or special skill and experience. The Secretaries of the Military Department concerned may also consider transfer to another Military Service.

4. TRANSITION BENEFITS. AC and RC members on active duty are entitled to the transition benefits established by Reference (~~a~~*ah*) when being separated or retired for disability unless waived by the DoD or prohibited by federal law.

5. DISPOSITIONS FOR UNFIT SERVICE MEMBERS

a. Permanent Disability Retirement. If the Service member is unfit, retirement for a permanent and stable compensable disability is directed pursuant to section 1201 or 1204 of Reference (c) either:

(1) When the total disability rating is at least 30 percent in accordance with the VASRD and the Service member has less than 20 years of service computed pursuant to section 1208 of Reference (c); or

(2) When the Service member has at least 20 years of service computed pursuant to section 1208 of Reference (c) and the disability is rated at less than 30 percent.

b. Placement on the TDRL. Retirement is directed pursuant to section 1202 or 1205 of Reference (c) when the requirements for permanent disability retirement are met, except the disability is not stable and may be permanent.

c. Separation With Disability Severance Pay

(1) Criteria. Separation is directed pursuant to section 1203 or 1206 of Reference (c) when the member is unfit for a compensable disability determined in accordance with the standards of this instruction, and the following requirements are met. Stability is not a factor for this disposition.

(a) The Service member has less than 20 years of service computed pursuant to section 1208 of Reference (c).

(b) The disability is rated at less than 30 percent.

(2) Service Credit

(a) Pursuant to section 1212 of Reference (c), a part of a year of active service that is 6 months or more is counted as a whole year, and a part of a year that is less than 6 months is disregarded.

(b) The Secretary of the Military Department concerned will credit members separated from the Military Services for a disability with a minimum of 3 years of service.

(c) The Secretary of the Military Department concerned will credit members separated from the Military Services for a disability incurred in the LOD in a designated combat zone tax exclusion area or incurred during the performance of duty in combat-related operations consistent with the criteria in paragraph ~~2b~~ *2.b.* of Appendix 5 to this enclosure with a minimum of 6 years of service.

(d) For the purposes of calculating active service for disability severance pay, the Secretary of the Military Department concerned will consider disabilities to be incurred in

combat-related operations when they are consistent with the criteria in paragraph ~~2b~~ *2.b.* of Appendix 5 to this enclosure.

(3) Transfer to Retired Reserve

(a) Pursuant to section 1209 of Reference (c), RC members who have completed at least 20 qualifying years of Reserve service and who would otherwise be qualified for retirement may forfeit disability severance pay and request transfer to an inactive status list for the purpose of receiving non-disability retired pay at age 60. The Secretary of the Military Department concerned may offer the member the option to transfer to the Retired Reserve.

(b) When disability severance pay is accepted, the Service member forfeits all rights to receive retired pay pursuant to chapter 1223 of Reference (c) at age 60. There are no provisions pursuant to Reference (c) to repay disability severance pay to then receive retired pay.

(4) Selected Reserve Early Qualification for Retired Pay. ~~Pursuant to section 12731 of Reference (c),~~ RC members with at least 15 and less than 20 years of qualifying service who would otherwise be qualified for ~~nonregular~~ *non-regular* retirement may waive disability disposition and request early qualification for retired pay in accordance with ~~12731(b)~~ *section 12731b* of Reference (c).

d. Separation Without Entitlement to Benefits. Discharge is directed in accordance with section 1207 of Reference (c) when the Service member is unfit for a disability incurred as a result of intentional misconduct or willful neglect or during a period of unauthorized absence.

e. Discharge Pursuant to Other Than Chapter 61 of Reference (c). An unfit Service member is directed for discharge in accordance with other provisions of Reference (c) and Reference (~~ad~~*ai*) and DoDI 1332.30 (Reference (~~ah~~*am*)) when he or she is not entitled to disability compensation due to the circumstances when either:

(1) The Service member is not entitled to disability compensation, but may be entitled to benefits under section 1174 of Reference (c)~~.~~*; or*

(2) The medical ~~impairment~~ *condition* of an RC member is non-duty related and it disqualifies the member for retention in the RC.

f. Revert with Disability Benefits. Revert with disability benefits is used to return a retiree recalled to active duty who was:

(1) Previously retired for disability.

(2) Determined unfit during the period of recall. For Service members previously retired for age or years of service, the compensable percentage of disability must be 30 percent or more to receive disability benefits.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AC	Active Component
ASD(HA)	Assistant Secretary of Defense for Health Affairs
~~ASD(RA)~~	~~Assistant Secretary of Defense for Reserve Affairs~~
ASD(M&RA)	*Assistant Secretary of Defense for Manpower and Reserve Affairs*
DAC	Disability Advisory Council
~~DASD(WCP)~~	~~Deputy Assistant Secretary of Defense for Warrior Care Policy~~
DASD(HSP&O)	*Deputy Assistant Secretary of Defense for Health Services Policy and Oversight*
DES	disability evaluation system
DoDD	DoD Directive
DoDI	DoD Instruction
D-RAS	disability rating activity site
~~EDES~~	~~Expedited Disability Evaluation System~~
FPEB	formal physical evaluation board
GC DoD	General Counsel of the Department of Defense
IDES	Integrated Disability Evaluation System
IDT	inactive duty training
IPEB	informal physical evaluation board
IT	information technology
LDES	Legacy Disability Evaluation System
LOD	line of duty
MEB	medical evaluation board
MTF	military treatment facility
PEB	physical evaluation board

PEBLO	physical evaluation board liaison officer
RC	Reserve Component
TDRL	temporary disability retired list
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
VA	Department of Veterans Affairs
VASRD	Department of Veterans Affairs Schedule for Rating Disabilities

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this instruction.

accepted medical principles. Fundamental deductions, consistent with medical facts, that are so reasonable and logical as to create a virtual certainty that they are correct. *The Service PEB will state with specificity the basis(es) for the conclusion.*

active duty. Defined in ~~Joint Publication 1-02~~ *the DoD Dictionary of Military and Associated Terms* (Reference (~~ai~~*an*)).

acute. Characterized by sharpness or severity.

armed conflict. A war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerilla action, riot, or any other action in which Service members are engaged with a hostile or belligerent nation, faction, force, or terrorist. Armed conflict may also include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in the custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner-of-war, or detained status.

catastrophic injury or illness. A permanent, severely disabling injury, disorder, or disease incurred or aggravated in the LOD that compromises the ability to carry out the activities of daily living to such a degree that a Service member requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others.

clear and unmistakable evidence. Undebatable information that the condition existed prior to military service or if increased in service was not aggravated by military service. In other words, reasonable minds could only conclude that the condition existed prior to military service from a review of all of the evidence in the record.

compensable disability. A medical condition that is determined to be unfitting due to disability and that meets the statutory criteria of chapter 61 of Reference (c) for entitlement to disability retired or severance pay.

competency board. A board consisting of at least three medical officers or physicians (including one psychiatrist) convened to determine whether a member is competent (capable of making a rational decision regarding his or her personal and financial affairs).

DAC. A DoD-only group that evaluates DES functions, identifies best practices, addresses inconsistencies in policy, discusses inconsistencies in law, addresses problems and issues in the administration of the DES, and provides a forum to develop and plan improvements.

DES. The DoD mechanism for determining return to duty, separation, or retirement of Service members because of disability in accordance with chapter 61 of Reference (c).

disability. Any ~~impairment~~ *condition* due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity. The term "disability" or "physical disability" includes mental disease, but not such inherent defects as developmental or behavioral disorders. A medical ~~impairment~~ *condition*, mental disease, or physical defect standing alone does not constitute a disability. To constitute a disability, the medical ~~impairment~~ *condition*, mental disease, or physical defect must be severe enough to interfere with the Service member's ability to adequately perform his or her duties.

duty-related medical conditions. Conditions that were incurred or aggravated while the AC or RC Service member was performing duty.

~~EDES. A voluntary expedited process to authorize benefits, compensation, and specialty care to Service members who sustain catastrophic injuries or illnesses.~~

elective surgery. Surgery that is not essential, especially surgery to correct a condition that is not life-threatening; surgery that is not required for survival.

final reviewing authority. The final approving authority for the findings and recommendations of the PEB.

grave. Very serious: dangerous to life-used of an illness or its prospects.

IDES. The joint DoD -VA process by which DoD determines whether ill or injured Service members are fit for continued military service and DoD and VA determine appropriate benefits for Service members who are separated or retired for disability.

instrumentality of war. A vehicle, vessel, or device designed primarily for military service and intended for use in such service at the time of the occurrence or injury.

LDES. A DES process by which DoD determines whether eligible wounded, ill, or injured Service members are fit for continued military service and determines appropriate benefits for Service members who are separated or retired for disability. Service members processed through the LDES may also apply for veterans' disability benefits through the VA pre-discharge Benefits Delivery at Discharge or Quick Start programs, or upon attaining veteran status.

LOD determination. An inquiry to determine whether an injury or illness was incurred when the Service member was in a military duty status. If the Service member was not in a military duty status, whether it was aggravated by military duty; or whether it was incurred or aggravated due to the Service member's intentional misconduct or willful negligence.

MEB convening authority. A senior medical officer, appointed by the MTF commander, who has detailed knowledge of standards of medical fitness and disposition of patients and disability separation processing and who is familiar with the VASRD.

MEB process. For Service members entering the DES, the MEB conducts the medical evaluation on conditions that potentially affect the Service member's fitness for duty. The MEB documents the Service member's medical condition(s) and history with an MEB narrative summary as part of an MEB packet.

medical ~~impairment~~ *condition*. Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

non-duty-related medical conditions. ~~Impairments~~ *Conditions* that were neither incurred nor aggravated while the *AC or RC Service* member was performing duty.

office, grade, rank, or rating

office. A position of duty, trust, and authority to which an individual is appointed.

grade. A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation.

rank. The order of precedence among members of the Military Services.

rating. The name (such as "Boatswain's Mate") prescribed for Service members of a Military Service in an occupational field.

PEBLO. The non-medical case manager who provides information, assistance, and case status updates to the affected Service member throughout the DES process.

permanent limited duty. The continuation on active duty or in the Ready Reserve in a limited-duty capacity of a Service member determined unfit because of disability evaluation or medical disqualification.

presumption. An inference of the truth of a proposition or fact reached through a process of reasoning and based on the existence of other facts. Matters that are presumed need no proof to support them, but may be rebutted by evidence to the contrary.

proximate result. A permanent disability the result of, arising from, or connected with active duty, annual training, active duty for training, or IDT, to include travel to and from such duty or remaining overnight between successive periods of IDT. Proximate result is a statutory criterion for entitlement to disability compensation under chapter 61 of Reference (c) applicable to RC members who incur or aggravate a disability while performing an ordered period of military duty of 30 days or less.

retention standards. Guidelines that establish medical conditions or physical defects that could render a Service member unfit for further military service and may be cause for referral of the Service member into the DES.

service aggravation. The permanent worsening of a pre-Service medical condition over and above the natural progression of the condition.

service treatment record. ~~A chronological record documenting the medical care, dental care and treatment received primarily outside of a hospital (outpatient), but may contain a synopsis of any inpatient hospital care and behavioral health treatment.~~ *The chronologic record of medical, dental, and mental health care received by Service members during the course of their military career. It includes documentation of all outpatient appointments (i.e., without overnight admittance to a hospital, clinic, or treatment facility), as well as summaries of any inpatient care (discharge summaries) and care received while in a military theater of operations. The service treatment record is the official record used to support continuity of clinical care and the administrative, business-related, and evidentiary needs of the DoD, the VA, and the individual.*

DoD INSTRUCTION 1332.45

RETENTION DETERMINATIONS FOR NON-DEPLOYABLE SERVICE MEMBERS

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	July 30, 2018
Releasability:	Cleared for public release. Available on the Directives Division Website at http://www.esd.whs.mil/DD/.
Incorporates and Cancels:	Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "DoD Retention Policy for Non-Deployable Service Members," February 14, 2018
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness

Purpose: In accordance with the authority in DoD Directive 5124.02, this issuance:

- Establishes policy, assigns responsibilities, and provides direction for retention determinations for non-deployable Service members.
- Provides guidance and instructions for reporting deployability data for the Total Force.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY. This issuance applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the "DoD Components").

1.2. POLICY. It is DoD policy that:

a. To maximize the lethality and readiness of the joint force, all Service members are expected to be deployable.

b. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for:

(1) A retention determination by their respective Military Departments.

(2) As appropriate, referral into the Disability Evaluation System (DES) in accordance with DoD Instruction (DoDI) 1332.18 or initiation of processing for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30. This policy on retention determinations for non-deployable Service members does not supersede the policies and processes concerning referral to the DES or the initiation of administrative separation proceedings found in these issuances.

c. Implementation for this policy is October 1, 2018.

1.3. INFORMATION COLLECTIONS. The Monthly Non-deployable Report, referred to in Paragraph 3.2. of this issuance, has been assigned report control symbol DD-P&R(M)2671 in accordance with the procedures in Volume 1 of DoD Manual 8910.01. The expiration date of this information collection is listed in the DoD Information Collections System at https://apps.sp.pentagon.mil/sites/dodiic/Pages/default.aspx.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) establishes and oversees policy on retention determinations for non-deployable Service members.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR MANPOWER AND RESERVE AFFAIRS (ASD(M&RA)). Under the authority, direction, and control of the USD(P&R), the ASD(M&RA):

a. Develops policy on the retention of non-deployable Service members.

b. Monitors the implementation of this guidance.

c. Tracks the number of non-deployable Service members and those non-deployable Service members retained in military service and the justification for such retention, in accordance with Section 3 of this issuance.

2.3. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS. Under the authority, direction, and control of the USD(P&R), the Assistant Secretary of Defense for Health Affairs:

a. Develops policy recommendations to the USD(P&R) for uniform retention medical standards in coordination with the Secretaries of the Military Departments.

b. Provides oversight of related medical policies and programs.

2.4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Will:

(1) Determine the deployability status of Service members.

(2) Make retention determinations consistent with this issuance for Service members who have been non-deployable for more than 12 consecutive months.

(3) Submit monthly reports identifying the number of non-deployable Service members for all components within their Departments to the Office of the USD(P&R) in accordance with Paragraph 3.2. of this issuance.

(4) Monitor compliance with requirements established in DoDI 6025.19 to ensure required evaluations, assessments, and other medically related actions are accomplished to improve individual and overall unit readiness.

b. May:

(1) Retain in service those Service members whose period of non-deployability exceeds the 12 consecutive month limit in Paragraph 1.2. of this issuance if determined to be in the best interest of the Military Service.

(2) Delegate the authority in Paragraph 2.4.(b)(1) of this issuance to retain in service those Service members whose period of non-deployability exceeds the 12 consecutive month limit. Such a delegation must be in writing, and may only be made to Presidentially Appointed, Senate-Confirmed officials; Senior Executive Service members; or general/flag officers serving at the Military Department or Service headquarters.

(3) Initiate administrative separation processing, or referral to the DES, as appropriate, prior to a non-deployable Service member being in a non-deployable status for 12 months when the Military Service determines there is a reasonable expectation that the reason will not be resolved and the Service member will not become deployable.

SECTION 3: PROCEDURES FOR TRACKING AND REPORTING SERVICE MEMBERS

3.1. TRACKING.

a. The Military Departments will monitor and track the number of Service members by Military Service that are:

(1) Non-deployable in accordance with the categories established in Paragraphs 3.5. and 3.6. of this issuance.

(2) Deployable with limitations in accordance with Paragraph 3.3. of this issuance.

(3) Deployable but have individual medical readiness (IMR) deficits in accordance with Paragraph 3.7. of this issuance.

(4) In training or in a transient status in accordance with the category defined in Paragraph 3.4. of this issuance.

b. To ensure accurate and consistent accounting across the DoD, Military Services will account for Service members in only one category. If a Service member can be accounted for in more than one category, the Service member will be counted only once and in the category with the highest priority listed in accordance with Paragraph 3.8. of this issuance.

3.2. REPORTING.

a. The Secretaries of the Military Departments will report to the ASD(M&RA) the number of non-deployable personnel (and other categories as provided in this section) for all Military Services, and their respective components, on a monthly basis.

(1) The format for the Monthly Non-deployable Report can be found at https://prhome.defense.gov/M-RA/Inside-M-RA/MPP/OEPM/.

(2) Reports are due by the end of each month with data current as the last day of the previous month. For example, the June Non-deployable Report is due by June 30th with non-deployable data as of May 31st.

b. The number of non-deployable Service members is reported by categories, either temporary or permanent, and grouped into medical, legal, or administrative sub-categories. Each sub-category is further broken down to account for the specific reasons or conditions that make a Service member non-deployable.

c. The number of Service members who are deployable with limitations, in accordance with Paragraph 3.3. of this issuance, will be categorized separately on the monthly report. Such Service members are not to be counted in the non-deployable populations.

d. The number of Service members who require urgent or emergent dental treatment for dental readiness (Dental Class 3), are overdue for annual dental screening (Dental Class 4), or are overdue for a Periodic Health Assessment (PHA) are reported as IMR Deficits in accordance with Paragraph 3.7. of this issuance. Such Service members are not counted in the non-deployable populations.

e. The number of Service members who are in a training or transient status are reported in one of the four categories listed in Paragraph 3.4. of this issuance.

3.3. DEPLOYABLE WITH LIMITATIONS. Service members with a medical condition that requires additional medical screening, or Combatant Command approval prior to deployment outside the continental United States, will be categorized as Deployable with Limitations. This includes, but is not limited to, conditions referred to in DoDI 6490.07.

3.4. TRAINING AND TRANSIENT. The Training and Transient category provides a means to track the human resources necessary to maintain a healthy force, within current end strength constraints. This category contains Service members who are not immediately ready for deployment and fall into one of the following four categories:

a. Initial Entry Training. These Service members are:

(1) Enlisted Service members at recruit training, initial skill training, and other proficiency or developmental training accomplished before moving to the member's first permanent duty assignment. This includes all in-transit time commencing upon entry into active service, through completion of the final course of initial entry training that terminates enlisted trainee status.

(2) Enlisted trainees who enter officer candidate school, officer training school, and Service academy preparatory school following enlistment on active duty. These members will be considered:

(a) Enlisted trainees from initial entry on active duty until commissioning.

(b) Upon commissioning, officer accession students and will remain in the initial entry training category for any subsequent initial entry training, or until they begin travel to their first permanent duty assignment.

(3) Officers at officer basic courses, and all initial skill and proficiency training taken before travel to the Service member's first permanent duty assignment. This includes all in-transit time from entry on active duty until completion of the last initial entry course of instruction.

(4) Reserve Component (RC) Service members (enlisted and officer) who enter the Ready Reserve and are awaiting initial entry training.

b. Cadets and Midshipman. These are individuals currently attending the U.S. Military Academy, the U.S. Air Force Academy, or the U.S. Naval Academy. In accordance with Section 115 of Title 10, United States Code (U.S.C.), cadets and midshipman are counted in the active duty end strength for their respective Service, but by policy are non-deployable while attending school.

c. All Other Training. These are Service members who are attending training that is 20 weeks or more in length, and is conducted after their initial entry training. Examples include Command and Staff Colleges, Senior Service College, the United States Army Sergeants Major Academy, medical residencies, and all other post-graduate professional education opportunities.

d. Transient. These are Service members who are not available for duty while executing permanent change of station orders at the time of the report. This category does not include military personnel who are:

(1) On temporary duty for training between permanent duty stations, or;

(2) Moving between entry-level courses of instruction, specifically Service members who have departed from one duty station and are in transit but have not yet reported for duty at the next permanent duty station.

3.5. TEMPORARY NON-DEPLOYABLE CATEGORIES.

a. Medical. Service members are considered temporarily non-deployable for one of three reasons:

(1) Patient. In accordance with DoDI 1120.11, Service members who are hospitalized and are projected to heal, recover, and return to full duty in less than 12 months are temporarily non-deployable.

(2) Medical Condition That Limits Full Duty. Service members who have temporary profiles or are in limited duty status are counted as temporarily non-deployable. Light duty will not be reported as non-deployable unless the duration exceeds 30 days, with discretion given to the medical officer to extend light duty status for up to 60 days, making light duty no longer than 90 days for conditions expected to recover or stabilize within that time.

(3) Pregnancy (including post-partum). Service members who are pregnant or in the post-partum phase are temporarily non-deployable. The post-partum phase ranges from 6 to 12 months after childbirth for female Service members and is determined by individual Service policy.

b. Legal. Service members are considered temporarily non-deployable for one of two reasons:

(1) Prisoner. Service members convicted by civilian or military authorities and sentenced to confinement of more than 30 days, but for 6 months or less, are temporarily non-

deployable. Service members confined for more than 6 months are not included in end strength numbers and will not be included in the monthly non-deployability report.

(2) Legal Action. Service members who are under arrest, confined 30 days or less, pending military or civil court action, under investigation, a material witness, on commander directed hold, pending non-judicial punishment action under Section 815 of Title 10, U.S.C., also known as Article 15 of the Uniformed Code of Military Justice (UCMJ), or pending discharge based on action under the UCMJ are temporarily non-deployable.

c. Administrative. These Service members are considered temporarily non-deployable for one of eight reasons:

(1) Absent Without Leave or Unauthorized Absence. Service members who are absent without leave, as defined in Section 886 of Title 10, U.S.C., also known as Article 86 of the UCMJ, will be considered as temporarily non-deployable.

(2) Family Care Plan. In accordance with DoDI 1342.19, Service members required but failing to have a family care plan in place are temporarily non-deployable.

(3) Adoption. Service members who are single parents or one member of a dual military couple and are adopting a child are temporarily non-deployable. They are non-deployable for at least 6 months after the child is placed in the home, or longer dependent on the administrative stabilization period prescribed by the jurisdiction in which the adoption occurred.

(4) Service Member Under 18. Service members who are not yet 18 years of age are temporarily non-deployable. The Child Soldier Prevention Act of 2007 prohibits Service members under the age of 18 from taking part in hostilities as a member of governmental armed forces.

(5) Humanitarian Assignment. Service members assigned to a location to provide support to a family member are temporarily non-deployable. These Service members typically receive 12 to 24 months stabilization by Military Service policy.

(6) Service Discretion. Military Services may designate Service members temporarily non-deployable when the previous categories do not apply. Examples include:

(a) Simultaneous Membership Program or Officer Candidate School.

(b) Education stabilization; mobilization deferral for affiliation after release from Active Component.

(7) Pending Administrative Separation. Service members being processed for administrative separation are temporarily non-deployable.

(8) Unsatisfactory Participants or Administrative Action Pending (RC Only). Service members who are determined to be unsatisfactory participants, as defined in DoDI 1215.13, are temporarily non-deployable.

3.6. PERMANENT NON-DEPLOYABLE CATEGORIES.

a. Medical. Service members are considered non-deployable for one of three reasons listed below.

(1) Permanent Limited Duty. Service members with a medical condition that permanently prevents deployment are non-deployable. This includes Service members processed through the DES who are not deployable and were retained in the Military Service. In accordance with Section 1214a of Title 10, U.S.C., Service members cannot be involuntarily administratively separated or denied reenlistment due to unsuitability based solely on the medical condition considered in the evaluation unless the request to separate the Service member is approved by the Secretary of Defense. The Military Service may direct the Service member to reenter the DES process to be reconsidered for retirement or separation for disability.

(2) Enrolled in DES. In accordance with DoDI 1332.18, Service members currently enrolled in the DES process are non-deployable. That includes those pending separation or retirement after receiving a "not fit for duty" determination through the DES.

(3) Permanent Profile Non-duty Related Action Needed (RC). Those RC Service members who have a permanent profile and are pending a decision on a line of duty determination are non-deployable.

b. Administrative. These Service members are considered non-deployable for one of three reasons:

(1) Sole Survivor, Surviving Family Member, or Deferred from Hostile Fire Zone. Service members who acquired the status in accordance with DoDI 1315.15 are non-deployable.

(2) Unable to Carry a Firearm. Service members who are subject to the provisions of Section 922 of Title 18, U.S.C. are non-deployable.

(3) Conscientious Objector. Service members who are granted restriction of military duties in accordance with DoDI 1300.06 are non-deployable.

c. Approved for Retention. This category accounts for Service members who are retained by the Military Department despite being in a non-deployable status for 12 months or longer. Service members who the Military Departments retained in Service and are considered non-deployable for one of two reasons:

(1) Combat Wounded. These are Service members whose injuries were the result of hostile action, meet the criteria for awarding of the Purple Heart, and whose injuries were not the result of their own misconduct.

(2) Other. These are Service members who are not designated as combat wounded but are non-deployable and retained in the Military Service by the Secretary of the Military Department in accordance with Paragraph 2.4. of this issuance.

3.7. IMR DEFICITS. These IMR categories are not considered non-deployable conditions. Components are expected to immediately correct all IMR deficits to ensure Service members are medically ready to deploy.

a. Overdue PHA. These Service members are not compliant with the requirement to complete a PHA in accordance with DoDI 6025.19.

b. Dental Readiness (Dental Class 3). Service members who require urgent or emergent dental treatment.

c. Overdue Dental Screening (Dental Class 4). Service members who are not compliant with the requirement to complete a dental screening in accordance with DoDI 6025.19.

d. Additional IMR Categories. In addition to dental categories (Dental Classes 3 and 4) and PHAs, the Military Departments track three additional areas of IMR: immunization status, medical readiness and laboratory studies, and individual medical equipment. In accordance with DoDI 6025.19, Service members who are not current in these areas are considered partially medically ready.

3.8. PRIORITIZATION OF SERVICE MEMBERS BY CATEGORY. This paragraph sets the prioritization for the grouping of Service members into categories to provide consistent reporting among the Military Departments, in accordance with Paragraph 3.1.(b) of this issuance. Service members will be counted only once, in a single category; Service members who may fall into more than one category will be reported in the priorities established in this paragraph. These categories are listed below in descending order of priority.

a. Deployed. This category includes Service members who are currently deployed. These Service members will not be counted in any other category (including deployable with limitations or approved for retention).

b. Deployable with Limitations.

c. Approved for Retention.

(1) Combat wounded – Non-deployable but retained.

(2) Other – Non-deployable but retained.

d. Permanent Non-Deployable.

(1) Medical permanent limited duty.

(2) Administrative.

(a) Sole survivor, surviving family member, or deferred from hostile fire zone.

(b) Unable to carry a firearm (e.g., Lautenberg Amendment).

(c) Conscientious objector.

(d) Ex-prisoner of war.

(3) Medical Enrolled in DES.

(4) Permanent profile non-duty related action needed (RC).

e. Training and Transient.

(1) Initial entry training.

(2) Cadets or Midshipmen.

(3) All other training.

(4) Transient (permanent change of station).

f. Temporary Non-Deployable.

(1) Medical.

(a) Patient (assigned to "Individuals Account").

(b) Medical condition that limits full duty.

(c) Pregnancy (including post-partum).

(2) Legal.

(a) Prisoner.

(b) Legal Action.

(3) Administrative.

(a) Absence without leave.

(b) Family Care Plan.

(c) Adoption.

(d) Service member under 18.

(e) Humanitarian assignment.

(f) Service Discretion.

(g) Pending Administrative Separation.

(h) Unsatisfactory participants or admin action pending (RC).

g. IMR Deficits.

(1) Overdue PHA.

(2) Dental readiness (Dental Class 3).

(3) Overdue dental screening (Dental Class 4).

SECTION 4: RETENTION DETERMINATION

4.1. RETENTION AUTHORITY FOR NON-DEPLOYABLE SERVICE MEMBERS. In accordance with Paragraph 2.4. of this issuance, the Secretaries of the Military Departments have retention authority.

4.2. RETENTION DETERMINATION.

a. The Secretaries of the Military Departments may retain Service members who are non-deployable in excess of 12 consecutive months, on a case-by-case basis, if determined to be in the best interest of the Service, based on:

(1) The Service member's ability to perform appropriate military duties commensurate with his or her office, grade, rank, or skill.

(2) The likelihood that the Service member will resolve the condition or reason that is the underlying cause of his or her non-deployable status.

b. The Secretaries of the Military Departments may approve retention for Service members who are non-deployable in excess of 12 consecutive months for up to:

(1) The length of time remaining on a Service member's enlistment contract; or

(2) Three years for officers, including warrant officers, and those enlisted members serving on indefinite contracts.

(3) Upon expiration of the retention period, the Secretary of the Military Department concerned may renew retention for a Service member on a case-by-case basis for periods stated in this paragraph.

c. The Secretaries of the Military Departments may establish procedures for Service members who are or will be non-deployable for 12 months or longer due to an administrative reason to request retention consideration.

d. Approval of the retention for Service members who are non-deployable for 12 months or longer will only be made for individual Service members, not an entire cohort or skill set of Service members.

e. Except as required by DoDI 1332.18, the Secretaries of the Military Departments may request from the Secretary of Defense the authority to automatically exempt Service members serving in specified positions from the requirement for a retention determinations pursuant to Paragraph 2.4.b.

f. When appropriate, Service members not recommended for further retention will be considered for processing for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30, or referral for disability separation in accordance with DoDI 1332.18.

4.3. SPECIAL CATEGORIES.

a. Pregnant and post-partum Service members, as a group, are exempt from Paragraph 2.4.a., for pregnancy-related health conditions during pregnancy through the post-partum period.

b. The Secretaries of the Military Departments have the authority to retain combat wounded Service members who have been evaluated through the DES and whose reason for non-deployability is a direct result of their combat wounds, if requested by the Service member.

(1) Disapproval of retention for non-deployable combat wounded Service members, who wish to be retained and whose reason for non-deployability is a direct result of their combat wounds, may not be delegated.

(2) Retention will be authorized in accordance with Paragraph 4.2.b.

c. Unless found unfit for duty through the DES, Service members serving in specified positions approved by the Secretary of Defense pursuant to Paragraph 4.2.e. are exempt from requiring a retention determination based solely on being in a non-deployable status for 12 months or longer. Upon reassignment, these Service members will again require a retention determination in accordance with Paragraph 4.2.a.

d. Unless sooner discharged or retired under another provision of law, or discharged due to misconduct or sub-standard performance, the Secretaries of the Military Departments may retain those Service members who are, or will be, non-deployable for 12 months or longer due to administrative reasons and who have attained such years of creditable service so as to be within 3 years of qualifying for:

(1) Regular retirement (or in the case of enlisted members of the Navy or Marine Corps, transfer to the Fleet Reserve or Fleet Marine Corps Reserve, as the case may be) pursuant to Sections 3911, 3914, 6323, 6330, 8911, or 8914 of Title 10, U.S.C.; or

(2) Non-regular retirement (but for age) pursuant to Sections 12731 and 12735 of Title 10, U.S.C., if, in the case of RC members other than RC members within 3 years of qualifying for regular retirement, they have attained at least 17 years of qualifying creditable service as computed in accordance with Section 12732 of Title 10, U.S.C., and continue to attain qualifying creditable service as computed under attains Section 12732 of Title 10, U.S.C. to become eligible for non-regular retirement within the 3-year period.

SECTION 5: AUTHORITIES FOR SEPARATIONS AND RETIREMENTS

5.1. In accordance with Paragraph 1.2. of this issuance, a Service member who has been non-deployable for an administrative reason (not medical or legal) for more than 12 consecutive months, will be processed for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30. Military Services should ensure expeditious administrative separation proceedings in accordance with Military Department and Military Service policies.

5.2. A Service member who has been non-deployable due to a physical disability that makes him or her potentially unfit for the duties of his or her office, grade, rank, or rating for more than 12 consecutive months will be referred into the DES in accordance with DoDI 1332.18.

GLOSSARY

G.1. ACRONYMS.

ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
DES	Disability Evaluation System
DoDI	DoD instruction
IMR	individual medical readiness
PHA	periodic health assessment
RC	Reserve Component
UCMJ	Uniformed Code of Military Justice
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness.

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

active duty. Defined in the DoD Dictionary of Military and Associated Terms.

active service. Defined in Section 101(d)(3) of Title 10, U.S.C.

active status. Defined in Section 101(d)(4) of Title 10, U.S.C.

combat wounded. Service members whose injuries were the result of hostile action, who meet the criteria for awarding of the Purple Heart, and whose injuries were not the result of their own misconduct.

deployable. A Service member who does not have a Service-determined reason that precludes him or her from deployment.

deployment. The movement of personnel into and out of an operational area or in support of operations. Deployment encompasses all activities from origin or home station through destination, specifically including inter-theater, and intra-theater movement legs, staging, and holding areas.

Military Departments. The Departments of the Army, Navy, and Air Force.

Military Service Headquarters. Headquarters, United States Army; Headquarters, United States Navy; Headquarters, United States Air Force; and Headquarters, United States Marine

Corps.

Military Services. The United States Army, the United States Navy, the United States Air Force, and the United States Marine Corps.

military specialty. A military occupational specialty in the Army and the Marine Corps; an Air Force specialty code in the Air Force; or a rating or Navy enlisted classification in the Navy.

non-deployable. A Service member who has a Service-determined reason that precludes him or her from deployment.

permanently non-deployable. A Service member who has a reason that precludes them from deployment, and there is a Service expectation that the reason will not be resolved and the Service member will never be deployable.

profile. A document used to communicate to commanders the individual medical restrictions for Soldiers and Airmen.

Ready Reserve. Defined in the DoD Dictionary of Military and Associated Terms.

reason code. The term used to define non-deployable categories.

separation. A general term that includes discharge, release from active duty, release from custody and control of the Military Services, transfer to the Individual Ready Reserve, and similar changes in Active and Reserve status.

temporarily non-deployable. A Service member who has a reason or reasons that precludes him or her from deployment, and there is a Service expectation that the reason or reasons will be resolved and the Service member will be deployable.

REFERENCES

DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
DoD Instruction 1120.11, "Programming and Accounting for Active Component (AC) Military Manpower," March 17, 2015
DoD Instruction 1215.13, "Ready Reserve Member Participation Policy" May 5, 2015
DoD Instruction 1300.06, "Conscientious Objectors," July 12, 2017
DoD Instruction 1315.15, "Special Separation Policies for Survivorship," May 19, 2017
DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended
DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014, as amended
DoD Instruction 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018
DoD Instruction 1342.19, "Family Care Plans," May 7, 2010, as amended
DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014
DoD Instruction 6490.07. "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees" February 5, 2010
DoD Manual 8910.01, Volume 1, "DoD Information Collections Manual: Procedures for DoD Internal Information Collections," June 30, 2014, as amended
Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition
The Child Soldier Prevention Act of 2007, 110th Congress, S.1175
United States Code, Title 10
United States Code, Title 18

Department of Defense
INSTRUCTION

NUMBER 6485.01
June 7, 2013

USD(P&R)

SUBJECT: Human Immunodeficiency Virus (HIV) in Military Service Members

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)), this instruction reissues DoD Instruction (DoDI) 6485.01 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV.

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. POLICY. It is DoD policy to:

a. Deny eligibility for military service to persons with laboratory evidence of HIV infection for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03 (Reference (c)).

b. Periodically screen Service members for HIV infection.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Unlimited**. This instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

7. EFFECTIVE DATE. This instruction:

a. Is effective June 7, 2013.

b. Must be reissued, cancelled, or certified current within 5 years of its publication in accordance with DoDI 5025.01 (Reference (d)). If not, it will expire effective June 7, 2023 and be removed from the DoD Issuances Website.

Jessica L. Wright
Acting Under Secretary of Defense for
Personnel and Readiness

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006 (hereby cancelled)
(c) DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
(d) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012
(e) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012
(f) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," January 3, 2006
(g) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(h) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
(i) DoD 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance Program (CQA) Regulation," June 11, 2004
(j) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
(k) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as amended
(l) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986
(m) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) provides overall policy implementation guidance for:

a. The personnel management of Service members with laboratory evidence of HIV infection.

b. Compliance with host-nation requirements for screening and related matters for Service members.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA) provides overall policy implementation guidance for the medical management of Service members with laboratory evidence of HIV infection and for health education programs to prevent the transmission of HIV.

3. UNDER SECRETARY OF DEFENSE FOR POLICY (USD(P)). The USD(P):

a. Identifies or confirms host-nation HIV screening and other related requirements and transmits this information to the USD(P&R).

b. Coordinates matters involving host-nation screening and other related requirements with the Department of State.

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Implement this instruction and any guidance issued under the authority of this instruction.

b. Report HIV test results to the Defense Medical Surveillance System pursuant to DoDD 6490.02E (Reference (e)).

c. Direct health care personnel providing medical care to follow the recommendations of the Centers for Disease Control and Prevention for preventing HIV transmission in health-care settings.

ENCLOSURE 3

PROCEDURES

1. TESTING AND SCREENING

a. Applicants for appointment, enlistment, or individuals being inducted into the Military Services will be screened for laboratory evidence of HIV infection in accordance with Reference (c).

b. Applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs will be tested for laboratory evidence of HIV within 72 hours of arrival to the program and denied entry to the program if such test is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV not later than during their commissioning physical examination, and denied a commission if they test positive.

c. All Service members will be screened periodically for laboratory evidence of HIV infection.

(1) Active duty (AD) and Reserve Component (RC) Selected Reserve (SELRES) personnel will be routinely screened every 2 years unless more frequent screenings are clinically indicated.

(2) Members of the SELRES will be screened at least once every 2 years. RC personnel will be screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.

(3) Testing for laboratory evidence of HIV for pre- and post-deployment must be conducted in accordance with DoDI 6025.19 (Reference (f)) and DoDI 6490.03 (Reference (g)).

d. A serum sample from all HIV force screenings will be forwarded to the DoD Serum Repository as directed by Reference (e).

2. MANAGEMENT

a. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection will be conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines, as described in DoDI 6025.13 and DoD 6025.13-R (References (h) and (i)).

b. In accordance with DoDI 6490.07 (Reference (j)), the cognizant Combatant Command surgeon will be consulted in all instances of HIV seropositivity before medical clearance for deployment.

c. An AD Service member with laboratory evidence of HIV infection will be referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses in accordance with DoDI 1332.38 (Reference (k)). An AD Service member with laboratory evidence of HIV infection determined to be fit for duty will be allowed to serve in a manner that ensures access to appropriate medical care.

d. An RC Service member with laboratory evidence of HIV infection will be referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for active duty for a period of more than 30 days will be denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members who are not on active duty for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, will be transferred involuntarily to the Standby Reserve only if they cannot be used in the SELRES.

e. AD and RC Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty will be separated or retired pursuant to Reference (k).

3. TRANSMISSION CONTROL. Transmission of HIV will be controlled through aggressive disease surveillance and health education programs for Service members. A Service member with laboratory evidence of HIV infection will receive training on the prevention of further transmission of HIV infection to others and the legal consequences of exposing others to HIV infection.

4. ADVERSE PERSONNEL ACTION. Information obtained during or primarily as a result of an epidemiologic assessment interview will not be used to support any adverse personnel action against the Service member in accordance with section 705(c) of Public Law 99-661 (Reference (l)). This prohibition does not apply to the use of such information for otherwise authorized rebuttal or impeachment purposes.

5. PRIVACY. The privacy of a Service member with laboratory evidence of HIV infection will be protected consistent with DoD 5400.11-R and DoD 6025.18-R (References (m) and (n)).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AD	active duty
ASD(HA)	Assistant Secretary of Defense for Health Affairs
DoDD	DoD Directive
DoDI	DoD Instruction
HIV	human immunodeficiency virus
RC	Reserve Component
SELRES	Selected Reserves
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USD(P)	Under Secretary of Defense for Policy

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this instruction.

adverse personnel action. A court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons.

epidemiologic assessment interview. Questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes.

HIV. The virus(es) associated with the acquired immune deficiency syndrome (commonly referred to as "AIDS").

laboratory evidence of HIV infection. A reactive and confirmed serologic result, and/or, reactive or quantitative nucleic acid result for HIV infection according to a Food and Drug Administration-approved test.

Department of Defense

INSTRUCTION

NUMBER 6490.07
February 5, 2010

USD(P&R)

SUBJECT: Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)) and the guidance in DoDDs 6200.04 and 1400.31 (References (b) and (c)), this Instruction establishes policy, assigns responsibilities, and provides procedures for ensuring that Service members and DoD civilian employees, including Coast Guard Service members and civilian employees at all times, including when the Coast Guard is a Service in the Department of Homeland Security by agreement with that Department, (hereafter referred to collectively as "DoD personnel") deployed and deploying on contingency deployments are medically able to accomplish their duties in deployed environments.

2. APPLICABILITY. This Instruction:

a. Applies to:

(1) OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as the "DoD Components").

(2) DoD personnel deployed and deploying on contingency deployments consistent with DoD and Service-specific guidance, including Reference (c) and DoD Instruction (DoDI) 1400.32 (Reference (d)).

b. Does not apply to contingency contractor personnel, who shall comply with the guidance in DoDI 3020.41 (Reference (e)), or to shipboard operations that are not anticipated to involve operations ashore, which shall follow Service-specific guidance.

c. Shall be used as a minimum medical standard for all deploying and deployed DoD personnel, BUT does not alter or replace:

(1) With respect to military personnel, the accession, retention, and general fitness for duty standards previously established by the Department of Defense, including those described in DoDI 6130.4, DoDD 6130.3, Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Memorandum, Assistant Secretary of Defense for Health Affairs (ASD(HA)) Memorandum, and DoDI 6485.01 (References (f) through (j), respectively).

(2) With respect to civilian employees covered by sections 791 and 794a of title 29, United States Code (also known and hereafter referred to as "The Rehabilitation Act of 1973, as amended" (Reference (k))), the legal obligations of a DoD Component as an employer pursuant to that Act.

(3) More stringent individual Military Department policy guidance or Service-specific readiness requirements.

3. DEFINITIONS. These terms and their definitions are for the purpose of this Instruction.

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

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

c. deployment. The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

d. medical assessment. The total of the pre-deployment activities described in section 1 of Enclosure 2 of this Instruction and those listed in paragraph E4.A1.1 of DoDI 6490.03 (Reference (l)).

e. trained DoD health-care provider. A physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, independent duty medical technician, or special forces medical sergeant.

4. POLICY. It is DoD policy that:

a. The medical standards in this Instruction are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

b. DoD personnel with existing medical conditions may deploy based upon a medical assessment as described in Enclosure 2 and subparagraph E4.A1.1.1. of Reference (l), which for civilian employees shall be consistent with subparagraph 4.g.(3)(c) of DoDD 1404.10 (Reference (m)), and the requirements of The Rehabilitation Act of 1973, as amended, when such civilian employees are covered by that Act, if all of these conditions are met:

(1) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

(2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

(3) Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the Military Health System. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

(4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

(5) In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, it is determined, based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

c. Individuals with the conditions in Enclosure 3, based on medical assessments in accordance with Enclosure 2 and Reference (l), shall not deploy unless a waiver can be granted according to the procedures in section 3 of Enclosure 2.

d. If a Service member is found qualified for retention with no limitations on assignments or deployments following evaluation of a medical condition by competent medical and personnel authority of his or her respective Service, and if the condition remains stable, a deployment waiver of that same condition is not required by this Instruction.

e. Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical

capabilities of the deployment. These additional standards must be consistent with The Rehabilitation Act of 1973, as amended, when applied to civilian employees covered by that Act.

f. Protected health information collected, used, and released in the execution of this Instruction shall be protected as required by DoD 6025.18-R (Reference (n)) and DoD 8580.02-R (Reference (o)).

5. RESPONSIBILITIES. See Enclosure 4.

6. PROCEDURES. See Enclosure 2.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Web Site at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. This Instruction is effective immediately.

Gail H. McGinn
Deputy Under Secretary of Defense (Plans)
Performing the Duties of the
Under Secretary of Defense for
Personnel and Readiness

Enclosures:
1. References
2. Procedures
3. Medical Conditions Usually Precluding Contingency Deployment
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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004
(c) DoD Directive 1400.31, "DoD Civilian Work Force Contingency and Emergency Planning and Execution," April 28, 1995
(d) DoD Instruction 1400.32, "DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures," April 24, 1995
(e) DoD Instruction 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces," October 3, 2005
(f) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005
(g) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, and Induction," December 15, 2000
(h) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Guidance for Medical Deferral," February 9, 2006
(i) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications," November 7, 2006
(j) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006
(k) Sections 791 and 794a of title 29, United States Code (also known as "The Rehabilitation Act of 1973, as amended")
(l) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(m) DoD Directive 1404.10, "DoD Civilian Expeditionary Workforce," January 23, 2009
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(o) DoD 8580.02-R, "DoD Health Information Security Regulation," July 12, 2007

ENCLOSURE 2

PROCEDURES

1. PERFORMANCE OF MEDICAL ASSESSMENTS. All DoD personnel serving in a contingency deployment as defined in section 3 of the front matter of this Instruction must undergo a medical assessment prior to deployment in accordance with subparagraph E4.A1.1.1. of Reference (l). The mandatory portions of the assessment are:

a. Completion of DD Forms 2795, "Pre-Deployment Health Assessment," and 2766, "Adult Preventive and Chronic Care Flowsheet" (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). Except for Coast Guard personnel, completed copies of both of these forms must be submitted to the Defense Medical Surveillance System and included in DoD personnel deployment paperwork, and shall serve as the deployment medical record. For Coast Guard personnel, the DD Form 2766 shall be placed in the member's health record, but all other procedures for Coast Guard personnel shall be as described in this Instruction for DoD personnel.

b. Medical record review.

c. Current periodic health assessment (Service members only).

d. Physical exam within 1 year of deployment (DoD civilian employees only).

2. DETERMINATIONS OF DEPLOYABILITY. A trained DoD health-care provider must make a provisional determination on DD Form 2795 as to the deployability of DoD personnel. This decision should be based on all of the information obtained in the medical assessment described in section 1 of this enclosure.

a. In general, DoD personnel with any of the medical conditions in Enclosure 3, and based on a medical assessment, shall not deploy unless a waiver is granted. Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in the deployed environment.

(1) For civilian employees covered by The Rehabilitation Act of 1973, as amended, it must be determined, before deployment and based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

(2) The requirement to provide reasonable accommodations for disabilities does not apply to deployment of military members, nor to civilian employees not covered by The Rehabilitation Act of 1973, as amended.

b. All individuals deemed not deployable at the deployment processing center shall be returned to their originating unit with a DD Form 2795 and a summary of their non-deployable medical condition to provide to the unit medical personnel. The civilian supervisor shall also be notified if the individual is deemed not deployable.

3. WAIVERS. If a commander or supervisor of DoD personnel (except for SOF personnel) wishes to deploy an individual with a medical condition that could be disqualifying (see Enclosure 3, the commander or supervisor must request a waiver. The waiver request shall be submitted to the applicable Combatant Commander through the individual's servicing military medical unit in the case of a Service member, or through the individual's personnel office in the case of a civilian employee, with medical input provided by the individual's medical provider.

a. Requests for a waiver shall include a summary of a detailed medical evaluation or consultation concerning the medical condition(s). Maximization of mission accomplishment and the protection of the health of personnel are the ultimate goals. Justification shall include statements indicating service experience, position to be placed in, any known specific hazards of the position, anticipated availability and need for care while deployed, the benefit expected to accrue from the waiver, the recommendation of the commander or supervisor, and the reasonable accommodations that can be provided for civilian employees covered by The Rehabilitation Act of 1973, as amended. For all DoD personnel, the factors listed in subparagraphs 4.b.(1) through 4.b.(4), (and subparagraph 4.b.(5) for civilian employees only) of the front matter shall be discussed.

b. For SOF personnel with any of the conditions listed in Enclosure 3, medical clearance may be granted by the CDRUSSOCOM, subject to the approval of the Combatant Commander under which the Service member is deployed or will deploy.

c. In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, a waiver must be granted if it is determined, based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

4. ROLES AND RESPONSIBILITIES

a. Commanders and Supervisors. Commanders and supervisors shall:

(1) Ensure deploying DoD personnel are appropriately assessed by competent medical authority before deployment, in accordance with Reference (l).

(2) Request waivers for DoD personnel they wish to deploy who have the medical conditions described in Enclosure 3.

(3) Ensure that DoD personnel under their command meet the medical standards of the gaining commander when individuals and their leaders deploy in support of other DoD Components. As these standards may differ by assignment, they must be coordinated separately for each deployment.

b. Supervisors. Supervisors shall additionally:

(1) Identify medical and physical requirements for deployable positions designated for fill by DoD civilian employees.

(2) Ensure that such requirements are documented in position descriptions, vacancy announcements, and other appropriate sources.

(3) Ensure that DoD civilian employees meet such requirements; take appropriate action when employees no longer meet identified requirements.

c. DoD Personnel

(1) DoD personnel in deployable positions shall be responsible for meeting the medical and physical requirements of their deployment-specific tasks.

(2) DoD personnel who are civilian employees selected for deployment opportunities outside their chain of supervision shall be responsible for meeting and maintaining the medical standards identified for the deployment by the responsible commanding officer.

ENCLOSURE 3

MEDICAL CONDITIONS USUALLY PRECLUDING CONTINGENCY DEPLOYMENT

This list of conditions is not intended to be all-inclusive. A list of all possible diagnoses and their severity that may cause an individual to be potentially non-deployable, pending further evaluation, would be too extensive. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, individuals with the conditions in paragraphs a. through h. of this enclosure, based upon a medical assessment as described in Enclosure 2 and Reference (l), shall not deploy unless a waiver is granted.

a. Conditions Affecting Force Health Protection

(1) Physical or psychological conditions resulting in the inability to effectively wear personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical and/or biological protective garments, regardless of the nature of the condition that causes the inability to wear the equipment if wearing such equipment may be reasonably anticipated or required in the deployed location.

(2) Conditions that prohibit immunizations or the use of force health protection prescription products (FHPPPs) required for the specific deployment. Depending on the applicable threat assessment, required FHPPPs may include atropine, epinephrine, and/or pralidoxime chloride (2-PAM chloride) auto-injectors; certain antimicrobials and antimalarials; and pyridostigmine bromide.

b. Unresolved Health Conditions Requiring Care or Affecting Performance

(1) Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity.

(2) Absence of a dental exam within the last 12 months or presence of the likelihood that dental treatment or reevaluation for oral conditions will result in dental emergencies within 12 months. Individuals being evaluated by a non-DoD civilian dentist should use DD Form 2813, "DoD Active Duty/Reserve Forces Dental Examination," as proof of dental examination (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm).

(3) Pregnancy.

(4) Any medical condition that requires either durable medical equipment or appliances, or periodic evaluation or treatment by medical specialists that is not readily available in theater.

(5) Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment.

(6) Cancer that requires continuing treatment or specialty medical evaluations during the anticipated duration of the deployment.

(7) Precancerous lesions that have not been treated and/or evaluated and that require treatment and/or evaluation during the anticipated duration of the deployment.

(8) Any medical condition that requires surgery or for which surgery has been performed that requires rehabilitation or additional surgery to remove devices.

(9) Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment.

(10) An acute exacerbation of a physical or mental health condition that could significantly affect duty performance.

c. Conditions That Could Cause Sudden Incapacitation

(1) Recurrent loss of consciousness for any reason.

(2) Any medical condition that could result in sudden incapacitation including a history of stroke within the last 24 months, seizure disorders, and diabetes mellitus type I or II treated with insulin or oral hypoglycemic agents.

d. Pulmonary Disorders. Asthma that has a forced expiratory volume-1 (FEV-1) of less than or equal to 60 percent of predicted FEV-1 despite appropriate therapy and that has required hospitalization at least 2 times in the last 12 months, or that requires daily systemic (not inhalational) steroids.

e. Infectious Disease

(1) Active tuberculosis or known blood-borne diseases that may be transmitted to others in a deployed environment.

(2) A diagnosis of human immunodeficiency (HIV) antibody positive with the presence of progressive clinical illness or immunological deficiency. The cognizant Combatant Command surgeon shall be consulted in all instances of HIV seropositivity before medical clearance for deployment.

f. Sensory Disorders

(1) Hearing Loss. The requirement for use of a hearing aid does not necessarily preclude deployment. However, the individual must have sufficient unaided hearing to perform duties safely.

(2) Vision Loss. Best corrected visual acuity must meet job requirements to perform duties safely.

g. Cardiac and Vascular Disorders

(1) Hypertension not controlled with medication or that requires frequent monitoring.

(2) Symptomatic coronary artery disease.

(3) History of myocardial infarction within 1 year of deployment.

(4) History of coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within 1 year of deployment.

(5) Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medical or electrophysiologic control (presence of an implanted defibrillator and/or pacemaker).

(6) Heart failure.

h. Mental Health Disorders

(1) Psychotic and/or bipolar disorders. (See Reference (i) for detailed guidance on deployment-limiting psychiatric conditions or psychotropic medications.)

(2) Psychiatric disorders under treatment with fewer than 3 months of demonstrated stability.

(3) Clinical psychiatric disorders with residual symptoms that impair duty performance.

(4) Mental health conditions that pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.

(5) Chronic medical conditions that require ongoing treatment with antipsychotics, lithium, or anticonvulsants.

ENCLOSURE 4

RESPONSIBILITIES

1. ASD(HA). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall review and issue to the Secretaries of the Military Departments and the Directors of the Defense Agencies and the DoD Field Activities technical adjustments to the deployment standards in Enclosure 3 as needed, based on changing conditions or additional unanticipated difficulties encountered in the in-theater management of medical conditions.

2. SECRETARIES OF THE MILITARY DEPARTMENTS, COMMANDANT OF THE COAST GUARD, AND DIRECTORS OF THE DEFENSE AGENCIES AND THE DoD FIELD ACTIVITIES. The Secretaries of the Military Departments, the Commandant of the Coast Guard, and the Directors of the Defense Agencies and the DoD Field Activities shall:

a. Direct their respective Components to apply and uniformly implement the standards in this Instruction.

b. Ensure that:

(1) All deploying DoD personnel assigned to their respective Service, Defense Agency, or DoD Field Activity have a medical assessment in accordance with Reference (l), including a medical record review, to evaluate their medical status before contingency deployments and other deployments pursuant to paragraph 4.a. of the front matter of this Instruction.

(2) Pre-deployment processes are in place to identify individuals with deployment-limiting medical conditions.

(3) DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

3. CHAIRMAN OF THE JOINT CHIEFS OF STAFF. The Chairman of the Joint Chiefs of Staff shall ensure that the Combatant Commanders:

a. Establish a minimum standard when developing medical requirements for entering the theater of operations that factors in the medical conditions described in Enclosure 3 of this Instruction.

b. Implement a medical requirements waiver process that includes waiver computerization and archival storage.

4. COMBATANT COMMANDERS. For all DoD personnel deployed or deploying to a theater within their respective Combatant Commands, the Combatant Commanders shall:

a. Establish a process for reviewing recommendations from the Services regarding the granting of exceptions to medical standards (waivers) for the conditions in Enclosure 3, including a mechanism to track and archive all approved or denied waivers and the medical conditions requiring the waivers.

b. Serve as the final approval authority for exceptions to the medical standards (waivers) made pursuant to the procedures in this Instruction.

5. COMMANDER, UNITED STATES SPECIAL OPERATIONS COMMAND (CDRUSSOCOM). The CDRUSSOCOM shall perform the responsibilities in section 2 of this enclosure for SOF personnel.

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 10-203

20 NOVEMBER 2014

Operations

DUTY LIMITING CONDITIONS

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This publication implements Air Force Policy Directive (AFPD) 10-2, *Readiness*. This Instruction describes how to communicate to Commanders the individual restrictions for Airmen due to medical reasons throughout the Air Force (AF). The application of restrictions is a Commander's program that is based on medical recommendations. This Instruction applies to all Regular Air Force (RegAF), Air National Guard (ANG) and Air Force Reserve Command (AFRC) Airmen (for the purposes of this Instruction, the term Airmen refers only to military members). It interfaces with AFPD 44-1, *Medical Operations,* and AFPD 48-1, *Aerospace Medicine Program*. This publication may be supplemented at any level, but all supplements must be routed to the Office of Primary Responsibility (OPR) listed above for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR listed above using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate chain of command. The authorities to waiver wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1. for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate tier waiver approval authority, or alternately, to the publication OPR for non-tiered compliance items. This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Authority to collect and maintain records prescribed in this AFI are outlined in Title 10, United States Code, Sections 1071-1097b. The applicable Privacy Act System Notice is F044 F SG E, Electronic Medical Records System. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of in accordance with the Air Force Records

Disposition Schedule (RDS) located in the Air Force Records Information Management System (AFRIMS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. The major changes include: Tiers were added for waiver authority for Wing Level or below requirements. Clarification was made on the location of initial Review-in-lieu-of Medical Board (RILO) review for the Air Reserve Component (ARC) to align with AFI 41-210, *TRICARE Operations and Patient Administration Functions*. Updates were made to realign Public Health and Medical Standards Management Element functions. The Exercise Physiologist and exercise prescription references were removed. There is no longer a requirement by this AFI for an exercise prescription.

Chapter 1

GENERAL PROVISIONS

1.1. Purpose. This Instruction establishes procedures for the documentation and administrative management of Airmen with injuries or illnesses that may impact their ability to perform their military duty. These procedures have been developed to ensure maximum utilization and readiness of personnel, while preserving their health and minimizing risk of further injury or illness. This Instruction and AFI 41-210, *TRICARE Operations and Patient Administration Functions,* describe appropriate courses of action for Integrated Disability Evaluation System (IDES) pre-screening disposition when individuals have medical conditions potentially affecting their continued retention for military service or deployability in the Air Force (AF), as outlined by the standards per AFI 48-123, *Medical Examinations and Standards*.

1.1.1. This Instruction provides a method to communicate medical recommendations to Commanders. This will allow optimum utilization of Airmen in their charge within the guidelines of the medical recommendations and ensure timely return to duty following medical evaluations related to potentially unfitting conditions.

1.1.2. Commanders may consult with the medical unit's Senior Profiling Officer (SPO) to maximize use of personnel with Duty Limiting Conditions (DLCs). An assessment based on operational risk of personnel assigned to a unit is critical to maintaining unit readiness at the highest degree possible.

1.1.3. Purpose of AF Form 422, *Duty Limiting Condition Repor*t. The AF Form 469 is used to describe physical limitations and recommend duty restrictions (DR) to the Commander when there is a potential risk to an Airman's health, safety and well-being, the safety of the mission, or the ability of the Airman to effectively accomplish the mission. Additionally, the AF Form 469 is used to convey limitations related to the AF Fitness Program (FP) as well as Fitness Assessment Exemptions (FAE). In general, the AF Form 469 will describe an Airman's limitations and Fitness Assessment Clearance/Exemptions.

1.1.4. Purpose of AF Form 422, *Notification of Air Force Member's Qualification Status*. The AF Form 422 is used for initial qualification, qualification for retirement or separation, military retraining, Permanent Change of Station (PCS), Professional Military Education (PME), and similar functions as directed in this or other guidance. The AF Form 422 describes what an Airman is qualified to do based on medical assessment (unless specifically directed otherwise, as in paragraph 3.3.2.1 of this Instruction).

1.2. Physical Profile System to include Physical Profile Serial Chart (PULHES). The physical profile system classifies individuals according to physical/functional abilities and long term availability for worldwide duty IAW AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted),* Air Force Officer Classification Directory (AFOCD) and enlisted structure found in the Air Force Enlisted Classification Directory (AFECD).

1.2.1. Applicability. The physical profile system applies to the following categories of personnel:

1.2.1.1. Applicants for appointment, enlistment, and induction into military service.

1.2.1.2. AD, and ARC Airmen; USAF Academy and Reserve Officers' Training Corps (ROTC) cadets; and students in the Uniformed Services University of Health Sciences (USUHS) and Health Professions Scholarship Program (HPSP).

1.2.2. Profiles. Profiles are descriptions of transient or permanent limitations to functioning which are used for establishing suitability for career fields or Air Force Specialty Codes (AFSC). A profile can be established on a DD Form 2808, *Report of Medical Examination*, an AF Form 422, or other forms as directed. Once a profile is established, it is considered current unless updated during a Preventive Health Assessment (PHA), the Airman has undergone a RILO (with or without initiation of an Assignment Limitation Code C (ALC-C)), Medical Evaluation Board (MEB), or a World Wide Duty (WWD) or Fitness for Duty (FFD) evaluation (ARC only), or has a current duty or mobility restriction (MR) of at least 6 months duration. See paragraph 3.1.2. of this Instruction for further guidance.

1.3. Duty limitations. Duty limitations are entered on the AF Form 469. Duty limitations will indicate what the member cannot do based on their current occupational duties with resultant mobility and/or fitness restrictions if appropriate. (T-2) The maximum allowable duration of the AF Form 469 following RILO or MEB is 15 months. (T-2) For any other restrictions the maximum allowable duration of the AF Form 469 is 365 days. (T-2) DLCs annotated on an AF Form 469 must be reviewed for appropriateness and accuracy at every clinical encounter between the Airman and a provider. (T-2) Additionally, the AF Form 469 must be re-validated and renewed or revised, as appropriate, at each PHA at a minimum. (T-1) See Chapter 3 of this Instruction for further guidance.

1.3.1. Any DLC which restricts mobility for a cumulative period of 365 days or may be considered unfitting for continued military service must undergo a review by the Deployment Availability Working Group (DAWG) for an Initial RILO referred to HQ AFPC Medical Retention Standards Branch (DPANM), or the appropriate ARC Chief of Aerospace Medicine (SGP), IAW AFI 48-123 and AFI 41-210. (T-1) The Initial RILO at DPANM or ARC SGP may result in Return To Duty (RTD) without restrictions, RTD with ALC-C, referral for MEB, or other outcomes as directed by DPANM or ARC SGP. See paragraph 4.2 of this Instruction for further guidance.

1.3.2. Aeromedical Services Information Management System (ASIMS) can track up to three DLCs simultaneously; however, an Airman may only have one active AF Form 469 at a time. (T-1) If a provider desires to add a new diagnosis to an existing AF Form 469, the mobility impact of the restriction and desired release date of the new functional limitations secondary to the new diagnosis must be considered in light of the existing AF Form 469 functional restrictions and dates (see AFI 10-203 Supplemental Guidance). (T-1) If the new diagnosis is mobility restricting and the release date will not exceed the maximum duration of the existing AF Form 469, the provider can edit the existing AF Form 469 and add the new functional limitations due to the new diagnosis. If the new diagnosis is mobility restricting and will exceed the maximum duration of the existing AF Form 469, the provider must re-accomplish an AF Form 469 including any pre-existing limitations. (T-1) If the new diagnosis is not mobility restricting, the existing AF Form 469 will allow the addition of the new diagnosis and an extended release date not greater than 365 days. **Note:** ASIMS maintains a record of all previous AF Form 469s.

1.3.3. Individuals may have up to three distinct medical conditions requiring DRs, MRs and/or FRs on an AF Form 469 with up to three separate expiration dates. If there is more than one diagnosis on the AF Form 469, the provider will indicate functional limitations (if any) and expiration date of each duty or MR in the "Restrictions" section, as well as limitations to fitness activities. (T-2) This will prevent the medical staff from having to initiate a new AF Form 469 when one set of restrictions reaches the expected release date, but the patient's status in terms of the AF Form 469 remains otherwise unchanged. If a MR expires prior to a DR, the AF Form 469 will allow an extended release date for the DR. (T-2)

1.4. Special Considerations.

1.4.1. ARC unique issues. For ARC Airmen, refer to AFI 48-123 and AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*.

1.4.1.1. For purposes of this Instruction, the term Medical Treatment Facility (MTF) will be used to refer to all AD and ARC Medical Units, unless otherwise specified as AD MTF for AD, Reserve Medical Unit (RMU) for AFRC, or Guard Medical Unit (GMU) for ANG units.

1.4.1.2. Medical Standards Management Element (MSME) is an AD element. The function of the MSME is executed by a 4N0X1 in AFRC and a full-time health technician for the ANG, or otherwise as directed. For the purpose of this Instruction, the term MSME will be used to include the AD and ARC functions.

1.4.2. Refusal to obtain medical evaluation or treatment. After evaluation by medical consultants, Airmen who refuse to obtain further medical evaluations or treatment for potentially disqualifying defects, as required or recommended, will be referred by the DAWG to DPANM or ARC SGP as applicable for Initial RILO or Fit for Duty (FFD) determination IAW AFI 41-210. (T-1) DPANM or ARC SGP will consider the Airman's retainability in the service with the medical condition in its current state and the probability of progression of disease or worsening of the medical condition without the recommended medical treatment. Depending on the final disposition of the case, the Airman may not be eligible for military disability payment and may be subject to involuntary separation under AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officer;* AFI 36-3208, *Administrative Separation of Airmen*; AFI 36-3209, or AFI 48-123.

1.4.2.1. Second opinion. Any Airman with a potentially disqualifying condition has the option of seeking a second opinion to explore treatment options. The second opinion must be provided by a consultant arranged through MTF referral processes, unless an ARC member is seeking a second opinion during a Fitness for Duty (FFD)/World-wide Duty (WWD) determination for a condition found Not in the Line of Duty (NILOD). (T-1) When both medical opinions agree and the Airman refuses all treatment options provided, an Initial RILO must be accomplished. (T-1) If the medical opinions differ, the Airman may choose one of the treatment options given. Further medical opinions will only be considered upon appeal to the MTF SGH who will determine whether the evaluation or treatment is a covered benefit which is deemed by the SGH to be medically necessary. (T-2)

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. Chief of Staff of the Air Force. Establishes AF personnel readiness goals and standards and is responsible for Force Readiness, including medical readiness to ensure the AF can meet national requirements.

2.2. Air Force Surgeon General. Establishes medical standards and procedures for recommending duty limitations.

2.3. Air Force Medical Operations Agency (AFMOA) Aerospace Medicine.

2.3.1. Provides implementation guidance to Major Commands (MAJCOM) and MTFs on medical standards and procedures.

2.3.2. Acts as liaison between MAJCOMs and Air Force Medical Support Agency (AFMSA).

2.4. MAJCOM SGP or ARC/SGP shall:

2.4.1. Act as liaison between the MTF and AFMOA.

2.4.2. Provide MAJCOM trend analysis (using de-identified, aggregate data) on duty limitations and reports to MAJCOM/CC as requested.

2.4.3. Act as liaison between MTFs and the Combatant Command (COCOM) SG for DLC issues that might impact the COCOM mission. See paragraphs 2.7.2. and 3.4.1.1. of this Instruction for additional guidance.

2.4.4. **(ARC/SGP only)** review all RILO/FFD cases as required by AFI 41-210.

2.4.5. Identifies Total Force Enterprise medical manpower requirements to accomplish requirements within this AFI and incorporates them into the Business Case Analysis and Program Operational Memorandum process. See AFI 48-149, *Flight and Operational Medicine Program*, for additional requirements.

2.5. Installation Communications Squadron/Group shall.

2.5.1. Assist the MTF to ensure communication requirements for the DLC program are met. (T-2)

2.5.2. Ensure providers/clinical staff, MSME, SGP, Public Health (PH) and Chief of the Medical Staff (SGH) access to the ASIMS Web and Armed Forces Health Longitudinal Technology Application (AHLTA), as applicable. (T-2)

2.6. MTF Commander (MTF/CC) shall: Note: MTF/CC for ARC medical units may delegate these responsibilities to SGP or SGH as deemed appropriate.

2.6.1. Ensure timely scheduling and appropriate completion of required examinations and consultations for Airmen with mobility limiting conditions (does not apply to ARC Airmen with non-duty related conditions) IAW this Instruction and supplemental guidance. (T-2)

2.6.2. Ensure timely submission of RILOs to DPANM or ARC SGP as applicable. (T-2)

2.6.3. Develop policies and/or guidance to ensure that a process for expeditious referrals (e.g. within 72 hours) is available for providers when such determination is necessary for an Airman to avoid delay or to prevent failure of a mobility mission, IAW AFI 44-176, *Access to the Care Continuum,* and AFMOA/CC guidance.

2.6.4. Ensure ARC Airmen with a non-duty related medical issues Existing Prior to Service (EPTS)/NILOD are directed to follow-up with their civilian providers. (T-2) Any delays in Airmen providing civilian medical records that affect the ability to establish the Individual Medical Readiness (IMR) requirements will be reported to the Airman's Commander IAW AFI 10-250, *Individual Medical Readiness.* (T-2)

2.7. MTF SGP shall:

2.7.1. Be appointed in writing IAW AFI 48-101, *Aerospace Medicine Enterprise*.

2.7.2. Advise MAJCOM/SGP or ARC/SGP for cases in which a unit commander and the next higher commander choose to non-concur with a MR recommendation (See 3.4.2.). (T-2)

2.7.2.1. Report aggregate profile, DLC, and deployment availability statistics (using de-identified, aggregate data) to MAJCOM/SGP or ARC/SGP as requested. (T-2)

2.7.2.2. Is responsible for ensuring profiling and duty limitation standards are met. (T-1)

2.7.2.3. Monitor the AF Form 422 and AF Form 469 processes; ensures timeline compliance. (T-1)

2.7.2.4. Monitor quality of DLC determinations, FAE, and applied medical standards as documented on AF Form 422 or AF Form 469. (T-1)

2.7.3. Serve as chairman of the DAWG. (T-2) Alternatively, the SGH may serve as the DAWG chairman if the MTF/CC determines that the SGP is not available or capable of overseeing the DAWG. In these instances, the MTF/CC will advise the MAJCOM/SGP or ARC/SGP of the change in DAWG Chair. Any other DAWG Chair waivers for this requirement will be approved by AFMOA/SGP.

2.7.4. Share responsibility with the SGH for training all providers and answering questions related to the appropriate completion of profiles and duty (including fitness) limitations and the MEB process (See AFI 10-203 Supplemental Guidance for additional information). (T-2)

2.7.4.1. The SGP will ensure that all Primary Care Management (PCM) providers understand the purpose of the DAWG and the processes used by the DAWG to meet its mission. (T-2)

2.7.5. Ensure, with assistance of the MSME, a method is in place for trigger events to be reported to the MSME and/or DAWG. (T-2)

2.7.6. RMU/GMU SGP shall: During Unit Training Assemblies (UTA), the SGP will ensure all open AF Forms 422 and AF Form 469 are finalized by the close of business (COB) of the last day of the UTA unless specific circumstances prevent it. (T-2)

2.8. MTF SPO shall:

2.8.1. Be the MTF/SGP IAW AFI 48-101. In rare instances where no credentialed Flight Surgeon (FS) is assigned to the MTF, the senior credentialed physician may serve as the SPO. (T-2)

2.8.1.1. For ANG - waiver requests must be submitted to NGB/SGP where the SPO is not a FS. (T-2)

2.8.2. Attend the DAWG. (T-2)

2.8.3. Serve as the installation's final medical authority on DR and/or MR and the application of medical standards as it applies to AF Forms 422 and AF Form 469. (T-1)

2.8.4. Coordinate with MSME to report profile, DLC, and deployment availability statistics to the DAWG. (T-1)

2.9. MTF SGH shall:

2.9.1. Share responsibility with the SGP for training all providers (see 2.7.4 and Supplemental Guidance). (T-2) This may include results of RILO reviews and quality reviews of DLC determinations (see 2.9.2. and 2.9.4.)

2.9.2. Be responsible for the clinical review and quality control of all documents and packages sent to DPANM or ARC SGP as applicable for RILO. (T-2)

2.9.2.1. For ARC personnel, the AD MTF is responsible for quality control and completion of Initial RILOs and MEBs only for duty-related conditions. (T-2)

2.9.2.2. RMU/GMU SGH is responsible for quality control and completion of non-duty related FFD/WWD determinations. (T-2)

2.9.3. Ensure clinical standards of care are met at each patient encounter IAW AFI 44-119, *Medical Quality Operations*.

2.9.4. Monitor quality of DLC determinations, FAE, and applied medical standards as documented on AF Form 422 or AF Form 469. (T-2) Ensure training is provided to the professional staff and teams to address any gaps of application of medical standards. (T-2)

2.9.5. Attend the DAWG. (T-2)

2.10. Clinic Providers (including specialty providers within the MTF) shall: Note: ARC Physical Examination Sections will ensure these actions are accomplished in an appropriate manner for ARC members seen by civilian providers. Please see the AFI 10-203 Supplemental Guidance for additional information.

2.10.1. Determine if conditions identified during patient encounters and special purpose examinations, specifically PHAs, affect the Airman's ability to: 1) meet deployment standards, 2) perform the duties of the assigned Air Force Specialty Code (AFSC), 3) meet retention medical standards, and/or 4) complete the Fitness Assessment (FA). (T-1)

2.10.1.1. The provider will use AF Form 469 to communicate duty and functional limitations and FAE to the unit Commander, in accordance with AFI 10-203 Supplemental Guidance. (T-1)

2.10.1.2. On initiation of an AF Form 469, providers must ensure Airmen understand the DLC process. (T-2)

2.10.2. Complete or coordinate clinical follow-ups/consultations needed to confirm diagnoses, determine and document the appropriate treatment plan, and estimate the expected timeline and level of recovery. (T-2) Every effort should be made to expedite evaluation/

treatment to ensure maximum functional recovery. This should be a high priority if Airman cannot perform their duties of their AFSC or do not meet mobility requirements.

2.10.2.1. Documentation from consultant evaluations, laboratory evaluations and other studies will be made available as needed to the DAWG for tracking and oversight, ideally in the notes section for the most current DLC in ASIMS. (T-2) Providers will actively coordinate referrals for consultant evaluations and studies recommended by the DAWG. (T-2)

2.10.2.2. ARC medical units will coordinate with AD MTFs or TRICARE to obtain follow-up and/or consultations for duty connected issues and any LOD determination in progress IAW AFI 36-2910, *Line of Duty (Misconduct) Determination.* (T-2) ARC Airmen with non-duty connected issues will be directed to see their civilian provider for additional evaluation with explicit instructions to provide clinical information to the medical unit in a timely manner. (T-2)

2.10.3. Refer a case to the DAWG for Initial RILO consideration when it is determined that an Airman may not meet retention standards IAW AFI 48-123 or is mobility restricted for a period that will, or is reasonably anticipated to, exceed 365 days. (T-1) If case is referred by DAWG for initial RILO, the provider will meet all requirements IAW AFI 41-210. (T-1) See Refer to DAWG feature on Knowledge Exchange for additional information.

2.10.4. Assess the impact of medical conditions or functional limitations on an Airman's ability to participate in unit physical fitness training as well as the impact on the FA. (T-1) Fitness Restrictions (FR) and/or FAE will be described by the provider on the AF Form 469 and will be processed IAW this Instruction and AFI 36-2905, *Fitness Program.* (T-1) See Chapter 3 of this Instruction for additional guidance.

2.10.5. Complete medical examinations required for assignment, retraining, or deployment. (T-1) Additionally, providers will assist MSME by making recommendations for patients with medical conditions that may affect assignment, retraining, or deployment. (T-1)

2.10.6. Will not notify an Airman's commander when an Airman self-refers or is medically referred for mental health care or substance misuse/abuse education services unless disclosure is authorized (this includes Mental Health providers), as described in DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members* or as noted below. (T-0, DoDI 6490.08)

2.10.6.1. For a situation that might require a deployment waiver IAW DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, Enclosure 3, and AFI 48-123; an AF Form 469 must be initiated in order to inform the Airman's commander to initiate the waiver if the service member is tasked to deploy. (T-0, DoDI 6490.07)

2.10.6.1.1. The local SGH and SGP will develop local protocol which covers all temporary medical treatment and evaluation that limit deployments, but meets retention standards. They will also identify non-Mental Health providers to sign the AF Form 469 when a mental health condition is the reason for a AF Form 469. If none are assigned the Airman's PCM will be responsible for signing the AF Form 469. See supplement for additional information. Any waivers for this requirement will be directed to AFMOA/SGP.

2.10.6.1.2. Comments placed on the AF Form 469 will be generic and apply to all medical conditions that meet retention standards but may be waived if requested (T-1). For example; "service member undergoing medical evaluation and/or treatment for a condition that precludes deployment at this time. A deployment waiver may be considered if tasked to deploy prior to expiration date. Contact (SGP/MSME/PCM) if tasked for deployment."

2.10.6.1.3. The local policy will apply to all conditions (not only mental health) to include but not limited to potential malignancies undergoing work-up that preclude deployment, symptomatic hypothyroid initiating medication, severe hypertension not stabilized with medication, and also initiation of medication for mental health diagnoses.

2.10.6.1.4. Providers must carefully weigh the rigors of potential assignments carefully to avoid exacerbations of conditions brought on by the rigors of contingency operations. See DoDI 6490.07, Enclosure 3, paragraph h, for a description of mental health situations that are disqualifying for deployment. (T-0, DoDI 6490.07)

2.10.6.2. If Command notification is not warranted per DoDI 6490.08, DoDI 6490.07, or AFI 48-123, an AF Form 469 will not be created for the specific encounter or clinical concern. (T-0: DoDI 6490.08)

2.11. Competent Medical Authority (CMA).

2.11.1. For Airmen requiring continuous monitoring after administrative qualification for Personnel Reliability Program (PRP), the CMA will report any medical condition requiring generation of an AF Form 469 to the losing Commander, gaining certifying official and the gaining CMA IAW DoD 5210.42-R_AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program.* (T-0: DoD 5210 .42-R_AFMAN 10-3902)

2.11.2. Once the gaining CMA (at installations with active PRP Airmen assigned) is notified that the incoming Airman has received an AF Form 469, the gaining CMA shares responsibility to monitor AHLTA, or equivalent for the ARC, for medical conditions which may preclude the Airman from assignment to the gaining base and PRP. (T-0: DoD 5210.42-R_AFMAN 10-3902) Care will be taken to ensure that distribution of a patient's protected health information (PHI) is limited to the minimum necessary and that these disclosures are properly accounted for IAW AFI 41-210. (T-1)

2.12. Clinical Consultants shall:

2.12.1. Provide timely, complete, and concise summaries (narrative summary or clinical encounter documentation) regarding an Airman's clinical status including specific functional limitations. (T-1)

2.12.1.1. Reports from clinical consultants in MTFs will be completed and returned to the requesting MTF within 30 days of the Airman's encounter with the consultant. (T-2) This may be delayed if significant studies are pending, but will not exceed 30 days following definitive diagnosis. **Note:** Consults on ARC Airmen must be completed within 30 days if the Airman is receiving care for a line of duty condition; otherwise they must be done within 90 days. (T-2)

2.12.1.2. If the case involves questions about the Airman's qualification for continued military service or deployability, the MTF clinical consultant shall include specific recommendations in the medical record or narrative summary regarding these issues and will communicate these recommendations to MSME within one duty day of the clinical encounter for referral to the DAWG. (T-1) See AFI 10-203 Supplement for additional guidance.

2.12.1.3. If a clinical consultant in an MTF determines an Airman requires a duty limitation, the consultant will initiate an AF Form 469 (or equivalent form specific for the service of the consultant), and will communicate this duty limitation to the Airman's PCM. (T-2) If the assigned PCM is not a provider in an AF MTF, the consultant's recommendation will be forwarded to the MSME office (or ARC equivalent) in the AF MTF nearest the Airman's duty location. (T-2) See AFI 10-203 Supplemental Guidance for additional guidance.

2.12.2. Only consider recommendations from civilian (non-MTF) clinical consultants that are related to, or describe, functional limitations. (T-2) AF providers are the final authority on deployment, medical retainability, and physical limitation recommendations (see paragraph 3.7 of this Instruction). (T-1) **Note:** ARC Airmen will ensure the ARC medical unit receives civilian provider medical documentation within 90 days of the encounter (T-1).

2.13. Profiling Officer (PO) shall:

2.13.1. Be appointed in writing by the MTF/CC. (T-1)

2.13.2. Be a FS(s) credentialed in Aerospace Medicine and familiar with these Instructions: AFI 48-123; AFI 48-149; AFI 44-170, *Preventive Health Assessment*; and AFI 36-2905. If no FS is assigned, the MDG/CC appoints the most qualified physician. (T-2)

2.13.3. Perform final review and co-signs all AF Forms 469 which include MRs of more than 30 days duration within one duty day of notification (or by COB on the next UTA for the ARC). (T-2)

2.13.4. Perform final review and co-signs all AF Forms 469 completed by the healthcare provider when the FAE duration is > 180 days (T-1). The PO should accomplish this review within one duty day of notification (or by COB on the next UTA for the ARC). (T-2)

2.13.5. When considering superseding a provider's recommendations, will communicate the reason(s) to the provider, the SGH, and the SPO. In cases where there is disagreement on profiling, duty limitations or FAE, the SPO will make the final determination after review of the records and, when appropriate, consultation with the unit Commander. (T-2)

2.14. MSME shall:

2.14.1. Manage the profiling/duty limitation system IAW this Instruction, the AFI 10-203 Supplement and AFI 48-149. (T-1)

2.14.1.1. Review and sign all AF Forms 469 except those initiated for FR or FAE of ≤ 180 days duration. (T-1) MSME will review and sign all AF Forms 422. (T-1)

2.14.1.2. Ensure all AF Form 469s are appropriately accomplished by medical providers (exception: AF Form 469s that include only FR and FAE ≤180 days in duration), and accomplishes a quality review using MTF acceptable and approved practices. (T-1)

2.14.1.3. Perform administrative quality reviews of DLCs, FAE with durations >180 days, physical examinations for qualification purposes, profiles, and appropriate clearances before these documents are finalized (exceptions: routine PHAs, RILO packages). (T-1) See AFI 10-203 Supplement.

2.14.1.4. Refer names of members with new AF Form 469 for pregnancy to PH for processing IAW paragraph 3.5 of this Instruction. (T-2)

2.14.1.5. Through ASIMS, ensure distribution of AF Forms 422 and AF Form 469 as directed in this instruction to the Airman's Commander (and/or the commander's designees IAW AFI 41-210) (T-1). Care will be taken to ensure that distribution of a patient's PHI is limited to the minimum necessary and that these disclosures are properly accounted for IAW AFI 41-210. (T-1)

2.14.1.5.1. Will coordinate with the ASIMS administrator on actions to include interfacing with units for transmission of information via ASIMS. (T-2)

2.14.1.6. Perform administrative quality control review on AF Forms 422 and AF Form 469 after Initial RILO, FFD, MEB or Physical Evaluation Board (PEB) processing as applicable. (T-1) Ensures ALC-C restrictions (or their removal) are correctly applied on the AF Form 469 as directed by DPANM or ARC SGP and IAW AFI 41-210. (T-1)

2.14.2. Serve as the liaison between unit Commanders, health care providers, PO, and Airmen. (T-1)

2.14.3. Perform requirements for personnel referred by MPF, or applicable agency, for retraining, PCS, Separation/Retirement, or special duty clearance. (T-2) This includes but are not limited to: Airmen recommended for retraining; applicants for special duty assignments or Palace Chase; PME or other formal school clearances; Airmen identified for overseas PCS clearances; Airmen requiring security clearance; or other physical qualification actions. (T-1)

2.14.3.1. The MPF will include available AFSCs and job descriptions for Airmen referred for retraining. (T-1)

2.14.3.2. Retraining Personnel: MSME will review retraining applications to ensure Airmen are qualified for entry into AFSC(s) specified for potential retraining. (T-1) The AF Form 422 will indicate each of the selected AFSCs the Airman is and is not qualified to enter. (T-1) See AFI 48-123 and AFI 10-203 Supplemental Guidance for additional information.

2.14.3.3. Will review assignment actions to ensure Airmen are qualified for PCS to gaining base IAW applicable Personnel Processing Codes (PPC). (T-1) The AF Form 422 will contain a statement as indicated by PPC listing. (T-1)

2.14.3.4. Palace Chase Applicants: The MSME will review applicant medical records to ensure AD members applying for Palace Chase meet retention standards IAW AFI 48-123. (T-1) AF Form 422 "PULHES" categories will not be upgraded for the purpose of Palace Chase. (T-1) If disqualifying medical conditions are discovered, the member will be referred to the PCM and/or the DAWG for further evaluation/review. (T-1)

2.14.4. Screen Officers who have been matched to overseas senior command position through the Command Screening Board (CSB) for mobility restrictions as soon as possible after being notified of their assignment. (T-1)

2.14.4.1. For these officers, MSME will not wait for deployment orders before initiating clearance. (T-1) The Colonels Management Office (A1/DPO) will instruct matched officers to initiate clearance immediately through their servicing MSME. A1/DPO will also provide the names to AF/SG3P (Public Health Branch) who will distribute them through the appropriate MAJCOMs to the members' servicing MSME. MSME will inform A1/DPO of any matched officers with mobility restrictions. (T-1)

2.14.4.2. Pre-deployment requirements that must be accomplished closer to the required report date do not need to be included in this initial clearance.

2.14.5. Attend the DAWG and produces metrics and required reports IAW this Instruction and per SGP direction. (T-1) ARC DAWG members and PH representatives are highly encouraged to attend co-located AD DAWG meetings.

2.14.5.1. Performs the required reviews as indicated in Chapter 4 of this Instruction in preparation for the DAWG. (T-1)

2.14.5.2. Provides support to the Physical Evaluation Board Liaison Officer (PEBLO) as needed for initial DAWG review for any case in which a provider believes that an Airman’s condition may not meet retention standards IAW AFI 48-123 or, in the opinion of the provider, the Airman will not be expected to return to full, unrestricted duty within 365 days of the initiation of a condition not compatible with mobility. (T-1)

2.14.5.3. Assist the PCM and PEBLO, via the DAWG, in identifying other Airmen who require RILO. (T-1)

2.14.6. Accomplish a DLC review (and medical record review if indicated) for Incoming Base Personnel when referred by PH. (T-1)

2.14.6.1. MSME will refer questions about duty limitations to the PCM. (T-1) Questionable limitations may also be made available to the PO to determine acceptable DRs, in consultation with the individual’s Commander and SPO as needed.

2.14.6.2. During this record review process, MSME will notify the PEBLO of any newly arrived Airmen who have ALC-Cs in order to facilitate tracking of Annual RILO requirements. (T-1)

2.14.7. For ARC medical unit MSME. During UTA, MSME will prepare all open AF Forms 422 and AF Form 469 for signature and finalization by the SGP by COB of the last day of the UTA unless specific circumstances prevent it. (T-2) The MSME must discuss with the SGP those circumstances that prevent closure of the forms. (T-2)

2.15. PH (or ARC equivalent) shall:

2.15.1. Review ASIMS for all AF personnel arriving on the installation on PCS orders. (T-1)

2.15.1.1. Personnel with current DLCs or ALCs will be referred to MSME for further review. (T-1)

2.15.1.2. Personnel with medical readiness issues (immunizations, dental, PHA, etc.) will be referred to the appropriate section of the MTF or gaining commander/unit health monitor to accomplish required actions. (T-1)

2.15.2. Manage pregnancy DLCs IAW paragraph 3.5. of this Instruction. (T-1)

2.15.3. Usually designated as the MTF ASIMS administrator. (T-2)

2.15.3.1. MTF ASIMS administrator will regularly update/validate unit contact information to ensure currency/accuracy for ASIMS notifications. (T-1)

2.15.3.2. MTF ASIMS administrator will coordinate with the MTF HIPAA Privacy officer to ensure that the unit Commander designates in writing those members of the unit approved to receive HIPAA-protected information, as well as those members allowed role-based access to ASIMS. (T-1) This information must be updated on a regular basis. (T-1)

2.16. Women's Health Clinic (not applicable to ARC).

2.16.1. On a monthly basis, the Women's Health Clinic (or equivalent section that manages pregnant Airmen) will provide MSME with an updated list of all pregnant Airmen on the installation. (T-1) The clinic representative will coordinate with MSME to ensure that this list is consistent with the ASIMS query for active Assignment Availability Code (AAC) 81 (pregnancy) cases IAW paragraph 4.1.3.4. of this Instruction. (T-1) This function will be performed by the fetal protection program managers for the ARC. (T-2)

2.17. Unit Commander shall:

2.17.1. Ensure unit and individual medical readiness IAW AFI 10-250.

2.17.2. Ensure unit Airmen are available for and complete examinations including required follow-up studies and final disposition in a timely manner. (T-2)

2.17.3. Work with MSME and/or the ASIMS administrator to ensure appropriate unit staff are designated to receive notification via ASIMS of information on individual Airmen IAW AFI 41-210. (T-0; DoD 6025.18-R, C7.11.1.2.1) Ensures adequate task cross-coverage and redundancy to allow the notification process to function despite individual absences (leaves, Temporary Duty assignments (TDY), deployments etc.) (T-1) Ensures their contact information is current and accurate and provides that information to MSME. (T-1)

2.17.4. Ensure that AF Forms 422 and AF Form 469 are issued to unit Airmen. (T-2) Ensures Airmen receiving an AF Form 422 or AF Form 469 are counseled and/or provided written instructions on duties and responsibilities when appropriate. (T-2)

2.17.4.1. For AF Form 469 actions which do not limit mobility, the Commander is not required to sign the form and may delegate these requirements to the Unit First Sergeant and the Airman's supervisor. (T-2)

2.17.4.2. For AF Form 469 actions limiting mobility, the Commander can concur with MR and must sign the AF Form 469 prior to issuing it to the Airman. (T-2)

2.17.4.2.1. If Commander non-concurs with mobility restriction on an AF Form 469, the Commander will contact the MTF/SGP within seven duty days. (T-2) See paragraph 3.4.2. of this Instruction for further guidance. (T-2)

2.17.5. Know the Fitness for Duty (FFD) status of the service members under their command. (T-1) The HIPAA privacy rule permits disclosures of PHI to Commanders and their designees without the patient's authorization, but these disclosures must be tracked. (T-0; 45 CFR §§164.512(k) and 164.528, DoD 6025.18-R, C7.11 and C13.1) Refer to AFI 41-210 for more information on Commander access to medical information.

2.17.6. Contact the SGP or SGH if there are concerns about the fidelity of past and/or present duty or MRs. (T-2) Specifically where the medical condition of an Airman appears to resolve or develop in close association with a new assignment, training opportunity, or deployment tasking.

2.17.7. Ensure Unit Airmen understand their roles and responsibilities in this Instruction. (T-2)

2.17.8. Report any trigger events (see 4.1.3.3.3. for details) to the SGP, and/or MSME; prefer to use the "Refer to DAWG Tool". (T-2)

2.18. Airman shall:

2.18.1. Report any new medical condition, medical conditions that potentially affect deployability, or any change in medical status, to the appropriate medical provider at the time of onset. (T-1) The Airman must also report all medical/dental treatment obtained through civilian sources to the appropriate military medical authority IAW AFI 41-210. (T-1) See AFI 48-123 for additional guidance regarding ARC Airmen.

2.18.2. Attend all scheduled medical appointments as directed and should inform unit supervisor of required follow-up evaluations and appointments. (T-3)

2.18.3. Make all attempts to resolve medical conditions in a timely manner. (T-1) This includes, but is not limited to, attendance at all appointments, active participation in rehabilitation, and using medications as prescribed by their health care provider. Failure to meet this requirement as determined by an appropriate medical authority and the Airman's Commander may result in MEB, FFD, and resultant administrative separation from the AF, without medical disability compensation. See AFI 48-123 for additional guidance regarding ARC Airmen.

2.18.4. When an Airman's failure to comply with medical assessment requirements renders the Air Force Medical Service (AFMS) unable to determine the Airman's current medical status, the following actions are deferred: clearance actions for deployment, PCS, retraining, attendance at service academies or PME, Military Personnel Appropriation (MPA) or Reserve Personnel Appropriation (RPA) orders, or any other orders status to include medical continuation (MEDCON) orders (ARC). **NOTE:** See AFI 36-2910 for guidance relating to MEDCON orders. (T-2)

2.19. Military Personnel Flight or Section (MPF, FSS or MPS).

2.19.1. Upon request, provides a listing of personnel with AACs of 31, 37, and 81 (pregnancy) from Military Personnel Data System (MilPDS) to MSME. (T-2) See section 4.1.3.5. of this AFI for details on management of this list.

2.19.2. Refers to MSME any Airman requiring special medical clearance actions as required with the appropriate information regarding the requirements. (T-1)

2.20. AFPC/DPANM (ARC/SGP).

2.20.1. DPANM reviews all AD RILO cases; members of ARC are reviewed by respective ARC/SGP IAW AFI 41-210.

2.20.2. The Colonels Management Office (A1/DPO) will provide DPANM a list of officers matched to senior leadership positions through the Command Screening Board (CSB) as soon as CSB results are available. (T-2) DPANM will review the list and notify A1/DPO of any CSB-matched officer with a duty limiting condition which would preclude taking the assignment. (T-2)

Chapter 3

ESTABLISHING AND DISSEMINATING DUTY LIMITATIONS

3.1. General Requirements.

3.1.1. **Completion of an AF Form 469.** When a provider determines an Airman needs a duty limitation, the following describe the minimum steps for completion of the AF Form 469. (T-1) See AFI 10-203 Supplemental Guidance for additional information.

3.1.1.1. The healthcare provider (or designee) will enter demographic data, diagnosis, physical limitations and/or restrictions and then specify resulting DRs, MRs, and/or FRs, and with a release date/s into ASIMS. (T-1) The provider or clinic staff must cross-check the Airman's organization and duty phone with the Airman. (T-2) In order to properly complete the AF Form 469, the provider must check a box for MR (see 3.4), DR (see 3.3), or FR (see 3.2), or some combination thereof. (T-1) Only specific limitations will be entered in the comments section as noted in 3.1.1.2. (T-1) Diagnoses will be recorded in the appropriate section of the AF Form 469 electronic interface, but will not be printed on the form. (T-0: 45 CFR §164.514(d), DoD 6025.18-R, C8.2) The provider will then electronically sign the "Health Care Provider" line on the form. (T-1)

3.1.1.2. The AF Form 469 is used solely to describe physical limitations, functional impairments, or specific restrictions. (T-1)

3.1.1.2.1. Functional limitations noted on the AF Form 469 will convey necessary detail to allow the Commander to make informed decisions concerning the management of his/her personnel. (T-1) Limitations will be timely, accurate and unambiguous and be written in simple terms understandable by non-medical leadership and supervisors. (T-1)

3.1.1.2.2. The AF Form 469 will contain no positive affirmations regarding the Airman's workplace or what the Airman can do in the workplace. (T-1) However, the AF Form 469 may contain positive ("should", "can", "will", etc.) instructions regarding an Airman's medical management. (Example: for an Airman who has undergone foot surgery, the AF Form 469 may state: "Airman should use hard orthopedic shoe in place of uniform footwear and should use crutches.") Refer to AFI 36-2903, *Dress and Personal Appearance of Air Force Personnel* for the alterations that are authorized.

3.1.1.2.3. If additional medical management inputs are included such as follow-up care appointments, do not include any reference that would describe the diagnosis. For example, instead of stating "member to follow-up with Infectious Disease Clinic in 90 days," state "member to follow-up with specialty care clinic in 90 days". This allows the command to know this is important for Airman to be released for appointments that are critical to return the Airmen to work or complete their medical evaluation, but does not disclose the diagnosis or type of clinic the patient may require.

3.1.2. **Completion of a AF Form 422.** The AF Form 422 is a profile containing descriptions of long-standing or permanent physical limitations which are used for

establishing suitability for career fields or AFSC. (T-1) The AF Form 422 also may be used by the DAWG to communicate to the commander and member that the member had a trigger event that was reviewed by the DAWG with the updated PULHES.

3.1.2.1. The AF Form 422 is updated when completing other medically related personnel functions, which include initial qualification, military retraining, PCS (if appropriate), PME, and similar functions as directed in this or other guidance. (T-1)

3.1.2.2. The AF Form 422 is updated after a RILO (with or without initiation of an ALC-C), MEB, WWD or FFD evaluation. (T-1) In these cases, re-accomplish a profile (PULHES) on an AF Form 422 to reflect updates from the RILO, MEB, WWD, or FFD determination. (T-1) If a member has an ALC-C removed during another DPAMN or ARC/SGP review, the AF Form 422 will be updated to reflect the new PULHES. (T-1)

3.1.2.3. Information noted on the AF Form 422 will convey necessary detail to allow the Commander and personnel system specialists to make informed decisions concerning the management of personnel. (T-1) Information will be timely, accurate and unambiguous and be written in simple terms understandable by non-medical leadership and personnel system specialists. (T-1) The diagnosis or other medical justification for the statements will not be placed on the AF Form 422 (T-0; 45 CFR §164.514(d), DoD 6025.18-R, C8.2). The requirements for follow-up care should not be included on the AF Form 422.

3.1.3. When AF Forms 422 and/or AF Form 469 are completed and MTF staff confirms that unit notification is indicated, the ASIMS program will automatically email the appropriate information to the Airman's commander or commander's designee(s).

3.1.3.1. Notifications made using the automated features of ASIMS are sent via un-encrypted email. The email contains a link to the ASIMS program that restricts access to those approved to receive PHI by the MTF HIPAA Privacy Officer (HPO) using Common Access Card (CAC) certificates. Notifications made outside of the ASIMS program must follow guidance in AFI 41-210 in order to protect PHI.

3.1.4. Any AFRC Airman with a condition that is disqualifying from his/her specific duties and/or has an AAC 31 is not allowed to participate in any pay or point gaining activity until the condition has resolved or waiver is granted IAW AFI 36-2254 V1, *Reserve Personnel Participation.*

3.2. FRs and FAEs.

3.2.1. If an Airman has a medical condition affecting fitness, but not impacting mobility, retention, or AFSC duties, an AF Form 469 will be generated by the provider who initially assesses the condition. (T-1) The AF Form 469 will detail functional limitations, specific FRs (to include restrictions from unit fitness activities if appropriate), and FAE. (T-1) See AFI 10-203 Supplemental Guidance for additional information. **NOTE:** These actions will be accomplished by the ARC MLO (or other appropriate designee) for ARC Airmen IAW AFI 36-2905.

3.2.1.1. If the FR and/or FAE is ≤180 days duration, the AF Form 469 will be signed and closed by the provider (or ARC MLO), a copy will be provided to the Airman at the time of the clinical encounter, and an electronic copy will be transmitted to the unit. (T-1)

3.2.1.2. If the FR or FAE is for a duration of > 180 days, or if it is a component exemption specifically for abdominal circumference (AC), the AF Form 469 must be signed (but not closed) by the provider (or ARC MLO), then reviewed by MSME as well as a PO, prior to closing the AF Form 469 and transmitting to the unit. (T-1) The Airman may be provided a draft printout of the restriction, however the provider will ensure that the Airman understands that this is only a draft that may be changed after review. The unit will not receive the FR or FAE from the MTF until after the AF Form 469 is reviewed by a PO. (T-1)

3.2.1.2.1. AC exemptions must be reviewed by the DAWG before final closure by any MTF PO and transmission to the unit. (T-1) (Exception: AC exemptions for pregnancy do not require DAWG review.)

3.2.1.2.2. The unit commander may choose to apply the draft FAE if the final AF Form 469 has not been received at the time of FA, however the final AF Form 469 will supersede the draft recommendations for all future FAs.

3.2.1.2.3. If an Airman has a chronic medical condition affecting fitness, the AF Form 469 may include FR and FAE with a term of validity of up to 365 days. These long-standing AF Form 469 will be reviewed by the PCM at the PHA. (T-1) The review will determine the need for restriction continuance, or any changes in the condition that may necessitate an Initial or other RILO. (T-1) Medical conditions impacting the FA only and not impacting mobility, retention, or AFSC duties do not automatically require Initial RILO. All FAE written for 365 days will be referred by the provider and/or MSME to the DAWG for review. (T-1) There are no permanent FA/FAE exemptions.

3.2.2. If an Airman has a valid AF Form 469 and changes duty location (PCS etc.), the AF Form 469 are valid at the gaining installation for FRs and FAEs. (T-2)

3.3. DRs Only.

3.3.1. For DRs with no mobility, retention, retraining, or fitness implications, the AF Form 469 signed by the health care provider will be made available electronically via ASIMS to MSME for review and signature. (T-1) Following MSME signature, the information will be made available via ASIMS email notification to the Airman's unit. PO review/signature is not required. See paragraph 3.1.3.1. of this Instruction for guidance on protecting PHI.

3.3.2. DRs that could permanently affect an Airman's ability to perform their AFSC-specific duties, but do not affect continued military service, will be handled administratively beginning with AFSC disqualification IAW AFI 36-2101 (Chapter 4) and AFI 48-123. (T-1)

3.3.2.1. The provider will initiate a new AF Form 422 stating "Member meets AF retention standards for continued service but does not meet AFSC-specific physical standards and is therefore disqualified for AFSC XXXX".(T-1) The diagnosis or other medical justification for the statement will not be placed on the AF Form 422 (T-0; 45 CFR §164.514(d), DoD 6025.18-R, C8.2).

3.3.2.2. MSME will review the AF Form 422 with the Airman (T-2). MSME will edit the AF Form 422 to annotate medical qualification statements for any prior AFSCs that have been held by the Airman.(T-1) **Note:** If MSME assesses that the Airman may not

be eligible for retraining, the case will be referred to the DAWG for Initial RILO consideration. (T-1) See AFI 10-203 Supplemental Guidance for additional information.

3.4. MR.

3.4.1. When a medical condition will prevent an Airman from deploying, with or without duty or fitness limitations, the provider will check the MR box on the AF Form 469 and enter the release date of the restriction. (T-1)

3.4.1.1. After electronic signature by the provider, the form will be automatically forwarded to MSME which will assess the form and determine if the condition will require an AAC 31 (release date of 31 to 365 days) or 81 (pregnancy). If an AAC 31 or 81 is needed, MSME will check the appropriate AAC box and sign the form which will then automatically forward to the PO.(T-1) (**Note:** MRs <31 days duration do not require AAC 31 or PO review/signature.)

3.4.1.2. The PO will review the restrictions and the coding and validate by electronic signature, and then forward the form electronically to the Airman's unit Commander via ASIMS email notification for concurrence/non-concurrence. (T-1) The AF Form 469 should be forwarded to the Squadron Commander within one duty day of initiation by the provider, but no later than two duty days (except for Code 81 which has up to 5 days). (T-2) For ARC Airmen, the AF Form 469 will be forwarded to the Commander prior to the Airman's next duty day. (T-2)

3.4.1.3. The Commander or designated representative will issue the form to the Airman following signature by the Commander. (T-2)

3.4.2. If a Commander chooses to non-concur on the MR, the Commander must contact the MTF/SGP within 7 duty days (COB on last day of UTA for ARC) of receipt of the mobility restricting AF Form 469 (no contact from the Commander will be considered concurrence). (T-2)

3.4.2.1. The MTF/SGP, with assistance from MSME, will collect and review pertinent medical data, consulting as needed with the provider who initiated the MR. (T-2) The MTF/SGP may override the provider's recommendation and revise or remove the MR in order to resubmit to the Airman's Commander. If the MTF/SGP agrees with the provider, the MTF/SGP will discuss the case with the Airman's Commander. (T-2)

3.4.2.2. If the MTF/SGP and Unit Commander disagree, the Airman can be placed on mobility status with the concurrence of the Commander's next reporting official (normally the Airman's Group Commander). If the second level Commander non-concurs as well, the final Commander acting on the AF Form 469 issues a completed copy to the Airman after the MTF/SGP notifies MSME of the action and MSME generates a new AF Form 469. (T-2) The new AF Form 469 will still reflect the MR and initial AAC but will include a statement indicating that the Airman's Squadron/Group Commander non-concurred and the Airman will be considered available for mobility/deployment. (T-2) Rationale for the decision will be documented by the MTF/SGP in the Airman's medical record. (T-2)

3.4.2.3. A specified deployment may have medical requirements determined by the COCOM. Thus, while a Commander may place an individual on mobility regardless of

medical recommendations, the gaining COCOM may not accept the Airman for deployment. For a defined deployment, the MTF will coordinate through its MAJCOM to the gaining COCOM regarding waiver of defined medical requirements.(T-1)

3.4.2.4. In the event of a Commander's non-concurrence on an AF Form 469 for an Airman with a condition which is unfitting for continued military service, an Initial RILO will still be prepared and forwarded to DPANM IAW AFI 41-210 (or to appropriate ARC SGP). (T-1)

3.4.3. Permanent MRs (e.g. ALC-C) may only be determined by DPANM or ARC SGP. These mobility limitations will be displayed on the AF Form 469 permanently at the bottom of the physical limitations/restrictions portion and once assigned, will not be changed, removed, or overridden by any local DLC or profile action (additional restrictions may be added as appropriate). (T-1) Only waiver authorities as described in AFI 41-210 may authorize deployment for individuals placed on ALC restrictions. Unit commanders may not non-concur with MRs directed by DPANM or ARC SGP (i.e. ALCs).

3.5. Pregnancy-related Duty Limitations.

3.5.1. When an Airman is diagnosed as pregnant, PH will be notified via direct referral from the provider or clinic staff, by an AF Form 469 initiated by the provider, or through other appropriate means, IAW AFI 44-102. (T-1) (For ARC, the Airman is required to notify the medical unit and provide proof of pregnancy). (T-1) If MSME receives a new AF Form 469 for pregnancy, it will be immediately forwarded to PH for appropriate action as the action office for the Fetal Protection Program. (T-1)

3.5.1.1. PH, in coordination with the PCM and if applicable the Women's Health Provider, will issue an initial AF Form 469 within 5 duty days of notification to PH or MSME of a positive pregnancy test. (T-1) The AF Form 469 will include standard DRs, MRs, and FRs (IAW para 3.5.2. of this Instruction). (T-1) For the ARC, the AF Form 469 will be processed the next UTA (T-1).

3.5.1.2. For pregnant Airmen assigned to a workplace monitored as part of the Occupational and Environmental Health Program (OEHP), standard duty limitations may require additional or altered limitations, based on workplace-specific hazards IAW AFMAN 48-146, *Occupational and Environmental Health Program Management.* (T-1) If indicated by the OEHP, the Airman's worksite will be evaluated for hazards that could affect the mother or fetus.(T-1) If this evaluation indicates the need for a change in the standard duty limitations, the AF Form 469 will be modified within 15 duty days (within two UTAs for ARC) of initial PH notification with restrictions tailored to the hazards of the Airman's workplace. (T-1) Bioenvironmental Engineering (BE) will provide a written workplace evaluation to PH based on either the latest workplace survey (if conducted within the last 12 months) or a specific site visit to identify workplace hazards. (T-1) PH will, in turn, coordinate with the installation Occupational and Environmental Health Consultant and the women's health provider or PCM to finalize the duty limitations on the AF Form 469. (T-1) ARC may have civilian OB/GYN consultation on duty limitations.

3.5.1.3. Duty limitations associated with pregnancy may require temporary removal from certain AFSC duties. Retraining will not be required.

3.5.2. The Obstetrics and Gynecology (OB-GYN) Consultants to the AF/SG will validate the AF standard DRs, MRs, and FRs for pregnancy annually and produce an updated AF Form 469 pregnancy overprint or template. The DAWG may approve changes to the standard template when deemed appropriate. Changes will be documented in the DAWG minutes. (T-1)

3.6. Multiple Action AF Form 469.

3.6.1. If an Airman requires an AF Form 469 be initiated for multiple purposes (mobility, duty, and/or fitness), MRs always have highest priority in processing. (T-1) This means that management of the AF Form 469 must follow the process described in paragraph 3.4. of this Instruction. (T-1) If there are no MRs, but there are DRs and FRs, then process the AF Form 469 following paragraph 3.3. of this Instruction. EXCEPTION: Pregnancy-related AF forms 469 will be processed IAW section 3.5. of this Instruction.

3.6.2. FR/FAE issued with either (or both) MR and DR may be printed and provided to the Airman by the provider as a draft (the provider would only sign in one place). Follow guidance in paragraph 3.2.1.2. of this Instruction on issuing a draft AF Form 469 for the Airman while the DR and MR follow the review processes described herein. (T-2)

3.7. External duty limitations (civilian or sister service). All AF personnel must report changes in physical status to their AF military medical unit. (T-1) Duty limitations from a non-AF provider are a recommendation and must be entered on an AF Form 469. (T-1) AF providers retain final mobility recommendation authority. (T-1)

3.8. Dental.

3.8.1. When an Airmen is placed into Dental Readiness Classification (DRC) 3, an AF Form 469 will be initiated (T-1). The AF Form 469 will be the primary means of notifying commanders that a member is in DRC 3 (T-1). See AFI 47-101, *Managing Air Force Dental Services*, for more information.

3.8.2. DRC 4 generally does not require an AF Form 469. However, if the class 4 extends beyond 30 days without resolution, an AF Form 469 may be used, at the discretion of the Chief of Dental Services in consultation with the SGP, as an additional tool to communicate the non-deployable status of the Airman to the unit. For the AFRC, if the Airman is in DRC 4 they will be placed in a No Pay, No Points status. (T-1)

Chapter 4

DAWG CASE MANAGEMENT REVIEW

4.1. Routine DAWG Case Reviews.

4.1.1. Purpose. The DAWG will be established at each wing/base level and will meet at least monthly to review personnel with a DLC that affects mobility, retention, or long-term physical fitness. (T-1) The DAWG will identify personnel not deployment eligible (Not Mission Capable, NMC) and track progress of the medical condition through resolution or definitive disposition. (T-1) They will further identify cases exceeding prescribed time limits, review a representative sample of DLCs, and provide feedback to PCM teams, including providers, via the SGH. (T-1) The DAWG will produce and provide a report to the MTF executive committee via the Aerospace Medicine Council (AMC). (T-1) The DAWG will also review cases referred for potentially unfitting medical conditions. (T-1)

4.1.1.1. The DAWG at ARC installations should meet monthly, but not less than quarterly. (T-2) At co-located bases, ARC representatives are highly encouraged to participate in the RegAF host base DAWG to ensure ARC Airmen requiring Initial RILOs and/or MEBs are managed appropriately (e.g. through RegAF channels for duty-related conditions or through ARC for non-duty related FFD/WWD conditions).

4.1.1.2. In certain circumstances, disclosures of an Airman's PHI by the DAWG are required by law and must be accounted for IAW AFI 41-210.

4.1.2. Membership will consist of the SGP, SGH, SPO, all available POs, MSME, PEBLO (or ARC equivalent), a PCM representative, and, as appropriate, an ARC Wing Fitness Program Manager (WFPM). Others may be assigned or invited to attend as needed (e.g. DoD/Veterans Affairs (VA) military services coordinator). Any invitees must be authorized to receive the PHI being discussed, otherwise attendance would not be permitted IAW AFI 41-210.

4.1.2.1. A mental health representative may be invited or appointed to the DAWG depending on the number and complexity of mental health cases to be reviewed.

4.1.2.2. Any member of the medical management team (Health Care Integrator, Case Manager, Utilization Manager, or Disease Manager) may be invited or appointed to provide clinical case management expertise, as desired. Similarly, a referral management specialist may be invited or included. (**Note:** Not applicable for ARC bases.) If this individual is not a nurse, the DAWG may consider including a clinical nurse to provide clinical case management input, support, and guidance to MSME.

4.1.2.3. A representative from the Women's Health Clinic (or equivalent section managing pregnant Airmen) may be invited or included as a member of the DAWG, at the discretion of the Chair, if indicated for better management of AAC 81 cases.

4.1.2.4. Providers who have empanelled cases being considered at the DAWG, or who initially referred a case or are involved in the clinical management of the case, may be invited to attend the DAWG based on the discretion of the DAWG Chair and the availability of the provider.

4.1.2.5. The DAWG Chair may invite attendees who are not assigned to the MTF staff, but only for those portions of the meeting that do not address individually identifiable health information. For PHI-related portions of the meeting, DAWG attendance by personnel not assigned to the MTF staff should be limited. If it is necessary for a unit commander/designees to attend, these personnel may only attend portions of the DAWG applicable to Airmen under their designated command structure.

4.1.3. The DAWG will review and provide oversight of the following processes: (T-1)

4.1.3.1. Airmen with DLCs which do not affect mobility. For Airmen with DLCs ≥ 365 cumulative days in duration but who are still mobility qualified (to include DR, FR, and/or FAE), the MSME will review each case following the review by the PCM as part of the PHA process. (T-1) Medical conditions affecting the fitness assessment only and not impacting mobility, retention, or AFSC duties do not automatically require Initial RILO.

4.1.3.2. AAC 31 Review. An ASIMS generated list of all personnel with an AAC 31 will be reviewed by MSME prior to the DAWG. (T-1) For cases identified for DAWG review, MSME will review the medical records, in consultation with the provider as appropriate, and be prepared to present issues and potential solutions for these cases. (T-1) Providers may be required to attend the DAWG meeting, at the discretion of the DAWG Chair, if deemed appropriate to discuss cases.

4.1.3.2.1. AAC 31 Review minimum reviews. Any AF Form 469 with an AAC 31 that has been in effect for 90 days or more will be reviewed to ensure the MR are applied appropriately to the clinical condition. (T-1) Once this 90-day review has been accomplished on a specific AF Form 469, it does not need to be reviewed again until it has reached 300 days in effect.

4.1.3.2.2. The issuing provider (or PCM if more appropriate) will be notified by MSME when an AF Form 469 with an AAC 31 reaches 300 days cumulative time (or will reach 300 days by the time of the next DAWG meeting) for a single condition in preparation for referral to DAWG. (T-1) If the DAWG determines that it is probable that the restrictions will not be lifted before one year has passed, an Initial RILO or FFD will be initiated immediately without waiting for 365 cumulative days under restriction to pass. (T-1) For ARC FFDs will follow the same timeline as initial RILOs. (T-2)

4.1.3.3. Potentially Unfitting Cases are reported to the DAWG through five trigger events. (T-1) A trigger event is a condition or occurrence which may indicate a service member has (a) medical and/or mental health condition(s) that is/(are) inconsistent with retention standards or deployability. Each DAWG should establish procedures and guidelines for reporting trigger events at its respective MTF; but the preferred method is the “Refer to DAWG” Tool in ASIMS. (T-1) See User Guide for Refer to DAWG Tool for additional details. Preliminary review of a trigger event should occur at the next scheduled DAWG meeting, and not more than 45 days after the case is referred to the PEBLO or MSME by the provider. See 4.2. for details of DAWG Review. (T-1) Trigger events include, but are not limited to, the following:

4.1.3.3.1. Provider, after discovering a potential or questionable service-disqualifying medical condition for any Airman regardless of rank, is responsible for submitting the case to the DAWG.

4.1.3.3.2. DAWG Surveillance Tracking determines that a member has a chronic condition which may preclude him/her from performing AFSC duties, deploying to field conditions, have an unfitting condition and/or will not return to mobility status prior to cumulative 365 days for condition or related issue(s). Regardless of the diagnosis, after 12 months of cumulative AAC 31 status for the same or related issue(s), the full case must be referred to DPANM via an initial RILO for adjudication review. (T-1)

4.1.3.3.3. Commander requests evaluation of unit service members due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.

4.1.3.3.4. DPANM (or ARC/SGP) directs. DPANM may identify conditions via an Annual or Modified RILO and direct the MTF to submit an Initial RILO package.

4.1.3.3.5. PCS, TDY or Deployment Cancellation or Curtailment for a medical or mental health reason.

4.1.3.4. AAC 81, Pregnancy Reviews. The MSME function will query ASIMS for all AAC 81 cases monthly and the continued pregnancy status will be confirmed by the Women's Health Clinic (or equivalent section that manages pregnant airmen). (T-1) Discrepancies will be resolved to ensure the earliest possible return of the Airman to unrestricted duty. (T-1) MSME will report to the DAWG on the overall rate of AAC 81 cases and the status of discrepancies. (T-1)

4.1.3.5. MPF Reconciliation. At least annually, and when deemed appropriate by the DAWG, MSME will request from the installation MPS a list of all personnel with an AAC 31, 37, and 81 for reconciliation with ASIMS data. (T-2) This reconciliation will be documented in the DAWG minutes, but will only need further discussion/investigation if significant discrepancies are found. (T-2)

4.1.3.6. Modified RILO due dates. The PEBLO (or ARC equivalent) will track Modified RILO due dates for all personnel with an ALC-C. (T-1) MSME (or PH) will assist in keeping this list current by advising the PEBLO of any new RILO cases (Airmen with an existing ALC-C) identified during the in-processing medical record review process (T-1). Prior to each DAWG, the PEBLO will review these records to identify problems which require attention. (T-1) Those cases that are identified with problems (overdue, complex diagnoses, etc.) will be reviewed at the DAWG with status updates provided by both the PEBLO and the PCM on cases currently being worked. (T-1) The ARC physical examination section will track ALC-C RILO due dates for WWD cases. (T-2)

4.1.3.7. MEDCON cases. The DAWG shall review initial medical continuation (MEDCON) cases for IDES consideration and will collaborate with the ARC Case Management Office on subsequent referrals to IDES. (T-2) See AFI 36-2910 for further information on management of MEDCON cases. For ARC DAWG, all MEDCON and Incapacitation Pay cases are to be reviewed. (T-2)

4.1.3.8. DLC quality review. The SGP and SGH will direct or conduct a review of the quality of DLC determinations and FAE as documented on AF Form 469 and present monthly statistics (quarterly for the ARC) on this review. (T-1) See AFI 10-203 Supplemental Guidance for additional information.

4.1.3.8.1. This review may be accomplished through the facility provider peer review program or other means as deemed appropriate by the DAWG, and will address questions per the AFI 10-203 Supplemental Guidance. The results will be presented to the Professional Staff (or ARC equivalent) at least annually or more frequently as determined by the DAWG. (T-2)

4.1.3.8.2. The proportion of DLCs to be reviewed will be determined by the DAWG (and documented in the minutes at least annually) but shall be an adequate sample to provide an accurate representation of the quality of DLCs in the MTF. (T-2) A specified portion of the DLCs must include FAE. (T-2)

4.1.3.9. Any potential adverse medical events (ie. Delay in diagnosis or medical error) noted at the DAWG should be reported to the SGH and MTF Healthcare Risk Manager IAW AFI 44-119.

4.2. DAWG Review for Initial RILO.

4.2.1. For cases referred to the DAWG, the DAWG will determine whether an Airman's condition(s) meets standards for continuing military service IAW AFI 48-123. (T-1) Once a case is referred to the DAWG, it should be reviewed at the next scheduled DAWG meeting, but no more than 45 days after the referral is made (for ARC 90 days). (T-1) The DAWG review will take into account all available and appropriate information related to the case. (T-1) The disposition of the DAWG review can be documented within the ASIMS "Refer to DAWG" Tool and may include:

4.2.1.1. Case dismissal. If the Airman is found to be fit for continued military service and mobility based on the information considered, the AF Form 469 may be updated appropriately and the case dismissed to routine medical care.

4.2.1.1.1. Case dismissal does not preclude the Airman being considered for DAWG review again in the future for the same condition if the Airman's status changes.

4.2.1.1.2. A note will be placed in the Airman's medical record indicating that the condition was reviewed for possible MEB or FFD and found to be fit without need for Initial RILO or MEB. (T-1) See AFI 10-203 Supplement and ASIMS "Refer to DAWG" Tool Guidance for additional information.

4.2.1.2. Initial RILO or FFD referral. The condition does not meet medical retention standards and/or the Airmen is not capable of deploying without some restrictions. In these cases, Initial RILO will be initiated IAW paragraph 4.2 of this Instruction and AFI 41-210. (T-1) For those cases where the Airman's hospitalization or treatment progress appears to have medically stabilized but the final prognosis or outcome may not be known for more than a year, the referral for Initial RILO will not be delayed as long as the course of recovery is relatively predictable and a reasonable determination can be made that the condition will be unlikely to resolve or improve to meet standards IAW

AFI 48-123 within 12 months. (T-1) See AFI 10-203 Supplemental Guide for additional information.

4.2.2. Initial RILO. Once the DAWG Chair directs that an Initial RILO is indicated, MSME will initiate an AAC 37 on the Airman's AF Form 469. (T-1) Individual providers will not initiate the AAC 37. (T-1) Once applied, the AAC 37 will remain in effect until DPANM directs removal via the AFPC/FL 4 or ARC SGP by memorandum. (T-1)

4.2.2.1. Once the Code 37 is initiated by the DAWG, the PEBLO will coordinate bringing the Initial RILO package to the next DAWG meeting IAW AFI 41-210. (T-1) If the Initial RILO package is not ready to present at the next DAWG meeting, the case must be tracked as an open item in the DAWG minutes, with an explanation of why it is delayed, until the package is complete and has been reviewed by the DAWG. (T-1) The MSME will also coordinate having the provider attend the DAWG if the DAWG Chair deems this appropriate. (T-1)

4.2.2.2. Once the Initial RILO package is complete (to include all specialty consultations and special studies), the entire package must be reviewed by the DAWG and signed off by either the SGH or SGP to ensure that it is complete and accurate. (T-1) This step serves as a final quality review and will be completed no more than 30 days (one UTA for ARC) after the case was initially reviewed at the DAWG. (T-1) If the final review is delayed beyond 30 days, the reason for the delay will be documented in the DAWG minutes. (T-1)

4.2.2.3. The Initial RILO packages will be forwarded to DPANM or ARC SGP as applicable for adjudication with a recommendation from the DAWG for either MEB or RTD (this recommendation is not binding on the adjudication by DPANM or ARC SGP) IAW AFI 41-210. (T-1)

4.2.3. DPANM or ARC SGP Adjudication. DPANM or ARC SGP as applicable will review the Initial RILO packages and will advise the PEBLO of the disposition via the AFPC Form 4 or as communicated from the ARC SGP. The disposition by DPANM or ARC SGP is final and has the same effect and authority as a MEB. The PEBLO will follow instructions noted below and in AFI 41-210. (T-1) The MSME will ensure below actions occur. (T-1)

4.2.3.1. RTD. If DPANM or ARC SGP directs that the Airman is RTD, the PEBLO will notify MSME and the provider. (T-1) MSME will immediately release the AAC 37. (T-1) AF Forms 422 and AF Form 469 will be initiated or updated (as appropriate) to reflect ongoing restrictions deemed appropriate by the DAWG. (T-1) A disposition of RTD does not preclude the Airman being considered for Initial RILO again for the same condition if the condition changes or deteriorates enough to warrant re-consideration.

4.2.3.2. ALC-C. DPANM or ARC SGP may direct RTD with application of an ALC-C. The PEBLO will notify MSME and the provider, and MSME will immediately release the AAC 37. (T-1) AF Forms 422 and AF Form 469 will be initiated or updated (as appropriate) with language directed by DPANM or ARC SGP as applicable and ongoing restrictions deemed appropriate by the DAWG. (T-1) MSME will use specific ALC-C language as outlined in AFI 41-210. (T-1)

4.2.3.2.1. DPANM is the authority to assign or remove the ALC-C on AD Airmen. The appropriate ARC SGP is the authority to assign or remove the ALC-C for ARC

Airmen. An assigned ALC-C code may be stratified based on risk to the individual as well as medical requirements. The code may be valid indefinitely, but must be reviewed and renewed IAW AFI 41-210 or specific guidance from DPANM or the appropriate ARC SGP for ARC Airmen.

4.2.3.2.2. For Initial RILOs returned from DPANM or ARC SGP with direction for RTD or ALC-C, MSME, in coordination with the provider and PO, will ensure that appropriate long-term FR and FAE are included on the AF Form 469 if indicated for review with annual PHA. (T-1)

4.2.3.3. Refer for MEB. If DPANM or ARC SGP determines that the Airman may be unfit for military duty, an MEB will be directed. (**Note:** Does not apply to NILOD conditions for ARC, see paragraph 4.2.4. of this Instruction) The PEBLO will notify MSME to ensure that the AAC 37 stays valid. (T-1) The PEBLO will initiate the VA Form 21-0819 *VA/DoD Joint Disability Evaluation Board Claim*, then forward the form to the provider for further clinical information and signature to initiate the Veteran's Affairs (VA) evaluation as part of the IDES IAW AFI 41-210 and other applicable regulations within 10 duty days of receiving the Form 4 from DPANM. (T-1)

4.2.3.4. Other. DPANM or ARC SGP may send a case back to the MTF for ongoing medical management, they may return with no action (reason will be provided), or they may request additional information. In each of these cases, appropriate restrictions and MTF actions will be detailed on the AFPC Form 4 or ARC SGP memorandum, to include disposition of the AAC 37. (T-1)

4.2.4. ARC Airmen with non-service connected issues will have a FFD/WWD determination. The respective ARC SGP will generally use the same Initial RILO package requirements for FFD/WWD determinations as AD Initial RILOs, but may specify additional (or fewer) criteria and processes. AD units supporting ARC Airmen will obtain and maintain a copy of applicable guidance. (T-2)

4.2.5. The authority to deploy an Airman with an ALC-C is based on stratification levels, or as specified in the reporting instructions for a defined deployment. A description of ALC stratification and the process for waiver requests are detailed in AFI 41-210.

4.3. Metrics.

4.3.1. The MSME function will develop a report from ASIMS data reflecting the current status of their wing and supported units, reporting through the DAWG to the MTF executive function and wing Commander (as required) via the AMC. (T-1) Components of the report will include:

4.3.1.1. Fully Mission Capable (FMC, formerly Medically Mobility Ready (MMR)) percentage. These Airmen are "green" for all ASIMS requirements and are capable of deploying with no medical actions required.

4.3.1.2. Partially Mission Capable (PMC, formerly Medically Mobility Capable (MMC)) percentage. These Airmen do not have an AAC 31, 37, or 81. They do have unmet ASIMS requirements that could be resolved within 30 days.

4.3.1.3. Not Mission Capable (NMC, formerly Medically Mobility Limited (MML)) percentage. These Airmen would require >30 days to become FMC and include those

with AAC 31, 37, or 81. It also includes Airmen with an ALC, regardless of stratification.

4.3.2. Diagnosis and Medication Surveillance. At least ten times per year, MSME will present findings to the DAWG of selected diagnostic or medication using queries as directed by the SGH to ensure Airmen with certain medical conditions do not remain unidentified in the mobility reporting system. (T-1) MSME will ensure the reviews are performed and will present findings at the DAWG, e.g., cases that may need DLC action or Initial RILO to the DAWG. (T-1) The SGH will ensure these findings are also presented at the Professional Staff or other appropriate forum at least annually. (T-2) See AFI 10-203 Supplemental Guidance for additional instructions. ARC should perform no less than quarterly.

4.3.3. In addition to the above metrics, the DAWG will track the following data each month and report to the MTF Executive committee via the AMC (quarterly for the ARC): (T-1)

4.3.3.1. Timelines and outcomes related to Initial RILOs/MEBs, as follows:

4.3.3.1.1. Average duration from the date a potential Initial RILO case via a trigger event is identified to the PEBLO/MSME until the DAWG determination for Initial RILO or case dismissal. (T-2) Metric is < 45 days. Each case that exceeds the metric will be documented in the DAWG minutes including the cause for the delay. (T-2)

4.3.3.1.2. Average duration from DAWG determination for Initial RILO until the case is transmitted to DPANM or ARC SGP as applicable (cases dismissed by the DAWG will not be included). (T-2) Metric < 30 days. Each case that exceeds metric will be documented in the DAWG minutes. (T-2)

4.3.3.1.3. Average duration from DPANM or ARC SGP notification to the MTF to conduct an MEB until referral into the IDES system. (T-2) Metric within 10 duty days (ARC next UTA). Each case that exceeds metric will be documented in the DAWG minutes. (T-2)

4.3.3.1.4. IDES Metrics as stated by AFI 41-210 and other guidance to PEBLO to monitor the IDES process. Each case that exceeds metric will be documented in the DAWG minutes. (T-2)

4.3.3.2. Overdue rate for Annual RILO cases (#cases overdue at time of DAWG meeting/total ALC-C cases in MTF rosters). (T-2)

4.3.3.3. Results of clinical quality review and recommended actions for significant trends identified. (T-2) See 4.1.3.8.

4.3.4. This list of metrics for the DAWG report is not exclusive of other metrics deemed appropriate by the DAWG or higher authority.

Chapter 5

FITNESS FOR DUTY (FFD)/ WORLD WIDE DUTY (WWD) AND PRESUMPTION OF FITNESS

5.1. ARC Airmen. ARC Airmen entitled to disability processing IAW 36-3212, *Physical Evaluation for Retention, Retirement, and Separation,* will undergo Initial RILO processing by RegAF MTFs. (T-2) ARC Airmen with non-duty related issues will undergo FFD/WWD processing by the ARC medical unit and be reviewed by the appropriate ARC SGP. (T-2) ARC SGP will provide additional guidance as needed. For FFD purposes, Commanders and their designees must receive medical information for fitness for duty determinations. Only the minimum information necessary will be provided. If disclosures of this information have not been specifically authorized by the Airman, the MTF will account for the disclosures IAW AFI 41-210. (T-0) DoDI 1332.38, 45 CFR §§164.502(b), 164.508, 164.512(k), DoD 6025.18-R, C8.2).

5.2. Presumption of Fitness. The existence of a physical defect or condition does not in itself necessarily provide justification for or entitlement to an Initial RILO, MEB, ALC, or FFD. For most Airmen approaching retirement, a full MEB is not necessary (see AFI 41-210, paragraph 4.53.1.4.). DPANM will review the Initial RILO package and determine the appropriate case disposition. Review by ARC SGP for the ARC will suffice unless the presumption of fitness is in doubt; ARC SGP retains the authority for medical hold in cases where presumption of fitness is in doubt for ARC Airmen. See AFI 36-3212, paragraph 3.17. for further guidance regarding presumption of fitness.

Chapter 6

LIMITED SCOPE MEDICAL TREATMENT FACILITIES (LSMTF) AND MEDICAL AID STATIONS (MAS)

6.1. Definitions.

6.1.1. LSMTFs are medical elements, flights, or small medical squadrons with a credentialed medical provider that do not provide the scope of services found in a medical group. LSMTFs are typically assigned to a line squadron or group (e.g. Air Base Squadron, Mission Support Group or Air Base Group). In some cases, a LSMTF may report directly to a wing or MAJCOM.

6.1.2. MAS are small medical elements without a credentialed medical provider and are typically located at a geographically separated unit (GSU) or a Munitions Support Squadron (MUNSS) site.

6.1.2.1. MUNSS sites are GSUs responsible for receipt, storage, maintenance and control of United States War Reserve Munitions in support of the North Atlantic Treaty Organization (NATO) and its strike missions. See AFI 21-200, *Munitions and Missile Maintenance Management*.

6.1.2.2. GSUs are units that are not at the same physical location or base as the parent unit.

6.2. Responsibilities.

6.2.1. MAJCOM/SG. The MAJCOM/SG for the supported GSU and MUNSS (LSMTF, MAS, and GSU without LSMTF or MAS) will assign the nearest AD AF MTF as the supporting MTF (with written concurrence of the MAJCOM/SG for the supporting MTF if assigned to a different MAJCOM), for each GSU and MUNSS within their area of responsibility to assist with the documentation and administrative management of Airmen with DLC.

6.2.2. Supporting MTF/CC

6.2.2.1. Is ultimately responsible for the documentation and administrative management of Airmen with DLCs as defined in this AFI at the GSU and MUNSS sites and will ensure appropriate support is provided. (T-1)

6.2.2.2. Will administer the Program Objective Memorandum (POM) for additional MTF personnel to meet the requirements to support assigned GSU and MUNSS sites based on current manpower models and increased workload. (T-1)

6.2.2.3. Will ensure a credentialed provider, preferably a PO, is available to counsel Airmen placed on AAC 31, 37, or 81 at the GSU and MUNSS sites. (T-2) This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the Airman's electronic medical record. (T-1)

6.2.3. MTF SGP at supporting MTF. Will ensure appropriate documentation and administrative management of Airmen with DLCs at the GSU or MUNSS sites. (T-1)

6.2.4. PO at the supporting MTF will perform PO duties for Airmen assigned to supported GSU or MUNSS sites who require an AF Form 422 or AF Form 469. (T-1)

6.2.4.1. If the GSU or MUNSS site Airman is not empanelled to a PCM at the supporting MTF and receives duty limitation recommendations from a civilian provider, the PO at the supporting MTF will initiate an AF Form 469 using the civilian provider's recommendations as a guide. (T-1) If the GSU or MUNSS Airman is empanelled, the PCM will perform this function. (T-1) The AF provider that transcribes the civilian provider's recommendations retains final authority on the restrictions placed on the AF Form 469. (T-1)

6.2.5. DAWG at the supporting MTF will administratively manage the DLC, AAC 31, 37, 81, ALC-C, and RILO (Initial and Annual) cases from the GSU and MUNSS sites as outlined in this Instruction. (T-1)

6.2.6. MSME at the supporting MTF will perform the MSME functions as outlined in this instruction for the supported GSU and MUNSS sites. (T-1) Video teleconferencing, teleconferencing, or electronic data and communication systems may be used to facilitate these functions. (T-1)

6.2.7. The PEBLO at the supporting MTF will perform their functions as outlined in this Instruction and AFI 41-210 for the supported GSU and MUNSS sites. (T-1) Video teleconferencing, teleconferencing, or electronic data and communication systems may be used to facilitate these functions. (T-1)

6.2.8. LSMTF Officer in Charge (OIC) or Non-commissioned Officer in Charge (NCOIC).

6.2.8.1. Will ensure that patients presenting for care are evaluated, treated and/or referred as appropriate by a credentialed provider. (T-1) **Note:** Credentialed providers at a LSMTF will have the same scope of responsibility as providers at the supporting MTF to include the appropriate evaluation, clinical management, referral, DLC and profile disposition, and narrative summary preparation as appropriate for their patients.

6.2.8.2. Will ensure that information for patients with DLCs is entered into ASIMS and, when indicated, made available electronically to the supporting MTF for MSME review and PO approval IAW this Instruction. (T-1)

6.2.8.3. Will ensure that medical records and provider staff are made available for the supporting MTF DAWG. (T-1)

6.2.8.4. Will coordinate with GSU and MUNSS site Commanders to ensure Airmen obtain the required exams and studies. (T-1)

6.2.8.5. Will ensure that LSMTF credentialed providers prepare an appropriate narrative summary when required within the time specified by policy and provide all supporting documents and information for Initial and Annual RILOs, MEB, or other IDES processing to the supporting MTF. (T-1)

6.2.8.6. If no LSMTF credentialed provider is available, the LSMTF OIC/NCOIC will ensure Airmen with a DLC that restricts mobility (AAC 31, 37, or 81) are referred to the supporting MTF to receive counseling by a credentialed provider, preferably a PO. (T-1) This counseling may occur via video teleconference or telephone when circumstances do

not allow face-to-face contact but will be documented by the credentialed provider in the Airman's electronic medical record. (T-1)

6.2.9. OIC overseeing MAS:

6.2.9.1. Will ensure that patients presenting for care are evaluated, treated and/or referred as appropriate under the supervision of a credentialed provider. (T-1) **Note:** MAS medical personnel will provide documentation and management of Airmen with DLCs as defined in this Instruction within their scope of training, manpower, and equipment. (T-1)

6.2.9.2. Will ensure that information for patients with a DLC are entered into ASIMS and, when indicated, made available electronically to the supporting MTF for MSME review and profile officer approval. (T-1) If ASIMS is not available at the supported site, then will ensure DLC information is forwarded to the supporting MTF for entry into ASIMS. (T-1) MSME will serve as the point of contact for this purpose. (T-1)

6.2.9.3. Will ensure that medical records and medical element staff are made available for the supporting MTF DAWG. (T-1)

6.2.9.4. Will coordinate with GSU or MUNSS site Commanders to ensure Airmen obtain the required exams and studies. (T-1)

6.2.9.5. Will ensure Airmen with a DLC that restricts mobility (AAC 31, 37, or 81) are referred to the supporting MTF to receive counseling by a credentialed provider, preferably a profile officer. (T-1) This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the Airman's electronic medical record. (T-1)

BURTON M. FIELD, Lt Gen, USAF
DCS Operations, Plans and Requirements

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Title 10 United States Code Section 8013

Executive Order (EO), 9397, *Numbering System for Federal Accounts Relating to Individual Persons,* November 22, 1943, as amended by EO 13476, *Amendments to EO 9397 Relating to Federal Agency Use of Social Security Numbers*, November 20, 2008.

DoDD 1332.18 *Separation or Retirement for Physical Disability,* December 1, 2003

DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, February 5, 2010

DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, August 17, 2011

DODR5210.42R_AFMAN 10-3902 *Nuclear Weapons Personnel Reliability Program (PRP),* 2 November 2010

AFPD 10-2 *Readiness*, 30 October 2006

AFPD 44-1 *Medical Operations*, 1 September 1999

AFPD 48-1 *Aerospace Medicine Enterprise*, 23 August 2011

AFI 10-250 *Individual Medical Readiness,* 9 March 2007

AFI 21-200 *Munitions and Missile Maintenance Management,* 13 November 2009

AFI 33-324 *The Information Collections and Reports Management Program: Controlling Internal, Public and Interagency Air Force Information Collections*, 1 June 2000

AFI 36-2101 *Classifying Military Personnel (Officer and Enlisted),* 14 Jun 2010

AFI 36-2254, Volume 1 *Reserve Personnel Participation,* 26 May 2010

AFI 36-2905 *Fitness Program*, 1 July 2010

AFI 36-2910 *Line of Duty (Misconduct) Determination,* 4 October 2002

AFI 36-3206 *Administrative Discharge Procedures for Commissioned Officers*, 9 June 2004

AFI 36-3208 *Administrative Separation of Airmen*, 9 July 2004

AFI 36-3209 *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members,* 14 April 2005

AFI 36-3212 *Physical Evaluation for Retention, Retirement, and Separation,* 2 February 2006

AFI 41-210 *TRICARE Operations and Patient Administration Functions*, 6 June 2012

AFI 44-109 *Mental Health and Military Law*, 1 March 2000

AFI 44-119 *Medical Quality Operations*, 16 August 2011

AFI 44-170 *Preventive Health Assessment*, 22 February 2012

AFI 44-172, *Mental Health*, 14 March 2011

AFI 44-176 *Access to the Care Continuum*, 12 September 2011

AFI 47-101 *Managing Air Force Dental Services*, 1 June 2009

AFI 48-101 *Aerospace Medicine Enterprise*, 19 October 2011

AFI 48-123 *Medical Examinations and Standards*, 24 September 2009

AFI 48-145 *Occupational and Environmental Health Program,* 15 September 2011

AFI 48-149 *Flight and Operational Medicine Program (FOMP)*, 29 August 2012

AFMAN 33-363 *Management of Records*, 1 March 2008

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule

Prescribed Forms

None

Adopted Forms

AF Form 422, *Notification of Air Force Member's Qualification Status*, 25 October 2007

AF Form 469, *Duty Limiting Condition Report*, 25 October 2007

AF Form 847, *Recommendation for Change of Publication*, 22 September 2009

DD Form 2808, *Report of Medical Examination*

VA Form 21-0819, *VA/DOD Joint Disability Evaluation Board Claim*

Abbreviations and Acronyms

AAC—Assignment Availability Code

AD—Active Duty

AETC—Air Education and Training Command

AF—Air Force

AFECD—Air Force Enlisted Classification Directory

AFI—Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFMS—Air Force Medical Service

AFMSA—Air Force Medical Support Agency

AFOCD—Air Force Officer Classification Directory

AFPC—Air Force Personnel Center

AFPC/DPANM—Air Force Personnel Center, Medical Standards Department

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AF/SG—Air Force Surgeon General

AHLTA—Armed Forces Health Longitudinal Technology Application

ALC—C —Assignment Limitation Code-C

AMC—Aerospace Medicine Council

AMP—Aerospace Medicine Primary

ANG—Air National Guard

ARC—Air Reserve Component

ASIMS—Aeromedical Services Information Management System

BE—Bioenvironmental Engineering

CAC—Command Access Card

CC—Commander

CMA—Competent Medical Authority

COB—Close of Business

COCOM—Combatant Commander

DAWG—Deployment Availability Working Group

DLC—Duty Limiting Condition

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DPANM—Headquarters Air Force Personnel Command, Medical Retention Standards Branch

DR—Duty Restriction

E-Publishing—Air Force document publishing website (www.e-publishing.af.mil)

EPTS—Existing Prior to Service

FA—Fitness Assessment

FAE—Fitness Assessment Exemption

FFD—Fitness for duty

FMC—Fully Mission Capable

FPM—Fitness Program Manager

FR—Fitness Restriction

FS—Flight Surgeon

GMU—Guard Medical Unit

GSU—Geographically Separated Unit

HIPAA—Health Insurance Portability and Accountability Act

IAW—In accordance with

IDES—Integrated Disability Evaluation System

IMR—Individual Medical Readiness

KX—Knowledge Exchange

LOD—Line of Duty

LSMFT—Limited Scope Medical Treatment Facility

MAJCOM—Major Command

MAS—Medical Aid Stations

MDG—Medical Group

MEB—Medical Evaluation Board

MEDCON—Medical Continuation

MilPDS—Military Personnel Data System

MLO—Medical Liaison Officer

MMC—Medically Mobility Capable

MML—Medically Mobility Limited

MMR—Medically Mobility Ready

MPA—Military Personnel Appropriation

MPS—Military Personnel Section

MR—Mobility Restriction

MSME—Medical Standards Management Element

MTF—Medical Treatment Facility

MUNSS—Munitions Support Squadron

N/A—Not Applicable

NARSUM—Narrative Summary

NATO—North Atlantic Treaty Organization

NGB—National Guard Bureau

NILOD—Not in Line of Duty

NMC—Not Mission Capable

OB—GYN ─Obstetrics and Gynecology

OCONUS—Outside the Contiguous United States

OEHP—Occupational and Environmental Health Program

OIC—Officer in Charge

OPR—Office of Primary Responsibility

PCM—Primary Care Manager

PCS—Permanent Change of Station

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PH—Public Health

PHA—Preventive Health Assessment

PHI—Protected Health Information

PMC—Partially Mission Capable

PME—Professional Military Education

PO—Profile Officer

POC—Point of Contact

POM—Program Objective Memorandum

PPC—Personnel Processing Code

PRP—Personal Reliability Program

PULHES—Physical Profile Serial Chart

RAM—Residency in Aerospace Medicine

RDS—Records Disposition Schedule

REG AF—Regular Air Force

RILO—Review In Lieu Of

RMU—Reserve Medical Unit

ROTC—Reserve Officer Training Corp

RPA—Reserve Personnel Appropriation

RTD—Return to Duty

SGH—Chief of the Medical Staff

SGP—Chief, Aerospace Medicine

SPO—Senior Profile Officer

TDY—Temporary Duty

TRICARE—The Triple Option Benefit Plan

UCMJ—Uniform Code of Military Justice

UDM—Unit Deployment Manager

UFPM—Unit Fitness Program Manager

UHM—Unit Health Monitor

USC—United States Code

USUHS—Uniformed Services University of Health Sciences

UTA—Unit Training Assemblies

VA—Veterans Affairs

WWD—World Wide Duty

Terms

ARC SGP—Chief of Aerospace Medicine for the appropriate Air Reserve Component, either Air Force Reserve Command or Air National Guard. When specific concerns are different for the two Reserve Components, the components will be specified by name (i.e. ANG/SGP and AFRC/SGP).

Disqualifying Defect—a medical condition that is unfitting for service in the Air Force IAW AFI 48-123, Chapter 5 (Retention Standards).

Duty Limitation—a recommendation resulting from a medical evaluation which, if applied explicitly, limits or restricts an Aiman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities.

Duty Limiting Condition—a medically-related condition (injury or illness) that results in a duty limitation. Commonly referred to as a DLC in this AFI, it is often used as an abbreviated term for the AF Form 469, *Duty Limiting Condition Report*. DLCs refers to DRs, MRs, and FRs.

Duty Restriction—a recommendation resulting from a medical evaluation which, if applied explicitly, restricts the activities that an Airman may perform in carrying out any and/all required or directed Air Force duties or responsibilities. While maintaining physical fitness is a responsibility of all Airmen, for purposes of this AFI, fitness activities are not included in the definition of Duty Restrictions.

Fitness Assessment Exemption—a recommendation resulting from a medical evaluation which, if applied explicitly, restricts one or more components of the Air Force Fitness Assessment

Fitness for Duty— Refers to the evaluation process when a service member has a condition which is questionable or disqualifying for military duty and not be in the line of duty. See AFI 48-123, Chapter 10 for additional details.

Fitness Restriction—a recommendation resulting from a medical evaluation which, if applied explicitly, restricts activities that an Airman may perform as part of a personal, unit-based fitness program, and/or Air Force Fitness Assessment.

Functional (or Physical) Limitation—the inability of an Airman to perform specific physical movements or actions based on an assessment of the Airman's injury or illness by a medical professional.

Functional (or Physical) Restriction—a report of an Airman's injury or illness, based on evaluation by a medical professional, that describes specific physical activities or functions that are recommended for the Airman to avoid to allow recovery or reduce risk of further injury.

Mobility Restriction—a recommendation resulting from a medical evaluation which, if applied explicitly, limits or restricts an Airmen's participation in deployment or mobility actions. Mobility qualifications are outlined in AFI 48-123.

Physical Profile—a long-standing or permanent assessment of an Airman's ability to participate in military activities. The physical profile is described using the PULHES system IAW AFI 48-123 with additional information in the Medical Standards Directory. It is validated annually at the PHA and as needed for actions related to Air Force career development.

Preventive Health Assessment (PHA)—A recurring assessment of an Airman's health status IAW AFI 44-170.

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 36-2603

18 SEPTEMBER 2017

Personnel

AIR FORCE BOARD FOR CORRECTION OF MILITARY RECORDS (AFBCMR)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available for downloading or ordering on the e-Publishing website at **www.e-Publishing.af.mil**.

RELEASABILITY: There are no releasability restrictions on this publication.

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(Daniel R. Sitterly, SES)
Pages: 17

This instruction implements DoDD 1332.41, *Boards for Correction of Military Records and Discharge Review Boards*, and AFPD 36-26, *Total Force Development*. It relates to procedures for correction of military records to remedy error or injustice and not to the Air Force Discharge Review Board (AFDRB). It tells how to apply for correction of military records and how the AFBCMR (the Board) considers applications. It implements the Board's statutory authority to act on applications. In collaboration with the Chief of Air Force Reserve (HQ USAF/RE), the Director of the Air National Guard (NGB/CF), and the Deputy Chief of Staff for Manpower, Personnel, and Services (HQ USAF/A1), the Assistant Secretary of the Air Force (Manpower and Reserve Affairs) (SAF/MR) develops Air Force Board For Correction of Military Records guidance. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of IAW the Air Force Records Disposition Schedule (RDS) in the Air Force Records Information Management System (AFRIMS). This publication applies to the Air National Guard (ANG) and the Air Force Reserve (USAFR). The authorities to waive FOA level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of*

Publication; route AF Forms 847 from the field through the appropriate functional chain of command. This instruction may not be supplemented.

This instruction directs collecting and maintaining information subject to the Privacy Act of 1974 authorized by Title 10, United States Code (U.S.C) § 1034 and 1552. System of Records notice F036 SAFCB A, Air Force Correction Board Records, applies.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include defining the authority of the Director, AFRBA to appoint AFBCMR panel members; expanding the authority of the Executive Director of the AFBCMR to return applications without action when all available avenues of administrative relief have not been exhausted, he or she determines the application is clearly frivolous, or the remedy that is requested is beyond the authority of the Board; defines a proper applicant; describes the Director's authority to reject a request for reconsideration of an application when an applicant fails to provide new and/or relevant evidence that was not reasonably discoverable when the original application was submitted; stipulates a three-year period from the date of an original AFBCMR decision in which to request a one-time reconsideration and incorporates authority of the Board to reconsider an application upon its own motion; incorporates modification of the definition of persons eligible to apply for relief to the Board in accordance with guidance issued by the Secretary of the Air Force (SAF) pursuant to 10 U.S.C. § 1552(g); incorporates guidance on the liberal consideration of post-traumatic stress disorder (or similar diagnosis) on requests to upgrade other than honorable characterizations of service (e.g., undesirable, under other than honorable conditions (UOTHC), bad conduct discharge (BCD), dishonorable discharge (DD), dismissal, etc.); incorporates statutory requirements in accordance 10 U.S.C. § 1552(g), as modified by the Fiscal Year (FY) 2015 National Defense Authorization Act (NDAA) § 521, that mandate that any medical opinion issued to the Board with respect to a member or former member of the armed forces who was diagnosed while serving in the armed forces as experiencing a mental health disorder shall include the opinion of a clinical psychologist or psychiatrist if the request relates to a mental health disorder; incorporates the statutory requirements in accordance with the FY 2015 NDAA § 547 that mandate a confidential review process for applicants who claim to be the victim of sexual assault; prescribes procedures under which a request for correction of a military record may be made if the request is made on behalf of a group of members or former members of the armed forces who were similarly harmed by the same error or injustice in accordance with the provisions of the 10 U.S.C. § 1552(b), as modified by the FY 2016 NDAA § 521; incorporates SAF/MR policy directing that senior leader (general officer and senior executive service) contact with the Air Force Review Boards Agency (AFRBA) be routed through the Director, AFRBA, or Principal Deputy Assistant Secretary of the Air Force, Manpower and Reserve Affairs; incorporates policy requiring advisory opinions pertaining to high-level decorations (Silver Star or higher), promotion issues, return to flying status, or containing allegations of reprisal to be signed by at least a colonel or GS-15 within the organization providing the advisory opinion.

1. Roles and Responsibilities.

1.1. **Secretary of the Air Force (SAF).** In accordance with 10 U.S.C. § 1552, *Correction of military records: claims incident thereto,* the SAF is authorized to correct any military record of the Department when the SAF considers it necessary to correct an error or remove an injustice. Such corrections shall be made by the Secretary acting through boards of civilians in the executive part of the Department.

1.2. **Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR).** SAF/MR exercises the authority under 10 U.S.C. § 1552 on behalf of the SAF. SAF/MR has further delegated this authority to the Director of the Air Force Review Boards Agency (AFRBA).

1.3. **Director, AFRBA:** The Director, AFRBA appoints all members of the Board. Board members must be members of the Senior Executive Service (SES) or hold the grade of GS-15. No one may be appointed a member of the Board within five years after relief from active duty as a commissioned officer of a regular component of an armed force, except by individual waiver approved by SAF/MR. This five-year waiting period will also apply to a reserve component commissioned officer, who after twenty years of active service, retired under 10 U.S.C. § 8911, 10 U.S.C. § 3911, or 10 U.S.C. § 6323.

1.4. **Executive Director, Air Force Board for Correction of Military Records (AFBCMR).** Administer and oversee the operation of the AFBCMR and develop and publish policy, procedures, and evaluation standards related to the correction of records process.

1.5. The AFBCMR operates within the Office of the Secretary of the Air Force according to 10 U.S.C. § 1552 and DoDD 1332.41, *Boards for Correction of Military Records (BCMR) and Discharge Review Boards (DRBs)*. The Board consists of civilians in the executive part of the Department of the Air Force who serve at the pleasure of the SAF. Three members constitute a quorum of the Board.

2. Board Responsibilities.

2.1. **Considering Applications.** The Board considers all applications properly brought before it. In appropriate cases, it recommends correction of military records to remove an error or injustice.

2.2. **Recommending Action.** When the Board determines an applicant has been the victim of reprisal in violation of 10 U.S.C. § 1034, or AFPD 90-3, *Inspector General, the Complaints Resolution Program*, it may recommend to the SAF that disciplinary or administrative action be taken against those responsible for the reprisal.

2.3. **Deciding Cases.** The Board normally decides cases on the written evidence contained in the record. It is not an investigative body; therefore, the applicant bears the burden of providing evidence of an error or injustice. However, the Board may, in its discretion, hold a hearing or call for additional evidence or opinions in any case. Applicants may request a hearing; however the decision to grant a hearing is at the sole discretion of the Board.

3. Application Procedures.

3.1. **Who May Apply.** The following persons/entities are eligible to apply to the Board for corrections of Air Force records ("Applicants"):

3.1.1. Current or former members of the United States Air Force, the Air National Guard (ANG), the Air Force Reserve (USAFR), or their predecessor organizations;

3.1.2. Current or former members of other armed services for whom the United States Air Force maintains a record;

3.1.3. The heirs or legal representatives of persons identified in 3.1.1 and 3.1.2 above;

3.1.4. Dependents, spouses, or former spouses of persons identified in 3.1.1 and 3.1.2 above; and

3.1.5. Employees or former employees of the Department of the Air Force, except in regard to civilian employment matters.

3.1.6. Apart from applicants qualified under 3.1.3, no applicant is eligible to obtain a correction of another person's record, unless the application pertains to a group of current or former members submitted under the provisions of 10 U.S.C. § 1552(b), as implemented by paragraph 3.10 below, that authorize the SAF to make such an application. However, this restriction in no way limits the authority of Air Force offices to make administrative corrections in cases of manifest error.

3.2. **Obtaining Forms.** Applicants may obtain a DD Form 149, *Application for Correction of Military Record Under the Provisions of 10 U.S.C. § 1552*, and Air Force Pamphlet 36-2607, *Applicants' Guide to the Air Force Board for Correction of Military Records (AFBCMR)*, from any of the following sources:

3.2.1. From the internet at the Department of Defense Publishing website, **http://www.dtic.mil/whs/directives/forms/eforms/dd0149.pdf** (DD Form 149), or Air Force e-publishing website, **http://www.e-publishing.af.mil/** (AFPAM 36-2607).

3.2.2. Any Air Force personnel or publications distribution office.

3.2.3. Most veterans' service organizations.

3.2.4. The Air Force Review Boards Office, SAF/CMO, 550 C Street West, Suite 40, Joint Base San Antonio-Randolph, TX 78150-4742.

3.2.5. The AFBCMR, 1500 West Perimeter Road, Joint Base Andrews Naval Air Facility Washington, MD 20762.

3.3. **Preparation.** Before applying, applicants should:

3.3.1. Review Air Force Pamphlet 36-2607, *Applicants' Guide to the AFBCMR*.

3.3.2. Discuss their concerns with a Total Force Service Center representative, finance office, or other appropriate officials who can refer applicants to available avenues of administrative relief (*e.g.*, performance reports – Evaluation Reports Appeals Board (ERAB), fitness test results – Fitness Assessment Appeals Board (FAAB), debts incurred while on active duty – Remissions Board, etc.) that do not require referral to the Board.

3.3.3. Exhaust all other available administrative remedies; otherwise, the Executive Director of the AFBCMR should administratively close the case, without prejudice, and return it without action.

3.4. **Submitting the Application.** Applicants should complete all applicable sections of the DD Form 149, including at least:

3.4.1. The name of the applicant or, when the applicant is an heir or legal representative, the name of the person whose record the applicant wishes the Board to correct. For group applications, see paragraph 3.10.

3.4.2. That person's social security number or military service number.

3.4.3. The applicant's current mailing address, e-mail address, and contact number(s). E-mail, when available, will be the primary means of communication between the AFBCMR staff and the applicant.

3.4.4. The error or injustice and specific correction to the military records required to remedy the alleged error or injustice. The applicant has the burden of providing evidence in support of their claim they are the victim of an error or injustice.

3.4.5. Legal proof of the applicant's status as heir or legal representative if requesting correction of another person's records.

3.4.6. The applicant's ink signature accompanying any paper or facsimile submission. A scanned or facsimile copy of the DD Form 149 is considered a legitimate application and may be transmitted via electronic means. The completion of an electronic fillable DD Form 149, found online, will require the use of a legitimate Department of Defense Common Access Card (CAC) or identity verified electronic or digital signature. If the applicant signs the form electronically without a verified signature, then he/she must also submit a scan of a notarized letter for the record stating the time and date the application was signed along with the submission. The person who is requesting a correction of his or her record must sign the application. If the individual whose record is at issue is deceased or cannot sign due to incompetency, the application may be signed by an heir or legal representative. Proof of death, incompetency, or power of attorney must accompany the application.

3.4.7. Applicants should mail the signed DD Form 149 and any supporting documents to the Air Force address on the back of the form if submitting in paper. To expedite processing, applicants may elect to file electronically. Electronic filing options include (1) email of submission to include the scanned or fillable DD Form 149 and supporting documents to **saf.mrbr.tier1@us.af.mil**, or (2) upload the scanned or fillable submissions through a secure web-based intake portal, similar to what is available via MyPers, if/when made available.

3.5. **Meeting Time Limits.** Applicants must file an application within 3years after the error or injustice was discovered, or, with due diligence, should have been discovered. Timeliness is not measured strictly from the date of the action/event the applicant alleges makes then the victim of an error or injustice, but is measured from the date of when the error or injustice was discovered or should have been discovered by the applicant with reasonable diligence.

In accordance with federal law, time on active duty is not included in the 3-year period. An application filed later is untimely and may be denied by the Board on that basis.

3.5.1. The Board may excuse untimely filing in the interest of justice.

3.5.2. If the application is untimely filed, the applicant should explain why the application was untimely filed and why it would be in the interest of justice for the Board to waive the statute of limitations.

3.6. **Stay of Other Proceedings.** Applying to the AFBCMR does not stay other proceedings.

3.7. **Representation by Counsel.** Applicants may be represented by counsel, at their own expense.

3.7.1. The term "counsel" includes members in good standing of the bar of any state; accredited representatives of veteran or service organizations recognized under 38 U.S.C. § 5902; and other persons determined by the Executive Director of the Board to be competent to represent the interests of the applicant.

3.7.2. See DoDD 7050.06, *Military Whistleblower Protection* and AFI 90-301, *Inspector General Complaints Resolution,* for special provisions in cases processed under 10 U.S.C. § 1034.

3.8. **Application format.** Applicants must use the DD Form 149. Along with the DD Form 149, applicants or counsel may submit briefs in support of applications.

3.8.1. Briefs may not exceed 25 double-spaced pages; must be typed or computer-printed on one side of each page, with the left margin justified, with not more than 12 characters per inch and no less than one-inch margins on all sides; and must be assembled without staples or bindings to permit easy reproduction and digital scanning. Electronic submissions are encouraged.

3.8.2. The Board staff will return an illegible application or brief and administratively close the case without action. Although administrative closure in no way precludes an applicant from re-applying at a later date, it does not suspend the three-year statute of limitations to file an application.

3.8.3. The Board staff will return electronic applications or briefs that cannot be opened on receipt and will close the case without prejudice, as above.

3.8.4. Rebuttals to advisory opinions must not exceed 10 pages and must meet the other requirements for briefs.

3.8.5. Supporting documentary evidence may exceed the 25-page limit, but must meet certain other requirements for briefs, to include legibility, the requirement to be assembled without staples or bindings to permit easy reproduction and digital scanning, and be printed on one side of each page.

3.8.6. In rare, complex cases, the Executive Director of the Board may waive the limitations on the length of briefs.

3.9. **Withdrawing Applications.** Applicants may withdraw an application at any time before the Board's decision. Withdrawal does not stay the 3-year time limit.

3.10. **Group Applications.** In accordance with 10 U.S.C. § 1552(b), the SAF may file a request for correction of a military record if the request is made on behalf of a group of members or former members of the Regular Air Force, Air National Guard, Air Force Reserve (or predecessor organizations) who were similarly harmed by the same error or injustice. Such a request must be staffed to the SAF for approval by the applicable MAJCOM, FOA, or HAF functional 2-letter office prior to submission to the AFBCMR. The staff package must be staffed in accordance with HAF staffing procedures. No specified form is required. At a minimum, coordination with SAF/GC and SAF/MR is required before staffing the request to SAF/OS, which must include the following:

3.10.1. A list indicating each individual's name and social security number.

3.10.2. A comprehensive summary of the facts and circumstance surrounding the purported error or injustice perpetrated against the group of named individuals supporting a determination that the group of named individuals are substantially similarly situated and have an identical basis for relief.

3.10.3. A description of the administrative remedies exhausted prior to seeking relief through the AFBCMR. All administrative avenues of relief must have been exhausted prior to submitting the application.

3.10.4. A specific recommendation as to the exact manner in which the records of the named individuals should be corrected, as well as identification of the agency responsible to carry out the correction of records, should the Board recommend that relief be granted.

3.10.5. SAF/MR will return any application not meeting the requirements above to the proponent without action. The proponent bears the same burden of proof as any individual applicant and the three-year statute of limitations also applies, although the Board could excuse the failure to timely file if it is in the interest of justice to do so. The Air Staff proponent of the application will be notified of the outcome of the case before the Board and is responsible for notification of each member represented in the application.

3.11. **Authority to Return Applications.** The Executive Director of the Board, or person delegated authority to act on his/her behalf, may return an application without action if he or she determines the applicant is not eligible to apply; the application is clearly frivolous; the applicant has not exhausted all available and effective administrative remedies; the requested remedy is unclear or is beyond the authority of the Board.

4. Board Actions.

4.1. **Board Information Sources.** The applicant has the burden of providing sufficient evidence of material error or injustice. The Board will recommend relief only when a preponderance (more likely than not) of evidence substantiates that the applicant was a victim of an error or injustice. The Board may request the applicant furnish additional information regarding matters before the Board.

4.2. Although not an investigative body, the Board may obtain the following from any organization/official within the Air Force or Department of Defense:

4.2.1. Any and/or all available military records (personnel, medical, financial etc.).

4.2.2. Advisory opinions. Advisory opinions represent the one and only opportunity the Air Force will have to affirm its position on a case and set forth its rationale. Advisory opinions will be staffed to agencies with a suspense of no more than 30 days **(T-1)** and must contain the following:

4.2.2.1. A statement of whether or not the requested relief can be accomplished administratively, whether or not the applicant has exhausted such administrative means before pursuing relief to the Board, and whether or not the application was timely filed.

4.2.2.2. A clear and concise summary of the relevant facts of the case, the applicant's contentions, an analysis addressing the crux issues of the case, and a recommendation based on the applicable Air Force policy, regulatory requirements, or applicable law in effect at the time of the alleged error or injustice.

4.2.2.3. Regardless of the recommendation provided (e.g., grant or deny), the advisory opinion shall include instructions on specific corrective action to be taken if the Board recommends relief be granted.

4.2.2.4. If the matter before the Board pertains to a high-level decoration (Silver Star or higher), promotion issues, return to flying status, or contains allegations of reprisal, the opinion must be signed by at least a colonel (O-6) or GS-15 within the organization providing the advisory. **(T-1)**

4.2.2.5. In the case of an applicant who was diagnosed while serving in the armed forces as experiencing a mental health disorder and the requested correction to the military records relates to a mental health disorder, any medical advisory will contain the opinion of clinical psychologist or psychiatrist in accordance with the provisions of 10 U.S.C. § 1552(g).

4.2.2.6. Certain cases may require multiple advisory opinions from a command or field operating agency (FOA) (e.g. AFPC, ARPC, NGB, AFRC, etc.). In such cases, the perspectives of multiple offices may be consolidated into a single opinion, or take the form of individual advisory opinions from the various offices. If multiple advisories are rendered, the opinions must represent the position of the command/FOA, not the individual office, and any differences on a specific issue must be reconciled within the command/FOA prior to submission to the BCMR **(T-1)**.

4.2.2.7. Commands/FOAs will appoint a single point of contact who will manage the command/FOA's internal advisory opinion development, staffing, coordination, and accountability processes. **(T-1)**

4.2.3. Relevant investigative reports (e.g. Inspector General (IG), Office of Special Investigation (OSI), Accident Investigation Reports, etc.).

4.3. **Applicant Notification.** Applicants shall be given an opportunity to review and comment on all correspondence and communications (including advisory opinions) to or from the AFRBA and with an entity or person outside the AFRBA that pertain directly to the applicant's case or may have a material effect thereon. This rule applies to spoken or telephonic communications, which must be summarized. This rule does not apply to

classified information; release of information which is otherwise prohibited or privileged by law or regulation (e.g., privacy act); any record previously provided to the applicant or known to be possessed by the applicant (such as records of adverse administrative actions showing acknowledgement by the applicant); purely administrative correspondence; and any military record that is or may be provided to the applicant by the Secretary of the military department or other source.

4.3.1. The applicant will be given no more than 30 days to review and respond to the material described in paragraph 4.3. The application will be processed for the Board's consideration at the end of the 30-day period with the available evidence of record, or upon receipt of the applicant's rebuttal, whichever occurs first. Applicants will not contact offices of primary responsibility (OPR) to respond to advisory opinions. Any response to the advisory opinion(s) will be submitted to the Board in writing before the end of the 30-day period described above.

4.3.2. Requests for an extension of the 30-day period will not be granted. Title 10, U.S.C., Section 1557 requires the Board to adjudicate 90 percent of its cases within ten months, with no single case exceeding 18 months in processing. Therefore, given this strict processing timeline, extensions to the 30-day period cannot be granted without compromising the Board's ability to comply with the provisions of 10 U.S.C. § 1557. However, an applicant may request their case be administratively closed, without prejudice, until such time as they are ready to proceed. Once ready to proceed, the applicant must notify the Board staff in writing (e-mail or regular mail) so processing of the case to the Board may be resumed.

4.3.3. If, in response to the advisory opinion, or at any other time, the applicant amends an active application for correction of records, the application may be closed at the discretion of the Executive Director and the applicant will be instructed to file a new DD Form 149 so the requests can be aggregated and adjudicated simultaneously.

4.3.4. Any requests for the status of an application before the Board (applicant initiated or otherwise) will be referred to the Air Force Review Boards Agency. Applicants may not make contact with OPRs to ascertain the status of their application before the Board, nor will OPRs divulge information to an applicant on the adjudication of their case before the Board, but will refer the inquiry to the Board staff for a response to the applicant. OPR access to the BCMR system of record is for official use only based on a strict need-to-know.

4.4. **Consideration by the Board.** A panel consisting of at least three board members considers each application. One panel member serves as chair. The panel's actions constitute the actions of the Board.

4.5. **Board Deliberations.** Normally, only members of the Board and Board staff will be present during deliberations. The panel chair may permit observers for training purposes or otherwise in furtherance of the functions of the Board.

4.6. **Board Hearings.** Applicants may request a hearing before the Board. Whether or not the Board authorizes a formal hearing is predicated on its finding that the applicant's presence, with or without counsel, would materially add to its understanding of the issues involved. The Board has the sole discretion to determine whether to grant a hearing. See

DoDD 7050.06, *Military Whistleblower Protection* and AFI 90-301, *Inspector General Complaints Resolution*, for special provisions in cases processed under 10 U.S.C. § 1034.

4.6.1. The Executive Director, AFBCMR, will notify the applicant and counsel, if any, of the time and place of the hearing. Written notice will be mailed or electronically transmitted not less than 30 days in advance of the hearing unless the notice period is waived by the applicant. Any response by the applicant must be received not later than 15 days before the hearing date, accepting or declining the offer of a hearing and, if accepting, provide information pertaining to counsel and witnesses. The Board will decide the case based on the evidence of record if the applicant declines the hearing, fails to respond, or fails to appear.

4.6.2. When granted a hearing, the applicant may appear before the Board, with or without counsel, and may present witnesses. It is the applicant's responsibility to notify witnesses, arrange for their attendance at the hearing, and pay any associated costs.

4.6.3. The panel chair conducts the hearing, maintains order, and ensures the applicant receives a full and fair opportunity to be heard. Formal rules of evidence do not apply, but the panel will generally consider relevancy and materiality when weighing evidence. Witnesses other than the applicant will not be present except when testifying. Witnesses will testify under oath or affirmation. A recorder will record the proceedings verbatim. The chair will normally limit hearings to two hours but may allow more time if necessary.

4.7. The Board will not recommend denial of an application on the sole ground the issue already has been decided by the SAF, Secretary of Defense (SECDEF), or the President of the United States in another proceeding.

4.8. **Liberal Consideration for Post-traumatic Stress Disorder (PTSD) and Related Conditions.** Liberal consideration will be given in cases where an applicant has presented evidence of a diagnosis of PTSD, or symptoms resembling PTSD, in requests to upgrade their other than honorable discharge (e.g., undesirable, under other than honorable conditions (UOTHC), bad conduct discharge (BCD), dishonorable discharge (DD), dismissal, etc.), where the applicant claims there is a causal nexus between the PTSD or PTSD symptoms and the misconduct which precipitated the discharge. If applicable, the three-year statute of limitations prescribed in paragraph 3.5 will be waived by the Board.

4.9. **Review of Sexual Assault Cases.** The Board will utilize a confidential process by which an individual who was the victim of a sex-related offense during service in the Armed Forces may challenge the terms or characterization of the discharge or separation of the individual from the Armed Forces on the grounds the terms or characterization were adversely affected by the individual being the victim of such an offense. The Board will give due consideration to the psychological and physical aspects of the individual's experience in connection with the sex-related offense and determine what bearing such experience may have had on the circumstances surrounding the individual's discharge or separation from the Armed Forces. To ensure confidentiality, the Board staff will ensure the application pertaining to such a person is processed in such a way as to preclude the access of the application, advisory opinions, and the Board's ultimate decision, to those without a need to know. Final Records of Proceeding (ROP) in such cases will not be posted to the reading room without the consent of the applicant.

4.10. **Board Recommendations.** The panel's majority vote constitutes the action of the Board. The Board shall make a final written recommendation to the SAF, or SAF's delegee, based on determination on the following issues:

4.10.1. Whether the application was filed within 3 years after the error or injustice was reasonably discoverable and, if not, whether the applicant has demonstrated that it would be in the interest of justice to excuse the untimely filing. When the Board determines that an application is not timely, and does not excuse its untimeliness, the application will be denied on that basis.

4.10.2. Whether the applicant has demonstrated the existence of a material error or injustice that can be remedied effectively through correction of the applicant's military record and, if so, what corrections are needed to provide full and effective relief.

4.10.3. Whether the provisions of the 10 U.S.C. § 1034 apply to the application. This determination is needed only when the applicant invokes this protection, or when the question of its applicability is otherwise raised by the evidence.

4.10.4. In cases identified under paragraph 4.10.3, the Board may recommend to the SAF that disciplinary or administrative action be taken against any Air Force official whom the Board finds to have committed an act of reprisal against the applicant. Any determination on this issue will not be made a part of the Board's ROP in the case at hand and will not be given to the applicant, but will be provided directly to the SAF under separate cover (paragraph 2.2).

4.11. **Record of Proceedings.** The Board staff will prepare a ROP following deliberations which will include:

4.11.1. The name and vote of each Board member.

4.11.2. The application.

4.11.3. Briefs and written arguments.

4.11.4. Documentary evidence.

4.11.5. A hearing transcript if a hearing was held.

4.11.6. Advisory opinions (if obtained) and the applicant's related comments.

4.11.7. The findings, conclusions, and recommendations of the Board.

4.11.8. Minority reports, if any.

4.11.9. Other information necessary to show a true and complete history of the proceedings.

4.12. **Minority Reports.** There will be situations where, after deliberations, a voting panel member will disagree with the recommendation of the majority. In those instances, the dissenting panel member(s) may prepare a minority report, which may address any aspect of the case, explaining the rationale for their position.

4.13. **Separate Communications.** The Board may send comments or recommendations to the SAF as to administrative or disciplinary action against individuals found to have committed acts of reprisal prohibited by the Military Whistleblowers Protection Act and on

other matters arising from an application not directly related to the requested correction of military records. Such comments and recommendations will be separately communicated and will not be included in the record of proceedings or given to the applicant or counsel.

4.14. **Final Action by the Board.** The Board sends the record of proceedings describing its recommendations on each application to the SAF or to the SAF's delegee for final decision. For Military Whistleblower cases (10 U.S.C. § 1034), if the applicant is not satisfied with the final decision, it may be appealed to the SECDEF.

4.15. The Board may identify DoD or Air Force policies, instructions, guidance or practices that are leading to, or likely to lead to unsound organizational decisions, unfair results, waste of government funds or public criticism. The Board will forward such observations directly to the appropriate offices of the Secretariat, the Air Staff, or both, for review and evaluation. Such observations will not be included in the ROP.

5. Decision of the SAF. In accordance with Secretarial delegations of authority, the SAF, or the SAF's delegee, will direct such action as the SAF or delegee deems appropriate on each case, including returning the case to the Board for further consideration. Cases returned to the Board for further reconsideration will be accompanied by a brief statement of the reasons for such action. If the SAF or delegee does not accept the Board's recommendation, the decision will be in writing and will include a brief statement of the grounds for his or her final decision.

5.1. **Decisions in Cases Under the Military Whistleblowers Protection Act.** In resolving an application for the correction of records made by a member or former member of the armed forces who has alleged a personnel action prohibited by the Military Whistleblowers Protection Act, the Board may review the matter. The SAF will issue decisions on such cases within 180 days after the application is filed. If the SAF fails to issue a final decision within that time, the applicant shall be deemed to have exhausted administrative remedies and may appeal to the SECDEF or Federal Court as applicable. Additionally, unless the full relief requested is granted, the Board will inform the applicant of their right to request review of the decision by the SECDEF. Applicants will also be informed of the following:

5.1.1. The name and address of the official to whom the request for review must be submitted;

5.1.2. The request for review must be submitted within 90 days after receipt of the decision by the SAF;

5.1.3. The request for review must be in writing and include the applicant's name, address, email address, and telephone number; a copy of the application to the AFBCMR, the final decision of the SAF, and a statement of the specific reasons the applicant is not satisfied with the decision;

5.1.4. The request must be based on the Board record; requests for review based on factual allegations or evidence not previously presented to the Board will not be considered under this paragraph, but may be the basis for reconsideration by the Board under paragraph 6.

5.2. In cases under paragraph 5.1 which involve additional issues not cognizable under that paragraph, the additional issues may be considered separately by the Board under paragraphs 3 and 4. The special time limit in paragraph 5.1 does not apply to the decision concerning these additional issues.

5.3. In resolving an application for the correction of records made by a member or former member of the armed forces in which the request is based on an alleged incorrect Inspector General finding of reprisal by the applicant, if the Board considers the applicant to have raised potentially new matters, it will refer the applicant's new matters to the Air Force Inspector General (SAF/IG).

5.3.1. SAF/IG will determine if the applicant's matters are, in fact, new, relevant, and material; and if so, whether the new matters warrant that SAF/IG reopen their investigation.

5.3.2. If SAF/IG finds no new matters in the application, or determines that the new matters are not relevant or material to the original reprisal determination, it shall return the case to the Board within 30 days, informing the Board of their determination. SAF/IG may also submit their analysis of the applicant's new matters to DoD IG for oversight and approval.

5.3.3. If SAF/IG revises in any way their original findings of reprisal by the applicant, SAF/IG will refer the case to DoD IG for statutorily required oversight and approval. Upon receipt of DoD IG's final approval, the case will be returned to the Board within 15 days.

5.3.4. Regardless of SAF/IG's determinations in paragraphs 5.3.1, 5.3.2, and 5.3.3, SAF/IG shall provide an advisory to the Board regarding its determination(s). At a minimum, the advisory shall address the applicant's contentions and provide a recommendation for granting or denying the requested relief.

5.4. In all cases, all relevant Inspector General records will be made available to the Board for their use in cases under paragraph 5.3 which involve additional issues not cognizable under that paragraph, the additional issues may be considered separately by the Board under paragraphs 3 and 4. The special time limit in paragraph 5.1 does not apply to the decision concerning these additional issues.

6. Reconsideration of Applications. The Board may reconsider an application if the applicant, within 3 years of the original decision, submits newly discovered relevant evidence that was not reasonably available when the application was previously considered. The request for reconsideration must be accompanied by a new DD Form 149, bearing the applicant's signature and describing the specific correction requested, as well as the reasons the applicant believes he or she is the victim of an error or injustice. Each request for reconsideration will be screened to determine whether or not it contains new and relevant evidence that was not available or reasonably discoverable when the original application was filed. New arguments about, or analysis of evidence already considered and additional statements that are cumulative to those already in the record of proceedings will not be considered new evidence. The Board may also reconsider an application upon its own motion.

6.1. If the request does not contain new evidence, the Executive Director or the Executive Director's designee will return it to the applicant without referral to the Board.

6.2. If the request contains new evidence, the Executive Director or his or her designee will refer it to a panel of the Board for a decision. The Board will decide the relevance and weight of any new evidence and whether it was reasonably available to the applicant when the application was previously considered. The Board may deny reconsideration if the new evidence is not relevant to the original matter or if it was reasonably available to the applicant when the original application was submitted. Otherwise, if the Board deems the evidence new and relevant, it will reconsider the case on the merits. In any case, an ROP will be prepared by the AFBCMR staff in accordance with paragraph 4.11.

6.3. If the AFBCMR receives a request for reconsideration more than 3 years after the Board's original decision, the case will be returned without action and the applicant will be advised the next remedy is appeal to a court of appropriate jurisdiction.

7. Action After Final Decision.

7.1. **Action by the Executive Director.** The Executive Director or his or her designee will inform the applicant or counsel, if any, of the final decision on the application. If any requested relief was denied, the Executive Director will advise the applicant of reconsideration procedures and, for cases processed under 10 U.S.C. § 1034, procedures for review by SECDEF. The Executive Director will send decisions requiring corrective action (directives) to the Chief of Staff of the Air Force (or appropriate designee) for necessary action. These directives are final and conclusive on all officers of the government. Directives will be staffed to command/FOA/Air Force/DoD agency responsible for promulgating the corrective action. Corrective action should be taken within 30 days **(T-1)** of the date of the instrument and copies of corrected documents should be provided to the Air Force Review Boards Agency Case Management Office. Commands/FOAs (e.g. AFPC, AFRC, NGB, AFRC, etc.) will appoint a single point of contact to manage the directive promulgation process. **(T-1)**

7.2. **Settlement of Claims.** The Air Force is authorized, under 10 U.S.C. § 1552, to pay claims for amounts due to applicants as a result of correction of military records.

7.2.1. The Executive Director will furnish the Defense Finance and Accounting Service (DFAS) with AFBCMR decisions potentially affecting monetary entitlement or benefits. DFAS will treat such decisions as claims for payment by or on behalf of the applicant.

7.2.2. DFAS settles claims on the basis of the corrected military record. Computation of the amount due, if any, is a function of DFAS. Applicants may be required to furnish additional information to DFAS to establish their status as proper parties to the claim and to aid in deciding amounts due.

7.2.3. Earnings received from civilian employment during any period for which active duty pay and allowances are payable will be deducted from the settlement. Amounts found due will be offset by the amount of any existing indebtedness to the government.

7.2.4. Payment of Expenses. The Air Force has no authority to pay expenses of any kind incurred by or on behalf of an applicant in connection with a correction of military records under 10 U.S.C. § 1034 or § 1552.

7.3. **Public Access to Decisions.** After deletion of personal information, AFBCMR decisions will be made available for review and copying via an electronic public reading room at **http://boards.law.af.mil/AF_BCMR.htm**.

8. Miscellaneous Provisions.

8.1. **Access to Records.** Applicants will have access to all records considered by the Board, except those exempted by law. Inasmuch as the AFBCMR is not the custodian for master personnel records, any applicant requesting these records will be referred to the National Personnel Records Center (NPRC), 1 Archive Drive, St. Louis, MO 63138, (314) 801-0800, **http://www.archives.gov/st-louis**, or, if still serving, the appropriate servicing personnel agency.

8.2. **Senior Leaders Communications with Air Force Review Boards Agency.** Any inquiry about a specific pending case before the AFBCMR by a senior official (general officer or Senior Executive Service (SES)) should be routed through the Director, AFRBA or the Principal Deputy Assistant Secretary of the Air Force (Manpower and Reserve Affairs).

DANIEL R. SITTERLY
Acting Assistant Secretary of the Air Force
Manpower and Reserve Affairs

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Fiscal Year 2015 National Defense Authorization Act (NDAA), Sections 521 and 547

Title 10, United States Code (U.S.C.), Section 1552

Title 10, U.S.C., Section 1556

Title 10, U.S.C., Section 1557

Title 10, U.S.C., Section 1034

DoDD 1332.41, *Boards for Correction of Military Records and Discharge Review Boards*, 8 March 2004

DoDD 7050.06, *Military Whistleblower Protection*, 15 April 2015

AFPD 90-3, *Inspector General, the Complaints Resolution Program,* 9 June 2016

AFI 90-301, *Inspector General Complaints Resolution*, 27 August 2015

AFMAN 33-363, *Management of Records*, 1 March 2008

AFPAM 36-2607, *Applicants' Guide to the Air Force Board for Correction of Military Records* **(AFBCMR)**, 3 November 1994

Secretary of Defense Memorandum, Supplemental Guidance to Military Boards for Correction of Military/Naval Records Considering Discharge Upgrade Requests by Veterans Claiming Post Traumatic Stress Disorder, 3 September 2014, and Acing Principal Deputy Secretary of Defense for Personnel and Readiness (OUSD-P&R) memorandum, Consideration of Discharge Upgrade Requests Pursuant to Supplemental Guidance to Military Boards for Correction of Military/Naval Records (BCMRs/BCNR) by Veterans Claiming Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI), 24 February 2016.

SAF/MR Memorandum, Senior Leader Communications with Air Force Review Boards Agency, dated 5 October 2011

SAF/MR Memorandum, Preparation of Advisory Opinions before the Air Force Board for Correction of Military Records (AFBCMR), dated 20 June 2012

Adopted Forms

DD Form 149, *Application for Correction of Military Records*, December 2014

AF Form 847, *Recommendation for Change of Publication*, 22 September 2009

Abbreviations and Acronyms

AFBCMR—Air Force Board for Correction of Military Records

AFDRB—Air Force Discharge Review Board

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFPC—Air Force Personnel Center

AFRBA—Air Force Review Boards Agency

AFRC—Air Force Reserve Command

AFRIMS—Air Force Records Information Management System

ARPC—Air Reserve Personnel Center

BCD—Bad Conduct Discharge

CAC—Common Access Card

DD—Dishonorble Discharge

DFAS—Defense Finance and Accounting Service

FOA—Field Operating Agency

NDAA—National Defense Authorization Act

NGB—National Guard Bureau

OPR—Office of Primary Responsibility

PTSD—Post-traumatic Stress Disorder

RDS—Records Disposition Schedule

SECDEF—Secretary of Defense

U.S.C—United States Code

UOTHC—Under Other Than Honorable Conditions

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 36-2606

27 JULY 2017

Personnel

REENLISTMENT AND EXTENSION OF ENLISTMENT IN THE UNITED STATES AIR FORCE

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at **www.e-publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

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Pages: 1355

This Instruction implements Air Force Policy Directive (AFPD) 36-26, Total Force Development. This instruction also implements Department of Defense Instruction (DODI) 1304.29, Administration of Enlistment Bonuses, Accession Bonuses for New Officers in Critical Skills, Selective Reenlistment Bonuses, and Critical Skills Retention Bonuses for Active Members; DoDI 1304.21, Policy on Enlistment Bonuses, Accession Bonuses for New

Officers in Critical Skills, Selective Reenlistment Bonuses and Critical Skills Retention Bonuses for Active Members; DoDI 1304.31, Enlisted Bonus Program; DoDD 1332.41, Boards for Correction of Military Records (BCMRs) and Discharge Review Boards (DRBs); and DoD Financial Management Regulation (DoDFMR) Volume 7A, Military Pay Policy - Active Duty and Reserve Pay, **Chapter 2**, Repayment of Unearned Portion of Bonuses and Other Benefits.

It provides guidance and procedures for reenlisting and extending enlistments in the Regular Air Force (RegAF), the Air Force Reserve (AFR) and the Air National Guard (ANG). In collaboration with the Chief of Air Force Reserve (AF/RE) and the Director of the Air National Guard (NGB/CF), the Deputy Chief of Staff for Manpower, Personnel, and Services (AF/A1) develops policy for reenlistment and enlistment in the United States Air Force. This publication may be supplemented at any level; all Major Command (MAJCOM) level supplements must be approved by the Human Resource Management Strategic Board (HSB) prior to certification and approval. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, Management of Records, and disposed

of in accordance with the Air Force Records Disposition Schedule (RDS) located in the Air Force Records Information Management System (AFRIMS).

This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974, 5 United States Code (U.S.C.) section 552a, authorized by 10 USC § 8013 and Executive Order 9397 (SSN), as amended by Executive Order 13478. The applicable Privacy Act System of Records Notices F036 AF PC C, Military Personnel Records Systems, F036 AF PC G, Selective Reenlistment Consideration, F036 AFPC D, Selective Reenlistment Bonus and/or Advance Payment Request and F036 AFPC L, Unfavorable Information File (UIF) apply. Waivers to this instruction are authorized and shall be processed IAW AFI 33-360, Publications and Forms Management. Waiver requests will be submitted using the AF Form 679, Air Force Publication Compliance Item Waiver Request/Approval, or via e-mail or memorandum if the form is unavailable. Waivers must be approved by the OPR.

Refer to Attachment 1 for glossary. Process supplements that affect any military personnel function as shown in AFI 33-360, Publications and Forms Management, with AF/A1P. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, Recommendation for Change of Publication; route AF Form 847s from the field through AF/A1PP, Military Force Policy Division, 1040 Air Force Pentagon, Washington, DC 20330 or AF/A1P **Workflow@pentagon.af.mil**.

The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360 for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Adds tier waiver authority information and adds new AF Form 1411-1, Cancellation of Extension of Enlistment in the Air Force.

Chapter 1

ROLES AND RESPONSIBILITIES

1.1. Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR).

1.1.1. The Assistant Secretary of the Air Force for Manpower and Reserve Affairs serves as an agent of the Secretary and provides guidance, direction and oversight for all matters pertaining to the formulation, review and execution of plans, policies and budgets addressing reenlistments.

1.2. Deputy Chief of Staff for Manpower, Personnel and Services (AF/A1). (RegAF Only)

1.2.1. Functional authority and is responsible for policy oversight and advisory services related to the Air Force reenlistment program.

1.2.2. The Chief, Force Management Policy Division provides functional management of the Air Force reenlistment program and:

1.2.2.1. Develops, coordinates and enforces Air Force reenlistment policy.

1.2.2.2. Issues departmental level program guidance to implement Air Force reenlistment policy.

1.2.2.3. Decision authority for all reenlistment and extension requests that are not addressed within this instruction.

1.3. Director of Personnel, Office of Air Force Reserve (AF/REP). (AFR Only)

1.3.1. Functional authority and is responsible for policy oversight and advisory services related to the Air Force Reserve retention program and:

1.3.2. Develops, coordinates, and enforces the reenlistment policy.

1.3.3. Issues program guidance to implement Air Force Reserve reenlistment policy.

1.3.4. Decision authority for all reenlistment and extension requests that are not addressed within this instruction.

1.4. Director, Manpower, Personnel and Services (NGB/A1). (NGB Only)

1.4.1. Manages the Air National Guard reenlistment program by establishing eligibility criteria and processing requirements for the Selective Reenlistment Program (SRP), reenlistment and extension of enlistment in the Air National Guard.

1.4.2. Establishes qualitative standards and guidelines for program implementation and evaluating the quality of SRP decisions.

1.5. Headquarters Air Force Personnel Center (AFPC), Director, Personnel Programs (AFPC/DP3). (RegAF Only)

1.5.1. Manages the Air Force reenlistment program by establishing eligibility criteria and processing requirements for the Selective Reenlistment Program (SRP), Career Job Reservations (CJRs), Critical Skills Retention Bonus (CSRB), Selective Retention Bonus (SRB) Program, reenlistments and extension of enlistment. This includes establishing

qualitative standards and guidelines for program implementation and evaluating the quality of SRP decisions. In addition, AFPC/DP3:

1.5.1.1. Interprets Air Force policy.

1.5.1.2. Provides guidance and implementation instructions to the MPS.

1.5.1.3. Provides operational oversight for standardization and evaluation of the Air Force reenlistment program.

1.5.1.4. Reviews/forwards approved requests for retention that are not addressed within this instruction.

1.5.1.5. Acts as required on behalf of the Commander, Air Force Personnel Center when delegated.

1.6. Headquarters Air Force Reserve Command (AFRC), Chief, Military Personnel Division (A1K). The issue

1.6.1. OPR for retention of personnel assigned to Air Force Reserve Command. AFRC/A1K coordinates with Air Reserve Personnel Center (ARPC) on Active Guard & Reserve (AGR) career management matters and with the HQ Readiness and Integration Organization (RIO) on Individual Reservist (IR) matters. RIO Detachment Commanders (Det/CCs) provide oversight and assistance to active component commanders for retention and career counseling. AFRC/A1K:

1.6.2. Interprets Air Force A1 policy as it relates to AFR personnel.

1.6.3. Provides guidance and implementation instructions to the Military Personnel Section (MPS). (T-2).

1.6.4. Provides operational oversight for standardization and evaluation of the Air Force Reserve Retention Program.

1.6.5. Publishes and analyzes quarterly AFR reenlistment and loss statistics.

1.7. Headquarters Air Reserve Personnel Center (ARPC), Career Sustainment Division (DPTS). The issue.

1.7.1. DPTS identifies Airmen who require SRP consideration or reconsideration. DPTS:

1.7.1.1. Acts as principal advisor to Det/CCs and Individual Mobilization Augmentee (IMA) and Participating Individual Ready Reserve (PIRR) members on all reenlistment issues.

1.7.1.2. Provides a structured program in compliance with this AFI.

1.7.1.3. Coordinates reenlistment and retention issues with appropriate RIO Det/CCs.

1.7.1.4. Reviews/forwards approved requests for retention that are not addressed within this instruction to AFRC/A1K.

1.7.1.5. Forwards all retention issues/questions to AFRC/A1K (AFR) as appropriate.

1.7.1.6. Utilizes the current Personnel Services Delivery Guide (PSDG) that provides procedures for operating the reenlistment program; and obtains and maintains all applicable

Personnel Services Delivery Memorandums (PSDM) relating to implementation and MPS management/responsibilities on various reenlistment programs.

1.7.1.7. Produces the monthly SRB Roster, sends it to the RIO Det/CCs for certification, and processes any termination action(s) they require.

1.8. Military Personnel Management Officer (MPMO). (ANG Only)

1.8.1. Ensures compliance with this directive across all ANG wings within their state/territory.

1.8.2. Reviews and forwards requests for retention that are not addressed within this instruction to the appropriate approval authority for consideration.

1.8.3. Coordinates policy guidance and issues resolution as a liaison between NGB/A1 and Wing MPS's and advises wing program managers on issues affecting reenlistment and extension of enlistment.

1.8.4. Processes reenlistment non-selection appeal cases requiring The Adjutant General (TAG) consideration.

1.8.5. Maintains oversight of ANG wing reenlistment or extension of enlistment programs.

1.9. Commander, Readiness and Integration Organization (RIO/CC), which is inclusive of the IMA and PIRR and share ADCON with the Active Component Commander. (AFR only)

1.9.1. Administers the Career Retention Program for IRs.

1.9.2. Det/CCs are responsible for developing Career Retention Programs to ensure retention of qualified IMA and PIRR members.

1.9.3. Det/CCs are responsible for implementing the Career Retention Program for their installation.

1.9.4. RegAF Commander. Initiates (as required), reviews and coordinates on all requests for action and recommends approval/disapproval of reenlistment program actions that are consistent with other qualitative actions.

1.9.4.1. Ensure requests outside established Air Force guidance are thoroughly viewed/considered and such requests are in the best interest of the Air Force.

1.9.4.2. Commanders forward their approved requests to RIO Detachment for processing.

1.10. Wing/Group Commanders (Unit Program Only). (AFR only) Wing and group commanders work with the MPS to develop and conduct an aggressive and continuous career retention program to ensure organizations are fully staffed.

1.11. Military Personnel Section (MPS), Career Development Program Manager.

1.11.1. The MPS Career Development Section is the base-level OPR for reenlistment programs. The MPS assists commander/civilian directors in maintaining mission readiness by affording qualified Airmen the opportunity to pursue an Air Force career. The servicing MPS identifies Airmen who require SRP consideration or reconsideration. The MPS:

1.11.1.1. Acts as principal advisor to commanders and Airmen on all reenlistment issues.

1.11.1.2. Provides a structured program in compliance with this AFI.

1.11.1.3. Coordinates reenlistment and retention issues with appropriate wing personnel.

1.11.1.4. Reviews/forwards approved requests for retention that are not addressed within this instruction to AFPC Reenlistments (RegAF), AFRC/A1K (AFR) or the state MPMO (ANG), as appropriate.

1.11.1.5. Operates reenlistment programs within National Guard Bureau (NGB)-directed guidelines (Applicable to ANG only).

1.11.1.6. Coordinates reenlistment and extension issues with appropriate state headquarters and/or Wing personnel (Applicable to ANG only).

1.11.1.7. Provides training to unit Commander's Support Staff (CSS) Reenlistment/Extension of Enlistment Program Managers to ensure effectiveness of unit programs (Applicable to ANG only).

1.11.1.8. Ensures documents completed by CSS Program Managers are error-free and submitted in a timely manner for processing (Applicable to ANG only).

1.11.1.9. Oversees the wing reenlistment and extension of enlistment program. Provides reports to wing leadership and state headquarters as required (Applicable to ANG only).

1.11.1.10. Ensures all reenlistment and extension actions are finalized in the Personnel Data System (PDS) prior to Expiration Term of Service (ETS) (Applicable to ANG only).

1.11.1.11. Forwards all retention issues/questions to AFPC Reenlistments (RegAF), AFRC/A1K (AFR) or the state MPMO (ANG), as appropriate.

1.11.1.12. Utilizes the current Personnel Services Delivery Guide (PSDG) that provides procedures for operating the reenlistment program and obtain and maintain all applicable Personnel Services Delivery Memorandums (PSDM) relating to implementation and MPS management/responsibilities on various reenlistment programs.

1.11.1.13. Produces the monthly SRB Roster, sends it to the commander/civilian directors for certification, and processes any termination action(s) they require.

1.12. Commander/Civilian Director.

1.12.1. Initiates (as required), reviews and coordinates on all requests for action and recommends approval/disapproval of reenlistment program actions that are consistent with other qualitative actions. Commander/civilian director:

1.12.1.1. Ensures appropriate retention decisions and requirements are taken.

1.12.1.2. Ensures requests that are not addressed within this instruction are thoroughly reviewed and considered in the best interest of the Air Force. Commander/civilian director forwards their approved requests to MPS for processing.

1.12.1.3. Appoints in writing an appropriate Noncommissioned Officer (NCO) as an additional duty Unit Career Advisor (UCA) to administer the Career Retention Program. Retrainees or Airmen in upgrade training are ineligible. The individual must be knowledgeable about AFR benefits and career opportunities, as well as a respected mentor within the unit. In large units or units with multiple monthly Unit Training Assemblies (UTAs), appoint an assistant UCA (Applicable to AFR only).

1.12.1.4. Reviews the reenlistment eligibility of assigned members each month and annotate SRP rosters accordingly. This roster is returned to the MPS as suspensed.

1.12.1.5. Completes AF Form 418, Selective Reenlistment Program Consideration for Airmen, to modify reenlistment eligibility from "selected" to "not selected" or, from "not selected" to "selected," as appropriate.

1.12.1.6. Coordinates reenlistment/extension of enlistment actions through the CSS to the MPS.

1.12.1.7. Maintains oversight of unit reenlistment/extension of enlistment programs.

1.12.1.8. Ensures reenlistment ceremonies are held in a dignified manner and in accordance with military protocol requirements.

1.12.1.9. Certifies eligibility for SRB on the monthly SRB Roster and returns the roster to the servicing Military Personnel Section noting any Airmen no longer performing SRB duties.

1.13. Commander Support Staff (CSS)/Unit Career Advisors (UCA).

1.13.1. The CSS provides oversight and management of the unit reenlistment and extension program and provides a monthly SRP roster to the commander/civilian director for reenlistment consideration. The CSS:

1.13.2. Performs quality control of completed retention-related forms ensuring all requirements are complete and reflect accurate data/entitlements/eligibility.

1.13.3. Provides a completed SRP Roster along with any required AF Forms 418 to the MPS for PDS processing (reenlistment [RE] code update) and filing.

1.13.4. Coordinates with the Wing Retention Office Manager (ROM) / Recruiting and Retention Non-Commissioned Officer (RRNCO) when reenlistment eligibility changes from "selected" to "not selected" or from "not selected" to "selected." (Applies to ANG only)

1.13.5. Provides a structured program in compliance with this AFI ensuring all unit personnel are processed through SRP and successfully complete reenlistment or extension of enlistment actions or are separated from service once contract term expires.

1.13.6. Assists commander/civilian directors in maintaining oversight of the unit reenlistment/extension program.

1.13.7. Assists the commander/civilian director by identifying quality control issues affecting SRP consideration.

1.13.8. Advises the commander/civilian director and Airmen on all reenlistment/extension policy issues.

1.13.9. Reviews/forwards commander/civilian director-approved requests for retention that are not addressed within this instruction to the MPS.

1.13.10. Assists the MPS with reenlistment/extension of enlistment actions, as required.

1.13.11. Ensures all reenlistment/extension of enlistment documents are error free and processed in a timely manner to the MPS for final action.

1.13.12. Complies with any requirements issued by the MPS related to the reenlistment/extension of enlistment programs.

1.14. Waivers and Recommended Changes.

1.14.1. Waiver Authority. AFPC/DP3SA with guidance from AF/A1P is the waiver authority for this instruction for RegAF, AFRC/A1KK with guidance from AF/REP is the waiver authority for AFR, and the Director of the Air National Guard (NGB/CF) is the waiver authority for this instruction for ANG. All RegAF waivers will be submitted to **afpc.dp3sa.workflow@us.af.mil** through the appropriate OPR for consideration. All AFR waivers will be submitted to **afrc.a1kk@us.af.mil** for consideration. All NGB waivers will be submitted to NGB/A1PP through the appropriate OPR for consideration.

1.14.1.1. Waiver authority for Tier 0: Non-AF authority (e.g. Congress, White House etc.)

1.14.1.2. Waiver authority for Tier 1: MAJCOM/CC (delegable no lower than MAJCOM/A1 [RegAF and AFR] or ANGRC/CC [ANG])

1.14.1.3. Waiver authority for Tier 2: MAJCOM/CC (delegable no lower than MAJCOM/A1K [RegAF and AFR] or NGB/A1 [NGB])

1.14.1.4. Waiver authority for Tier 3: Wing/CC (delegable no lower than unit commander or equivalent for all components)

1.14.1.5. Waiver authority for Non-tiered compliance items targeted for functions above the wing or equivalent is MAJCOM/A1K office (RegAF and AFR) or MAJCOM/A1PP (ANG).

1.14.2. Waiver Process.

1.14.2.1. Process waiver requests IAW AFI 33-360.

1.14.2.2. If deemed necessary, submit additional data to substantiate the waiver request.

1.14.2.3. Tier 0 waiver: Following a MAJCOM/CC (delegable no lower than MAJCOM Director) request, the appropriate MAJCOM functional OPR will submit the package to AFPC/DP3SA (RegAF), AFRC/A1KK (AFR), or NGB/A1PP (ANG). The respective MAJCOM OPR will submit the package to the publication OPR (i.e. external agency/Non-AF authority) for concurrence/approval. Package results will be provided to the appropriate MAJCOM functional OPR.

1.14.2.4. Tier 1 waiver: Following a MAJCOM/CC (delegable no lower than MAJCOM Director) request, the appropriate MAJCOM functional OPR will submit the package to AFPC/DP3SA (RegAF), AFRC/A1KK (AFR), or NGB/A1PP (ANG). The respective MAJCOM functional OPR will submit the package to AF/A1P and/or AF/A1 for concurrence. Package results will be provided to the appropriate MAJCOM functional OPR.

1.14.2.5. Tier 2 waiver: Staff waiver requests in accordance with MAJCOM guidance.

1.14.2.6. Tier 3 waiver: Staff waiver requests in accordance with Wing guidance.

1.14.3. Waiver Period. Tier 1, 2, and 3 waivers may be approved for a period not to exceed the requested waiver period or 30 calendar days after the approving commander's tour length, whichever is shorter. Waivers automatically expire 30 days after a change of command unless the new commander renews the waiver.

1.14.4. Filing Process. A copy of approved waivers are required to become part of the approver's and requestor's official records.

1.14.5. Waivers and the Management Internal Control Toolset (MICT). The requesting commander/director will ensure appropriate waiver information is entered in the MICT within 7 days of waiver approval notification.

Chapter 2

SELECTIVE REENLISTMENT PROGRAM (SRP)

2.1. SRP Policy.

2.1.1. Reenlistment in any component of the Total Force is not an inherent individual right. It is a privilege and confers an obligation to serve. Airmen may be considered for reenlistment or extension if they (T-2):

2.1.1.1. Meet eligibility requirements.

2.1.1.2. Have qualities essential for continued service.

2.1.1.3. Can perform duty in a career field in which the Air Force has a specific need.

2.2. SRP Objective.

2.2.1. The SRP objective is to ensure the Air Force retains only Airmen who consistently demonstrate the capability and willingness to maintain high professional standards.

2.2.2. The SRP applies to all enlisted personnel; however, SRP is administered separately within each component.

2.3. SRP Authority.

2.3.1. Commander/civilian directors have total SRP selection authority as long as no other factors barring immediate reenlistment exist. Commander/civilian directors may non-select any Airman for reenlistment at any time outside of the SRP window. Being rendered ineligible to reenlist can impact an Airman's opportunity to be selected for an assignment, promotion, and/or retraining and may impact the Airman's future eligibility to be retained. The selection/non-selection decision will not be based on Airman's career intent and will be consistent with other qualitative decisions. Commander/civilian directors will not use the SRP to deny reenlistment when involuntary separation is more appropriate. Commander/civilian directors may reverse their selection/non-selection decision at any time. (T-1).

2.3.2. For IMA and PIRR members, the selection authority is the commander of the unit of assignment/attachment. (Applicable to AFR only)

2.4. SRP and Airman Promotion Program Relationship.

2.4.1. The objective of both programs is to ensure the career force consists of highly qualified, professional Airmen. SRP non-selection makes Airmen ineligible for promotion.

2.4.2. SRP non-selection automatically cancels projected promotion line numbers. (Applies to RegAF only).

2.4.3. Airmen non-selected for reenlistment also become ineligible for promotion. (Applies to AFR and ANG).

2.5. SRP Process. The SRP process varies depending upon the assigned component of the Airman being considered for reenlistment. These variances are divided into separate sections below.

2.6. SRP in the Regular Air Force.

2.6.1. The MPS Career Development Section receives a Master SRP Roster from the Personnel Systems Manager (PSM) Not Later Than (NLT) the 1st of each month.

2.6.1.1. This roster identifies First Term Airmen (FTA) who have completed 33 months (4 year enlistees) or 57 months (6 year enlistees) on current enlistment and Second Term/Career Airmen within 13 months of ETS.

2.6.1.1.1. Two separate Reports on Individual Personnel (RIPs) are also produced: one for the Airman and one for the Airman's supervisor. The RIPs notify the Airman of his/her SRP/Career Job Reservation (CJR) eligibility window and provide instructions on reenlistment. Supervisors use the other RIP to provide a recommendation to the commander/civilian director in order to aid in the selection/non-selection decision.

2.6.2. The MPS sends SRP consideration rosters and RIPs monthly to the respective commander/civilian directors. The roster is used to control/suspense RIPs to supervisors. The SRP Roster has the following four parts:

2.6.2.1. Part I (SRP Actions) identifies Airmen requiring SRP consideration or reconsideration. Part I also generates RIPs for Airmen requiring SRP consideration (except for Airmen with RE code 3B). The RIPs assist supervisors and commander/civilian directors in evaluating Airmen for continued service. Supervisors wishing to recommend denial of reenlistment must initiate an AF Form 418. (T-1). Commander/civilian directors must take SRP action within 30 calendar days for Airmen whose ineligibility condition no longer exists. (T-1).

2.6.2.2. Part II (SRP Monitor) identifies Airmen with quality indicators (referral evaluations, an Unfavorable Information File [UIF], etc.), who were already considered under SRP. Commander/civilian directors use this product to determine if SRP reconsideration is appropriate. If so, the unit will initiate an AF Form 418 for selection/non-selection. (T-1).

2.6.2.3. Part III (CJR Eligibility) identifies eligible FTA who have not yet applied for a CJR. RIPs advise Airmen and immediate supervisors of the CJR eligibility criteria and their responsibilities.

2.6.2.4. Part IV (Reenlistment Ineligibility) identifies reenlistment-ineligible Airmen.

2.6.3. Commander/civilian directors review the SRP roster to consider whether members will be denied reenlistment, selected for reenlistment or to reverse previous non-selection. The commander/civilian director only receives AF Form 418s non-recommending retention from supervisors. The supervisor initiates an AF Form 418 and completes Section I and II and forwards to the commander/civilian director.

2.6.3.1. If the commander/civilian director agrees with the supervisor's recommendation to non-select, the commander/civilian director completes the AF Form 418 and forwards to the MPS along with Part I of the SRP roster.

2.6.3.2. If the commander/civilian director disagrees on the non-selection, then the commander/civilian director marks the form accordingly and files it based on the AFRIMS RDS.

2.6.3.3. If the commander/civilian director determines the Airman will not be selected for reenlistment, then the commander/civilian director may direct the supervisor to initiate an AF Form 418 or he/she may initiate an AF Form 418 and forward to the MPS.

2.6.3.4. Only the commander/civilian director's decision selects or non-selects the Airman for continued service. (Note: Airmen non-selected for reenlistment will separate on their current date of separation and will not be extended for any reason other than appeal processing. Therefore, it is incumbent commander/civilian directors make timely non-selection decisions). (T-1).

2.6.3.5. After 30 days (from date of SRP Roster), if the commander/civilian director has not taken action to deny reenlistment (AF Form 418), then Military Personnel Data System (MilPDS) automatically updates RE code to allow reenlistment. RE codes update as follows (See **Chapter 5** for definitions):

2.6.4. Reenlistment Codes.

2.6.4.1. RE code 3C changes to RE code 1R.

2.6.4.2. RE code 1M changes to RE code 1K or 1P or 1Q.

(Note: If the PSM office has not received the Master SRP Rosters [RRSRTR], confirm that system is configured to handle/distribute this roster. If the PSM office has verified the configuration and still has not received this roster by the 1st of month, contact the Operations Control Center [DSN 665-5004] to see if there is an issue with delivery/receipt of MilPDS products).

2.6.5. Delaying SRP Actions.

2.6.5.1. When Airmen require SRP consideration upon arrival to the new duty location, the gaining commander/civilian director may delay SRP consideration for no more than 90 calendar days after Date Arrived Station (DAS).

2.6.5.2. If the Airman received SRP consideration, the former MPS advises the gaining MPS of the selection or non-selection status and forwards the supporting documentation.

2.6.5.3. If the Airman did not receive SRP consideration, the new commander/civilian director may delay SRP consideration.

2.6.6. Early SRP Consideration.

2.6.6.1. Commander/civilian directors will conduct early SRP consideration for Airmen who have not previously received formal SRP consideration as specified below. (T-1).

2.6.6.2. Airman is otherwise eligible to reenlist (RE code 3C or 1M) and requests voluntary early separation for one of the reasons listed below:

2.6.6.2.1. PALACE CHASE.

2.6.6.2.2. Officer training program (other than Air Force Reserve Officer Training Corps [AFROTC]). (Refer to paragraph 5.11. for additional RE code update information).

2.6.6.2.3. Early release to further education.

2.6.6.2.4. Sole surviving son or daughter.

2.6.6.2.5. Early release from extension or voluntary separation programs directed by USAF.

2.6.6.2.6. Accepting public office.

2.6.6.2.7. Pregnancy or childbirth.

2.6.6.2.8. End of year early release.

2.6.6.2.9. Miscellaneous reasons.

2.6.6.2.10. Early separation programs directed by USAF. AFPC Separations will announce the program and provide the eligibility criteria and processing instructions. AFPC Reenlistments must work with AFPC Separations once the separation is loaded to change RE code to 3A or 2X for FTA and verify RE code has been changed to 1J or 2X for Second Term and Career Airmen. (T-1).

2.6.7. When to use AF Form 418.

2.6.7.1. The AF Form 418 documents non-selection/selection for continued service or reconsideration actions and also documents an Airman's reenlistment ineligibility due to unsatisfactory fitness. Commander/civilian directors use the AF Form 418 when:

2.6.7.1.1. Denying reenlistment during the SRP process.

2.6.7.1.2. Airmen were initially ineligible for consideration during their SRP window for reasons in Table 5.4, Table 5.5 or Table 5.6, but later become eligible for consideration. Commander/civilian director must initiate SRP consideration within 30 calendar days. (T-1).

2.6.7.1.3. Airmen previously denied reenlistment and commander/civilian director reverses decision.

2.6.7.1.4. Airmen require early SRP consideration. (Note: When removing negative RE codes [to include RE code 4K] for Airmen who are not in their SRP window or not eligible for SRP consideration, update RE code 3C or 1M respectively. These Airmen appear on the SRP roster upon entering their SRP window. If the Airman is in his/her SRP window, then update RE code to 3B and these Airmen appear on Part I of next month roster for SRP reconsideration).

2.6.8. Commander/civilian director considerations on SRP. Commander/civilian directors will consider the following before making a decision: (T-1).

2.6.8.1. Enlisted Performance Report (EPR) ratings.

2.6.8.2. Unfavorable information from any substantiated source.

2.6.8.3. The Airman's willingness to comply with Air Force standards (i.e. fitness, dress/appearance, timeliness etc.).

2.6.8.4. The Airman's ability (or lack of) to meet required training and duty performance levels.

2.6.8.5. A fit for duty finding by a Physical Evaluation Board (PEB) does not automatically entitle an Airman to reenlist upon completion of their required active service.

However, an Airman may not be denied reenlistment on the basis of the same condition for which a PEB found the Airman fit for duty.

2.6.9. Derogatory information from a previous enlistment will not be considered as a basis for denial of subsequent reenlistments.

2.6.10. Non-selection for Reenlistment.

2.6.10.1. The supervisor recommends that the Airman not be selected for reenlistment by completing AF Form 418 and forwarding to the commander/civilian director with supporting documentation.

2.6.10.2. The commander/civilian director reviews the AF Form 418 and SRP RIP, signs the SRP roster and notifies the Airman of the non-selection (unit only). If the Airman does not appeal the decision, the commander/civilian director notifies the Airman they will be discharged on their ETS (DOS for RegAF), and sends the SRP roster and AF Form 418 to the MPS for processing.

2.6.10.3. The MPS receives the SRP decision and updates the Airman's RE code.

2.6.11. Commander/civilian director action on AF Form 418.

2.6.11.1. The commander/civilian director places an "X" or initials in the appropriate item of the AF Form 418 and enters the specific reason(s) for non-selection in the remarks area. The commander/civilian director signs and dates the form and attaches any supporting documentation to substantiate non-selection decision. Supervisor recommendation is optional. (Note: When Airmen are unavailable due to Temporary Duty [TDY], leave, etc. and do not return within 30 days of the decision date, commander/civilian director includes the following statement in the upper margin of the AF Form 418: "Airman is unavailable due to [TDY, leave, etc.] until [expected return date]").

2.6.11.1.1. For Airmen non-selected under SRP, the commander/civilian director may discuss the non-selection with the Airman's supervisor before making final decision. The commander/civilian director will discuss the following items with the Airman: specific reasons for non-selection, areas needing improvement, promotion ineligibility (to include automatic cancellation of projected promotion line numbers) and the possibility of future reconsideration and selection. (T-1).

2.6.11.1.2. Counsel Airman on appeal process and ensure they understand they must acknowledge receipt of notification immediately, but they have up to 3 calendar days to render an appeal intent. Airmen who will have completed at least 16, but fewer than 20 years Total Active Federal Military Service (TAFMS) on current ETS will be counseled on their ETP options. Also see paragraph 2.6.15. (T-1).

2.6.11.1.2.1. Airmen may elect to appeal the denial of reenlistment.

2.6.11.1.2.2. Airmen may elect not to appeal the denial decision and will be separated or retired, if eligible on current DOS.

2.6.11.1.2.3. Airmen may elect to request an exception to policy (ETP) to extend to reach minimum retirement eligibility and not appeal the denial decision.

2.6.11.1.3. Ensure Airman acknowledges receipt of notification of non-selection on the AF Form 418 during the personal interview. (T-1).

2.6.11.1.4. Ensure Airman renders their appeal intent on the AF Form 418 within 3 calendar days of acknowledgment, if applicable. (T-1).

2.6.11.1.5. Provide Airman with a copy of the AF Form 418 and supporting documentation, maintains a copy of the package and sends the original to the MPS for processing. (T-1).

2.6.11.1.6. If appealing, directs the Airman to report to the MPS for counseling on appeal process and requirements. (T-1).

2.6.11.2. For Airmen reconsidered and selected:

2.6.11.2.1. The commander/civilian director places an "X" or initials in the appropriate item of Section II and commander/civilian director signs and dates the form. (T-1).

2.6.11.2.2. Forwards AF Form 418 to MPS for update of appropriate RE code.

2.6.12. MPS Action with AF Form 418. (T-1).

2.6.12.1. Upon receipt of the AF Form 418 from unit, the MPS will quality review the AF Form 418 and return to unit if incomplete. If the AF Form 418 is complete, enter the Airman's current RE code and new RE code (2X, 4J, etc.) and date MilPDS was updated on the AF Form 418. (T-1).

2.6.12.2. Update appropriate RE code in MilPDS (2X, 4J, etc.) upon receipt of the AF Form 418, regardless of appeal intent.

2.6.12.3. Review the AF Form 418 to determine member's intent to appeal. If member does not intend to appeal, forward the form for filing in Automated Records Management System (ARMS). If member intends to appeal refer to appeal processing procedures.

2.6.12.3.1. Update appeal suspense date in appropriate block.

2.6.12.3.2. Counsel the Airman on the appeal suspense requirements and appeal process.

2.6.12.3.3. Extend Airmen as needed to await results of appeal of non-selection.

2.6.13. Processing SRP Non-selection Appeals.

2.6.13.1. Airmen's appeals are due to the MPS no later than 10 calendar days from the date the Airman indicates his/her appeal intent on the AF Form 418. Written extension requests must be submitted on or before the 10th calendar day. Requests for extensions past the 10th calendar day may be approved by the FSS commander/civilian director if circumstances warrant; early submissions are authorized. FSS commander/civilian directors limit the extension to 5 calendar days and only one extension may be approved. Airmen with unique and documented circumstances such as emergency leave, illness or injury may be granted a delay to submit their appeal. In such cases, the Airman must immediately advise the MPS of the circumstances and provide the MPS with supporting documentation. The MPS will forward supporting documentation to AFPC Reenlistments for review and if approved, a new appeal suspense date will be established. Requests submitted after the 10th calendar day will be disapproved, and the Airman is considered to have failed to submit the appeal. (Exception: If the 10th calendar day falls on a weekend or holiday, an Airman may submit an appeal on the following duty day). The MPS:

2.6.13.2. Suspenses a copy of the AF Form 418 pending receipt of the appeal package.

2.6.13.2.1. Completes the AF Form 418 by marking "Airman's appeal was not received by the appeal date", dating and signing the block, as applicable, or forward the original for file in the ARMS and return a copy to the Airman's commander/civilian director.

2.6.13.2.2. Completes the AF Form 418 by marking "Airman's appeal was received by appeal date", dating and signing the block, as applicable. Continue appeal processing.

2.6.13.3. The MPS constructs a case file containing the AF Form 418 (with any attached documentation from the commander/civilian director), appeal documentation submitted by the Airman, the last 5 EPRs, a copy of AF Form 1137, Unfavorable Information File Summary (if applicable) and any other pertinent information. Legal reviews and the commander/civilian director recommendations are not considered new information, unless either adds new documentation/information. (Note: Provide Airmen 3 calendar days to rebut any new information added to the case file after they submit their appeal.)

2.6.13.4. Reviewing officials must return cases to the MPS before forwarding up the chain when new documentation or comments are added to the case file by any reviewing official. (Note: This does not apply to commander/civilian director recommendations based on existing documentation/matters or legal reviews).

2.6.13.5. The MPS will provide the Airman a copy of the added documentation and suspense the rebuttal. If the Airman fails to submit a rebuttal as required, the MPS will indicate the Airman failed to submit rebuttal remarks to the documentation dated, (insert date) as required in the remarks and forward the case file to the next reviewing level.

2.6.13.5.1. Within 5 workdays, the MPS sends the case file to the servicing legal office for review and suspenses for completion. The servicing legal office refers the case back to the MPS after legal review. (T-1).

2.6.13.5.2. Within 5 workdays of receiving the legal review, the MPS forwards the case file to the Airman's appeal authority as outlined in Table 2.1. All packages are routed through the Airman's group commander when the appeal authority is the wing commander and routed through both the group and wing commanders when the appeal authority is Secretary of the Air Force (SecAF). Any commander in the reviewing chain may approve an Airman's appeal. (Note: After the case file has been sent to the appropriate appellate authority and the appeal has been denied, the case file cannot be sent to the next level to have the decision overturned).

2.6.13.5.2.1. Extend Airmen as needed while undergoing the appeal process IAW Table 6.1, Rule 22.

2.6.14. When the SecAF is the appeal authority, process the case as follows:

2.6.14.1. After all routing is complete; the MPS maintains a copy of the case file and forward the original package to the Airman's parent MAJCOM/Direct Reporting Unit (DRU)/Field Operating Agency (FOA) A1 for administrative accuracy and SRP eligibility verification.

2.6.14.2. MAJCOM/DRU/FOA A1 sends the case file to MAJCOM/DRU/FOA legal office for review and the MAJCOM/DRU/FOA legal office includes legal advisory in case file. If upon receipt of the MAJCOM/DRU/FOA legal review the MAJCOM/DRU/FOA A1 approves appeal, complete the AF Form 418 and return the case to the servicing MPS. If the MAJCOM/DRU/FOA A1 recommends disapproval, the MAJCOM/DRU/FOA A1 includes the MAJCOM/DRU/FOA legal review and MAJCOM/DRU/FOA A1 denial recommendation and forwards the case files to AFPC Reenlistments via Legal Transit for processing.

2.6.14.3. AFPC Reenlistments will ensure the case file meets all requirements outlined above or coordinate with the MAJCOM/DRU/FOA A1 as needed on missing/incomplete documentation before processing to AFPC legal office. Send case file to AFPC legal office for legal review. Upon receipt of AFPC's legal review, AFPC Reenlistments will update and forward the case to the Headquarters Air Force, Force Management Policy Division for processing to the SecAF and for final decision. After receiving SecAF decision, AFPC Reenlistments will notify the servicing MPS and the Airman's MAJCOM/DRU/FOA A1 of the decision and will send a copy of the SecAF memorandum. AFPC Reenlistments will forward a copy to ARMS for filing in the Airman's record. (T-1).

2.6.14.4. Any commander in the reviewing chain may approve an Airman's appeal. The appeal authority completes the AF Form 418. (Exception: SecAF memo constitutes completion of this section).

2.6.14.5. Upon receipt of completed appeal case files, the MPS provides a copy to the Airman's commander/civilian director. The commander/civilian director notifies the Airman of the final appeal decision and ensures the Airman receives a copy of the SecAF memo and acknowledges the appeal decision on the AF Form 418.

2.6.14.6. Appeal approval at any level restores reenlistment eligibility effective back to the date of the commander/civilian director's disapproval. If the Airman was rendered ineligible for certain personnel actions (i.e. promotion consideration, reenlistment), these actions are given reconsideration based upon the date the commander/civilian director signed the AF Form 418. MPS updates the appropriate RE code, forwards the AF Form 418 and/or appeal approval memorandum for filing in the ARMS, and maintains the case file in accordance with AFRIMS RDS.

2.6.14.7. If the appeal is disapproved, the MPS verifies RE code 2X is updated and maintains the case file in accordance with AF RIMS RDS.

2.6.15. Career Airmen who have been denied reenlistment and who will complete at least 16 years, but fewer than 20 years TAFMS on current ETS may elect to request an ETP to extend to reach minimum retirement eligibility; no other extension/extension reason will be considered. Any commander in the reviewing chain may approve the ETP in writing; however, the Chief, Force Management Policy Division is the final disapproval authority.) (Note: This ETP when approved, terminates the appeal process and the Airman remains in RE code 2X, but obtains retainability as directed. These Airmen retire with RE code 2V, unless otherwise discharged or other appropriate RE code applies. If the ETP is denied, then the Airman may within 10 calendar days elect to appeal the denial of reenlistment in accordance with (IAW) para 2.6.13 of this instruction. To be eligible for the ETP, the Airmen must (T-1):

2.6.15.1. Have completed at least 16 years, but fewer than 20 years TAFMS on current ETS.

2.6.15.2. Have been denied reenlistment.

2.6.15.3. The Airmen will (T-1):

2.6.15.3.1. Complete and submit a written request to extend under this exception within 10 calendar days to reach retirement eligibility. There are no extensions to the 10 calendar day period.

2.6.15.3.2. The memorandum will justify why the extension should be approved.

2.6.15.3.3. Outline the number of months required to reach minimum retirement eligibility IAW AFI 36-3203, Service Retirements.

2.6.15.3.4. Address performance under current enlistment, any substantiated unfavorable information, compliance (or lack of) to duty/training standards and any related facts for the reviewing/approving official.

2.6.15.3.5. Submit the final written request to the MPS within 10 calendar days from the date the Airman delivered their appeal statements. (Note: Commanders/civilian directors/first sergeants are not privy to the member's ETP memorandum.)

2.6.15.3.6. Obtain the directed retainability within 10 days, when ETP is approved.

2.6.15.4. The unit commander/civilian director may (T-1):

2.6.15.4.1. Prepare memorandum for the reviewing officials as to why the extension should be denied/approved.

2.6.15.4.2. Submit their memorandum within 10 calendar days to the MPS. If the memorandum is not received by the end of the 10th calendar day, the ETP is processed by the MPS without further delay.

2.6.15.4.3. Not review the written comments from the Airman.

2.6.15.4.4. Complete/endorse the retainability documents, when ETP is approved.

2.6.15.5. The MPS:

2.6.15.5.1. Notifies the unit commander/civilian director (in writing) they are in receipt of an extension request under this ETP, and establishes a 10 calendar day suspense for their comments/memorandum. The memorandum may support the request or recommend the ETP be denied based on supported facts. There are no extensions to the 10 calendar day period.

2.6.15.5.2. Processes the memorandum from the Airman and commander/civilian director (if received) along with the AF Form 1137 (if applicable), the last 5 EPRs, and any relevant documentation. (Note: If a memorandum was not received from the commander/civilian director, the MPS will add a signed statement that "comments from the commander/civilian director were requested, but not received within the time required.).

2.6.15.5.3. Processes the case file to the servicing legal office for review. The servicing legal office refers the case back to the MPS after legal review.

2.6.15.5.4. Upon receipt of the legal office review, processes the case file through the Airmen's group commander when the appeal authority is the wing commander and routes through both the group and wing commanders when the appeal authority is SECAF. Any commander/civilian director in the reviewing chain may approve an Airmen's appeal in writing. (Note: Once the case file has been sent to the appropriate approval authority it cannot be sent to the next level to have the decision overturned.).

2.6.15.5.4.1. Extends Airmen as needed while undergoing the ETP process IAW Table 6.2, Rule 23.

2.6.15.5.5. Upon receipt of final ETP decision, the MPS (T-1):

2.6.15.5.5.1. Notifies the commander/civilian director on final ETP decision. (T-1).

2.6.15.5.5.2. Complete documents when ETP is approved. (T-1).

2.6.15.5.5.3. Notifies/briefs the Airman on final ETP decision, forwards all documentation for filing in Airman's electronic records and advises/establishes appeal suspense (in writing), if ETP is denied IAW paragraph 2.6.13 of this instruction. (T-1).

2.6.15.5.6. If ETP was not approved by the wing commander; MPS will maintain a copy of the case file and forwards the original package to the Airman's parent MAJCOM/DRU/FOA/A1 for determination. (T-1).

2.6.15.6. MAJCOM/DRU/FOA A1 will send the case file to MAJCOM/DRU/FOA legal office for review. If upon receipt of the MAJCOM/DRU/FOA legal review the MAJCOM/DRU/FOA A1 approves appeal in writing and the case is returned to the servicing MPS. If the MAJCOM/DRU/FOA A1 recommends disapproval, the MAJCOM/DRU/FOA A1 includes the MAJCOM/DRU/FOA legal review and MAJCOM/DRU/FOA A1 denial recommendation and forwards the case files to AFPC Reenlistments for processing via Legal Transit.

2.6.15.7. AFPC Reenlistments will (T-1):

2.6.15.7.1. Review the case file and forwarded the ETP to Air Staff for consideration.

2.6.15.7.2. Notify the MPS of Air Staff's decision and direct appropriate course of action in compliance with Air Staff's decision.

Table 2.1. Reenlistment Appeal Authority.

If the Airman is:	Appeal Authority	See Note:	
First Term Airmen	Respective Group Commander	1, 2	
Career Airmen who complete 20 or more years total service on current ETS	Respective Group Commander	1, 2	
Second Term and Career Airmen who complete fewer than 16 years total service on current ETS	Respective Wing Commander	1, 3	
Career Airmen who complete at least 16 years, but fewer than 20 years total service on current ETS	Secretary of the Air Force	1	
Any Airman assigned in a joint base construct, the wing commander level for appeal purposes	Air Force commander above the group level	1	
Notes: 1. After the case file has been considered by the appellate authority and the appeal has been denied, the decision is final and the case cannot be sent to a level above that authority to have the decision overturned. The Airman's ETS at the time of denial establishes the appeal level and will not change due to the member completing additional service. (T-1). 2. These Airmen appeal to their wing commander, if the group commander made the SRP non-selection decision. 3. These Airmen appeal to their MAJCOM/DRU/FOA A1, if the wing commander made the SRP nonselection decision).			

2.7. SRP in the Air Force Reserve (AFR). The MPS will provide an ETS roster to the Group Career Assistance Advisors (GCAAs)/UCAs 14 months prior to member's ETS, and provide a control/suspense RIP to supervisors. For IMA/PIRR members, ARPC/DPT will provide the rosters to the RIO Detachments. HQ RIO Detachments will provide the SRP notification memorandum. (T-2).

2.7.1. Reenlistment code YY must be entered for those members for whom SRP has been generated. (T-2).

2.7.2. Commanders review SRP rosters to consider whether Airmen should be selected or denied reenlistment, or to reverse previous non-selection. In selecting Air Force enlisted members for reenlistment, commanders give primary consideration to initial eligibility and performance. Commanders review the following documents before making a decision: (T-2).

2.7.2.1. Supervisor's recommendation.

2.7.2.2. EPR ratings.

2.7.2.3. Unfavorable information from any substantiated source.

2.7.2.4. Airman's compliance with Air Force standards (i.e. fitness, dress and appearance, timeliness, etc.).

2.7.2.5. Airman's ability to meet required training and duty performance levels.

2.7.2.6. Other Factors. Potential, grade and skill level, aptitudes, education, motivation, self-improvement efforts, training and participation, derogatory information, physical condition, military bearing, attitude and behavior, assumption of responsibilities, and other related information.

2.7.3. Supervisor receives the SRP RIP, considers the whole person concept and provides the unit commander recommendations on members being considered for reenlistment by initialing and signing the SRP RIP. (T-2).

2.7.4. Unit commanders make the final decision on whether a person is eligible for reenlistment or extension by initialing and signing the SRP roster. (Note: For IMA and PIRR members, the unit commander is the commander of the member's unit of assignment/attachment.)

2.7.5. Members indicate their reenlistment intentions by initialing, signing, and dating the SRP roster. For IMA and PIRR members, RIO Detachments will obtain the member's reenlistment intent if it is not indicated on the SRP roster. (T-2).

2.7.5.1. If the member selects "will not" or "undecided," as the reenlistment intention, the unit commander counsels the member and writes comments in the space provided on the SRP.

2.7.5.2. The UCA counsels members who are undecided or have declined reenlistment and attaches the AF Form 158, USAFR Contact and Counseling Record, to the SRP.

2.7.5.3. MPS/GCAA counsels members undecided or who have declined reenlistment within 3 months prior to the ETS. Circumstances surrounding reenlistment decision may warrant presenting the member with other retention options. If, after counseling the member regarding reenlistment, they indicate that they will decline reenlistment, the unit commander and the Career Development element must be notified. The member must be informed that they must out-process during their last UTA (or when in status for IMA and PIRR members) before their ETS. (T-2).

2.7.6. The MPS receives the SRP roster no later than 7 months prior to the ETS for update and files the form accordingly. For IMA and PIRR members, the SRP roster is produced by ARPC/DPT approximately 14 months prior to the ETS. The RIO Detachment is responsible for obtaining the required endorsements on the SRP notification memorandum and returning it to ARPC/DPT no later than 7 months prior to member's ETS.

2.7.7. If a unit commander has not submitted an AF Form 418 denying a member reenlistment 6 months prior to ETS, the member will be considered eligible to reenlist.

2.7.8. Final Unit Commander Approval. In order to ensure the member's reenlistment eligibility status is unchanged, immediately prior to reenlistment, coordination must be made with the unit commander to verify that the member is still selected for reenlistment. (T-2).

2.7.9. Administered by ARPC/DPT in partnership with unit commanders or equivalent, the AGR Review Board (ARB) selects appropriate AGRs for reenlistment within the AGR program

2.7.10. Non-selection for Reenlistment.

2.7.10.1. The supervisor recommends that the member not be selected for reenlistment by completing AF Form 418 and forwarding to the commander with supporting documentation.

2.7.10.2. The unit commander reviews the AF Form 418 and SRP RIP, signs the SRP roster and notifies the Airman of the non-selection. If the Airman does not appeal the decision, the commander notifies the Airman he/she will be discharged on his/her ETS, and sends the SRP roster to the MPS for processing.

2.7.10.3. The MPS receives the SRP decision and, if the Airman does not appeal the decision, updates the Airman's reenlistment eligibility status (RBA) code and processes discharge on the ETS.

2.7.10.4. The unit commander will coordinate any adverse action with the Det/CC prior to initiation of action for IMA and PIRR members. (T-2).

2.7.10.4.1. Unit Commander. Notifies IMA and PIRR members of non-selection for reenlistment via an AF Form 418 within 30 days of non-selection. The notification package must include all supporting documentation used in making the non-selection decision. The member must be provided information on available appeal options. (T-2).

2.7.10.4.2. The immediate supervisor and the unit commander or Det/CCs with Uniform Code of Military Justice (UCMJ) authority over the IMA or PIRR member are the issuing authority. (T-2).

2.7.10.4.3. If the IMA or PIRR member chooses not to appeal the decision, the member must acknowledge receipt and return the entire package to the non-selection authority (normally the unit commander). The unit commander, in turn, forwards the entire package to their servicing RIO Detachment.

2.7.11. Air Force Reserve Non-Selection Appeal Process.

2.7.11.1. A Reservist may appeal non-selection for reenlistment through one of two options: the Senior Reserve Commander or an Appeal Board. Under either method, the decision of the Senior Reserve Commander is final (For IMA and PIRR members this will be the RIO/CC). (Exception: Air Reserve Technicians [ARTs], See paragraph 2.7.12.3.5)

2.7.11.2. The unit commander or RIO Det/CC informs the Reservist, in writing, they have until the next scheduled UTA/Inactive Duty for Training (IDT) or 30 days, whichever is later, to provide documentation in support of his/her appeal to the MPS. Airmen may submit favorable information and written statements on their behalf from those that have knowledge of the case.

2.7.11.3. The MPS (RIO Detachment) will notify the Wing Commander (RIO Det/CC) when an Airman has been non-selected for reenlistment and has requested an appeal board. The MPS (RIO Detachment), with concurrence of the MPS/CC or superintendent (RIO Det/CC), will select members to serve on the board and submit the list of members to the Senior Reserve Commander for approval. (T-2).

2.7.11.4. The Appeal Board will consist of at least three members, one of whom must be a field grade officer. Enlisted members must be E-7 or above and at least one grade higher than the member being considered. An MPS representative will serve as a non-voting

technical advisor and recorder; the MPS does not count as one of the three members on the board. (Note: Only Numbered Air Force (NAF) personnel may serve as board members for NAF assigned members who are appealing their reenlistment.) (T-2).

2.7.11.5. Senior Reserve Commander approves board members. (For IMA and PIRR members this will be the RIO/CC.)

2.7.11.5.1. MPS (RIO Detachment) sends an appointment letter signed by the Senior Reserve Commander to each selected member notifying them of the date, time, place, and requirements of the Appeal Board. All members of the Board must be in military status while serving on the Appeal Board. (For IMA and PIRR members this will be the RIO/CC.)(T-2).

2.7.11.5.2. The MPS advises the appealing member, in writing, of the date, time, and location of the Appeal Board and provides suspense for additional documentation required prior to scheduled date. (For IMA and PIRR members this will be the RIO/CC.)

2.7.12. Appeal Board.

2.7.12.1. The board will review the written appeal, AF Form 418 and any other documentation presented to make a recommendation. (T-2).

2.7.12.1.1. Will prepare a written report to the Senior Reserve Commander and attach all reviewed documentation to the report. (For IMA and PIRR members this will be the RIO/CC.) The report will include: (T-2).

2.7.12.1.1.1. Location, date, time and purpose of the meeting.

2.7.12.1.1.2. Names of the board members.

2.7.12.1.1.3. Board recommendation.

2.7.12.1.1.4. Reason(s) for the Board's recommendation.

2.7.12.1.2. The Senior Reserve Commander will review all documentation received from the Appeal Board and either uphold the commander's non-selection or approve the Airman's appeal. (Note: For IR and PIRR members this will be the RIO/CC.) The Senior Reserve Commander will complete the AF Form 418 and forward it to the MPS. (T-2).

2.7.12.2. Appeal is approved.

2.7.12.2.1. The Senior Reserve Commander notifies the member's immediate commander, in writing, of the final decision and attaches the AF Form 418. (For IMA and PIRR members this will be the RIO/CC).

2.7.12.2.2. The case file is returned to the MPS for final actions (RIO for IMA and PIRR members).

2.7.12.2.3. Unit commander will instruct the member to complete the applicable portion of the AF Form 418 and will send the completed copy to the MPS. (T-2).

2.7.12.2.4. The member is scheduled for reenlistment.

2.7.12.2.5. For unit members, the Career Assistance Advisor (CAA) updates the appropriate RBA code according to the findings of the Appeal Board and files the package IAW RDS. For IMA and PIRR members, RIO will file the package IAW RDS and notifies the Det/CC to contact member to reenlist. (T-2).

2.7.12.3. Appeal is denied.

2.7.12.3.1. The Senior Reserve Commander notifies the Airman's immediate commander that the non-selection decision was upheld and appeal denied. (For IMA and PIRR members this will be the RIO/CC.) The unit commanders will: (T-2).

2.7.12.3.1.1. Counsel the member concerning their status before their ETS expires. (T-2).

2.7.12.3.1.2. Explain to the member why they were not selected for reenlistment. (T-2).

2.7.12.3.1.3. Have the member complete the applicable portion of the AF Form 418. (T-2).

2.7.12.3.1.4. For members serving on an extension, terminate the extension and take immediate ETS discharge action. (T-2).

2.7.12.3.1.5. The RIO/CC serves as the final selection/non-selection authority for IMA/PIRR. The RIO/CC will have the case file reviewed by ARPC/JA to ensure legal sufficiency. In cases where a disagreement arises between the parent commands (AFRC) and the Regular Air Force commander regarding reenlistments, AFRC reserves the right to determine who will/will not participate, and their conditions of participation. RIO is the final decision authority for IMA and PIRR members. (T-2).

2.7.12.3.2. For members with a remaining Military Service Obligation (MSO), the MPS will work with the Career Development element to reassign the Reservist to the non-participating IRR within 30 days of the date final non-selection occurred. Change ETS to equal MSO before reassignment. Update reenlistment code in MilPDS. (T-2).

2.7.12.3.3. The MPS will take final personnel actions to include sending the case file to ARMS. (T-2).

2.7.12.3.4. If the Senior Reserve Commander initiates the AF Form 418 for denial of reenlistment, then the appeal authority is the NAF/CC (For IMA and PIRR members this will be the RIO/CC). The decision of the NAF/CC is final. (T-2).

2.7.12.3.5. ARTs denied reenlistment after appeals have the option to further appeal to the AFRC/CV through AFRC/A1K. MPSs advise ART personnel electing to appeal, and the ART must submit a written appeal to the MPS within 15 calendar days of the date the Airman was notified in writing of non-selection.

2.8. SRP in the Air National Guard (ANG).

2.8.1. CSS actions: (T-3).

2.8.1.1. Each UTA, the CSS will generate a listing from the PDS and identify assigned Airmen with an ETS that will expire within the next 14 months. (T-3). This listing is herein

referred to as the "SRP roster." (Note: MilPDS does not automatically generate SRP rosters; contact the PSM if you need assistance.)

2.8.1.2. Identify ANG reenlistment and extension ineligibility factors (Table 5.13) and provide this information along with the SRP Roster to the unit commander.

2.8.1.3. Assist commander in the preparation and finalization of required AF Form 418 (see para 2.8.7.).

2.8.1.4. Provide AF Form 418 to the servicing MPS in accordance with para 2.8.7.

2.8.1.5. Dispose of reenlistment program documentation in accordance with Table 5.15.

2.8.2. Unit Commander Actions (T-2):

2.8.2.1. Review the SRP roster and determine reenlistment eligibility; consideration must include (but is not limited to) the following factors:

2.8.2.1.1. EPR ratings.

2.8.2.1.2. Unfavorable information from any substantiated source over the course of a member's career.

2.8.2.1.3. Compliance with Air Force standards.

2.8.2.1.4. Ability to meet required training and duty performance levels.

2.8.2.1.5. Medical readiness. Note: A fit for duty finding by a PEB does not automatically entitle an Airman to reenlist upon completion of their required active service. However, an Airman may not be denied reenlistment on the basis of the same condition for which a PEB found the Airman fit for duty.

2.8.2.2. To not-select for reenlistment, line through the Airman's name on the SRP roster and initiate an AF Form 418 in accordance with para 2.8.6.

2.8.2.3. Selected Airmen will remain on the SRP roster.

2.8.2.4. Also consider the eligibility status of Airmen listed on the SRP who were previously determined ineligible for reenlistment.

2.8.2.4.1. To change eligibility from "not-selected" to "selected", complete an AF Form 418 and attach to the SRP roster.

2.8.2.4.2. No action is required if a previous determination of ineligibility is not changing.

2.8.2.5. Consider any AF Forms 418 provided by supervisors in accordance with para 2.8.6.

2.8.2.6. Sign the SRP roster and return to the CSS for action.

2.8.3. The signed SRP roster is the only documentation required to change an Airman's Reenlistment Eligibility (RE) in PDS to "selected" for Airmen who have not been previously considered.

2.8.4. AF Form 418 is required to change eligibility to "not-selected" or, to change a previous ineligible determination to "selected." Do not prepare AF Forms 418 for first-time consideration of Airmen listed on the SRP roster who are determined eligible.

2.8.5. After 30 days from date of SRP Roster, if the commander has not taken action to deny reenlistment (AF Form 418), the CSS changes the RE Code in PDS to "selected." If the unit commander elects to change RE to "not selected" during subsequent SRP review, an AF Form 418 will be required. (T-3).

2.8.6. Early or Delayed SRP Actions.

2.8.6.1. Commanders will conduct early SRP consideration for Airmen who have not previously received formal SRP consideration and are otherwise eligible to reenlist who request voluntary early separation from the Air National Guard. (T-3).

2.8.6.2. When Airmen require SRP consideration upon arrival at a new duty location, the gaining commander may delay SRP consideration for no more than 90 calendar days after DAS.

2.8.7. AF Form 418.

2.8.7.1. The AF Form 418 documents selection and non-selection for continued service and reconsideration actions. In the situation of selection, the AF Form 418 will be used to ensure the servicing MPS has an approved maximum service commitment from the member's unit commander.

2.8.7.2. Commanders use the AF Form 418 when (T-2):

2.8.7.2.1. Approving or denying reenlistment during the SRP process.

2.8.7.2.2. Reversing decision on Airmen previously denied reenlistment.

2.8.7.3. ANG supervisors may initiate an AF Form 418 at any time to provide to the unit commander.

2.8.7.3.1. If the commander concurs with the supervisor's recommendation, the commander completes Sections III and IV of the AF Form 418 and forwards it to the CSS for action.

2.8.7.3.2. If the commander disagrees with the supervisor's recommendation, the commander marks the form accordingly and files the form IAW RDS.

2.8.8. Commander Action on AF Form 418.

2.8.8.1. The unit commander signs and dates the form and attaches any supporting documentation to substantiate the reenlistment eligibility decision. Supervisor recommendation is optional.

2.8.8.2. For Airmen non-selected under SRP:

2.8.8.2.1. The commander discusses the non-selection with the Airman's supervisor before making the final decision. The commander discusses the following items with the Airman (T-3):

2.8.8.2.1.1. Specific reasons for non-selection.

2.8.8.2.1.2. Areas needing improvement.

2.8.8.2.1.3. Promotion ineligibility.

2.8.8.2.1.4. Possibility of future reconsideration.

2.8.8.2.2. Counsel the Airman on the appeal process and ensure he/she understands the requirement to acknowledge receipt of notification immediately, and that they have 3 workdays to render an appeal intent. Airmen who refuse to acknowledge receipt of the notification forfeit their appeal intent and the MPS updates the RE code to 2X. The commander annotates in the Airman's signature block "Airman has refused to sign". (Note: Airmen will not be provided the opportunity to change their mind at a later date.)

2.8.8.2.3. Ensure the Airman completes Section IV to acknowledge receipt of notification of non-selection during the personal interview.

2.8.8.2.3.1. If the Airman is unavailable (TDY, leave, etc.) and will not return within 30 days of the decision date, the commander includes the following statement in the upper margin of the AF Form 418: "Airman is [insert reason] until [expected return date]") and finalize actions within 3 workdays from the Airman's return date.

2.8.8.2.4. Ensure the Airman completes Section V to render appeal intent within 3 workdays of acknowledgment, if applicable.

2.8.8.2.5. Place an "X" or initials in the "Not Selected for Reenlistment" block in Section III and enter specific reason(s) for non-selection in the remarks area.

2.8.8.2.6. Sign and date the form (Section III) and attach any supporting documentation to substantiate non-selection decision.

2.8.8.2.7. Ensure Airman completes Section IV to acknowledge receipt of notification of non-selection during the personal interview.

2.8.8.2.8. Provide Airman with a copy of the AF Form 418 and supporting documentation, and maintain a copy of the package, sending the original to the MPS for processing.

2.8.8.2.9. If appealing, direct the Airman to report to the MPS for counseling on appeal process and requirements.

2.8.8.3. For Airmen reconsidered and selected:

2.8.8.3.1. The commander places an "X" or initials in the "Recommended for Reenlistment" block of Section II and signs and dates the form.

2.8.8.3.2. Forward AF Form 418 to the MPS for update of appropriate RE code.

2.8.8.3.3. Provide a copy of the AF Form 418 to the member.

2.8.8.3.4. The Section IV, Airman's Acknowledgement, is not required when changing eligibility from "not selected" to "selected."

2.8.9. ANG MPS Actions with AF Form 418:

2.8.9.1. Upon receipt of the AF Form 418 from a unit, the MPS will perform a quality review to ensure all blocks are appropriately marked and all required signatures are present. (T-3).

2.8.9.2. Return incomplete AF Forms 418 to the submitting unit.

2.8.9.3. Complete Section VIII, "MPS Action."

2.8.9.4. Update appropriate RE ineligibility code in MilPDS upon receipt of the AF Form 418 regardless of appeal intent.

2.8.9.5. Annotate date of update in MilPDS in Section VIII.

2.8.9.6. Review Section V to determine member's intent to appeal.

2.8.9.6.1. If member does not intend to appeal, sign and date Section VIII and forward the form for filing in ARMS. Return a copy of the completed AF Form 418 to the unit commander.

2.8.9.6.2. If member intends to appeal, update the appeal suspense date in appropriate block of Section VIII, counsel the Airman on the appeal suspense requirements and appeal process and finalize all appeal actions.

2.8.9.7. Update PDS with appropriate RE code.

2.8.10. ANG SRP Non-Selection Appeal Process.

2.8.10.1. Airmen must submit an appeal to the MPS no later than 10 calendar days (for Drill Status Guardsman [DSG], submit the appeal during the next UTA) from the day they complete AF Form 418, Section V. (T-3).

2.8.10.2. MPS will suspense a copy of the AF Form 418 pending receipt of the appeal package. (T-3).

2.8.10.2.1. Written requests to extend past the 10 calendar days (for DSG, submit the appeal during the next UTA) may be approved by the FSS commander, if circumstances warrant. FSS commanders limit the extension to 5 calendar days and only one extension may be approved. The Airman must request the extension on or before expiration of suspense. (T-3).

2.8.10.2.1.1. Airmen with unique and documented circumstances such as emergency leave, illness or injury may be granted a delay to submit their appeal. In such cases, the Airman must immediately advise the MPS of the circumstances and provide supporting documentation.

2.8.10.2.1.2. Provide extension requests to the Chief, MPS Force Management Branch for consideration. If approved, a new appeal suspense date will be established.

2.8.10.2.1.3. Requests submitted after the 10th calendar day period or after the next scheduled UTA (DSG) will be disapproved and the Airman is considered to have failed to submit the appeal. (Exception: If the 10th calendar day falls on a weekend or holiday, the Airman may submit an appeal on the following duty day.) (T-3).

2.8.10.2.2. MPS will document on the AF Form 418, Section VIII, whether an appeal was received by the suspense date. (T-3).

2.8.10.2.2.1. If the appeal is not received within the required time frame, complete Section VII by marking Airman's appeal "Was Not Received by Appeal Date," and update the RE code in MilPDS as appropriate. Forward the original AF Form 418 for file in the ARMS and return a copy to the Airman's commander.

2.8.10.2.2.2. If the appeal was received within the required time frame, complete Section VIII by marking Airman's appeal "Was" received by appeal date, date and sign the block. Continue appeal processing.

2.8.10.3. Prepare an appeal case and route to the appeal authority listed in Table 2.1. for consideration.

2.8.10.3.1. The MPS constructs a case file containing the AF Form 418, documentation submitted by the Airman and commander, any EPRs closing out within the past five years, a copy of AF Form 1137 (if applicable) and any other pertinent information.

2.8.10.4. Within 5 workdays from receipt of appeal, the MPS sends the case file to the servicing legal office for review and suspense for completion.

2.8.10.5. The servicing legal office reviews the case, includes any pertinent recommendations, and returns the case back to the MPS.

2.8.10.6. Within 5 workdays of receiving the legal review, the MPS will forward the case file to the appeal authority. (T-3).

2.8.10.7. Any commander in the reviewing chain may approve an Airman's appeal. (Note: After the case file has been sent to the appropriate appellate authority and the appeal has been denied, the case file cannot be sent to the next higher authority to have the decision overturned.) (T-3).

2.8.10.7.1. If the appeal is approved by a commander in the Airman's reviewing chain, that commander will complete Section IX of the AF Form 418 and return the case file to the MPS for final processing. (T-3).

2.8.10.8. Denial of appeal is completed by the appropriate appeal authority listed in Table 2.1.

2.8.10.8.1. If an appeal is denied, the appeal authority completes Section IX of the AF Form 418 and returns the case file to the MPS for final processing.

2.8.10.9. All packages must be routed through the Airman's Group Commander for review when the appeal authority is the Wing Commander. (T-3).

2.8.10.10. All packages must be routed through both the group and wing commanders for review when the appeal authority is TAG of the State. (T-2).

2.8.10.11. Reviewing officials must return cases to the MPS before forwarding up the chain when new documentation or comments are added to the case file. (Note: This does not apply to commander recommendations based on existing documentation/matters or legal reviews.) (T-3).

2.8.10.11.1. Airmen will be provided the opportunity to rebut any new documentation of comments.

2.8.10.11.2. MPS will provide the Airman a copy of any new information added to the case after they submitted their appeal and suspense the rebuttal. ANG Airmen are given 5 workdays or after the next scheduled UTA (DSG) to rebut any new information added to the case file after they submit their appeal. (T-3).

2.8.10.11.3. If the Airman fails to submit a rebuttal as required, the MPS indicates on the AF Form 418, Section IX, Remarks, "The Airman failed to submit rebuttal remarks to the documentation dated (insert date) as required" and forward the case file to the next reviewing level.

2.8.10.11.4. If the Airman submits the rebuttal within the suspense, the MPS will indicate in Section IX, Remarks, "The Airman submitted rebuttal remarks to the documentation dated (insert date)," and forward the case file to the next reviewing level. (T-3).

2.8.10.12. Any commander in the reviewing chain may approve an Airman's appeal. The appeal authority completes Section IX of the AF Form 418.

2.8.10.13. Upon receipt of completed appeal case files, the MPS will provide a copy of the AF Form 418 to the Airman's commander. (T-3).

2.8.10.14. The commander notifies the Airman of the final appeal decision.

2.8.10.15. Appeal approval at any level restores reenlistment eligibility effective back to the date of the commander's disapproval. If the Airman was rendered ineligible for certain personnel actions (i.e. promotion consideration, reenlistment), these actions are given reconsideration based upon the date the commander signed the AF Form 418.

2.8.10.16. MPS updates the appropriate RE code, forwards the AF Form 418 and/or appeal approval memorandum for filing in the ARMS, and maintains the case file IAW the AFRIMS RDS.

2.8.10.17. MPS maintains the case file in accordance with AFRIMS RDS.

Table 2.2. ANG Reenlistment Appeal Authority.

If the Airman is:	Appeal Authority	See Note:
First Term Airmen	Group Commander	1, 2, 3
Career Airmen who will complete 20 or more years total service on current ETS	Group Commander	1, 2, 3
Career Airmen who will complete fewer than 16 years total service	Wing Commander	1, 2, 3, 4
Career Airmen who will complete at least 16 years, but fewer than 20 years creditable service for retirement on current ETS	State Adjutant General (TAG)	1, 2, 3, 5
Any Airman assigned to a Joint Force Headquarters	State Adjutant General (TAG)	1, 2, 3, 5
Notes: 1. In the Joint Base construct, the approval authority must be an Air Force, Air Force Reserve or Air National Guard commander above the group level. (T-3). 2. If the Wing Commander initiated the AF Form 418, approval authority is The Adjutant General (TAG). 3. FTA or Career Airmen who will complete 20 or more years Total Service on current ETS appeal to their respective group commander. (Exception: These Airmen appeal to their Wing Commander if the Group Commander made the SRP non-selection decision). 4. Appeal authority becomes the TAG if the wing commander made the SRP non-selection decision. 5. TAG may delegate authority to no lower than the Director of Staff (DS).		

2.8.11. Final Decision.

2.8.11.1. Once the case file has been considered by the approval authority, the decision is final and the case cannot be sent to a level above that authority to have the decision overturned.

2.8.12. Changes in Reenlistment Status. (T-2).

2.8.12.1. If the unit commander selects a member for reenlistment, but later deems the member ineligible to reenlist, the commander prepares an AF Form 418 and processes it as an initial non-selection.

2.8.12.2. If the commander does not select the member initially but later reconsiders the member for reenlistment, the commander prepares AF Form 418. The commander places an "X" in the "Selected" block on AF Form 418, has the member sign the AF Form 418, and processes it as an initial selection; sends the form to MPS. The MPS updates the reenlistment code in accordance with this instruction.

Chapter 3

CAREER JOB RESERVATION (CJR) PROGRAM (APPLIES TO REGAF ONLY)

3.1. CJR Program Eligibility. The CJR program applies to Airmen in the RegAF and is not applicable to Air National Guard or AF Reserve Airmen. The CJR program objective is to prevent surpluses and shortages in the career force. AFPC controls first term reenlistments by maintaining a career job requirement file for each Air Force Specialty Code (AFSC).

3.1.1. All FTA, regardless of AFSC, must have a CJR in order to reenlist. (T-1).

3.1.2. If the Airman does not receive a CJR during his/her window based on the CJR "rank-order" process, they will not be allowed to compete for a CJR later in their career and he/she will be required to separate on their DOS. (T-1).

Table 3.1. CJR Window.

ITEM	If the Airman is a:	then the CJR window is	Notes
1	4-year enlistee	first duty day of the month they complete 35 months, but not later than the last duty day of the month they complete 43 months	1, 2, 3
2	6-year enlistee	first duty day of the month they complete 59 months, but not later than the last duty day of the month they complete 67 months	1, 2, 3
Notes: 1. Commander/civilian directors and supervisors receive monthly computer-generated products identifying CJR-eligible Airmen who have not received an approval. 2. FTA who requests a CJR in their secondary AFSC must complete a memorandum requesting a CJR in other than their Control Air Force Specialty Code (CAFSC). (T-1). Requests are submitted through the MPS to AFPC Reenlistments via normal processing procedures. 3. Airmen will only meet CJR boards during their CJR eligibility window if eligible. (T-1).			

3.2. CJR "Rank-order" Process . AFPC Reenlistments uses a quality "rank-order" process to issue CJRs to Airmen serving in constrained AFSCs. Airmen compete for a CJR in their respective initial Term of Enlistment (TOE) group (4-year or 6-year enlistee). AFPC awards CJRs to the most qualified Airmen within their initial TOE year group, and quotas are allocated on a percentage basis of those competing in each TOE year group for that month's board. (For example: If in a particular month 70 percent of eligible Airmen are 6-yr enlistees, then 70 percent of the available quotas are awarded to the top 6-year enlistees and the remaining 30 percent are awarded to the top 4-year enlistees).

Table 3.2. CJR Rank-order Factors. (T-1).

Item	Factor	Explanation

1	UIF	Any UIF code puts the Airman at the bottom of their AFSC list. (Example: A SSgt with a UIF will be considered after all other Airmen who do not have a UIF [regardless of rank])
2	Top 3 Performance Assessments	Performance Assessments are not added together, they are considered as individual factors.
3	Grade	SSgt is considered before SrA
4	Projected grade	SSgt selects are considered before SrA
5	Date of Rank (DOR)	Senior DOR is considered first
6	Total Active Federal Military Service Date (TAFMSD)	Senior TAFMSD is considered first

3.3. CJR Waiting List. Airmen on the waiting list compete on a monthly basis within their CAFSC. The waiting list rank order number may fluctuate as information changes or as new Airmen apply. (Example: If an Airman has received a UIF or if new Airmen with projected promotions apply since the last board, the Airman moves down on the list). Monthly notification RIPs to supervisors advise Airmen and their supervisors of current waiting list numbers and encourage retraining.

3.3.1. Airmen receive final rank-order consideration during the month they complete 43 months for a 4-year enlistee or the month they complete 67 months for a 6-year enlistee. If a CJR has not been awarded, the Airman cannot reenlist in their current AFSC and separate on their DOS. (Example: If an Airman's DOS is 15 Nov 2016, final rank-order consideration occurs through June 2016). (T-1).

3.3.2. Airmen only meet CJR boards during their CJR eligibility window (35th – 43rd month for 4 year enlistees, 59th – 67th month for 6-year enlistees. Their CJR window cannot be extended to match the new DOS from any extension. (Note: Airmen with approved CJRs who extend their enlistments will have their CJR expire on the new DOS. MPS must request that AFPC Reenlistments update CJR expiration date to reflect new DOS.) (T-1).

3.3.3. Airmen who are on the CJR waiting list and whose AFSC is removed from the constrained list will receive a CJR. Airmen who are removed from the waiting list prior to the AFSC being removed (RE code 3I) do not receive supplemental consideration unless AF/A1 provides further guidance.

3.4. Processing Wing or Senior Host Commander Override Requests. Airmen qualify for a Commander Override if they were on the CJR waiting list, but were not awarded a CJR during his/her window (RE code 3I). When a Commander Override request is approved, AFPC Reenlistments will reduce the number of CJRs available in that AFSC during the next monthly CJR board. (T-1). This means that one Airman on the constrained wait list does not receive a CJR. Therefore, commander/civilian directors must ensure the Airman they recommend is deserving of a wing or senior host Commander Override request. (T-1). Commander Override approval authority rests with AFPC/CC.

3.4.1. Wing or senior host commander may request a Commander Override in rare instances and only if the Airman meets all of the following:

Table 3.3. Commander Override Considerations.

Item	Factor
1	Not have a UIF or lost time on their current enlistment
2	No record of nonjudicial punishment (NJP) on current enlistment
3	All EPRs must reflect that the member has met the Minimum Expectations

3.4.2. Commander/civilian directors process override requests to the wing or senior host commander through the MPS. Units include in the case file a:

3.4.2.1. Memorandum signed by the Airman, to include an endorsement from the commander/civilian director.

3.4.2.2. Copies of all EPRs.

3.4.2.3. Current Single Uniform Report Format (SURF) (AAD005-Active Amn Reenlistment SURF).

3.4.2.4. Any other supporting documentation to be considered. (Example: Copy of approved decoration citations or additional awards the Airman has received (if applicable); Below-the-Zone (BTZ), promotion to SSgt, Stripes for Exceptional Performers (STEP) promotions, 12 Outstanding Airman of the Year (OAY), Airman of the Year, Professional Military Education (PME) awards, etc.).

3.4.3. The Chief, MPS will review the case file and process/route the case file to the wing or senior host commander for approval/disapproval. The MPS returns a Commander's Override request to the originating unit if it does not meet the minimum criteria in Table 3.3.

3.4.4. The wing or senior host commander reviews the case file and indicate his/her decision. If the wing or senior host commander disapproves the request, the case file is returned to the Chief, MPS who notifies the Airman's commander/civilian director of the disapproval.

3.4.5. If wing or senior host commander recommends approval, the commander indicates his/her approval and return to the case file to the MPS. The MPS forwards approved case files to AFPC Reenlistments in accordance with current processing instructions.

3.4.6. AFPC Reenlistments will review request and ensure all requirements are met. Case files not meeting the criteria or missing required documents will be returned to the MPS for correction. AFPC Reenlistments will:

3.4.6.1. Construct case file and forward to AFPC/CC for approval/disapproval.

3.4.6.2. If the Commander's Override is disapproved, AFPC Reenlistments notifies the MPS of disapproval action. The MPS notifies the commander/civilian director of the disapproval.

3.4.6.3. If the Commander's Override is approved, AFPC Reenlistments:

3.4.6.3.1. Updates CJR code "C" in MilPDS. (T-1).

3.4.6.3.2. Notifies MPS of approval action. The MPS notifies the unit commander/civilian director of the approval.

3.4.7. Overrides are not permitted once an AFSC has been removed from the constraint list or upon closure or suspension of the CJR program.

3.5. Actions on Receipt of Approved CJRs. Approved CJRs do not expire until the Airman's DOS. If an Airman extends his/her enlistment, the MPS submits a request to AFPC Reenlistments to update CJR expiration to match the new DOS. Airmen can have an approved CJR on file and an approved separation on file at the same time. MPS notifies Airmen who receive approved CJRs while in TDY or patient status.

3.6. Actions Involving Retraining and Special Duty CJRs. Eligible FTA may apply for FTA Retraining even if they have an approved CJR in their current skill or are on the CJR waiting list.

3.6.1. MPS must notify AFPC Reenlistments in accordance with current processing procedures (prior to reenlistment/extension) when individuals are selected for retraining. Once notified, AFPC Reenlistments updates CJRs as follows:

3.6.1.1. AFPC Reenlistments issues CJR in the retraining AFSC (reenlistment availability code "B") when the Airman can satisfy the retraining retainability requirement by extending. B-quota Airmen are not eligible to reenlist in the retraining AFSC until completion of technical training and must meet the criteria in paragraph 5.11.2. If the Airman received an approved Base of Preference (BOP) in conjunction with retraining, the Airman cannot reenlist in the retraining-in AFSC until successful completion of technical training. (Note: Eligible Airmen may reenlist in lieu of extending for retraining. See paragraph 4.7.)

3.6.1.1.1. If the Airman received an approved BOP in conjunction with retraining, the Airman must reenlist IAW AFI 36-2110, Assignments. Also see paragraph 4.6. (T-1).

3.6.1.2. AFPC Reenlistments issues retraining CJR in the current AFSC (reenlistment availability code "K") when the Airman cannot satisfy the retraining retainability requirement by extending their enlistment. K-quota Airmen must reenlist within 45 days of CJR being issued and is not eligible to extend for the retainability. See paragraph 4.7 for SRB eligibility. (T-1).

3.6.2. Airmen may request a CJR in their current skills, as an exception to the normal CJR eligibility criteria (paragraph 3.1), if they were eliminated from retraining for reasons beyond their control or if the Air Force cancelled their retraining.

3.6.3. Airmen who apply and are approved for a special duty assignment and who do not have a CJR, may apply for a CJR in the special duty or Reporting Identifier (RI) (8XXXX or 9F, 9L, 9R or 9S only). If approved, the AFPC Reenlistments updates the CJR in the special duty AFSC.

3.7. Processing CJR Exception to Policy (ETP) Request. Ordinarily, Airmen in constrained AFSCs who were ineligible for a CJR during their CJR window will not have or be given another opportunity to compete/apply for a CJR. However, AFPC Reenlistments will consider ETP requests when reasons beyond the member's control (FTA who did not have their citizenship, pending Medical Evaluation Board [MEB], etc.) prevented them from being eligible for a CJR during their normal window. The MPS assists the Airman in applying for a CJR as an ETP.

3.7.1. Commander/civilian directors are responsible for investigating allegations and disapproving unsubstantiated ETP requests. Substantiated requests will be processed to the MPS. The MPS processes the ETP to AFPC Reenlistments via normal processing procedures.

3.7.2. If an ETP is approved by AFPC Reenlistments, the Airman will be given supplemental consideration and rank-ordered using their respective CJR window. If a CJR is earned, the quota will be taken from the overall quota in that constrained AFSC and the MPS notified. If the Airman did not rank high enough to earn a CJR, AFPC Reenlistments will advise the MPS. The MPS advises the commander/civilian director of AFPC Reenlistments determination.

Chapter 4

SELECTIVE RETENTION BONUS (SRB) PROGRAM (APPLICABLE TO REGAF ONLY)

4.1. Purpose and Application. *SRB program applies to Airmen in the RegAF and is not applicable to Air National Guard or AF Reserve Airmen.* SRB is a monetary incentive paid to Airmen serving in certain selected critical military skills who reenlist for additional obligated service. The bonus is intended to encourage the reenlistment of sufficient numbers of qualified enlisted personnel in military skills with either demonstrated retention shortfalls or high training costs. Airmen can expect to serve in the SRB specialty for the entire enlistment for which the bonus was paid. The SRB program set forth in this Chapter is subject to authorization under 37 USC § 331 for such bonuses. The combined CSRB and SRB received during a career cannot exceed $200,000, unless specifically authorized as an exception by the Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD [P&R]). (**Note**: SRB contracts may not exceed 24 years of obligated service for all SRB authorized specialties unless otherwise directed by AF/A1.)

4.1.1. Airmen do not qualify for the SRB if they reenlist or extend their enlistments for any purpose other than continued active service in the SRB skill.

4.1.2. Reenlist IAW Table 5.2 for at least 3 years; or extend IAW Table 6.2, Rules 12, 13, 14, 16 and 29 (in one increment) in the RegAF for at least 36 months. SRBs may be designated by AFSC, Zone, skill-level, grade, unit, or to meet other condition(s) as determined by the SecAF. When a Zone is used as part of the SRB criteria, the Zone is determined by the Airman's TAFMS at the time of reenlistment or date he/she enters the extension. (**Note**: The Airman's pay grade on their DOE will be used to calculate the SRB.)

4.1.3. Airmen reenlisting/extending in Zone E incur an Active Duty Service Commitment (ADSC) for a period equal to the term for which the SRB is paid. Reference Table 4.1.

4.1.4. The SRB multiple indicates the severity of the retention problem and the level of pay authorized to deal with the problem.

4.1.5. Eligible Airmen may receive a SRB in each zone, but only one SRB per zone. The maximum SRB payable is $90,000 per zone unless otherwise directed by AF/A1. Eligible Airmen may receive more than one zone at the same time. (**Example**: An Airman who reenlists and receives a Zone A SRB then reenlists again prior to the Zone A SRB expiring and is eligible for a Zone B, the Airman would receive both payments until they receive the last Zone A authorization.)

4.2. SRB-Eligible AFSCs . AF/A1P reviews each Air Force Specialty for award or adjustment of the SRB at least once per year. (**Note**: Reenlistments or extensions of any length executed prior to the effective date of AF/A1 announcement message are valid and are not be cancelled or declared void for the purpose of qualifying for a SRB.) Airmen who execute a reenlistment/qualifying extension the same day as the effective date will not be entitled to the SRB. **(T-1).**

4.2.1. AF/A1 may use one or more of the following criteria to designate SRB skills:

4.2.1.1. Shortfalls in meeting current and projected retention objectives (retention rates and size of specific year groups, as well as adjacent year groups).

4.2.1.2. Shortages in current and projected NCO (SSgt through MSgt) manning.

4.2.1.3. High training investment and replacement cost for the skill.

4.2.1.4. Expected improvement in retention resulting from designation as a SRB skill.

4.2.2. AF/A1 announces SRB changes (increases, decreases, additions and deletions). The effective date of any changes will be outlined in the releasing message/PSDG.

4.3. General Eligibility Criteria.

4.3.1. Airmen qualify for the SRB if they meet all the following:

4.3.1.1. Are serving in the grade of A1C or higher.

4.3.1.2. Are qualified and serving in a SRB skill in the appropriate zone and reflected on the current SRB authorized listing. Both CASFC and Duty Air Force Specialty Control (DAFSC) must match SRB AFSC. **(T-1).** See Table 4.2 and paragraph 4.8. (**Note:** The Airman must be performing [DAFSC] in the SRB AFSC and maintain a CAFSC in the SRB-AFSC. **[T-1].** Any documents submitted with an unauthorized/erroneous SRB will require reenlistment/extension documents to be re-accomplished. Any erroneously awarded SRB payments will be terminated and recouped. Airmen not serving in the SRB skill are not entitled to future SRB payments. This includes Airmen departing the AFSC on education programs.) **(T-1).**

4.3.1.3. Are eligible to reenlist or extend.

4.3.1.4. Reenlist for at least 3 years or extend their enlistments (in one increment) in the RegAF, without a break in service of more than 24 hours, for a period of at least 36 months.

4.3.1.5. Extensions qualifying for a SRB begin payment on the day the extension is entered and SRB eligibility is based on the following:

4.3.1.5.1. Zone is determined by the date the Airmen enters the extension.

4.3.1.5.2. AFSCs and multiples in effect (by Zone) on the date extension is approved determine the amount of SRB. Future changes to SRB skills list do not affect the Airman's SRB entitlements. (**Example**: If an Airman extends while serving in the Zone A window, but will be in the Zone B window on the day the extension is entered, the Airman receives a Zone B bonus, if a Zone B SRB is authorized. Likewise, if an Airman extends while serving in Zone A, but will be in Zone B, and there is no Zone B authorization, the Airman would not qualify for a SRB).

4.3.1.5.3. Have not previously received severance pay or separation pay.

4.3.2. Airmen in Air Reserve components do not receive the SRB if they enlist in the RegAF, following discharge from the Reserves, during or at the end of an ADT period. Reservists on RegAF extended active duty (EAD) tours may receive a SRB if they enlist in the RegAF. They must meet all other eligibility criteria. **(T-1).**

4.3.3. Break-in service Airmen may receive the SRB if they reenlist in the Air Force within 2 years after discharge or release from active duty (other than ADT). If authorized, the entitlement is included on their enlistment contract executed at the point of accession.

4.3.4. Former officers may receive the SRB if they reenlist in the RegAF within 3 months after release from active duty as officers, as long as they served as enlisted Airmen just before serving as officers. They must meet all other eligibility criteria. **(T-1).** If authorized, the entitlement is included on their enlistment contract executed at the point of accession.

4.4. SRBs when applying for Commission . Airmen are not eligible for a SRB if they reenlist or enter an extension in order to get required retainability for a commissioning program after the selection date. Airmen may be eligible for a SRB if they reenlist or enter an extension before the selection date. In these cases, SRB payments do not occur, pending official selection or non-selection. See paragraph 4.4.3.

4.4.1. Airmen selected for a commissioning program and need retainability are not authorized the SRB.

4.4.2. Airmen already receiving an SRB on their current enlistment are not eligible to apply for a commissioning program until they have served 50% of the SRB contract. Contract completion is determined from their DOE to the application due date.

4.4.2.1. Airmen departing the SRB skill will have their SRB remaining payments terminated (if applicable) and any unearned portions of the SRB is recouped.

4.4.3. Airmen who have not served 50% of their SRB contract must request an ETP in order to meet the board. Request must be processed through the Airman's unit commander/civilian director to AFPC Reenlistments prior to the board convening date. AFPC Reenlistments forwards all requests to the Force Management Policy Division for approval/disapproval.

4.4.4. Airmen selected for a commissioning program who are receiving SRB installment payments from a previous reenlistment/extension will have their SRB suspended/terminated effective one day prior to class start date of commissioning program.

4.4.4.1. AFPC Officer Accessions will provide AFPC Reenlistments a class roster of all prior service commissioning program selectees prior to each Officer Training School (OTS) class start date. **(T-1).**

4.4.4.2. AFPC Reenlistments takes action to suspend/terminate future SRB installments and/or recoup unearned portions of previous SRB payments via current processing procedure.

4.4.4.3. Defense Finance and Accounting Service (DFAS) terminates payments effective the date of commissioning IAW Department of Defense Financial Management Regulation (DoDFMR) Volume 7A, *Military Pay Policy – Active Duty and Reserve Pay*, **Chapter 2**, *Repayment of Unearned Portion of Bonuses and Other Benefits*, and reinstates payments when commissioning does not occur and the Airman returns to duty in the SRB skills, minus unserved days.

4.4.5. Airmen applied for commissioning program and results not announced. Airmen with ALC-5 updated in MilPDS may reenlist and qualify for a SRB, but do not receive the SRB unless non-selected for the commissioning program. The following actions must occur:

4.4.5.1. The MPS must advise member that SRB payment is suspended pending selection/non-selection.

4.4.5.2. The MPS must notify AFPC to request suspension of the SRB via current processing procedures.

4.4.5.3. AFPC sends case file to DFAS citing Airman is pending selection/non-selection for a commissioning program and requests SRB payment suspension.

4.4.5.4. The MPS notifies AFPC Reenlistments via current processing procedures when results are announced to release suspension (non-selected) or terminate SRB (selected).

4.4.5.5. AFPC Reenlistments forwards the case file to DFAS and request either release of suspension or termination of SRB as appropriate.

4.4.6. Airmen serving in SRB AFSCs who have applied (or are within 12 months of applying) for a commissioning program or are awaiting selection results and do not have sufficient retainability to await the outcome of their selection board may request an extension IAW Table 6.2, Rule 28d of this AFI. The extension cannot exceed 4 months after the board convenes and maximum total extension period is 12 months. The MPS will **(T-1).**

4.4.6.1. Provide a memorandum from the Airman and approved by the commander/civilian director. (**Note**: Include the board convening date.) **(T-1).**

4.4.6.2. Completed AF Form 1411 citing "To await OTS results" in the remarks. **(T-1).**

4.4.6.3. Counsel Airmen that exercising this option may affect future SRB Zone eligibility.

Table 4.1. SRB Eligibility Zones.

ITEM	If the Airman has	then the authorized Zone is	Notes
1	At least 17 months continuous active service (other than ADT as a reservist) but no more than 6 years, 00 months and 00 days TAFMS	A	**1, 2, 3, 4, 5**
2	At least 6 years but no more than 10 years, 00 months and 00 days TAFMS	B	**1, 3, 4, 5, 6**
3	At least 10 years but no more than 14 years, 00 months and 00 days TAFMS	C	**1, 3, 4, 5, 7**
4	At least 18 years but no more than 20 years, 00 months and 00 days TAFMS	E	**1, 3, 4, 5, 8, 9**

Notes:
1. Airmen must meet requirements per paragraph 4.3. **(T-1).**
2. The reenlistment or extension must permit completion of at least 6 years TAFMS. **(T-1).**
3. Reenlist or extend their enlistments (in one increment) in the RegAF for at least 3 years.
4. Have not previously received a SRB in this Zone.

5. Eligibility is based on discharge date. The discharge date is the day prior to the reenlistment or day prior to entering an enlistment. Also see paragraph 4.1.1 and 4.6.
6. Including current enlistment and periods of active duty, including ADT as a reservist on the discharge date (for reenlistment the day prior to the reenlistment or for extensions the day prior to entering an extension). The reenlistment or extension must permit completion of at least 10 years TAFMS. **(T-1).**
7. The reenlistment or extension must permit completion of at least 14 years TAFMS. **(T-1).**
8. The reenlistment or extension must permit completion of at least 20 years TAFMS. **(T-1).**
9. Airmen reenlisting/extending in Zone E will incur an ADSC 69 equal to the period for which the SRB is paid. The only ADSC waiver for retirement that is applicable is for "hardship" as stated in AFI 36-3203. **(T-1).**

4.5. Special Conditions . Airmen with exactly 6 years of active duty on the date of reenlistment or beginning of an extension of enlistment are paid a Zone A bonus, if otherwise eligible and if they have not previously received a Zone A bonus. If they have received a Zone A bonus or no Zone A bonus is designated, they may be paid a Zone B bonus if otherwise eligible. Airmen with exactly 10 years of active duty on the date of reenlistment or beginning of an enlistment are paid a Zone B bonus if otherwise eligible and they have not received a Zone B bonus. If they have received a Zone B bonus or no Zone B bonus is designated, they may be paid a Zone C bonus if otherwise eligible.

4.5.1. Airmen who are in a special duty and who have an assignment back into their CAFSC may reenlist in the CAFSC and receive the SRB. See paragraph 4.7.

4.5.2. Airmen who are in SRB authorized AFSCs and are obtaining retainability for duties into any AFSC or special duty outside their SRB-AFSC are not authorized to reenlist in the SRB AFSC. These Airmen reenlist in the special duty AFSC without SRB entitlement, if additional retainability is required or he/she may extend their enlistment to meet retainability requirements. Airmen must complete at least 50 percent of their enlistment before being considered/applying for release from the SRB AFSC. **(T-1).** Airmen departing from SRB-AFSCs will have their remaining SRB payments terminated/recouped IAW the DoDFMR. Also see paragraph 4.12. **(T-1).**

4.6. Eligibility for Retrainees (Voluntarily/Involuntarily) of SRB Skills and Developmental Special Duty (DSD) . Airmen attain SRB eligibility when they qualify for and serve in a SRB-designated skill. When Airmen are selected for retraining and must reenlist in accordance with paragraph 3.6.1.2 or Second Term/Career Airmen reenlist to obtain retraining retainability, their CAFSCs and retraining-in AFSCs determine SRB eligibility and the multiple as indicated in Table 4.1.

4.6.1. Voluntary Retraining. Airmen receiving a SRB may volunteer as an ETP to retrain only if they are within the month they will complete at least 50% of their current enlistment, at the time of request. No other requests will be considered. AF/A1 is the approval authority for these types of requests. There are several factors that will determine whether requests will be approved (manning, career field health, etc.). If approved for retraining all unearned portions of the bonus will be recouped and all future/anniversary payments will be terminated. AFPC Retraining will notify AFPC Reenlistments via current processing procedures of affected Airmen in order to initiate termination/recoupment actions through DFAS. **(T-1).**

4.6.2. Involuntary Retraining. AFPC Retraining will make every effort to prevent involuntary retraining for Airmen receiving a SRB. Airmen who are involuntary retrained as a result of the Noncommissioned Officer Retraining Program (NCORP) are not required to repay unearned portions of a SRB. However, they will not receive any future/anniversary payments. AFPC Retraining will notify AFPC Reenlistments via current processing procedures of affected Airmen in order to initiate termination of future payments through DFAS. **(T-1).**

4.6.3. Developmental Special Duty (DSD). Airmen receiving a SRB must have completed 50% of their current enlistment and sign a memorandum waiving the remaining payment portion of the SRB to be considered for a DSD position. Airmen who are selected for DSD will have their SRB terminated IAW the DoDFMR. AFPC Assignments will notify AFPC Reenlistments via current processing procedures of affected Airmen in order to initiate termination of future payments through DFAS. (**Exception**: Airmen who are selected for a DSD position within their career field retain future SRB payments.)

4.6.4. Also see paragraph 4.11.2.

Table 4.2. SRB Eligibility for Retrainees (Voluntary/Involuntary) and DSD.

ITEM	If the Airman is:	and	then the Airman is:	**Notes**
1	Obtaining retainability for retraining before Class Start Date (CSD)	is retraining from a SRB skill to another SRB skill with an equal multiple	eligible for the SRB at the same multiple	1, 2, 3
2	Obtaining retainability for retraining before CSD	is retraining from a SRB skill to another SRB skill with a higher or lower multiple	eligible for the SRB at the multiple for the current skill, or the retraining-in skill, whichever is lower	1, 2, 3
3	Retraining from a non-SRB skill to a non-SRB skill or from a SRB skill to a non-SRB skill		not eligible for the SRB	
4	A Second Term/Career Airmen obtaining retainability for retraining before CSD	and is retraining from the slick SRB- skill into a feeder SRB-skill	eligible for the SRB at the multiple for the current skill or the retraining-in skill, whichever is lower	1, 2, 3
5	Obtaining retainability after Class Grade Date (CGD) from retraining IAW this instruction	reenlistment/extension occurs in same zone and within 30 days from CGD	eligible for the SRB at the zone and multiple in effect at the time of retraining approval	1, 2, 3

6	Obtaining retainability after CGD from retraining IAW this instruction	reenlistment/extension does not occur in same zone of retraining approval	not eligible for the SRB unless the AFSC is authorized a SRB in the current zone at the time of reenlistment/extension	
7	Selected for DSD assignment	is currently in a SRB skill/zone	not eligible SRB	

Notes:
1. Airmen approved for retraining or who are in a retraining status are only authorized the SRB multiple in effect at the time of approved retraining. Airmen whose SRB was reduced or terminated since approval for retraining must reenlist/extend (if authorized) on or after the effective date outlined in the SRB releasing message. They must be awarded the 3-skill level and enter upgrade training for the next higher skill level to qualify for the SRB multiple level in effect when he/she received final approval. Failure to reenlist within the prescribed time period will result in loss of eligibility for the SRB at the previous multiple. (**Note**: The Airman must get retraining approval before the specialty termination or multiple reduction effective date, and the Airman must be in the same SRB zone on the date of reenlistment). **(T-1).**
2. Airmen will not normally be authorized to retrain out of the skill until they have completed the contract period for which they received the bonus. **(T-1).**
3. Airmen who received a SRB are identified by Assignment Limitation Code (ALC)-O.

4.7. Eligibility for Airmen in Additionally Awarded SRB Skills (Including Continental United States (CONUS)/Overseas Imbalanced SRB Skill into an awarded SRB Skill).

4.7.1. Airmen with an assignment into an awarded SRB AFSC (other than their current CAFSC); or Airmen who are in a special duty and who have an assignment back into their SRB-CAFSC may reenlist in the SRB skill provided:

4.7.1.1. Meet all reenlistment eligibility criteria.

4.7.1.2. Receive official notification of an assignment into the SRB AFSC.

4.7.1.3. Reenlist within 90 days of their departure date on Permanent Change of Station (PCS) or Permanent Change of Assignment (PCA) into the SRB skill. If they reenlist more than 90 days prior to departure, they will reenlist in their current CAFSC and receive the corresponding SRB and multiple (if applicable).

4.7.2. Airmen may be eligible to delay obtaining required PCS or PCA retainability in order to qualify for the SRB IAW Table 6.2, Rule 12, if they have a DOS prior to 90 days before the PCS or PCA projected departure date and are otherwise eligible. Also see AFI 36-2110.

4.7.3. Airmen can expect to serve in the SRB skills for the entire period of the enlistment.

4.7.4. Airmen request reenlistment from a special duty back into their CAFSC. MPS processes requests according to the PSDG. MPS also advises Airmen regarding eligibility, estimated bonus amount, bonus recoupment if not fulfilling the term of enlistment or if not maintaining technical qualification, and the possibility of changes to SRB skills and multiples throughout the year.

4.8. Use of SRB Airmen . SRB recipients may not perform duty outside their SRB specialty for more than 90 consecutive days in a 360 day period or a combined total of 90 days within a 360 day period. (**Note**: This does not apply to deployment taskings. Airmen in SRB skills may be tasked to deploy/fill non-SRB duties without SRB interruption.)

4.8.1. Airmen may not be re-assigned/selected to duties outside the SRB skill prior to completing at least 50% of their reenlistment/extension. Duties in the SRB skill are defined IAW the Air Force Enlisted Classification Directory. If selected for duties outside the SRB skill, the commander/civilian director will notify the MPS and the SRB will be terminated/recouped IAW the DoDFMR. The MPS initiates a Case Management System (CMS) case to AFPC Reenlistments, requesting the SRB be terminated and recouped. AFPC Reenlistments reviews the case and request DFAS take appropriate action.

4.8.2. SRB Airmen may perform additional duties as directed by their commander/civilian director. Additional duties are those duties performed in addition to the Airman's primary skill/duty and will not result in a change of AFSC or duty title.

4.9. Computing SRB Awards .

4.9.1. Compute all SRB award amounts using one month's base pay, times the years extending/reenlisting, times the SRB multiple. The Airman's base pay on date of discharge is used to calculate the SRB. Therefore, if SSgt Jones was promoted on 1 May 2016 and reenlisted on 1 May 2016, the SRB would be calculated on his/her base pay for the rank of SrA.

4.9.2. The MPS will verify the Airman's SRB data (number of days to be paid, SRB multiple and Zone) is correct in the Master Military Pay Account within 10 calendar days after update and take all necessary actions to correct the SRB data. The MPS will compute the approximate SRB entitlement and consult with their local finance office as needed. If entitlement is over/underpaid, process the necessary case to AFPC Reenlistments for action.

4.10. Method of Payment .

4.10.1. 50% Lump Sum Payment with Annual Installments Option. Unless otherwise stated by AF/A1, Airmen receive 50% of their SRB at reenlistment and the remainder in equal anniversary payments as noted in Table 4.3.

4.10.2. When offered by AF/A1 in the announcement message, Airmen receive up to 100% lump sum payment option with the remainder as outlined in the announcement message/PSDG.

4.10.3. Airmen with a break in service (prior service) of more than 24 hours do not receive payment until 30 days after arrival at the first permanent duty station following reenlistment.

4.10.4. Initial payment: Airmen receive the percentage designated (per the releasing message/PSDG) of the total amount (less applicable taxes) on the reenlistment date or the day they enter an extension. Airmen receive the remaining percentage of the SRB amount (less applicable taxes) in equal annual amounts on each anniversary of the initial payment for the term of the reenlistment or extension as listed in the announcement message/PSDG.

Table 4.3. SRB TOE in whole years and number of anniversary/installment payments when Airmen receive 50% of their entitlement.

TOE in whole years:	then initial payment is:	Number Anniversary/Installment Payments
6	50%	5
5	50%	4
4	50%	3
3	50%	2

4.10.5. Accelerated installment payments are not authorized.

4.11. SRB Reduction or Termination Actions .

4.11.1. Airmen serving in SRB skills announced for a SRB reduction or termination must extend or reenlist before the effective date of change in order to receive the bonus. **(T-1).** (**Note**: Airmen may only reenlist if he/she has a service-directed reason or are within the reenlistment window as established by Air Force policy.)

4.11.2. Airmen approved for retraining or who are in a retraining status are only authorized the SRB multiple in effect at the time of approved retraining. Airmen whose SRB was reduced or terminated since approval for retraining must reenlist/extend (if authorized) on or after the effective date outlined in the SRB announcement message. They must be awarded the 3-skill level and enter upgrade training for the next higher skill level to qualify for the SRB multiple level in effect when he/she received final approval for retraining. **(T-1).** Failure to reenlist within the prescribed time period results in loss of eligibility for the SRB at the previous multiple. (**Note**: The Airman must get retraining approval before the specialty termination or multiple reduction effective date and be in the same SRB zone on the date of reenlistment). **(T-1).**

4.11.3. AF/A1 announces SRB reduction or termination actions.

4.11.4. MPS contacts the Airman when the following situation(s) apply:

4.11.4.1. Contact all Airman that have projected reenlistment with an effective date on or after the effective date of the SRB listing, verify the SRB multiple against the new listing to see if the SRB has changed. **(T-1).**

4.11.4.1.1. For each AFSC where the SRB is terminated or decreased, contact all Airmen who are projected for reenlistment and inform them of the changes and their options. Correct the Airman's AF Form 901, *Reenlistment Eligibility Annex to DD Form 4,* to remove the SRB authorization, when applicable. **(T-1).**

4.11.4.2. For each AFSC where the SRB has increased or a SRB has been added and the reenlistment is on or after the increase effective date, the MPS notifies the Airman and correct the Airman's AF Form 901 to reflect the correct SRB multiple.

4.11.4.3. If the SRB has changed, the SRB authorization currently on file in MilPDS must be deleted and a new authorization requested. **(T-3).**

4.11.4.4. If an E63/E6C has been accomplished, process an E64/E6D to change the projection on DFAS files after the SRB authorization has been changed in MilPDS. **(T-3).**

4.11.4.5. If the Airman's reenlistment consummated on DFAS files with an incorrect SRB entitlement, process the correction to AFPC Reenlistments via current processing procedure. **(T-3).**

4.12. Termination/Recoupment/Repayment of SRB . SRB termination also requires recoupment of the percentage representing the unserved part of the additional obligated service. Commander/civilian directors cannot authorize termination without recoupment. Airmen must remain technically qualified for effective performance in the SRB skill and complete the full term of enlistment or extension of enlistment in the SRB skill. **(T-1).** Failure to do so may result in termination and recoupment. SRB termination/recoupment/repayment is processed as outlined in the DoDFMR Volume 7A, **Chapter 2**. Recoupment determinations will be made on a case-by-case basis consistent with the criteria set forth DoDFMR Volume 7A, **Chapter 2** for Airmen paid a bonus under this instruction.

4.13. SRB AFSC Disqualification . Airmen disqualified from SRB-authorized AFSCs have their future payments terminated and recouped, if applicable, IAW the DoDFMR Volume 7A, **Chapter 2**. **(T-0).**

4.13.1. AFPC Classification refers all AFSC disqualification cases (AFI 36-2101, *Classifying Military Personnel [Officer and Enlisted]*) to AFPC Reenlistments for review/action.

4.13.2. AFPC Reenlistments will review all cases and refer those with SRB-authorized AFSCs to DFAS for termination and recoupment, if applicable IAW the DoDFMR Volume 7A, **Chapter 2 (T-0)**. AFPC Reenlistments refers cases back to AFPC Classifications when complete or if no SRB termination/recoupment action applies.

4.14. Combat Zone Tax Exclusion . SRB payments (initial payment and annual installments) are not taxable for Airmen who reenlist or extend (36 or 48 months) in a month during which they qualify for combat zone tax exclusion. They must either reenlist or extend in the designated combat zone, or at another location during the same month in which they served in the designated combat zone. If the Airman sells leave in conjunction with reenlistment, only leave days earned while in the deployed location are tax excluded. **(T-0).**

4.15. Assignment Limitation Code (ALC)-O and SRBs . Second Term and Career Airmen serving in SRB skills must have a SRB updated in MilPDS prior to reenlisting. **(T-1).** ALC-O does not update on Second Term or Career Airmen unless the SRB is updated prior to the reenlistment being updated. Refer to the PSDG for update procedures. (**Note**: If this code is not updated, future actions such as retraining, commissioning programs and approval into special duties are affected.)

4.16. SRBs and Airmen Approved for Special Duty/Reporting Identifiers . Airmen are not eligible for a SRB if they reenlist or enter an extension in order to get required retainability for a special duty or reporting identifier. (**Note**: Airmen in SRB AFSCs with approved special duty/reporting identifier will reenlist in the CAFSC of the special duty/reporting identifier AFSC.) **(T-1).** See paragraph 4.8 for Airmen in Additionally Awarded SRB Skills (Including CONUS/Overseas Imbalanced SRB Skill into an awarded SRB Skill). (**Note:** This paragraph does not apply to Reporting Identifier 9S000.)

4.17. Eligible for SRB and Electing not to Accept an SRB . Airmen eligible for an SRB on their current enlistment or eligible extension may elect not to accept the SRB designated for that reenlistment/extension. Airmen who elect not to accept the SRB must complete the applicable

Section of the AF Form 901 or AF Form 1411. The decision not to accept the SRB is irrevocable once the AF Form 901 or AF Form 1411 has been approved by the commander/civilian leader and accepted for reenlistment/extension of enlistment by the MPS representative. No exceptions will be considered.

4.18. Selective Retention Bonus (SRB) Roster. The MPS Career Development Section receives a SRB Roster from the PSM NLT the 1st of each month. This roster identifies Airmen who have an ALC-O in-system and are receiving a SRB and notifies the commander/civilian director of those Airmen who must be performing SRB-related duties.

4.18.1. The MPS sends SRB rosters monthly to the respective CSS for review/validation and unit commander/civilian director review/signature.

4.18.2. Commander/civilian director reviews the SRB roster to consider whether Airmen are performing SRB-related duties. See para 4.8.1. If an Airman is determined to not be performing SRB duties, the unit will forward the necessary documentation to the MPS for SRB termination and recoupment actions, if necessary. Commander/civilian director returns the SRB roster to the MPS as suspensed.

4.18.3. The MPS will review the SRB roster and take action as required.

Chapter 5

REENLISTMENTS

5.1. General Instructions. Reenlistment in the Regular Air Force, Air Force Reserve or Air National Guard is a command prerogative and is not an inherent right of any individual. Airman not selected for reenlistment via SRP will not be reenlisted but may qualify for extension of enlistment.

5.2. SRP Reconsideration. SRP reconsiderations are accomplished by unit commander/civilian directors prior to a member's ETS/DOS.

5.2.1. Reenlistment may be limited based on the needs of individual service components.

5.2.2. The MPS will **(T-1)**:

5.2.2.1. Ensure all Airmen receive a UCMJ/reenlistment briefing from the legal office within 30 days (or the next IDT/AT participation Air Reserve Component [ARC]) of reenlistment.

5.2.2.2. Ensure all reenlistment contracts contain the documents as listed in Table 5.1.

Table 5.1. Reenlistment Documents.

ITEM	Component	Forms Required
A	RegAF	DD Form 4/1 and 4/2, *Enlistment/Reenlistment Document Armed Forces of the United States* AF Form 901, *Reenlistment Eligibility Annex to DD Form 4* AF Form 1089, *Leave Settlement Option* (**Note**: As needed when Airmen elects a change after completing the AF Form 901 and prior to date of reenlistment)
B	AFR	DD Form 4/1 and 4/2, *Enlistment/Reenlistment Document Armed Forces of the United States*
C.	ANG	DD Form 4/1 and 4/2, *Enlistment/Reenlistment Document Armed Forces of the United States*

5.3. Reenlistment Ceremony . Commander/civilian directors ensure ceremonies are conducted in a dignified and professional manner, appropriate for an official act in a place that provides reverence to the oath being taken; safety of all participants should also be paramount.

5.3.1. Airmen may request any commissioned officer (RegAF, AFR, ANG or retired) in the U.S. Armed Forces to perform the ceremony and may invite guests. Reenlistments can be conducted on any day of the year. The reenlistee and the officer administering the oath have traditionally had the U.S. flag forming a backdrop for the oath. **(T-0).**

5.3.2. The reenlistee and reenlisting officer must wear an authorized uniform for the ceremony. **(T-1).** (**Exception**: The uniform requirement is optional for retired officers.)

Airmen and reenlisting officials may not conduct a reenlistment in the Air Force physical training uniform.

5.4. Who May Administer the Oath of Enlistment . The oath may be taken before the President, the Vice-President, the Secretary of Defense, any commissioned officer, or any other person designated under regulations prescribed by the Secretary of Defense. RegAF, AFR, ANG or retired commissioned officers of the U.S. Armed Forces may administer the oath. Officers who resigned their commissions and transferred to the Obligated Reserve Section (ORS) or the Nonaffiliated Reserve Section (NARS) may not administer the oath. (**Exception**: Commissioned warrant officers in the grade of CW2, CW3 and CW4 may also administer the oath.)

5.5. Processing and Place of Reenlistment . Airmen must reenlist at their home station unless they are absent due to deployment, hospitalization or are in a pipeline status (school, overseas returnee, etc.). **(T-1).** Airmen must be present for duty and cannot reenlist while on leave, while in a separation status or after departing their unit of assignment on terminal leave for separation. **(T-1).** (**Example**: If SSgt Smith is reenlisting on 15 Feb 2015, he must not be in a leave status on 15 Feb 2015.) (**Note:** Airmen returning from a leave status may not reenlist the next day following their leave. Airmen who have been determined to be in a leave status at the time of reenlistment must execute a new reenlistment/contract when not on leave.)

5.5.1. MPS gives Airmen departing on deployment a reenlistment package if they desire to reenlist and their ETS or DOS expires while deployed. The package includes documents listed in Table 5.1. **(T-1).**

5.5.1.1. The home station MPS:

5.5.1.1.1. Obtains the Airman's signature on all appropriate documents.

5.5.1.1.2. Coordinates with the MPS at the deployed location to ensure proper completion of the reenlistment documents.

5.5.2. The MPS/PERSCO at the deployed location:

5.5.2.1. Provides the Airman their copy of reenlistment contract, if more than 30 calendar days will expire between the reenlistment date and the date the Airman will return to home station.

5.5.2.2. Forward all remaining copies to the home station MPS for final processing.

5.6. Reenlistment of Non-U.S. Citizens . Non-U.S. citizens, enlisting on or after 1 November 1982, must become U.S. citizens during their initial enlistment before they are eligible to reenlist. **(T-0).** Airmen may be eligible to extend under paragraph 6.6.5.4 (*Applies to RegAF and AFR only*). **(T-0).** Citizens of Micronesia and Palau may be eligible for reenlistment even if they do not have their citizenship. These cases will be worked through AFPC Reenlistments to Air Staff for approval. **(T-0).**

5.7. Informed Decision (ID) Program . The CAA at every installation will publicize and conduct an ID seminar. **(T-2).** This seminar is an educational experience specifically designed to enhance one's knowledge of Air Force benefits, highlight program requirements and processes. All RegAF first term and second term Airmen are required to attend unless pending involuntary separation. **(T-2).** Reserve Component Airmen are counseled prior to reenlistment. See AFI 36-2624, *The Career Assistance Advisor, First Term Airmen Center and Enlisted Professional Enhancement Programs*.

5.8. Reenlistment of Sole Surviving Sons or Daughters. Airmen who qualify as sole surviving sons or daughters waive any right to claim discharge or assignment limitations as sole surviving sons or daughters upon their reenlistment. They may request reinstatement of their sole survivor status through assignments at any time. If approved, they may again qualify for assignment limitation, but not for discharge or release from active duty.

5.9. Erroneous Enlistment/Reenlistment Documents Returned for Correction. There are two types of erroneous reenlistment documents. The first consists of contractual errors made in violation of this publication, such as the reenlistment of ineligible Airmen or Airmen not issued a CJR. The second is administrative, involving typographical errors, strikeovers, misspellings, erroneous computation of required retainability or SRB, etc.

5.9.1. Contractual Errors. Airmen not authorized to reenlist or in violation of this AFI (no CJR, not meeting Time in Service/Time in Grade ineligible RE code, etc.) will have their contract voided. AFPC Reenlistments (AFRC/A1K for AFR, ARPC/DPT for IMA and PIRR, and NGB/A1PP for ANG), directs the MPS to void the contract and take action as needed to remove any documentation from all systems of record. **(T-1).**

5.9.2. Administrative Errors. MPS will not correct administrative errors discovered in items 2, 5, 8, 18b, 19b and 19f of the DD Form 4. **(T-1).** Administrative errors in these items will necessitate the deletion and re-creation of the DD Form 4. Also see paragraph 5.9.4.3.1. Administrative errors may be corrected on the AF Form 901, if the Airman and Air Force agree. However, any unauthorized/erroneous SRB necessitates re-accomplishment of the document(s) and are terminated and recouped. If the corrections were made on the forms, stamp "CORRECTED COPY" in the upper margin of the corrected pages, ensure the Airman initials the corrected area(s), and make a photocopy of the corrected forms for the Airman. The MPS corrects MilPDS and Defense Joint Military Pay System- Active Component (DJMS-AC), as appropriate and distributes the documents IAW Table 5.10.

5.9.3. AFPC Reenlistments will direct the AF Form 901 be corrected to reflect the authorized SRB in cases where an SRB was not properly documented on the contract or direct an unauthorized SRB entitlement be removed from the AF Form 901.

5.9.4. Documents Returned to MPS for Correction(s). AFPC Reenlistments returns enlistment contracts to servicing Chief, MPSs for correction. (**Example**: Missing signatures, when dates do not match reenlistment date on DD Form 4 and/or AF Form 901, incomplete contracts, missing pages, or incomplete forms, etc.) The MPS makes appropriate corrections to the contract(s) and returns the contracts and transmittal to AFPC Reenlistments by the established suspense. Also see paragraph 5.9.2.

5.9.4.1. The Airman and the MPS representatives must initial each correction. **(T-1).** Stamp "CORRECTED COPY" in the upper margin of the corrected pages. Make a photo copy of the corrected forms and comply with the disposition instructions in Table 5.10.

5.9.4.2. Do not make corrections to the form stamped "DO NOT CORRECT THIS COPY" unless there is no ARMS copy and the Airman does not have a copy.

5.9.4.2.1. In those situations, correct the copy stamped "DO NOT CORRECT THIS COPY" and type "Only Available Copy" in the upper margin of the corrected pages. Make a photo copy of the corrected forms and comply with the disposition instructions in Table 5.10.

5.9.4.3. Reaccomplish the DD Form 4/1 and AF Form 901 if there is no ARMS copy or the Airman does not have a copy. (**Note**: The Airman's current commander or civilian director holding the position will sign the corrected form(s) and the current date is used.) **(T-1).**

5.9.4.3.1. If contract is reaccomplished, stamp "RECONSTRUCTED COPY" in the upper margin of the new contract. The forms are dated using the current date and signed by the Airman's current commander/civilian director. Make a photo copy of the corrected forms and comply with the disposition instructions in Table 5.10. (**Note**: Commanders or civilian directors may not refuse to re-accomplish these documents or deny reenlistment.)

5.9.4.3.2. The MPS sends the original documents to AFPC Reenlistments for review as outlined in Table 5.10 and corrects MilPDS and DJMS-AC, as appropriate.

5.10. Oath of Enlistment. All Airmen enlisting or reenlisting must take the oath of enlistment: **(T-1).**

"I, (State your full name), do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God."

5.10.1. All Airmen have the choice to make the words "So help me God" optional in the enlistment oaths (both orally and written).

5.10.1.1. Airmen who make a choice to "affirm" the oath of office/oath of enlistment and/or omit the words "So help me God" may also line through the words "swear" and/or the words "So help me God."

5.11. Reenlistment in the Regular Air Force (RegAF).

5.11.1. Once an Airman has reenlisted, they must initial next to the lined text, as applicable, and sign the DD Form 4. A reenlistment is considered executed once the Airman has been approved to reenlist (AF Form 901), the enlistee has taken the oath of enlistment, and both the reenlistee and administering officer have signed the DD Form 4. **(T-0).**

5.11.2. Eligibility**.**

5.11.2.1. RegAF Airmen may be eligible to reenlist if they meet all of the requirements: **(T-0).**

5.11.2.2. Are eligible for immediate reenlistment according to Table 5.3.

5.11.2.3. Can fill a specific requirement in their skill or another skill through retraining.

5.11.2.4. Are selected by their commander/civilian director under the SRP (refer to 2.6.).

5.11.2.5. Meet a condition listed in Table 5.9.

5.11.2.6. To qualify for an SRB is not a reason to reenlist.

5.11.3. In addition to the above basic eligibility criteria, FTA may reenlist if they have an approved CJR IAW Table 5.9.

Table 5.2. FTA, Second-Term/Career Airmen Reenlistments.

ITEM	A	B
	If the Airman is eligible and is a	**the Airman may reenlist**
1	First Term, 4-year enlistee	after completing 36 consecutive months on the current enlistment if the Airman has an approved CJR. A prior service Airman is considered FTA when the prior active service is less than 24 months. See notes 1 and 2.
2	First Term, 6-year enlistee	after completing 60 consecutive months on the current enlistment if the Airman has an approved CJR. See notes 1 and 2.
3	FTA may reenlist in a retraining status	See items 1 and 2 above, complete retraining and possess the 3-skill level in the new AFSC. See notes 1 and 2.
4	Second Term and Career Airmen	provided they possess another awarded AFSC with a skill level commensurate with their current grade in order to reenlist in the retraining AFSC at the 3-skill level, be within the current reenlistment window as established by Air Force policy or have a service directed reason. See notes 1 and 2.

Notes*:*
1. Airmen must project reenlistments NLT 120 days prior to their DOS or they are projected for separation. **(T-1).**
2. The MPS will project all reenlistments in-system upon receipt of approved AF Form 901, or no later than 120 days before DOS, whichever comes first. **(T-1).** Failure to project reenlistments automatically causes MilPDS to project the Airman for separation, and cancels other personnel actions. The MPS will refer to the PSDG for procedures for projecting reenlistments and requesting CJR/SRB authorizations. **(T-1).** (**Note**: AFR and ANG personnel are not authorized to enlist, reenlist, or extend under this section unless recalled to Extended Active Duty under 10 USC § 12301 voluntary or involuntary recall. Enlisted personnel who wish to apply under 10 USC § 12301(d), voluntary recall, must apply through AFPC Enlisted Accessions. **(T-1).** EAD orders indicate recall authority. Contact AFPC Enlisted Accessions for guidance and instructions or refer to AFI 36-2002, *Regular Air Force and Special Category Accessions*).

5.11.4. Term of Enlistment (TOE). The minimum TOE is four years unless the Airman has more than 24 months of obligated service. Under no circumstances can the reenlistment, along with combined obligated service exceed 72 months or exceed the Airman's HYT plus 1 month. (**Exception**: Enlisted Airmen who have been selected to enter the United States Air Force Enlisted Remotely Piloted Aircraft (RPA) Pilot Program and attend the Undergraduate RPA Training (URT) course may reenlist for a period of 8 years. Airmen reenlisting under this exception may not execute a reenlistment, along with combined obligated service to exceed 96 months.)

5.11.4.1. Airmen do not have the option to add additional months or reduce obligated service to the reenlistment contract (refer to Table 5.8., Terms of Reenlistment). Regardless of the number of years authorized, a reenlistee's new DOS must exceed the previous DOS. **(T-1).** (**Note**: An Airman may only reenlist for 6 years if they are within

29 calendar days of DOS. Similarly, Airmen can reenlist for 5 years only if they have 12 months or less of obligated service).

5.11.4.1.1. If an Airman has between 25 and 36 months of remaining obligated service, they can reenlist for 3 years plus obligated service.

5.11.4.1.2. Airmen reenlisting who are HYT restricted may not exceed their HYT plus 1 month. Airmen will be separated on their HYT date. For Airmen who are eligible for an SRB, their SRB will be calculated based only on TOE years (a minimum of 3 years). If the TOE is less than 3 years, the Airman is ineligible for an SRB. Also see Table 5.8.

5.11.4.2. Annotate the TOE on the DD Form 4/1, Section 8 to reflect the TOE in years and months. (**Note**: The MPS must line through "weeks" and type in "months." **(T-1).** Annotate the number of months (obligated service) to satisfy the full enlistment. The Airman will initial the change to the reenlistment document.)

5.11.4.3. Obligated service. Include remaining obligated service (in excess of 29 calendar days) into the reenlistment. **(T-1).**

5.11.4.3.1. Obligated service is that time in excess of 29 calendar days from the Date of Enlistment (DOE) to the DOS. Any partial month of 29 calendar days or less is not considered in the total obligated service. Obligated service will be listed on the contract in the months of the TOE. Therefore, if an Airman has 1 year and 2 months of obligated service, the DD Form 4 will reflect 14 in Section 8 to reflect the 14 months of obligated service.

5.11.4.3.2. Airmen who cannot reenlist to their HYT may be eligible to extend under Table 6.2, Rule 27.

5.11.4.4. Constructive Reenlistment. The Chief, Sustainment and Transition Operations Division, Air Force Personnel Center is delegated authority to approve a constructive reenlistment when determined a constructive reenlistment is appropriate (i.e., for Airmen to reach his/her HYT) under the authority of 10 USC § 1552 (a) (2) without consideration by the Air Force Board for Correction of Military Records. (DODD 1332.41, *Boards for Correction of Military Records [BCMRs] and Discharge Review Boards [DRBs]*; 10 USC § 1552.)

5.11.4.4.1. Airmen submit these requests through their commander/civilian director to their MPS for processing to AFPC Reenlistments for review and further processing.

5.11.4.4.2. For example: I request a constructive reenlistment to obtain 13 months retainability to retire at my HYT. I am ineligible to reenlist based on HYT and I cannot extend since I have already extended 42 months of the 48-month maximum.

5.11.4.5. Airmen scheduled for reenlistment within 7 calendar days of their DOS must complete the following statement during reenlistment processing **(T-1)**: "*I intend to reenlist immediately after separation. I hereby authorize my retention in service for a period not to exceed 7 calendar days beyond my date of separation (DOS), to complete separation processing, should I, immediately before or after separation, and before reenlistment, decline to reenlist."* Retain this statement with the reenlistment package until reenlistment occurs. Airmen may not request reenlistment once they enter the 7-calendar day extension

period; this extension is for separation processing only. Do not complete AF Form 1411 for this extension, and do not complete this statement for Airmen scheduled to reenlist more than 7 calendar days before their DOS.

5.11.5. FTA/NCORP Retrainees**.** Airmen who retrained under FTA Retraining/NCORP may request cancellation of an extension obtained for retraining that has not been entered contingent upon immediate reenlistment. Airmen must be reenlistment eligible IAW paragraph 5.11.2 and may only request cancellation of the extension within 30 days after class graduation date. **(T-1). Exception**: FTA who are not reenlistment eligible IAW para 5.11.2 and Table 5.2 may submit an ETP to have their request granted and must do so within 90 days of becoming reenlistment eligible. Upon approval, the Airman must reenlist within the next 30 days. All other extensions will be considered as obligated service, see para 5.11.2 and Table 5.2 for reenlistment eligibility. (**Note**: Extension cancellation and reenlistment must occur the same date.) **(T-1).**

5.11.5.1. The MPS will:

5.11.5.1.1. Ensure extension has not been entered and the cancellation is within 30 days after class graduation. **(T-1).**

5.11.5.1.2. Ensure only the extension authorized for FTA/NCORP retraining is cancelled. **(T-1).** (*Example 1*: Airman extends 23 months for FTA/NCORP retraining; all 23 months may be forgiven if not entered.) (*Example 2*: Airman extends 7 months for an assignment and 16 months for FTA retraining, only the 16 months for FTA retraining could be forgiven if not entered.)

5.11.5.1.3. Complete the AF Form 1411-1, *Cancellation of Extensions of Enlistment in the Air Force.* **(T-1).**

5.11.5.1.4. Project the reenlistment in MilPDS and cancel the extension upon receipt of completed reenlistment documents. **(T-1).**

5.11.5.1.5. Extensions obtained for FTA/NCORP retraining that have been entered will not be forgiven and will be considered as obligated service. **(T-1).** Airmen will reenlist based on the criteria set forth in this instruction as stated in **Chapter 5**. **(T-1).**

5.11.6. Reenlistment Documents. Airmen completing/executing the forms listed in Table 5.1 formally document a reenlistment and those documents represent a legally binding contract between the Air Force and reenlistee. The MPS completes the DD Form 4/1 IAW DODI 1304.2, *Accession Processing Data Collection Forms* and this instruction. The AF Form 901 will be completed IAW the Reenlistment PSD Guide. Incomplete or inaccurate documents are returned to the Airman's servicing MPS for corrections and can result in an erroneous reenlistment agreement, possible loss of payment of SRB entitlement, etc. Any documents submitted with an unauthorized or erroneous SRB will require the reenlistment/extension documents to be re-accomplished. Any erroneously awarded SRB payments will be terminated and recouped.

5.11.6.1. Special care must be taken to ensure all items are completed correctly without errors. White-out or correction tape or fluid will not be used on these forms. Corrections in items 2, 5, 8, 18b, 19b and 19f require a new DD Form 4 to be accomplished. **(T-1).**

5.11.6.2. The forms can only be signed in black, blue, or blue-black ink when completed manually (non-digitally signed).

5.11.6.3. Only the Airman's home station unit commander/civilian director completes the AF Form 901. (**Exception**: Section Commanders on G-series orders may also sign.)

5.11.7. Reenlistment Agreements. The MPS documents *only* approved/authorized Air Force reenlistment agreements on AF Form 901. (**Note**: All reenlistment agreements are identified on the AF Form 901. If the Airman has no reenlistment agreement(s), the MPS will mark the block indicating no reenlistment agreement(s). **(T-1).**

5.11.7.1. The MPS must authorize only the following guarantees on AF Form 901: **(T-1).**

5.11.7.1.1. Approved retraining.

5.11.7.1.2. Approved Airman for training program that leads to an Air Force commission.

5.11.7.1.3. Approved Base of Preference (BOP) or in-place BOP (for FTA only).

5.11.7.1.4. Other approved agreements authorized by current AF/A1. (**Note**: The MPS will specify the approved agreement in the area provided.) **(T-1).**

5.11.8. Discharge for the Purpose of Immediate Reenlistment. Discharge always occurs before Airmen reenlist. The discharge will remain in effect if the Airman does not reenlist within 24 hours. MPS will not give the completed AF Form 901 to the Airman until reenlistment occurs. **(T-1).** Do not use the AF Form 901 for prior service enlistments or for former officer entering the Air Force in enlisted status. (**Note**: Commanders or civilian directors holding the position may not refuse to sign AF Form 901, and then permit Airman to remain otherwise eligible for reenlistment. In such cases commander/civilian directors will immediately notify the MPS of the specific circumstances in writing and submit the required documentation (AF Form 418, etc.) within 7 calendar days.) **(T-1).**

5.11.8.1. The AF Form 901 documents the commander's/civilian director's approval to reenlist and also documents discharge for the purpose of immediate reenlistment.

5.11.8.2. The Chief, MPS or designated representative authenticates the AF Form 901. **(T-1).** The designated representatives must be assigned to the MPS or Geographically Separated Unit (GSU) personnel function and in the grade of TSgt, GS-06, or higher, and act as the service representative for the reenlistment and validate/confirm eligibility/entitlements. **(T-2).**

5.11.8.3. MPS ensures the commander or civilian director holding the position documents certification on AF Form 901. Airmen will not be provided the DD Form 4 without an approved/signed AF Form 901 from the commander/civilian director. (**Note**: DD Form 256AF, *Honorable Discharge Certificate,* is not be issued to Airmen to be discharged for the purpose of immediate reenlistment within 24 hours.)

5.11.9. Leave Settlement. Airmen may sell a maximum of 60 days accrued leave during their career. Accrued leave may be sold and paid upon reenlistment or entering into the first extension of enlistment, to include subsequent reenlistments. MPS refers to AFI 36-3003, *Military Leave Program,* and the PSDG for DJMS-AC update instructions, as applicable.

5.11.9.1. Airmen may change their leave settlement election provided:

5.11.9.1.1. Airmen reenlisting must change their election before they reenlist and document their change on an AF Form 1089, *Leave Settlement Option*. All Airmen are counseled prior to reenlistment. **(T-0).**

5.11.10. Airmen reenlisting for the purpose of obtaining an Air Force commission. Publications governing selection for a program leading to an Air Force commission take precedence over reenlistment restrictions imposed by this publication.

5.11.10.1. Airmen may reenlist to obtain service retainability required for the particular commissioning program. This includes FTA who have not completed 36 months TAFMS on their current enlistment (60 months for 6-year enlistees).

5.11.10.2. MPS updates RE code 3A for FTA selected for Air Force commissioning programs who have not reached the SRP consideration point. MPS updates RE code 1J for all other Airmen selected for commissioning programs. (**Note**: MPS cannot update RE code 1J or 3A until the Airman is projected for separation).

5.11.10.3. Refer to paragraph 4.4 for restrictions pertaining to Airmen serving in SRB skills.

5.11.11. Identifying and Notifying Reenlistment-Ineligible Airmen. MPS uses the SRP roster to identify First Term, Second Term and Career Airmen ineligible to reenlist. MPS sends the commander/civilian director a monthly list of ineligible Airmen for informational purposes only.

5.11.12. HYT and Age 60 Restrictions. The reenlistment terms outlined in Table 5.9 prevent Airmen from violating the HYT and age 60 restrictions discussed below. Requests for HYT adjustments, waivers or corrections will be sent to AFPC Retirements via current processing procedures. (**Note:** Under no circumstances will any reenlistment or extension exceed the month following Airman's HYT or age 60, whichever occurs first.)

5.11.12.1. Airmen may not reenlist or extend their enlistment if the new DOS exceeds the month following their 60th birthday. If approved, the reenlistment or extension period may not exceed the month following the HYT for the Airman's grade, or age 60, whichever occurs first. (**Exception**: Airmen may reenlist for a period that permits them to serve at least 20 years TAFMS, but they may not exceed the age 60 restriction.)

5.11.12.2. First Term Airmen may not reenlist if the new DOS will exceed their HYT plus 1 month. Also see paragraph 5.11.12.2.2. However, they may qualify for an extension of enlistment to establish a DOS at HYT (refer to paragraph 6.6.9 and Table 6.2).

5.11.12.2.1. SSgts may not reenlist if the new DOS will exceed their HYT plus 1 month. Also see paragraph 5.11.12.2.2. However, they may qualify for an extension of enlistment to establish a DOS at HYT (refer to paragraph 6.6.9.1 and Table 6.2).

5.11.12.2.2. Reenlistment eligible FTA in SRB skills authorized to receive a Zone A SRB, may reenlist for periods exceeding their HYT date, provided the reenlistment occurs before they complete 6 years TAFMS and do not establish a DOS exceeding 10 years TAFMS. See Table 4.1, Item 1 for additional eligibility criteria.

5.11.12.2.3. Airmen in the grade of TSgt authorized to receive a Zone E SRB, may reenlist for periods exceeding their HYT plus 1 month, provided the reenlistment

authorizes the Airman the Zone E SRB and does not establish a DOS exceeding 22 years TAFMS. See Table 4.1, item 4 for additional eligibility criteria.

5.11.12.2.4. CSRB. For Airmen authorized a CSRB, the HYT may be waived at the discretion of the SecAF or designated representative. AFPC will adjust the HYT after the CSRB contract is processed.

5.11.12.3. Airmen with at DOS that exceeds HYT due to HYT reduction, demotion, etc. will have their DOS adjusted to match their new HYT date. Before beginning any separation package, consult AFI 36-3208, *Administrative Separation of Airmen*. The separation authority may withhold execution of a separation for any reason in the best interest of the Air Force. **(T-1).**

5.11.13. Reduction to HYT grades:

5.11.13.1. Airmen subsequently promoted or whose HYT has been extended will execute a new contract to meet future retainability requirements. The previous contract will not be re-instated.

5.11.13.2. Airmen receiving an SRB will receive their full entitlement, provided they have executed a new reenlistment/extension and serve in the same SRB skill.

5.11.14. Reenlistment of Non-U.S. Citizens. Non-U.S. citizens who obtain U.S. citizenship will be assigned an RE code and must have SRP consideration completed to remove the RE code and reenlist. **(T-0).** Non-U.S. citizens who fail to obtain U.S. citizenship during their initial enlistment will separate with the applicable RE code. **(T-0).**

5.11.15. Air Force Fitness Program, Airmen Medically Disqualified and Airmen in RI 9A000/9A100/9A200/9A300. Commander/civilian directors may review and determine reenlistment eligibility for Airmen who have a first time fitness failure and will review and determine reenlistment eligibility for all Airmen who remain in the Unsatisfactory category after two or more tests within 24 months (IAW AFI 36-2905, *Fitness Program*). Commanders/civilian directors may place Airmen in the Unsatisfactory category in reenlistment eligibility 4J by completing the AF Form 418 and stating "Airman in Unsatisfactory fitness category, is reenlistment ineligible and placed in RE code 4J." **(T-1).**

5.11.15.1. Successfully reaching a Satisfactory or Excellent fitness category does not automatically restore reenlistment eligibility. The commander/civilian director may remove the reenlistment ineligibility condition by completing an AF Form 418 after the Airman successfully transitions to a Satisfactory or Excellent fitness category, or the commander/civilian director may choose to continue the reenlistment ineligibility until after the Airman receives a second consecutive Satisfactory or Excellent fitness assessment score at which time an AF Form 418 will be completed removing the Airman's 4J – Fitness Failure reenlistment ineligibly code. An ineligible Airman (RE code 4J) requiring retainability to reach the Satisfactory or Excellent fitness category may request an extension of enlistment according to Table 6.2, Rule 18. If eligibility for reenlistment is denied, Airman will be placed in RE Code 2X and is not eligible to extend or reenlist (except to appeal the non-selection). If the Airman is later made reenlistment eligible, then the commander/civilian director will complete an AF Form 418 and the MPS or equivalent updates the RE code to a more applicable code. **(T-1).** Refer to AFI 36-2905 for additional information.

5.11.15.2. Airmen in RE code 4K may not reenlist when pending evaluation by a MEB or PEB unless waiver is approved. See Table 5.7, Item 2.

5.11.15.2.1. Airmen in RE code 4K may voluntarily extend their enlistment under Table 6.2, Rule 9 of this AFI. Limit extensions to a period outlined by AFPC Medical Standards, not to exceed a maximum 24 months. See **Chapter 6**.

5.11.15.3. All Airmen disqualified from their AFSC and in RI of 9A000, 9A100, 9A200 or 9A300 are updated to RE code 4G. Commander/civilian directors may not waive Airmen in RE code 4G to permit reenlistment unless the Airman has been selected and approved for retraining or Special Duty. In these cases the commander/civilian director takes action as outlined in paragraph 2.6.7 through 2.6.11.

5.11.15.3.1. Airmen disqualified and in RI 9A000 or 9A100 may execute a one-time extension in order to remain on active duty for a total period of 12 months to qualify/compete for retraining/Special Duty. Under no circumstances can the extension period combined with the remaining obligated service exceed 12 months. The length of the extension, if any is based on the date of the formal disqualification approval not to exceed 12 months. Airmen will extend IAW Table 6.2, Rule 28d of this AFI. **(T-1).** If the Airman is not approved for retraining or Special Duty during this period, he/she separates on his/her DOS.

5.11.15.3.2. Airmen in RI 9A200/9A300 remain in RE code 4G and separate on DOS unless the commander/civilian director initiates early separation or subsequently completes retention versus separation package and retain the Airman.

5.11.16. Waiver of Reenlistment Ineligibility Conditions (Lost Time and Civilian Criminal Court Convictions). (Applies to AFR and ANG members when in an active status.) Airmen may request waivers to reenlist to their unit commander/civilian director because they have 5 or more days lost time, or have a civil court conviction (Table 5.6, item 5 or 13). (**Note**: Civil court convictions automatically render Airmen ineligible for the length of the maximum allowable Manual for Courts Martial [MCM] confinement period for the same or most closely related offenses. The MPS must contact the servicing legal office to determine the MCM confinement period.) **(T-1).**

5.11.16.1. Airmen must request a waiver to reenlist. The Airman's supervisor will complete an AF Form 418. See paragraphs 2.6.7 through 2.6.11 for processing the AF Form 418. **(T-1).**

5.11.16.1.1. If the waiver is approved, the commander/civilian director ensures the Airman acknowledges receipt, and then sends the AF Form 418 to the MPS for processing. The MPS updates RE code 1A (can only be updated immediately before Airman reenlists or extends), documents the waiver reason/authority on the AF 901, and attaches the waiver to the contract for file in ARMS.

5.11.16.1.1.1. When Airmen receive approved waivers and reenlist, the reenlistment ineligibility condition no longer applies.

5.11.16.1.1.2. When Airmen receive approved waivers to extend their enlistment, the MPS will re-update the ineligibility conditions after updating the extension. Waivers are only valid for one extension.

5.11.16.1.1.3. When Airmen elect separation after receiving approved waivers, the MPS re-update the ineligibility condition, unless a higher priority code applies.

5.11.16.2. If disapproved, the commander/civilian director ensures Airman acknowledges receipt. The Airman may elect to appeal the disapproval decisions. Process the appeal as outlined in paragraph 2.6.13 through 2.6.14.7.

5.11.17. Return to Duty Program (RTDP). Airmen eligible are: 1) an enlisted Airman sentenced by court-martial to a dishonorable or bad conduct punitive discharge, with or without adjudged confinement, whose discharge has not been executed, or 2) an enlisted Airman sentenced by court-martial to a period of confinement, with or without adjudged dishonorable or bad conduct punitive discharge. Airmen in either of these examples who have otherwise met the requirements in AFI 31-105, *AF Corrections System,* may present a request to return to active status as specified in AFI 31-105. The Air Force Clemency and Parole Board (AFC&PB), using the criteria outlined in AFI 31-105, will decide if post trial enlisted Airmen have been rehabilitated. In every case, the needs of the service will govern the return-to-duty of these Airmen.

5.11.17.1. Airmen sentenced to a punitive discharge (with or without) confinement which was upgraded by the AFC&PB to an honorable discharge are separated with the new discharge characterization and eligible to reenlist under RE code "1S". Airmen become eligible for reentry to service as determined by AFI 36-2101.

5.11.17.2. Airmen sentenced to confinement without a punitive discharge may be returned-to-duty by the AFC&PB with an RE code "2D" which prevents reenlistment until Airman have served at least 6 months after release from confinement and, are otherwise eligible, and their unit commander/civilian directors select them for reenlistment under the SRP or approve reenlistment waivers.

5.12. RE Codes. Accurate RE codes are vital to ensure the Air Force retains and reenlists only those Airmen selected for continued service and prevents ineligible Airmen from continued service. The MPS will update, monitor, and maintain accurate RE codes in MilPDS. Incorrect codes can prevent or allow the selection of Airmen for reenlistment, promotion, separation, retirement and reassignment. **(T-1).** The MPS will:

5.12.1. Update RE codes in MilPDS using the following hierarchy: 2*"letter"*, 4*"letter"*, 3*"letter"*, and 1*"letter"*. **(T-1).**

(**Note:** No RE code takes precedence over RE codes in 2*"letter"*, to include pending MEB/PEB. MPS will re-update RE code to 2*"letter"* in such cases. **[T-1].**)

5.12.2. Update the appropriate RE code according to the hierarchy in paragraph 5.12.1 in MilPDS when two or more RE codes apply. **(T-1).**

5.12.3. Update the appropriate RE code with the longest duration in MilPDS when two or more RE codes in the same series apply. **(T-1).**

5.12.4. Leave RE code 2X in MilPDS unless SRP selection occurs or RE code 2X is being replaced by a higher priority code. **(T-1).**

5.12.5. Verify RE codes in MilPDS NLT 60 days for all Airmen separating. Incorrect or inappropriate RE codes are corrected as needed. Refer requests for corrections to AFPC Reenlistments via current processing procedures. (**Note:** See Tables 5.3 - 5.6).

Table 5.3. Applicants Eligible for Immediate Reenlistment (RE-1 Series).

ITEM	A **An applicant is eligible for immediate reenlistment (within 24 hours after separation) and eligible for prior service enlistment under any of the following conditions, provided the Airman is otherwise eligible.**	B **RE status code entry in MilPDS is:**
1	Ineligible to reenlist, but condition waived. (Do not separate Airmen with this RE code. Remove this code from MilPDS when an Airman elects to separate. Update the appropriate RE code from Table 5.4, Table 5.5, or Table 5.6 before the Airman separates. Refer to paragraph 5.11 and Table 5.7., note 1 and 4).	**1A**
2	Eligible to reenlist, but elects separation. (Airmen selected under the SRP and elect separation are given RE code 1J) (See notes.) Eligible to reenlist, but elects separation. (Airmen selected under the SRP and elect separation are given RE code 1J.) (See notes)	**1J**
3	Career Airmen selected by the commander/civilian director under the SRP and 13 months or less remain before completing 20 years TAFMS. (**Do not separate Airman with this RE code.)**	**1K**
4	Eligible to reenlist, Second Term or Career Airmen not yet considered under the SRP. (**Do not separate Airman with this RE code.**)	**1M**
5	Eligible to reenlist, Second Term or Career Airmen with less than 19 years TAFMS selected by the commander/civilian director under the SRP and either 13 months or less remain before original ETS, or Airmen serving on an extension of enlistment. (**Do not separate Airman with this RE code.**)	**1P**
6	Eligible to reenlist, Career Airmen with more than 20 years TAFMS selected by the commander/civilian director under the SRP and either 13 months or less remain before original ETS, or Airmen serving on an extension of enlistment. (**Do not separate Airman with this RE code.**)	**1Q**
7	First Term Airmen selected for reenlistment under the SRP. (see notes) (**Do not separate Airman with this RE code.**) (See item 2.)	**1R**
8	Air National Guard and Air Force Reserve Airmen serving on voluntary or involuntary EAD. (These Airmen are eligible to request enlistment in the RegAF only and apply IAW AFI 36-2002. Enlistment requests come through AFPC Enlisted Accessions for approval.)	**1T**

Notes*:*
1. Refer to paragraph 5.11.10 to determine applicable RE code for FTA selected for programs leading to an Air Force commission.
2. Refer to paragraph 2.6.6 and Table 5.5 for Airmen who receive early SRP consideration for separation.
3. 1A will not be updated on FTA.

Table 5.4. Conditions Barring Immediate Reenlistment (RE-2 Series).

ITEM	A	B
	An applicant is ineligible to reenlist in the Regular Air Force and, unless specifically authorized by paragraph 6.6.5. or Table 6.2., not authorized to extend enlistment under any of the following conditions	**RE status code entry in MilPDS is**
1	AFPC denied reenlistment. (Reserved for AFPC use only.)	**2A**
2	Separated with a general or under-other-than-honorable-conditions (UOTHC) discharge.	**2B**
3	Involuntarily separated with an honorable discharge; or entry level separation without characterization of service.	**2C**
4	Returned prisoner with less than 6 months of service since return to duty. (See note 1)	**2D**
5	Serving a period of probation and rehabilitation (P&R) (See note 1).	**2E**
6	Undergoing, or separated while undergoing rehabilitation in a DoD regional confinement facility under the direction of AFSFC/SFC. (See note 1)	**2F**
7	Participating in or failed the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program for drugs, or has failed to complete the ADAPT program. (This code remains valid until the Airman completes the program or the commander/civilian director removes the ineligibility condition for an Airman in the aftercare program.)	**2G**
8	Participating in the ADAPT program for alcohol, or has failed to complete the program. (This code remains valid until the Airman completes the program or the commander/civilian director removes the ineligibility condition for an Airman in the aftercare program. Do not update this code for self-identified Airmen unless they fail the program.)	**2H**
9	Non-U.S. citizen serving on initial enlistment. (Refer to paragraph 5.11.14.)	**2I**
10	Under investigation by military or civilian authority, the outcome of which may result in discharge or court-martial action (see note 1) (Do not separate Airmen with this RE code.)	**2J**
11	Has been formally notified by the commander/civilian director of initiation of involuntary separation action. (See note 1 & 2)	**2K**
12	Civil court charges pending for an offense for which the MCM authorizes confinement for the same or most closely related offense, or court-martial charges have been preferred, or court-martial action is under appellate review.	**2L**
13	Serving a sentence or suspended sentence of court-martial; or separated while serving a sentence or suspended sentence of court-martial.	**2M**

14	Conscientious objector whose religious convictions preclude unrestricted assignment. Update this RE code when the Airman requests separation or is discharged for this reason. (See note 1)	**2N**
15	Absent without leave (AWOL); deserter or dropped from rolls (DFR).	**2P**
16	Personnel medically retired or discharged.	**2Q**
17	Airman is within 23 months of 60th birthday, completed at least 18 years, 1 month of TAFMS, and 13 months or less remain until DOS. (See notes)	**2R**
18	Airman is within 23 months of 60th birthday, completed at least 18 years, 1 month of TAFMS, and more than 13 months remain until DOS. (See notes)	**2S**
19	Airman possesses an HYT date of at least 20 years TAFMS, is within 23 months of HYT date, and 13 months or less remain until DOS. (See notes)	**2T**
20	Airman possesses an HYT date of at least 20 years TAFMS, is within 23 months of HYT date, and more than 13 months remaining until DOS. (See notes)	**2U**
21	Applied for retirement or retirement has been approved.	**2V**
22	Retired and recalled to active duty.	**2W**
23	First Term, Second Term, or Career Airman nonselected for reenlistment. (See note 1)	**2X**
Notes*:* 1. Refer to Table 6.2 to determine the Airman's eligibility to request an extension of the current enlistment. 2. MPS must initiate a request via current processing procedure to AFPC Classifications**. (T-1).** Include all pertinent documentation in the case file.		

Table 5.5. Conditions Barring Immediate Reenlistment (RE-3 Series).

ITEM	A	B
	An applicant is ineligible for immediate reenlistment (within 24 hours after separation), but eligible for prior service enlistment with an approved waiver (provided the Airman is otherwise qualified) under any of the following conditions (See notes).	**RE status code entry in MilPDS is**
1	FTA who separates before completing 36 months (60 months for a 6-year enlistee) on current enlistment and who has no known disqualifying factors or ineligibility conditions except grade, skill level, and insufficient TAFMS (Refer to paragraph 2.6.).	**3A**
2	First Term, non-prior service, female Airmen who enlisted into the Air Force and it was later discovered they were pregnant before their enlistment, and were immediately discharged.	
3	First Term Airman "involuntarily separated" (entry-level) for inability to satisfactorily progress in a required training program without characterization of service; or a First-Term Airman "involuntarily separated" for failure to progress in military training	

	required to be qualified for service with the Air Force or for performance of primary duties; or Prior Service Airman involuntarily separated for failure to progress in military training required to be qualified for service with the Air Force or for performance of primary duties. (See Note 4)	
4	First Term, Second Term or Career Airman who was ineligible to reenlist (Table 5.4, Table 5.5, or Table 5.6), the ineligibility condition no longer exists, and the Airman requires SRP consideration or reconsideration. (AF Form 418 is completed.) (**Do not separate Airmen with this RE code.)**	**3B**
5	FTA not yet considered under the SRP. Remove this code from MilPDS when Airmen are selected or non-selected for reenlistment, or become ineligible for reenlistment). (**Do not separate Airmen with this RE code.)**	**3C**
6	Second Term or Career Airman who refused to get PCS or TDY assignment retainability, to include declining retainability for a deployment. (See note 3)	**3D**
7	Second Term or Career Airman who refused to get retainability for training or retraining, or who declined to attend training or retraining.	**3E**
8	Airman selected for non-retention by Air Force Enlisted Retention Board (ERB).	**3F**
9	FTA selected under SRP, no CJR available and removed from the CJR waiting list.	**3I**
10	Reserved for use by AFPC or the Air Force Board for Correction of Military Records (AFBCMR) when no other reenlistment eligibility code applies or is appropriate.	**3K**
11	Airman selected for non-retention by Air Force Quality Force Review Board (QFRB).	**3Q**
12	Separated with Special Separation Benefit (SSB).	**3S**
13	Separated with Voluntary Separation Incentive (VSI) or separated under Enlisted Voluntary Separation Pay (VSP) Program.	**3V**

Notes*:*
1. Unless specifically authorized by paragraph 6.6.5, or Table 6.2, Airmen serving in these RE codes cannot extend their enlistments.
2. Airman who does not possess RE codes 1#, 2R, 2S, 2T, 2U, 3C, 3I, or 4D cannot extend under rules 11, 13, and 14.
3. AFI 36-3802, *Personnel Readiness Operations*, contains procedures for declining retainability for AEF deployments. This does not include indeterminate TDYs as prescribed in AFI 36-2110.
4. Airmen who are discharged due to a medical injury occurring in Basic Military/Technical Training who are unable to continue in a training program due to those injuries may be considered under this RE code, provided no other condition applies.

Table 5.6. Conditions Barring Immediate Reenlistment (RE-4 Series).

ITEM	A	B
	An applicant is ineligible to reenlist in the Air Force and, unless specifically authorized by paragraph 6.5. or Table 6.2., is not authorized to reenlist under any of the following conditions:	**RE status code entry in MilPDS is**
1	Separated for hardship or dependency reasons. (see note 1)	**4A**
2	Separated for concealment of juvenile records, minority, failure to meet physical standards for enlistment, failure to attain a 9.0 reading grade level as measured by the Air Force Reading Abilities Test (AFRAT), or void enlistments.	**4C**
3	Grade is SrA/E-4, completed at least 7 years TAFMS, but fewer than 16 years TAFMS and is not currently selected for promotion to SSgt/E-5; or Grade is SSgt/E-5, completed at least 14 years TAFMS, but fewer than 16 years TAFMS and selected for promotion to TSgt/E-6.	**4D**
4	4 year enlistee and grade is A1C (with less than 12 months TIG) or below and Airmen completed 31 or more months, if a FTA; or 6 year Enlistee and grade is below SrA and has completed 55 or more months, if a FTA; or Second Term/Career Airmen and grade is A1C or below and has less than 16 years of TAFMS. (See notes 2, 3, and 4)	**4E**
5	Five or more days lost time during current enlistment. (Airmen with 5 or more calendar days lost time are not eligible to reenlist unless they receive an approved waiver according to Table 5.7.) (See notes 2 and 3)	**4F**
6	No AFSC skill level commensurate with grade (see notes 3 and 5). Update this code on FTA upon completing 31 months (4-year enlistee) or 55 months (6-year enlistee) on current enlistment who does not possess a skill level commensurate with grade in an awarded AFSC (CAFSC, 2AFSC, 3AFSC or 4AFSC). FTA must possess an AFSC at the 3-skill level. **(T-1).** Second Term and Career Airmen serving in the grade of SrA or SSgt must possess an AFSC at the 5-skill level (3-skill level when no 5-skill level exists). **(T-1).** Second Term and Career Airmen serving in the grade of TSgt or MSgt must possess an AFSC at the 7-skill level. Second Term and Career Airmen serving in the grade of SMSgt or CMSgt must possess an AFSC with at least a 9-skill level. Airmen serving in Reporting Identifiers (except 9A000, 9A100, 9A200, 9A300, 9A400, 9A500, 9JXXX, or 9TXXX) or Special Duty Identifiers are considered to possess an AFSC skill level commensurate with grade. **(T-1).**	**4G**

7	Serving suspended punishment pursuant to Article 15, UCMJ. (See note 3)	**4H**
8	Serving on the Control Roster (See note 3)	**4I**
9	Received Unsatisfactory fitness assessment (Reference AFI 36-2905, *Fitness Program,* and see note 3.)	**4J**
10	Airman is pending evaluation by MEB/PEB. (Refer to paragraph 5.11.15.2.)	**4K**
11	Separated commissioning program eliminee OTS, Airman Education and Commissioning Program (AECP) and so on.	**4L**
12	Air Force breach of enlistment/reenlistment agreement.	**4M**
13	Convicted by civilian authorities. (Airman remains ineligible for length of the maximum allowable MCM confinement for the same or most closely related offense.)	**4N**

Notes*:*
1. This code does not apply to Airmen separated for the sole reason of pregnancy.
2. Airmen who do not possess RE codes 1#, 2R, 2S, 2T, 2U, 3C, 3I, or 4D cannot extend under Table 6.2, Rules 11, 12, and 13.
3. Airman may be eligible to request an extension of enlistment.
4. Update this code on FTA (4-year enlistee) who has completed 31 months on current enlistment, is serving in the grade of A1C and has less than 12 months TIG (refer to paragraph 5.11.2.) and no other higher priority ineligibility factor exists. Update this code on FTA (6-year enlistee) who has completed 55 months on current enlistment and does not hold the grade of SrA.
5. Update this code on FTA upon completing 31 months (4-year enlistee) or 55 months (6-year enlistee) on current enlistment who does not possess a skill level commensurate with grade in an awarded AFSC (CAFSC, 2AFSC, 3AFSC or 4AFSC). FTA must possess an AFSC at the 3-skill level. **(T-1).** Second Term and Career Airmen serving in the grade of SrA or SSgt must possess an AFSC at the 5-skill level (3-skill level when no 5-skill level exists). **(T-1).** Second Term and Career Airmen serving in the grade of TSgt or MSgt must possess an AFSC at the 7-skill level. **(T-1).** Second Term and Career Airmen serving in the grade of SMSgt or CMSgt must possess an AFSC with at least a 9-skill level. **(T-1).** Airmen serving in RI (except 9A000, 9A100, 9A200, 9A300, 9JXXX, or 9TXXX) or Special Duty Identifiers are considered to possess an AFSC skill level commensurate with grade. **(T-1).**

Table 5.7. Conditions Requiring a Waiver to Reenlist.

ITEM	**A**	**B**
	If the Airman is ineligible to reenlist due to:	**the Airman may request a waiver from the commander/civilian director (except for rule 4 and 6) to reenlist provided the Airman is otherwise eligible and is:**
1	five or more days lost during current enlistment (Table 5.6, item 5);	not using this waiver provision for the purpose of separation (see notes 1, 2, 3, 4 and refer to paragraph 5.11.17).

2	pending MEB/PEB	Airmen in SRB AFSCs may request waiver through their commander/civilian director. AF/A1 is final approval. Airmen may initiate the request 6 months prior to DOS (see note 5).
		Airmen in non-SRB AFSCs may request waiver through their commander/civilian director. FSS/CC is final approval. Airmen may initiate the request 6 months prior to DOS (see note 5).
3	receiving a PCS assignment that requires the Airman to reenlist immediately following completion of technical school retraining;	FTA who is unable to extend to qualify for the assignment. (The Chief, MPS at the technical training location is the approval authority for this waiver [see note 2].)
4	civil court conviction (Table 5.6, item 13);	a First Term, Second Term, or Career Airman (see notes 1, 2, 3, 4, and refer to paragraph 5.11.17).
5	Airman disqualified from their AFSC and in RI 9A000, 9A100, 9A200 or 9A300 and previously held RE code of 4G;	Has been selected and approved for retraining or special duty (see notes 1, 2, 3, and refer to para 5.11.15.3.)
6	Insufficient grade/TIG as a First Term Airman and in RE code 4E	the commander/civilian director may request a waiver to extended to meet grade/TIG requirements to reenlist through their respective group commander to AFPC Reenlistments. When approved by AFPC Reenlistments, these Airmen are extended to meet reenlistment eligibility.

Notes:
1. Commander/civilian director must submit written approval of the waiver condition to the MPS. Update RE code 1A in MilPDS before executing the reenlistment. RE code 1A is only applicable to FTA who previously had an approved CJR and the CJR was later suspended. FTA who did not receive an approved CJR during their CJR window are ineligible to request a CJR while holding RE code 1A and, therefore, cannot reenlist. Remove RE code 1A from MilPDS immediately following update of the extension or immediately following the Airman's reenlistment (refer to paragraph 4.16.) and update to a more applicable RE code.
2. Airman must meet all other eligibility requirements for reenlistment or an extension of enlistment. **(T-1).**
3. All reenlistment ineligibility conditions must be waived by the commander/civilian director in order to allow an Airman to reenlist. The commander/civilian director may waive two or more ineligibility conditions concurrently on the same form. **(T-1).** However, if there is an ineligibility condition for which there is no waiver provision, the commander/civilian director cannot grant a waiver.
4. An Airman who has lost time or has been in confinement is not eligible to extend until their lost time has been computed and corrected.
5. To qualify, the Airman must be currently performing in the SRB skills (C/DAFSC), not be assigned in a patient status (9P000), medical condition is stable as determined by medical authorities and otherwise be eligible to reenlist. The Airman/commander/civilian director will submit the following documents to the MPS: **(T-1).**
a. Commander/civilian director recommendation: Certifying the Airman is performing duties within the AFSC and specify any duties the Airman is unable to perform (if applicable).
b. Primary Care Manager (PCM): PCMs assess the Airman's capabilities and limitations with respect to performing core task within his/her AFSC, state whether the Airman's condition is stable and prognosis for continued improvement.
c. Provide Business Case Analysis: Describe how the Airman's utilization within the AFSC fills valid Unit Manning Document (UMD) requirement and benefits the overall community.
d. Waiver processing procedures: The MPS will review the case file for completeness and return all incomplete requests to the unit. **(T-1).** . Complete case files will be forwarded to AFPC Reenlistments via current processing procedures. AFPC will review for completeness and forwards to AF/A1. **(T-1).** AF/A1 will obtain Functional Manager (FM) and Career Field Manager (CFM) recommendation and obtain AF/A1 review and final determination. AF/A1 notifies appropriate parties of the final decision. The MPS will advise the unit commander/civilian director on the final decision. **(T-3).** If approved to reenlist through the waiver process, the RE code 4K will be temporarily removed to allow update of the reenlistment, but the MPS will re-update the RE code to 4K once the reenlistment consummates. **(T-1).** (**Note:** In all cases, Airmen will retain the RE code 4K until medically cleared for duty.)

Table 5.8. Terms of Reenlistment.

Rule	If the Airman is eligible to reenlist IAW para 5.1, this table and is a (see all notes below)	And has the following remaining obligated service	And can reenlist with the remaining obligated service without exceeding	Then the authorized Term of Reenlistment in whole years is

			HYT plus 30 days for	
1	First Term/Second Term and Career Airman.	29 calendar days or less	4, 5 or 6	4, 5 or 6 plus the remaining obligated service months. (See notes 1-4)
		30 days to 12 months	4 or 5	4 or 5 plus the remaining obligated service months. (See notes 1-4)
		13 – 24 months	4	4 plus the remaining obligated service months. (See notes 1-4)
		25 – 36 months	3	3 plus the remaining obligated service months. (See notes 1-4)
	If the Airman is eligible to reenlist IAW para 5.1, this table and is a (see all notes below)	**And has the following remaining obligated service**	**And cannot reenlist in accordance with Rule 1 above due to HYT**	**Then the authorized Term of Reenlistment in whole years is**
2	First Term/Second Term and Career Airman	48 months or less		2, 3 or 4, plus the remaining obligated service months. (See notes 1-5)

Notes*:*

1. Airmen must meet conditions authorizing reenlistment in paragraph 5.11.2 and Table 5.3. **(T-1).**
2. Current obligated service determines how many years Airman is authorized to reenlist. Obligated service is added to the number of years reenlisting and the combination cannot exceed 6 years (72 months).
3. Current HYT rules apply.
4. All Airmen reenlist IAW rules 1 - 2 above and may later extend as needed to reach HYT plus 1 month per Table 6.2, Rule 27 (separation) or Table 6.2, Rule 4 (retirement). Paragraph 5.11.4 applies.
5. Airmen must reenlist the maximum number of years allowed (plus the obligated service); not to exceed HYT plus 1 month.

Table 5.9. Conditions Authorizing Reenlistment.

Rule	A	B
	If the Airman is eligible to reenlist according to Table 5.3 and is a	**the Airman may reenlist (see notes 1, 2 and 3)**
1	First Term, 4-year enlistee	after completing 36 consecutive months on the current enlistment if the Airman has an approved CJR (refer to Table 5.2, item 1). Prior service Airmen are considered FTA when the prior active service is less than 24 months.
2	First Term, 6-year enlistee	after completing 60 consecutive months on the current enlistment if the Airman has an approved CJR (refer to Table 5.2, item 2).
3	Second Term or Career Airman	to obtain retainability for promotion to MSgt, SMSgt, or CMSgt (upon announcement of promotion increment number for the upcoming month).
4		to get required retainability for service schools.
5		to obtain required retainability for PCS, PCA or TDY assignment, to include deployments.
6		to obtain required retainability for Post 9/11 GI Bill or Continuation Pay under the Blended Retirement System.
7		to obtain required retainability for completion of an extension to an overseas tour, or provide 12 months service retainability after arrival of command-sponsored family members at an overseas location.
8		within the 90-day period before ETS
9		within the 15-month period before an established (or requested) Date Eligible to Return from Overseas (DEROS) if the Airman requires additional retainability.
10		within the 15-month period before DOS if the Airman has elected (or is maintaining) an indefinite DEROS.
Notes*:* 1. The MPS must ensure the authorized and requested term if reenlistment must be sufficient to assume any period of authorized obligated service owed as a result of prior extensions of enlistment. **(T-1).** 2. Cash settlement for accrued leave is authorized any time an Airman reenlists not to exceed a total of 60 days throughout the Airman's career. 3. Current HYT rules apply per paragraph 5.11.12.		

Table 5.10. Disposition of Reenlistment/Extension Documents.

ITEM	A	B	C
	Form or Document	**Total Number of Copies**	**Disposition**

1	DD Form 4, *Enlistment/Reenlistment Document Armed Forced of the United States*	3	**Original**--forward within 5 days of reenlisting to: AFPC /DP1SSR 550 C Street West Ste 10 Randolph AFB TX 78150 **Note**: Remove all extraneous documents except waiver memorandums. **1st copy**--Airman's copy. **2nd copy**--MPS copy.
2	AF Form 901, *Reenlistment Eligibility Annex to DD Form 4/1 and 4/2*	3	Attach to the corresponding copies of the DD Form 4/1 and 4/2 and follow the instructions outlined in item 1.
3	Correspondence concerning waiver or special authorization to reenlist	3	Attach to the corresponding copies of the new DD Form 4/1 and 4/2, and follow the disposition instructions outlined in item 1.
4	Statement authorizing retention on active duty for the purpose of medical examination	1	Destroy after the Airman reenlists. (as directed by the RDS)
5	AF Form 418, *Selective Reenlistment Program Consideration*	3	**Original**--forward within 5 days to: AFPC/DP1SSR 550 C Street West Ste 21 Randolph AFB TX 78151-4723 **1st copy**--Commander/civilian director's copy. **2nd copy**--Airman's copy (as directed by the RDS)
6	Approved correspondence authorizing CJR, Table 3.1, note 2.	2	**Original**--MPS copy. Destroy when the Airman reenlists
7	AF Form 1089, *Leave Settlement Option, if applicable*	2	**Original**--Attach to the corresponding copies of the DD Form 4 or AF Form 1411, if first extension of enlistment and follow the instructions outlined in item 1. See paragraph 6.3. **1st copy**--MPS copy. **2nd copy**--Airman's copy.
8	AF Form 1411, *Extension of Enlistment in the Air Force*	3	**Original**--forward within 5 days of extending to: AFPC/DP1SSR 550 C Street West Ste 10

	or AF Form 1411-1, *Cancellation of Extensions of Enlistment in the Air Force*		Randolph AFB TX 78150 **1st copy**--MPS copy. **2nd copy**--Airman's copy.

5.13. Reenlistment in the Air Force Reserve (AFR).

5.13.1. Who is Eligible for Reenlistment. **(T-2).**

5.13.1.1. Members assigned to RegAF or Reserve units formed as supplements (augmentation) in the event of mobilization.

5.13.1.2. IMA and PIRR

5.13.1.3. PIRR assigned to Ready Reinforcement Personnel Section (RRPS) Civil Air Patrol (CAP) or AFR squadrons.

5.13.1.4. Individual Ready Reserve (IRR) members participating in the IRR incentive program.

5.13.1.5. Standby Reserve members assigned to the nonaffiliated Reserve section ND (includes Reservists with or without Military Service Obligations (MSO) who have requested assignment to this section to continue participation after being designated a key employee or an appointed or elected official).

5.13.1.6. Members being assigned to the Selected Reserve from the IRR, ARPC, who are within 6 months of ETS.

5.13.2. Requirements for Reenlistment.

5.13.2.1. In the United States and its Possessions and Territories. For Unit Reservists, the Wing/Group/UCA reenlists members. For IMA and PIRR members, HQ RIO Detachment or MPS Representative may assist in the reenlistment. Under no circumstances will an IMA or PIRR member reenlist without approved paperwork and approval from unit commander.

5.13.2.2. Outside the United States and its Possessions and Territories. Any overseas Air Force MPS may reenlist a member. The MPS must get authorization from home station MPS and commander, (ARPC/DPA for AGRs), to reenlist members not under their jurisdiction. Prior approval from RIO Detachment for IMA and PIRR members is required for reenlistment. **(T-2).**

5.13.2.3. When a member reenlists away from home station, ensure the actual place of reenlistment is entered into item 4 on the DD Form 4. This may affect the eligibility of potential tax incentives, especially when member is entitled to participate in the AFR Enlisted Incentive Program upon reenlistment.

5.13.3. Qualifications and Policy. **(T-2).**

5.13.3.1. Members are initially eligible if they meet the age, grade, physical, and screening requirements:

5.13.3.1.1. Must be recommended by the unit commander.

5.13.3.1.2. Serving in the grade of E-3 (A1C) or higher.

5.13.3.1.3. Must be a United States citizen.

5.13.3.1.4. Meet medical standards as outlined in AFI 48-123, *Medical Examinations and Standards*.

5.13.4. Reservists reenlistment within the following timeframes. **(T-2).**

5.13.4.1. Unit/Individual Reservist **not** participating in the incentive program within 6 months of current ETS. AFRC/A1K may waive the requirement; however, member must reenlist prior to ETS to be considered for the incentive program. Termination of the incentive does not adjust the window of reenlistment eligibility.

5.13.4.2. Incentive eligible members currently receiving an incentive must reenlist within 30 days of current ETS. AFRC/A1K may waive the requirement. However, member must reenlist prior to ETS for bonus consideration. Termination of the incentive does not adjust the window of reenlistment eligibility.

5.13.4.3. AGRs selected for an initial/subsequent tour, if necessary, must reenlist prior to their recall to EAD or continued duty. **Exception**: Member does not have to be within 6 months of current ETS to reenlist for AGR tours.

5.13.4.3.1. Reenlistment action will be accomplished by the servicing MPS.

5.13.4.3.2. Extend the member for the minimum amount of time necessary to satisfy the retainability requirement.

5.13.4.4. Members eligible for reenlistment within 6 months of current ETS.

5.13.4.5. Members requiring retainability for specific programs and are outside of the regular reenlistment windows. (i.e., transfer of education benefits [TEB]).

5.13.5. Airmen who completed less than 6 years of their MSO **(T-2)**: Must have an existing MSO to retain the obligation into the new reenlistment contract and:

5.13.5.1. Adjust current ETS to equal completion of 6 years MSO.

5.13.5.2. TOE is 6 years.

5.13.5.3. DOE is the date MSO was initially incurred Date Initial Entry Uniformed Services (DIEUS).

5.13.6. Airmen who completed at least 6 years of their MSO **(T-2)**:

5.13.6.1. Reenlistment will be concurrent with their assignment to the participating program (first UTA) for unit members and concurrent with assignment gain date for IMA and PIRR members. If no remaining MSO, term of enlistment will be 2 to 6 years. The Reserve selection retention process (RESSRP) RIP and recommendation of the commander is not required. TOE must also cover any retainability requirements (i.e. retraining).

5.13.6.2. Members required to reenlist concurrent with their assignment to the unit program who decline to reenlist will be reassigned to the non-participating/IRR within 30 days of the date they declined to reenlist. Do not apply this rule to PALACE CHASE.

5.13.6.3. Update ETS to equal MSO before reassignment.

5.13.6.4. Update military PDS.

5.13.7. Retention after completion of 18 or more, but less than 20, years of service. (10 USC § 1176, prohibits AFRC from involuntarily separating enlisted personnel within sanctuary. **(T-0).**

5.13.7.1. Reserve Members in Active Status**.** A Reserve enlisted member serving in an active status who is selected to be involuntarily separated (other than for physical disability or for cause), or whose term of enlistment expires and who is denied reenlistment (other than for physical disability or for cause), and who on the date on which the member is to be discharged or transferred from an active status is entitled to be credited with at least 18 but less than 20 years of service computed, may not be discharged, denied reenlistment, or transferred from an active status without the member's consent before the earlier of the following:

5.13.7.1.1. If as of the date on which the member is to be discharged or transferred from an active status the member has at least 18, but less than 19 years of service, then:

5.13.7.1.1.1. The date on which the member is entitled to be credited with 20 years of service computed or,

5.13.7.1.1.2. The third anniversary of the date on which the member would otherwise be discharged or transferred from an active status.

5.13.7.1.2. If as of the date on which the member is to be discharged or transferred from an active status the member has at least 19, but less than 20, years of satisfactory service are authorized to serve to:

5.13.7.1.2.1. The second anniversary of the date on which the member would otherwise be discharged or transferred from an active status.

5.13.7.1.3. Commanders cannot cancel extensions for quality of force reasons in this category. Commanders must pursue involuntary discharge for cause if they do not want personnel in this category to retire. **(T-0).**

5.13.7.1.4. MPS Commanders will approve requests for extension of enlistment on sanctuary protected enlisted personnel for the years, months, and/or days necessary for the member to meet minimum Reserve retirement eligibility. **(T-0).**

5.13.7.1.5. For IMA and PIRR members. RIO will process the request to place the member in Reserve Sanctuary. Notification will be made to the applicable Det/CC of actions taken. RIO will forward extension paperwork (AF Form 1411) to the Det/CC for completion.

5.13.8. Members Not Eligible for Reenlistment. **(T-2).** A member whose reenlistment code is anything other than eligible or has been selected, but undecided about reenlistment is ineligible to reenlist.

5.13.9. Waivers of Reenlistment Ineligibility. **(T-2).** The SecAF may grant or deny reenlistment to any person if it is in the best interest of the Air Force. The Senior Reserve Commander makes the final determination on grade waiver.

5.13.9.1. Submit requests for SecAF through command channels to AFRC/A1K.

5.13.9.1.1. RIO forwards Individual Reservist requests, ARPC/DPA forwards AGR requests, and Wings forward unit personnel requests to AFRC/DPT.

5.13.9.2. Headquarters Action. AFRC/DPT send requests they deem sufficiently supported for consideration to AFRC/CC. AFRC/CC forwards the requests to SecAF for determination. 5.13.9.2.1. If a member is not eligible for reenlistment, the unit commander does one of three things:

5.13.9.2.1.1. Initiates a request for waiver of the disqualification.

5.13.9.2.1.2. Denies reenlistment.

5.13.9.2.1.3. Requests termination of the reenlistment by an administrative discharge.

5.13.9.2.2. If administrative discharge is approved, the commander sends the member a copy of the administrative discharge order and a letter stating existing directives did not authorize reenlistment and reenlistment is invalid. In the letter, the commander gives specific reasons for the discharge and explains service during the reenlistment may not be credited for any purpose.

Table 5.11. Air Force Reserve Reenlistment Reason Codes.

If member	**then reason code is**
is eligible to reenlist	5A
has been selected, undecided about reenlistment	5B
is ineligible, due to poor fitness score	5C
has been denied reenlistment based on unsatisfactory participation/performance, attitude, military bearing, or behavior (see note 1) (AF Form 418, required)	5E
is a Non-US Citizen and failed to obtain us citizenship in first enlistment	5F
AFR ineligible NCO status denied/vacated	5G
is serving in grade E-3 (A1C) or below	5H
is under consideration for administrative discharge (see note 2)	5I
has applied for or is approved for retirement or is within 23 months of mandatory retirement	5K
has been selected, declined reenlistment	5L
is undergoing Article 15 action	5M
is a conscientious objector, or a person with religious convictions that would prevent unrestricted assignment	5N
is assigned to ISLRS	5O
is assigned to NARS but is not eligible to take part for points	5P
is awaiting AFRC/SG consideration of a physical disqualification	5Q
is preparing for the ecclesiastical ministry in an accredited or recognized theological seminary (see note 3)	5R
is eligible for extension of High Year Tenure Date (HYTD)	5S
is approved for extension of HYTD	5T

is not approved for extension of HYTD	5U
is USAFR eligible not yet selected	YY

Notes:
1. Unsatisfactory participation is not limited to UTA attendance.
2. Included in this category are members who are physically disqualified in accordance with AFI 48-123, members who take civilian employment with a foreign government without prior approval by the SecAF to retain status, and members of foreign country armed forces.
3. Members must reenlist for a period equal to their temporary nonmilitary or religious mission (not more than 30 months) plus the service remaining on their previous enlistment **(T-3)**.

5.13.10. Pre-Reenlistment Interview.

5.13.10.1. MPS/CAA (supervisor/CC for IMA/PIRR, with guidance from RIO Detachment) reviews the following items with the member before reenlistment:

5.13.10.1.1. Eligibility for Retired Pay. To be eligible for Reserve retirement with pay at age 60 a member must have at least 20 years satisfactory service (10 USC § 12731(f)). **(T-0).**

5.13.10.1.2. Qualifications for Reenlistment.

5.13.10.1.2.1. Medical Standards. To ensure members meet AFR medical standards outlined in AFI 48-123, the Military Treatment Facility must certify medical eligibility. Medical standards must be current at the time of reenlistment. **(T-2).**

5.13.10.1.2.2. Prior to reenlistment, members must receive an UCMJ Article 137 briefing. **(T-3).**

5.13.11. Terms of Reenlistment and Extensions. **(T-2).**

5.13.11.1. Terms of reenlistment are for 1, 2, 3, 4, 5, or 6 years.

5.13.11.2. One year enlistments are only authorized for prior service applicants who completed their MSO, are enlisting in the AFR for the first time since completion of their MSO, and are enlisting in an AFSC they currently hold at the 5-skill level, or higher. Applicants enlisting and voluntarily retraining must have a minimum enlistment period of 3 years. **(T-2).**

5.13.11.3. Member's reenlistment contract must not exceed their HYTD. **(T-2).** Members with a HYTD within six years may reenlist for the years, months, and days up to their HYTD.

5.13.12. Reenlistments Accomplished Away from Home Station. **(T-2).**

5.13.12.1. The procedures and reenlistment criteria for members reenlisting away from home station are the same, with the exception of coordination of the reenlistment.

5.13.12.2. CAA must coordinate with the MPS or Personnel Support for Contingency Operations (PERSCO) team at the deployed or TDY location to ensure the reenlistment is accomplished in accordance with this AFI. **(T-2).**

5.13.12.3. The CAA provides the member with detailed information on the proper reenlistment procedures, incentive eligibility, and timeframe in which the reenlistment must take place.

5.13.12.4. Documentation. The original signed DD Form 4 must be forwarded to the member's home station MPS (unit members) or ARPC/DPT, who will mail the original for IMA/PIRR to AFPC for upload in ARMS. **(T-2).**

5.13.13. Documentation**.**

5.13.13.1. The completed DD Form 4 formally documents a reenlistment and represents a legally binding contract between the Air Force and reenlistee. The DD Form 4 is completed IAW DoDI 1304.02. Complete DD Form 4. The DD Form 4 must be typed in upper case letters. MPS distributes the form as follows. **(T-0).**

5.13.13.2. For Unit Members:

5.13.13.2.1. Send the original form to ARMS. **(T-2).**

5.13.13.2.2. Give the second copy to the member. **(T-2).**

5.13.13.2.3. The third copy is kept by the MPS in accordance with AFRIMS. **(T-2).**

5.13.13.3. For IMA/PIRR. The closest MPS will complete DD Form 4 for members approximately 6 months prior to ETS. Upon completion, the RIO Detachment will send documentation to ARPC/DPT for update. **(T-2).**

5.13.13.4. For AGRs. Send the original for ARMS processing, provide copies to the individual and to ARPC/DPA. **(T-2).**

5.14. Reenlistment in the Air National Guard (ANG)

5.14.1. Unit Commander Concurrence**.**

5.14.1.1. No Airman will reenlist or extend their enlistment without the concurrence of their unit commander. Members must first be considered under the SRP and be identified with an appropriate PDS RE code (refer to **Chapter 2** for SRP procedures). **(T-3).**

5.14.1.2. A commander may approve or deny reenlistments and extension of enlistments to any member of his or her command. **(T-3).**

5.14.1.3. Retention in the ANG is a command prerogative and is not an inherent right of any individual unless the member has between 18 and 20 years of satisfactory service towards a reserve retirement. In those cases, only the SecAF may deny retention. **(T-0).**

5.14.1.4. Airmen rendered ineligible for reenlistment or extension of enlistment via SRP or due to ineligibility factors contain within Table 5.13 will be separated from the ANG on their ETS. **(T-2).**

5.14.1.5. For unique situations or circumstances not contained within this instruction, refer to Attachment 3, ANG Routing of Waiver requests and Exceptions to Policy.

5.14.2. Form requirements**.** Complete the following forms, as necessary, before each reenlistment or extension of enlistment action:

5.14.2.1. NGB Form 3621, *ANG Eligibility Checklist for Enlistment, Reenlistment, or Extension*. Airman will complete this mandatory questionnaire prior to any reenlistment or extension actions. **(T-3).**

5.14.2.1.1. If the Airman answers "Yes" to any questions, he/she may be ineligible for reenlistment or extension of enlistment. Use Table 5.13 to determine eligibility. Additional information may be requested from the member to make a final determination.

5.14.2.1.2. Submit completed NGB Form 3621 for filing in ARMS as an attachment to the DD Form 4 or AF Form 1411, as applicable.

5.14.2.2. Airmen complete AF Form 2030, *USAF Drug and Alcohol Abuse Certificate,* prior to any reenlistment or extension of enlistment actions. **(T-3).**

5.14.2.2.1. Self-admission to any illegal drug use or possession after enlistment in the ANG, will result in immediate discharge IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*. **(T-2).**

5.14.2.2.2. If the member answers yes to any questions, they may be ineligible for reenlistment or extension of enlistment. Use Table 5.13 to determine eligibility.

5.14.2.2.3. Forward completed copy for filing in ARMS.

5.14.2.3. AF Form 418, (**Chapter 2** provides guidance for the completion of AF Form 418)

5.14.2.3.1. Submit completed copy for filing in ARMS.

5.14.2.3.2. AF Form 418 is only required when RE Code is changing to "not selected" or from "not selected" to "selected." **(T-3).**

5.14.2.4. DD Form 4, Prepare this form for each applicant who reenlists (refer to myPers for guidance - **https://gum-crm.csd.disa.mil**).

5.14.2.4.1. Ensure that each entry is accurate and verified by the applicant or by substantiating documents.

5.14.2.4.2. Submit completed copy for filing in ARMS.

5.14.2.5. AF Form 1411.

5.14.2.5.1. Use this form to document extensions of enlistments.

5.14.2.5.2. Submit completed copy for filing in ARMS.

5.14.2.6. AF Form 1411-1.

5.14.2.6.1. Use this form to document cancellation of extensions of enlistments.

5.14.2.6.2. Additional guidance for forms completion is available at myPers - **https://gum-crm.csd.disa.mil** (ANG/FSS Resources).

5.14.3. Terms of Reenlistment in the ANG**.** Unless there is a specific requirement for which reenlistment is being accomplished (e.g. Military Service Commitment), Airmen may request

to reenlist for a period of 1, 2, 3, 4, 5, or 6 years with Commander's concurrence. Table 5.12 provides categories of reenlistment that require specific terms of reenlistment.

Table 5.12. Terms of Reenlistment in the Air National Guard.

RULE	A	B	C
	Are selected by their commander and applicant is:	**Then reenlist for:**	**Notes:**
1	Participating in Statutory Tour/ AGR Program, EAD tour application approved by AFPC or due to mobilization.	A period that will coincide with their Active Duty (AD) tour. Those mobilized may reenlist for a period that exceeds the period to which ordered to AD. The effective date will occur on the date of the reenlistment.	2
2	An Airman who is reenlisting within 30 days or less prior to ETS.	A period requested by the member and approved by the unit commander. The effective date of reenlistment will occur the next day after current ETS. **Example**: ETS is 30 Jan 10, member reenlists on 11 Jan 10 for three years; their new DOE will be 31 Jan 10 and their ETS will become 30 Jan 13.	
3	An Airman who is reenlisting within 31 to 90 days prior to ETS. **Exception**: An Airman drawing a bonus is ineligible to reenlist/extend under this rule.	A period requested by the member and approved by the unit commander. The effective date will occur on the date of the reenlistment. **Example**: ETS is 30 Jan 10; member reenlists on 14 Dec 09 for three years, their new DOE will be 14 Dec 09 and their ETS will become 13 Dec 12.	1
4	Selected for service commitment that requires specific retainability.	See ANGI 36-2101, *Assignments within the Air National Guard,* for reenlistment requirements. The effective date will occur on the date of the reenlistment.	1, 3
5	To meet retainability requirement for Montgomery GI Bill(MGIB) eligibility (Selective Reserve [SR], SR-Kicker, or Chapter 33)	A period that will coincide with their retainability requirement. The effective date will occur on the date of the reenlistment.	1
6	State Selective Reenlistment Board, reenlisting more than 90 days prior to ETS	Reenlist for 1 year, ONLY if member has/will exceed total of 48 months of extensions on current enlistment contract.	1

7	Airman has accumulated four year maximum period limitation of all extensions to any one enlistment under 10 USC § 509 and is selectively retained by unit commander to allow further Fitness Assessment	Reenlist for 1 year provided Reenlistment Eligibility has been changed by Unit CC to "Selected" (See para 2.6)	
Notes: 1. Persons who are participants in the ANG Incentive Program are ineligible to reenlist until completion of the contract for which they enlisted with the incentive, unless such reenlistment is to qualify for attendance at an in-residence training school or state educational benefits (not MGIB). 2. Members who are in an incentive eligible AFSC as identified by NGB/A1 and who are partially mobilized under the provisions of 10 USC § 12302 may reenlist early for six years to establish eligibility for a reenlistment bonus, provided they are not currently in the cash bonus program, and meet all other criteria for a reenlistment bonus. 3. Member is required to complete an ANG Service Commitment Agreement.			

5.14.4. Concurrent Reenlistment**.** Individuals who reenlist in the ANG must concurrently reenlist as a Reserve of the Air Force in the same grade for a period equal to their ANG reenlistment. **(T-0).**

5.14.5. SRP Non-selection**.** Airmen who are not recommended for reenlistment via the SRP (**Chapter 2**), are not allowed to reenlist and will separate at ETS unless they receive an approved extension of enlistment or reenlistment eligibility is reconsidered and documented via AF Form 418. **(T-3).**

5.14.6. Reenlistment to qualify for Incentive Program**.**

5.14.6.1. Refer to Table 5.12 for reenlistment to qualify for the ANG Incentive Program.

5.14.6.2. For additional information regarding incentive eligibility requirements, contact the Wing ROM.

5.14.7. ANG Oath of Enlistment**.**

5.14.7.1. Ensure that the oath on DD Form 4, is administered before any officer of the National Guard of the State or Territory, or of Puerto Rico, or the District of Columbia, as the case may be, or before any other person authorized by the law of the jurisdiction concerned to administer oaths of enlistment in the National Guard (32 USC § 304 - *Enlistment Oath*). **(T-0).**

5.14.7.2. In unusual circumstances, and when state statute does not prohibit, a federally recognized officer of the United States Armed Forces may administer the oath.

5.14.7.3. In accordance with 32 USC § 304, each person enlisting in the Air National Guard shall sign an enlistment contract and subscribe to the following oath **(T-0)**:

"I do hereby acknowledge to have voluntarily enlisted this __ day of ____, 20_, in the _____ National Guard of the State of _____ for a period of __ year(s) under the conditions prescribed by law, unless sooner discharged by proper authority. "I, _____, do solemnly swear (or affirm)

that I will support and defend the Constitution of the United States and of the State of _____ against all enemies, foreign and domestic; that I will bear true faith and allegiance to them; and that I will obey the orders of the President of the United States and the Governor of _____ and the orders of the officers appointed over me, according to law and regulations. So help me God."

5.14.7.4. The United States flag must form a backdrop for the participants. **(T-0).**

5.14.8. HYT Restrictions. ANG establishes HYT for all enlisted members at age 60, however NGB/A1 may approve participation beyond age 60, but no later than age 62 in certain situations. HYT for ANG is addressed at the time of initial enlistment.

5.14.9. Air Force Fitness Program, Airmen Medically Disqualified and Airmen in RI 9A000/9A100/9A200/9A300. **(T-3).**

5.14.9.1. Fitness Program.

5.14.9.1.1. Airmen who fail to attain a passing fitness score as outlined in AFI 36-2905, may be rendered "not selected" for reenlistment by their unit commander under the Selective Reenlistment Program (**Chapter 2**).

5.14.9.1.2. Successfully completing fitness assessment does not automatically restore an Airman's reenlistment eligibility.

5.14.9.1.3. Commanders may complete AF Form 418, to modify RE at any time prior to the member's ETS.

5.14.9.1.4. Airman approaching ETS who are not selected for reenlistment may submit a request for extension of enlistment to their unit commander for consideration.

5.14.9.1.5. Commanders may retain an individual previously not selected for reenlistment because of fitness assessment failure by reconsidering RE.

5.14.9.1.5.1. Minimum term of reenlistment is 12 months.

5.14.9.1.5.2. RE must be changed from "not selected" to "selected" via AF Form 418 before reenlistment actions can be completed. **(T-2).**

5.14.9.1.6. Separate Airmen on ETS who are not approved for reenlistment or extension of enlistment.

5.14.9.2. Airmen disqualified and in RI 9A000 or 9A100 may execute a one-time extension for a total period of 12 months to qualify/compete for retraining/Special Duty.

5.14.9.2.1. Under no circumstances will the extension period combined with the remaining obligated service exceed 12 months.

5.14.9.2.2. The length of the extension, if any is based on the date of the formal disqualification approval not to exceed 12 months.

5.14.9.2.3. Separate Airman at ETS who are not approved for retraining or Special Duty.

5.14.9.3. Airmen in RI 9A200/9A300 will separate at ETS unless the commander initiates early separation or subsequently completes requirements to retain the Airman.

5.14.10. Reenlistment Ineligibility Factors**.**

5.14.10.1. Table 5.13 lists factors that render an individual ineligible to reenlist in the ANG.

5.14.10.2. Refer any questionable cases to the Airman's servicing MPS for resolution prior to executing and reenlistment action.

Table 5.13. ANG Reenlistment and Extension Ineligibility Factors.

RULE	A	B	C
	INELIGIBILITY FACTOR	**EXPLANATION/DETERMINATION GUIDELINES**	**Notes:**
1	Morally Unacceptable - Category 1 Offenses	Conviction or adverse adjudication of 6 or more category 1 Offenses within a 365-day period in the last 3 years.	3, 5, 7
2	Morally Unacceptable - Category 2 Offenses	Persons convicted by a civilian court under circumstances as indicated below:	
		Three or less offenses.	3, 4, 7
		Category 2 offenses included in a pattern of misconduct may not be waived by the Director of Staff (DS) and must be submitted to NGB/A1P per Rule 4. **(T-2)**	4, 7
3	Morally Unacceptable - Category 3 Offenses	Persons convicted by a civilian court under circumstances as indicated below:	
		One or more offenses except First Offense Driving Under the Influence (DUI).	2, 4, 7
		First Offense DUI.	3, 4, 7
		Category 3 offenses included in a pattern of misconduct must be submitted to NGB/A1P per Rule 4. **(T-2)**	4, 7
4	Morally Unacceptable - Category 4 Offenses	A person convicted by civilian court of an offense classified as a felony under state or federal statutes or convicted of one or more Category 4 offenses.	1, 5, 7
5	Persons under restraint to include parole, probation, or suspended sentence	Court imposed restrictions, such as confinement, supervised parole or probation, or work detail. The following are not considered forms of restraint: (a) a fine, whether or not suspended, (b) an unconditional suspended sentence, (c) unsupervised, unconditional parole or probation.	1
6	Members under investigation by military or civilian authorities (including Office of Special Investigation (OSI) pending the outcome	When ETS is imminent, and members are under investigation, they may voluntarily extend their enlistment for 6-month periods using this rule as authority and following the procedures in this instruction to remain as members in the ANG until the case is decided. If they elect not to extend and the commander chooses not to extend them	1

	of which may result in administrative discharge processing	administratively, they will be separated on ETS and reenlistment is barred. (Appropriate comment will be made on National Guard Report of Separation and Record of Service, NGB Form 22, Remarks).	
7	Under the influence of alcohol or drugs (10 USC § 504)	Persons who are under the influence of alcohol or drugs will not be processed.	1
8	Drug users/Drug abusers	Members identified through the drug identification process are ineligible for reenlistment/extension.	1
9	Alcoholics/Alcohol Rehabilitation Program	Persons known to be addicted to alcohol.	1
		Individuals who have documentation indicating successful completion of rehabilitation program, who have maintained sobriety for at least two years and are medically qualified.	3
10	Mental illness (10 USC § 504)	A person with a diagnosed (Diagnostic and Statistical Manual or the International Statistical Classification of Diseases and Related Health Problems) history of a mental disorder(s).	7
11	National security risk	Persons who admit or whose available records show that they have engaged in any act or acts designed to destroy or weaken the US. In addition, persons will be denied reenlistment if the acceptance is not clearly consistent with the interest of national security IAW AFI 31-501, *Personnel Security Program Management.*	1
12	Non-US Citizens	Non-US Citizens who enlist in the ANG must acquire US citizenship status during their initial enlistment to be eligible for reenlistment/extension. **(T-0)**.	1
13	Reserve Officer Training Corps (ROTC) Students	Students enrolled in the advanced course of Air Force ROTC, Army ROTC, or Naval ROTC or scholarship students in these programs. This does not include those enrolled in Air Force ROTC courses under the sponsorship of a state program that uses Air Force ROTC as a commissioning source.	1
14	Not selected for retention	Individuals not selected for reenlistment by commander at ETS on the AF Form 418 or not retained under State Selective Reenlistment Program (SRRP). Enlistment can be extended if the Airman is in an approved Medical Hold Status or by Administrative Extension of Enlistment.	

15	Conviction of "Crime of Domestic Violence" (See Attachment 1, Terms.)	Individuals with a qualifying conviction of domestic violence, which occurred prior to or after 30 Sep 96. To determine if a particular conviction meets the domestic violence crime criteria, consult with the local Staff Judge Advocate (SJA).	1
Notes: 1. A waiver request will be submitted to NGB/A1PP. **(T-3).** 2. Waiver authority is the DS. This waiver authority will not be further delegated beyond the DS. 3. If the incident occurred while the member was in the ANG and punishment was received under Article 15 or other military judicial/administrative action and the member is otherwise qualified for reenlistment/extension, no waiver is required. 4. Category 4 offenses are a bar to reenlistment/extension regardless of when the offense was committed. 5. Airmen classified as Wounded Warriors and diagnosed with Post Traumatic Stress Disorder (PTSD) are not barred from reenlistment or extension. Airmen must be awarded 9WXXX as secondary or tertiary AFSC. **(T-1).** 6. If the Airman is assessed by a credentialed and privileged Department of Defense (DoD) healthcare provider and found fit for duty, and the member is otherwise qualified for reenlistment/extension, member will be allowed reenlistment/extension.			

5.14.11. ANG RE Codes**.** Refer to Table 5.14 to determine reenlistment eligibility based on the RE code contained in the member's PDS record.

5.14.11.1. Airmen with an RE code which renders them ineligible to reenlist may be eligible to request extension of their current enlistment - refer to **Chapter 6** for extension of enlistment policy.

Table 5.14. ANG RE Codes.

Rule	Narrative Reason	Eligible to reenlist	Eligible to extend	PDS code entry:	Notes:
1	Eligible - Selected by Commander	Yes	Yes	6A	
2	Eligible - Member elected separation or discharge	N/A	N/A	6B	
3	RE under Review	No	No	6C	1
4	Under Investigation by Mil/Civ authority which may result in discharge.	No	Yes	6D	2
5	Serving period of probation and rehabilitation	No	Yes	6E	
6	Pending Discharge - Voluntary	N/A	N/A	6G	
7	Pending Discharge - Involuntary	No	No	6H	
8	Retirement Application has been submitted	N/A	Yes	6I	
9	Was ineligible to reenlist - Condition Waived	Yes	Yes	6J	
10	Career Airman Refused 7-Level Training	No	No	6K	
11	Unsatisfactory Fitness Score	No	Yes	6L	

Rule	Narrative Reason	Eligible to reenlist	Eligible to extend	PDS code entry:	Notes:
12	Separation pending – Unsatisfactory Fitness Category for greater than 24 months	No	No	6M	
13	Formal School Eliminee being separated	No	No	6N	
14	Medically disqualified - Pending Waiver	No	Yes	6P	
15	On conditional release pending enlistment other unit	Yes	Yes	6Q	
16	Non-US Citizen failed to obtain US Citizenship in first enlistment	No	No	6R	3
17	Pending Grad from Acad Mil Science/Flt Screening Program	No	No	6S	4
18	Unsatisfactory Participant/Potential Unsatisfactory Participant	No	No	6T	
19	Not selected for retention by Commander	No	No	6U	5
20	ANG Member will reach age 60 in 12 months	Yes	Yes	6V	6
21	No AFSC awarded which is commensurate with grade	No	Yes	6W	7
22	ANG Eligible not yet considered	No	No	99	8

Notes:
1. Member currently within the 14 months reenlistment eligibility review window. Once commander has made final selective reenlistment decision update the appropriate RE Code as determined by the commander.
2. Member may be administratively extended for the purpose of allowing sufficient time for conclusion of a trial or investigation for a violation of the UCMJ or the State Military Code.
3. This code will be updated on those ANG members who fail to apply or do not obtain US citizenship during initial enlistment.
4. This code will be updated on those members scheduled to attend Academy of Military Science (AMS) or the Flight Screening Program.
5. This code will be updated on those members who have been non-retained under Selective Reenlistment of Air National Guard Officer and Enlisted Personnel.
6. This code will be updated for those members approaching retirement eligibility and require 12 or less months additional time in service.
7. Members can be extended provided they have been approved for retraining. RE Code 6W will remain in the PDS until RE has been approved by commander.
8. PDS generated RE Code at the time of initial accession gain is completed. Do not extend or reenlist a member until commander has recommended reenlistment or denial of reenlistment.

5.14.12. Disposition of documents used to establish reenlistment in the ANG**.** Table 5.15. lists the disposition of all documents used to establish an Airman's reenlistment in the ANG.

Table 5.15. Disposition.

Form or Document	Copies	Disposition
DD Form 4/1 and 4/2, *Enlistment/Reenlistment Document – Armed Forced of the United States*	3	**Original** ARMS **1st copy**--Airman's copy. **2nd copy**--MPS copy. Review ARMS to ensure a copy is available then destroy after 3 months.
AF Form 901, *Reenlistment Eligibility Annex to DD Form 4*	3	Attach to the corresponding copies of the DD Form 4/1 and 4/2 and follow the instructions outlined in item 1, column C.
Correspondence concerning waiver or special authorization to reenlist	3	Attach to the corresponding copies of the new DD Form 4/1 and 4/2, and follow the instructions outlined in item 1, column C.
Statement authorizing retention on active duty for the purpose of medical examination	1	Destroy after the Airman reenlists (as directed by the RDS).
AF Form 418, *Selective Reenlistment Program Consideration*	3	**Original** ARMS. **1st copy**--commander's copy. **2nd copy**--Airman's copy
AF Form 1089, *Leave Settlement Option*	2	**Original**—Attach to the corresponding copies of the DD Form 4/1 or AF Form 1411, if first extension of enlistment, and follow the instructions outlined in item 1, column C. **1st copy**--MPS copy. Destroy 3 months after the Airman reenlists or enters into the first extension of enlistment (as directed by the RDS). **2nd copy**--Airman's copy.

Chapter 6

EXTENSIONS OF ENLISTMENT

6.1. General Information. Under certain circumstances, an Airman's current enlistment period may be extended. Extension of enlistment may be voluntarily requested by Airmen. This chapter outlines the policies and procedures that affect extension of enlistment for Airmen in all components of the Air Force. Unique component extension of enlistment requirements are divided into three Sections as follows:

6.1.1. Paragraph 6.6: Airmen assigned to the RegAF.

6.1.2. Paragraph 6.7: Airmen assigned to the AFR.

6.1.3. Paragraph 6.8: Airmen assigned to the ANG.

6.2. Extension Limitations .

6.2.1. The MPS will limit extensions to the minimum number of months needed to achieve the intended purpose. Airmen extend in whole month periods only. Only Airmen in SRB AFSCs may extend for 36 or up to 48 months in one increment to qualify for an authorized SRB even though less retainability is required. When enlistments or reenlistments begin on the first day of a month, the extended DOS is always the last day of the month. (**Example**: If Airman's date of enlistment is 1 May, and the DOS is 30 April, then a 1-month extension would result in a 31 May DOS.)

6.2.2. Voluntary extensions for all Airmen are limited to a maximum of 48 months per enlistment (10 USC § 509). This **cannot** be waived. **(T-0).**

6.3. Leave Settlement . Airmen may sell leave only upon entry into the first voluntary extension of their current enlistment.

6.3.1. Leave is sold once Airman enters the extension. If the Airman enters the extension in a different Fiscal Year (FY) from when they signed the form, ensure the Airman understands leave may be lost. Airmen cannot sell leave if they have already sold 60 days in their career or are entering a second or subsequent extension of enlistment. The Airman's base pay on ETS determines the payment. Airmen document their election on the AF Form 1411. Airmen may change their leave settlement elections at any time prior to the 10 day calendar period of the effective date of entry into the extension of enlistment on an AF Form 1089. (RegAF MPS refers to the PSDG for DJMS-AC update instructions.)

6.3.2. The MPS must verify the Airman's leave election as documented on the AF Form 1411 or AF Form 1089, if applicable before processing the E6 transaction to DFAS-IN.

6.4. Erroneous Extension Documents . Also refer to paragraph 5.9 as this applies to this section as well. This paragraph applies to the AF Form 1411 and AF Form 1411-1. Only AFPC Reenlistments (AFRC/A1K for AFR) (NGB/A1PP for ANG) can authorize correction of contractual errors.

6.4.1. Contractual Errors. Airmen not authorized to extend or in violation of this AFI (no CJR [when in constrained skills], ineligible RE code, etc.) will have their contract voided.

6.4.2. Administrative Errors. MPS may correct administrative errors discovered on the AF Form 1411 or AF Form 1411-1, if the Airman and Air Force agree. However, any documents submitted with an unauthorized/erroneous SRB will require the document(s) to be re-accomplished. (**Note**: When an Airman refuses to initial/sign the corrected AF Form 901, removing the SRB in the event it is deleted from the list, the MPS will document the AF Form 901 by entering the following statement on the reverse: "(Grade, name, SSN of Airman) has refused to sign this document acknowledging and confirming his or her ineligibility for the bonus.") Any erroneously awarded bonus will be terminated and recouped. If corrections were made on the forms, stamp "CORRECTED COPY" in the upper margin of the corrected pages and make a photocopy of the corrected forms for the Airman. The MPS corrects MilPDS and DJMS-AC, as appropriate and distributes the documents IAW Table 5.10.

6.4.2.1. AFPC Reenlistments (AFRC/A1K for AFR) (NGB/A1PP for ANG) will direct the AF Form 1411 be corrected to reflect the authorized SRB in cases where an SRB was not properly documented on the contract and the Airman executed a qualifying extension or direct an unauthorized SRB entitlement be removed from the AF Form 1411. The Airman and MPS representatives initial each correction. When correcting the ARMS copy of the AF Form 1411/1411-1, type "Corrected Copy" in the upper margin of the AF Form 1411/1411-1, make a photo copy of the corrected AF Form 1411/1411-1 and comply with the disposition instructions in Table 5.10 and the RDS located in the AFRIMS.

6.4.3. Correcting administrative errors on contracts returned for correction: The MPS retrieves the ARMS copy and makes appropriate corrections to the form.

6.4.4. The Airman and MPS representative initial each correction. Type "CORRECTED COPY" in the upper margin of the corrected pages; make a photocopy of the corrected forms and comply with the disposition instructions in Table 5.10.

6.4.5. Do not make corrections to the form stamped "DO NOT CORRECT THIS COPY" unless there is no ARMS copy and the Airman does not have a copy.

6.4.6. In those situations, correct the copy stamped "DO NOT CORRECT THIS COPY" and type "Only Available Copy" in the upper margin of the corrected pages; make a photo copy of the corrected forms and comply with the disposition instructions in Table 5.10.

6.4.7. Do not reaccomplish the AF Form 1411/1411-1 unless there is no ARMS copy and the Airman does not have a copy.

6.4.8. If contract must be reaccomplished, type "Reconstructed Copy" in the upper margin of the new contract. **(T-1).** All dates for signatures must be actual date signed. **(T-1).** Make a photo copy of the corrected forms and comply with the disposition instructions in Table 5.10. (**Note**: Commanders may not refuse to re-accomplish these documents).

6.4.9. The MPS sends the corrected/reconstructed copy IAW Table 5.10., corrects MilPDS, verifies DFAS files and takes appropriate action if needed, and DJMS-AC as appropriate.

6.5. Extension Cancellation .

6.5.1. The AF Form 1411-1 will be used to document all cancellations of extensions. Other reasons may preclude cancellation of an extension and are processed according to paragraph 6.5.1. (**Note**: RE code 4K Airmen later cleared may cancel if not entered or reenlist

immediately with obligated service waived, if entered.) Extensions may ***not*** be cancelled if, at a minimum, any of the following apply:

6.5.1.1. The Airman has entered the extension.

6.5.1.2. The Airman extended under Table 6.2, Rule 23, 25, 28b, 28c, 28d or 29 (**Exception**: If Airman extended as a nominee for the 12 Outstanding Airmen of the Year and not selected [Rule 28b]).

6.5.1.3. The Airman extended for elective surgery.

6.5.1.4. The duration of the obligation is changed by the Air Force. (**Example**: Airman extended for a four-year controlled tour and after arrival, the controlled tour is changed to a three-year tour.)

6.5.1.5. The Airman extended for an assignment, or the Airman extended for an assignment and departed for that (or any other) location (to include to accept retraining or a special duty).

6.5.1.6. This does not preclude early separation if Airman applies for voluntary separation or is involuntarily discharged.

6.5.2. The commander/civilian director may request extension cancellation if a reenlistment ineligibility condition in Table 5.4 and/or Table 5.6 causes cancellation of the reasons for which an Airman extended. (**Note:** Commanders/civilian directors cannot request extension cancellation if the affected Airman is a lengthy-service Airman [refer to paragraph 6.6.3], the extension reasons were fulfilled or still exist, or the Airman extended according to Table 6.2, Rules 17 through 24.)

6.5.2.1. The commander/civilian director notifies the Airman, in writing, of their intent to request extension cancellation, and advises the Airman they may submit a statement on their own behalf within 5 workdays of acknowledgment. The commander completes AF Form 1411-1, attaches their intent letter and the Airman's statement, and sends the documents to the Chief, MPS for approval or disapproval.

6.5.2.2. If the Chief, MPS approves the extension cancellation, complete AF Form 1411-1:

6.5.2.2.1. The MPS attaches any supporting documentation to the ARMS copy of AF Form 1411-1, deletes the extensions from MilPDS once finalized, and verifies DFAS files (take appropriate action if needed). The MPS then sends the Airman copies of the AF Form 1411-1 and the initial notification letter to the commander.

6.5.2.2.2. The commander/civilian director ensures Airman indorses the initial notification letter, acknowledging receipt of the decision and that an appeal may be submitted in accordance with paragraph 6.6.11 and disposes of the forms according to Table 5.10. The commander/civilian director ensures the Airman documents appeal intent before returning the letter to the MPS for processing according to paragraph 6.6.11.

6.5.2.3. The Chief, MPS disapproves extension cancellation request by completing AF Form 1411-1 and enters their rationale in the remarks section:

6.5.2.3.1. The MPS sends the Airman's copy of the AF Form 1411-1 and the initial notification letter to the commander/civilian director and suspenses the remaining copies of the forms pending receipt of the Airman's acknowledgment.

6.5.2.3.2. The commander/civilian director ensures the Airman indorses the initial notification letter, acknowledging receipt of the decision, and returns the letter to the MPS.

6.5.2.3.3. The MPS attaches the letter to the ARMS copy of AF Form 1411-1 and disposes of the forms according to Table 5.10.

6.5.3. Airmen may request extension cancellation to immediately reenlist due to unique and unusual circumstances or when other reasons for cancellation were not used or are inappropriate and when fulfilling the extension would result in an injustice. The Airman may request extension cancellation under this provision *only* when the extension has not been executed. The MPS and member's commander/civilian director ensures the extension cancellation and reenlistment occur on the same day. (**Note**: Non-receipt of a Retention Bonus [RB] is not an injustice.)

6.5.3.1. The MPS assists the Airman in completing AF Form 1411-1, Section II and suspenses the form pending final action. Refer to paragraph 6.6.8 for general processing instructions. Chief, MPS may disapprove the request, but AFPC Reenlistments (for RegAF Airmen) is the approval authority.

6.5.3.2. The MPS completes AF Form 1411-1 to document approval or disapproval, attaches copies of the correspondence to each copy of the AF Form 1411-1, and disposes of the form according to Table 5.10. MPS deletes extension from MilPDS as appropriate.

6.5.4. The Airman may request cancellation of extensions initiated according to Table 6.2, Rules 12 through 16, if the reason for the extension was cancelled, or no longer exist. Airmen must request cancellation no later than 30 calendar days following notification that the original reason for the extension was cancelled or no longer exists. Commander/civilian director coordination is not required. The Air Force considers failure to cancel the extensions within this time period as willingness on the part of the Airman to serve out the extension. (**Example:** An Airman extended to qualify for a CONUS PCS assignment, but was notified of assignment cancellation before entry into the extension. The Airman must submit the cancellation request within 30 calendar days of assignment cancellation notification.) **(T-1).** (**Note:** Requests for extension cancellation after the 30 calendar day period are denied by the MPS and are not to be forwarded to AFPC Reenlistments for consideration; however, the Airman may petition the AFBCMR for relief.)

6.5.4.1. The MPS enters the authority for cancellation and a brief explanation in the remarks section of the AF Form 1411-1 as follows: "Assignment cancelled per AFPC Reenlistments email, dated 15 Jun 2015."

6.5.4.2. When Airmen request extension cancellation IAW paragraph 6.6.5.4, the MPS will complete the AF Form 1411-1 without referral to the commander.

6.5.5. When an existing extension (not yet entered) is subject to cancellation according to paragraphs 6.6.5.2 or 6.6.5.3 and is to be replaced by an extension of a shorter duration, MPS administratively corrects the contract.

6.5.6. FTA/NCORP retrainees may request cancellation IAW paragraph 5.11.5 of this AFI.

6.6. Extension of Enlistment in the Regular Air Force (RegAF). Extension Approval Authority**.** AFPC Reenlistments reserves authority to approve extensions of enlistment under certain conditions specified in Table 6.2. Airmen must be eligible to extend and have a service-directed reason as documented in Table 6.2 to extend. (**T-0).** Airmen requesting to extend for any reason(s) when no other rule in Table 6.2 applies may request an extension under Table 6.2, Rule 28d. See paragraph 6.6.8. Otherwise, base-level officials resolve all requests for extensions and extension cancellation. An extension is considered executed once the Airman has been approved to extend (AF Form 1411), and both the Airman and commander/civilian director have signed the AF Form 1411.

6.6.1. The Chief, MPS or their designated representatives approve or disapprove extension or extension cancellation requests (AF Form 1411/1411-1). Designated representatives must be assigned to the MPS or GSU personnel functions, and possess the grade of TSgt, GS-6, or higher. **(T-2).** The MPS ensures the commander on G-series orders or civilian director documents their recommendation on the AF Form 1411.

6.6.1.1. Personnel specified in paragraph 6.6.1 will review extensions executed and act as the service representative for the extension of enlistment and validate/confirm eligibility/entitlements. **(T-1).**

6.6.1.2. If deployment occurs, MPS updates these extensions in MilPDS and distributes the forms according to Table 5.10. If deployment does not occur, MPS destroys the AF Form 1411 at the end of the exercise (as directed in the RDS). (**Note**: Do not update extensions in MilPDS produced for the sole purpose of an exercise.)

6.6.2. Extension Limitations**.**

6.6.2.1. In the event AFSCs are constrained, AF/A1 may limit FTA extensions to a specified period (10 USC § 509). **(Note**: Otherwise, there is no limit to the number of valid extensions. Involuntary extensions [for example, extensions for STOP LOSS and administrative/disciplinary hold] do not count towards the maximum number of months an Airman can extend.) See paragraph 6.6.2.

6.6.2.2. Refer to paragraph 6.6.9 for information on HYT and age 60 extension restrictions.

6.6.2.3. The MPS will not authorize Airmen to cancel a previously approved extension for the purpose of combining it with additional extensions, to reenlist rather than extend, or to enhance SRB entitlements. Likewise, the MPS will not combine extensions to qualify Airmen for an SRB. **(T-1).**

6.6.3. Extensions for Lengthy-Service Airmen. Attachment 1 contains the definition of lengthy-service Airmen. Refer to 10 USC § 1176(a) for background information.

6.6.3.1. The extension approval authorities specified in paragraph 6.6.1 will not deny extensions requested by lengthy-service Airmen if the extension period does not exceed 20 years, 1 month of TAFMS, and the Airman is otherwise eligible for the extension. This restriction applies even if the requested DOS does not permit the Airman to complete 20 years TAFMS. (**Example**: If a lengthy-service Airman will complete 18 years, 6 months

on DOS, and requests a 4-month extension to obtain a passing fitness score, approval authorities cannot deny the extension request.)

6.6.3.2. Commanders may not request extension cancellation if the affected Airman is a lengthy-service Airman (refer to paragraph 6.5.1.). The MPS returns request to commander without taking further action.

6.6.4. Extensions for Service-Directed Requirements. Airmen may, if otherwise eligible, reenlist according to Table 5.3, 5.8 and 5.9 or extend their enlistments according to Table 6.2 for the minimum number of months required.

6.6.4.1. Eligible Airmen serving in SRB skills, who hold a 3-skill level or higher in the SRB skill, may extend their enlistments in one increment for a minimum period of 36 months up to, and including, a maximum period of 48 months. Airmen may use this provision only if they are extending according to Table 6.2, Rules 12, 13, 14 and 29 and have not already extended for a total period of 12 or more months. Airmen may use this extension option even if they require less retainability.

6.6.4.1.1. Airmen qualify for an SRB entitlement on the day they sign the extension but do not receive the SRB payment until the day they enter the extension provided they remain qualified.

6.6.4.1.2. The MPS will review the current SRB skills list to ensure Airmen are serving in SRB skills (CAFSC and DAFSC) or when requesting extensions. **(T-3).** The day the Airman enters an extension determines the SRB Zone. (**Example**: If an Airman extends while serving in the Zone A window, but will be in the Zone B window on the day the extension is entered, the Airman receives a Zone B bonus if eligible according to Table 4.1, item 2. The day the Airman signs the extension determines the SRB multiple level. Future changes to the SRB skills list do not affect SRB entitlements.) (**Note**: The MPS must accurately review the current SRB authorization listing and accurately calculate the Airman's TAFMS to determine the SRB zone the Airman will be in upon entering the zone.) **(T-1).**

6.6.4.1.3. Eligible for SRB and Electing not to Accept an SRB. Airmen eligible for an SRB on their current enlistment or eligible extension may elect not to accept the SRB designated for that reenlistment/extension. Airmen who elect not to accept the SRB must complete the applicable Section of the AF Form 901 or AF Form 1411. The decision not to accept the SRB is irrevocable once the AF Form 901 has been approved by the commander/civilian leader and accepted for reenlistment/extension of enlistment by the MPS representative. No exceptions will be considered.

6.6.5. Extensions for Reenlistment-Ineligible Airmen. The MPS may approve extensions for reenlistment-ineligible Airmen as indicated below. (**Note**: MPS will not permit Airmen to extend while SRP reconsideration [RE code 3B] is pending.) **(T-1).** Commanders must conduct SRP consideration within 30 days when the ineligibility condition no longer exists. **(T-1).** *See* **Chapter 2** *and 2.6.*

6.6.5.1. Career Airmen ineligible to reenlist who hold RE codes 2R through 2U may request extensions provided they have not refused to obtain service-directed retainability or cancelled an extension for the purpose of separation.

6.6.5.2. FTA who have the RE code 3C who require additional retainability may request extensions if otherwise qualified. FTA do not need approved CJRs in order to extend, unless the AFSC is constrained and prohibited from extending or if the Air Force denied the Airman a CJR IAW para 3.6.2.

6.6.5.3. Reenlistment ineligible Airmen may only request extensions if ineligibility conditions allow for an extension in Table 6.2. For example, Airmen may not extend to obtain retainability for promotion under Table 6.2, rule 1, if RE code is 4J.

6.6.5.4. First term non-US citizens (RE code 2I) may request extensions to attain citizenship, provided they have already applied for citizenship and are within 120 days of their DOS. The requested extension period may not exceed their projected swear-in date plus 30 days, or 6 months, whichever is sooner. The MPS may authorize additional 6-month extensions as needed (not to exceed 48 months total). If citizenship is not granted prior to the end of Airman's 48 cumulative extension months, waivers are not to be granted and the Airman separates on their DOS.

6.6.5.5. Airmen who appeal SRP non-selection (RE code 2X) may request extensions of enlistment to await the outcome. When the appeal authority is at the Wing or below, the MPS approves extensions in one-month increments until the Airman's appeal is finalized. When the appeal authority is the SecAF, the MPS approves extensions in three-month increments until the Airman's appeal is finalized. (**Note**: MPS must contact AFPC Reenlistments three months prior to ETS, if appeal is still being processed and member has already extended 45 months on current enlistment.) **(T-1).**

6.6.5.6. Lengthy-service Airmen who are non-selected under the SRP may request extension of enlistment in order to obtain minimum retirement eligibility.

6.6.5.7. Constructive Reenlistments. See paragraph 5.11.4.4.

6.6.6. Extensions for Airman Medically Disqualified (Medical Hold). AFPC Medical Standards is the sole approval authority for ALC-C, Medical Hold and non-emergent elective surgery during a RegAF service member's final six months of service. Medical Hold is a method of retaining a service member beyond an established retirement or separation date for reason of disability processing, for conditions when presumption of fitness does not apply. It is not used for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective treatment of medical defects, non-emergent elective surgery or its subsequent convalescence. Extensions approved under this paragraph are subject to age, HYT and the maximum length limitations/restrictions. (**Note**: Commanders may not disapprove.)

6.6.6.1. The MPS will:

6.6.6.1.1. Receive verification from AFPC Medical Standards outlining the number of months of the approved medical hold extension. **(T-1).**

6.6.6.1.1.1. Process the extension IAW current Air Force procedures.

6.6.6.1.1.2. Airmen cannot be forced to remain in service beyond their ETS. They must agree in writing to a medical hold and execute the AF Form 1411. **(T-1).**

6.6.6.1.1.3. Airmen extending under this rule may immediately reenlist once medically cleared and obligated service (Medical Hold portion) is waived.

6.6.6.1.1.4. Airmen who have not entered the extension may request cancellation. The Airmen must submit the cancellation request within 30 days of the MEB/PEB return to duty adjudication. **(T-1).**

6.6.6.1.1.5. Airmen extending under this rule and later removed from medical hold or who declines continued medical hold or MEB/PEB in writing have their DOS established by AFPC Reenlistments.

6.6.6.2. Airmen in RE code 4K may voluntarily extend their enlistment under this AFI when additional retainability is needed for promotion. (**Note**: In all cases, Airmen will retain the RE code 4K until medically cleared for duty.) **(T-1).** Limit extension period to a maximum of 24 months.

6.6.6.3. Limit pregnancy extensions (Airman or spouse) to the minimum number of months required to establish a DOS of delivery date plus one month.

6.6.7. Extension Reasons. Table 6.2 lists the approval conditions for voluntary extensions of enlistment. MPS will ***not*** approve extensions requested for the purpose of: **(T-1).**

6.6.7.1. Personal convenience or monetary advantage, except as specified under Table 6.2, Rule 28b-d.

6.6.7.2. Increasing bonus entitlement (not applicable to paragraph 6.6.4.1).

6.6.7.3. Providing additional time to make a career decision or deferring separation to coincide with civilian plans.

6.6.7.4. Applying for a CJR or requesting retraining consideration.

6.6.8. How to Complete and Process Extension of Enlistment or Cancellation(s) of Extension of Enlistment Requests: The MPS uses AF Form 1411 to document all extension and AF Form 1411-1 to document extension cancellation requests.

6.6.8.1. The MPS verifies RE codes by MilPDS inquiry before initiating AF Form 1411 and enters all appropriate data elements. The MPS ensures the requests comply with all general limitations and requirements.

6.6.8.2. The commander makes recommendations by entering disapproval rationale in the appropriate section of the AF Form 1411 or on a separate sheet and sends the form and any attachments to the MPS.

6.6.8.3. The MPS personnel identified in paragraph 6.6.1 will take the following actions: **(T-1).**

6.6.8.3.1. The commander recommends approval of the extension by completing the AF Form 1411. Refer to paragraph 6.6.3 for restrictions concerning lengthy-service Airmen. The extension is approved/disapproved once the extension action has been updated in MilPDS.

6.6.8.3.1.1. Update approved extensions in MilPDS (refer to the PSDG), verify DFAS file (take appropriate action if needed), and comply with the disposition instructions in Table 5.10 and refer to AFRIMS RDS Table 36-13 and 36-14 for disposition instructions.

6.6.8.3.2. When the commander recommends disapproval, send request to the Chief, MPS for decision. Chief, MPS may disapprove the request, or recommend approval and send the request to the FSS/CC for resolution. (**Note**: Chief, MPS will approve request for lengthy service Airmen as outlined by paragraph 6.6.3.) **(T-1).**

6.6.8.3.3. Refer to paragraph 6.6.11 for disapproved extension requests and comply with the disposition instructions in Table 5.10. Refer to AFRIMS RDS Table 36-13 and 36-14 for additional disposition guidance.

6.6.8.4. When extension requests require AFPC Reenlistments consideration (Table 6.2, Rule 28d):

6.6.8.4.1. The Airman will:

6.6.8.4.1.1. Prepare memorandum requesting extension. **(T-1).**

6.6.8.4.1.2. Forward request to their commander who considers the request and recommends approval or disapproval. **(T-1).** If the commander disapproves request, the commander will notify Airman of decision not to support the extension. **(T-1).** If the commander recommends approval, the Airman will forward request to MPS. **(T-1).**

6.6.8.4.2. The MPS will:

6.6.8.4.2.1. The MPS will create case files consisting of the memorandum, and any additional supporting documentation. (**Note**: Do not initiate/complete an AF Form 1411.) **(T-1).**

6.6.8.4.2.2. Forward requests to AFPC Reenlistments according to current guidance for review and final approval/disapproval.

6.6.8.4.2.2.1. Upon receipt of AFPC Reenlistments approval, initiate/complete AF Form 1411 and reference AFPC Reenlistments approval in the remarks on the AF Form 1411, update approved extensions in MilPDS (refer to the PSDG), verify DFAS files (take appropriate action if needed) and comply with the disposition instructions in Table 5.10. Refer to AFRIMS RDS Table 36-13 and 36-14 for additional disposition guidance.

6.6.8.4.2.3. Upon receipt of AFPC Reenlistments disapproval, the MPS advises the Airman of disapproval and closes the case.

6.6.8.4.3. AFPC Reenlistments will:

6.6.8.4.3.1. Ensure package is complete and return incomplete packages. **(T-1).**

6.6.8.4.3.2. Provide the MPS approval/disapproval notification. **(T-1).**

6.6.9. HYT and Age 60 Restrictions. The restrictions outlined in paragraph 5.11.12 and 5.11.12.1 also apply to extensions. Request for HYT adjustments, corrections, and/or waivers are sent to AFPC Retirements via current processing procedures. (**Note:** Under no circumstances can any reenlistment or extension exceed the Airman's HYT plus 1 month, unless otherwise provided.)

6.6.9.1. Airmen may extend to establish a DOS at their HYT plus 1 month or age 60, provided they are otherwise eligible and are within 2 years of their HYT plus 1 month or age 60 (Table 6.2, rules 3 and 27).

6.6.9.2. TSgts who wish to serve 6 months time-in-grade before HYT retirement may qualify for extensions according to Table 6.2, rule 1.

6.6.9.3. First Term Airmen extending under paragraph 6.6.4 may extend their enlistments beyond their HYT plus 1 month if authorized to receive a Zone A SRB and their new DOS won't exceed the last day of the month during which they complete 10 years TAFMS. See paragraph 4.5 for additional eligibility criteria.

6.6.9.4. Airmen in the grade of TSgt extending under paragraph 6.6.4 may extend their enlistments beyond their HYT plus 1 month if authorized to receive a Zone E SRB and their new DOS won't exceed the last day of the month during which they complete 22 years TAFMS. See table 4.1, item 4 for additional eligibility criteria.

6.6.9.5. CSRB - For Airmen authorized a CSRB, the HYT may be waived at the discretion of the SecAF or designated representative. AFPC will adjust after the CSRB contract is processed.

6.6.9.6. Airmen with DOS that exceeds HYT due to demotion, etc. will have their DOS adjusted to match their new HYT date. Before beginning any separation package, consult AFI 36-3208. The separation authority may withhold execution of a separation for any reason in the best interest of the Air Force. **(T-1).**

6.6.10. Extension Counseling Requirements. Airmen must initial or MPS mark the applicable statements on the AF Form 1411. **(T-1).** Counselors must be assigned to the MPS or GSU personnel function and possess the grade of A1C, GS-4, or higher. **(T-2).** Counselors explain each applicable item to the Airman and complete the appropriate section of the AF Form 1411.

6.6.11. Extension Appeal Processing. This paragraph applies to extensions and cancellation of extensions of enlistment (except extensions approved/disapproved by AFPC Reenlistments [Table 6.2, rule 28d]) which are disapproved or cancelled according to paragraph 6.5.

6.6.11.1. The Airman will acknowledge receipt of the disapproval of cancellation recommendation within 1 workday following receipt of the AF Form 1411-1. **(T-1).** Airmen also acknowledge that a written appeal may be submitted to the MPS within 5 workdays of the acknowledgment date.

6.6.11.2. When an Airman does not elect to appeal, the MPS forwards the AF Form 1411-1 to ARMS for filing. When the Airman elects to appeal, the MPS places the AF Form 1411/1411-1 (as appropriate) into suspense, pending receipt of the appeal. If the Airman does not submit an appeal within the proper time frame, the MPS annotates the 1411-1 or AF Form 1411 as appropriate and disposes of the case according to Table 5.10.

6.6.11.3. When Airmen submit a written appeal:

6.6.11.3.1. The MPS sends the appeal and a photocopy of all pertinent documentation (AF Form 1411/1411-1, attachments, etc.) to the servicing legal office for review. MPS includes the legal advisory in the case file then sends the case file to the group commander within 5 workdays. Legal advisories are not considered new information; and commander recommendations are not considered new information, unless the

commander adds new documentation/information. (**Note**: Give Airmen 3 workdays to rebut any new information added to the case file after the appeal is submitted.)

6.6.11.3.1.1. When the group commander is the appeal authority, he/she will approve or disapprove the appeal and return it to the MPS. **(T-1).** If approved, reference paragraph 6.6.11.4. If disapproved, reference paragraph 6.6.11.5.

6.6.11.3.1.2. When the SecAF is the appeal authority, the case must process through both the group and wing commander. **(T-1).** The group commander may approve the appeal or recommend disapproval and return it to the MPS. If the group commander approves, see paragraph 6.6.11.4. If the group commander disapproves the appeal, package is sent to the wing commander.

6.6.11.3.1.3. If the wing commander approves appeal, see paragraph 6.6.11.4. If the wing commander disapproves the appeal, the wing commander returns package to the MPS. The MPS makes a copy for their records and forwards the original package to AFPC Reenlistments for processing to the SecAF.

6.6.11.3.1.4. If the wing commander denied the extension request, the appeal authority is their parent MAJCOM, DRU or FOA Director of Personnel (A1).

6.6.11.4. When the appeal is approved, the appeal authority completes the AF Form 1411 or AF Form 1411-1. The MPS officials will notify the Airman/commander and make the appropriate updates in MilPDS using normal processing procedures and forward the case file to ARMS for filing. **(T-1).**

6.6.11.5. When the appeal is disapproved, MPS ensures the Airman acknowledges receipt of the disapproval. The MPS attaches the statement and disapproval correspondence to the AF Form 1411/1411-1. (**Note**: MPS gives the Airman a copy of the documentation upon request.) Ensure a copy of the case file is sent to ARMS for filing in the Airman's electronic records.

Table 6.1. Extension Appeal Authority.

If the Airman is a:	**Appeal Authority**	**See Note:**
First Term Airmen	Respective Group Commander	1, 2
Career Airmen who complete 20 or more years total service on current ETS	Respective Group Commander	1, 2
Second Term and Career Airmen who complete fewer than 16 years total service on current ETS	Respective Wing Commander	1, 3
Career Airmen who complete at least 16 years, but fewer than 20 years total service on current ETS	SecAF	1
Any Airman assigned in a joint base construct, the wing commander level for appeal purposes	Air Force commander above the group level	1
Notes*:* 1. Once the case file has been considered by the approval authority, the decision is final and the case cannot be sent to a level above that authority to have the decision overturned.		

2. These Airmen appeal to their wing commander, if the group commander made the SRP non-selection decision
3. These Airmen appeal to their MAJCOM/DRU/FOA A1, if the wing commander made the SRP nonselection decision.

6.6.12. Involuntary Extensions. These include Air Force initiated extensions that do not consider the member's desire and may be executed due to STOP LOSS and/or administrative/legal holds for investigation and disciplinary reasons (this does not include Medical Hold extensions unless the member is incapacitated and unable to submit a voluntary statement). Involuntary extensions do not count as obligated service on the next reenlistment and do not count towards the maximum number of months authorized as outlined in paragraph 6.2.2.

6.6.12.1. Forward administrative/legal holds for investigation extensions to AFPC Separations via current processing instructions.

6.6.12.2. Extensions executed for STOP LOSS are annotated "STOP LOSS" in the remarks section of the AF Form 1411.

6.6.13. Extensions for Air Force Fitness Program. See paragraph 5.11.15.1.

6.6.14. Extensions for Airmen in Reporting Identifier (RI) 9A000/9A100/9A200/9A300. See paragraph 5.11.15.3.1.

Table 6.2. Reasons for Extensions of Enlistment.

RULE	A **If an Airman requests an extension of enlistment to**	B **and**	C **the request may be approved or disapproved at MPS level unless otherwise indicated below**	D **and the reason code entry in MilPDS is**
PROMOTION				
1	Obtain retainability for promotion to the grade of MSgt, SMSgt, or CMSgt (promotion sequence number has been released for the upcoming month)	the Airman requires retainability to assume the new grade. This rule also applies to Airmen selected for promotion, but who do not have an announced promotion effective date. These Airmen may not establish a DOS beyond the last day of the promotion cycle. TSgts may also use this rule to serve six months' time-in-grade before retirement at HYT. Airmen may extend under this rule if they are ineligible to reenlist because of HYT or age 60.		**A**

2	**DELETED**			
RETIREMENT				
3	Retire the first day of the month following HYT date, adjusted HYT date, or age 60	the Airman is within two years of HYT date or age 60. (Airmen must establish a DOS of at least the last day of their HYT month. **(T-1).** Airmen may not extend under this rule if they refused to obtain service-directed retainability.)		**B**
4	Retire not later than the first day of the month following completion of 20 years TAFMS (for reasons other than HYT)	the Airman is ineligible to reenlist due to age 60; or the Airman was nonselected under the SRP. This rule applies to Airmen who are within two years of attaining minimum retirement eligibility. Airmen may not extend if they refused to obtain service-directed retainability.		**C**
5		the Airman elected retirement instead of PCS, training, or retraining and has completed at least 19 years TAFMS, but fewer than 20 years TAFMS, on notification date. Extension may not exceed a total of 12 months		**C**
6		and the Airman is ineligible to reenlist and rules 4 and 5 do not apply. (This rule applies to Airmen who are within two years of attaining minimum retirement eligibility. Airmen may not extend if they refused to obtain service-directed retainability.) (**Exception**: See AFI 36-2301, *Developmental Education*)		**C**
7	Retire in lieu of a PCS assignment	the Airman elects retirement on or before the first day of the seventh month following assignment notification. (Do not use this rule for Airmen assigned overseas or serving on maximum CONUS stabilized tours.)		**D**

8	Retire during a requested extension period	the Airman has at least 19 years TAFMS, is eligible to apply for retirement, and the requested extension period does not exceed a total of 12 months. (Do not use this rule for Airmen who possess a reenlistment eligibility code in the 2 (except 2V), 3, or 4 series, or for Airmen notified of an assignment, training, or retraining but have not accepted or refused the assignment, training, or retraining. This rule also does not apply to disability retirements.)		**E**
MEDICAL CARE				
9	Remain on active duty pending completion of MEB/PEB or medical hold (RE code 4K). Also see Table 5.7.	the Airman has memorandum from AFPC Medical Standards which outlines the recommended extension length. Limit extensions to a period outlined in the memorandum, not to exceed a 24-month period.	(**Note**: Commanders may not disapprove.)	**7**
10	To permit government medical care due to pregnancy (Airman or spouse) or serious injury or illness	the Airman will not complete 20 years TAFMS on current enlistment. **(T-1).** Reenlistment ineligible Airmen may execute extensions under this rule. For pregnancy extensions, limit extensions to delivery date plus 1 month.	AFPC Reenlistments is the *final* disapproval authority .	**H**
11	**DELETED**			
ASSIGNMENT				
12	Obtain retainability for a CONUS or overseas PCS, PCA, or TDY assignment, or to qualify for an SRB in conjunction with an assignment according to paragraph 4.7	the Airman requires retainability. Limit extensions submitted according to paragraph 6.6.5 to the minimum number of months required for the Airman to establish a DOS within 90 days of projected departure date. Establish a DOS for deployments for return date plus no more than 60 days. (If Airman has sold leave, any		**I (see note)**

		remaining leave that cannot sell is added to the 60 days.)		
13	Obtain retainability for command sponsorship at an overseas location	the Airman requires retainability.		**J (see note)**
14	Obtain retainability for an overseas tour extension or to maintain indefinite DEROS	the Airman requires retainability. Airmen must extend in minimum increments of 3 or more months in order to maintain an indefinite DEROS. **(T-1).** See AFI 36-2110, for indefinite DEROS requirements.		**L (see note)**
TRAINING OR RETRAINING				
15	Participate in a program leading to commission, approved education program or to qualify for PME	the Airman is a selectee and requires retainability.		**M**
16	Obtain retainability for training or approved retraining (On-the-Job Training [OJT] or formal school)	the Airman requires retainability. Includes Airmen in RI 9A000 and 9A100 in RE code 4G. Also see paragraph 5.11.15.3. 1.		**N**
OBSERVATION, PUNISHMENT, PROBATION AND REHABILITATION				
17	Complete the Control Roster Observation	limit extension to minimum number of months to complete observation period plus 30 days.		**O**
18	Attain a passing fitness score and the Airman is coded IAW Table 5.6, Item 9.	Airmen in the poor fitness category may extend for the minimum number of months needed to meet standards (See AFI 36-2905 for extension periods) or until the commander removes the reenlistment ineligibility. Limit extensions to 4 or 7 months.		**P**
19	Complete ADAPT Program	the commander has not yet removed the Reenlistments ineligibility factor during		**Q**

		aftercare. (Limit extensions to the minimum number of months needed to complete aftercare. Do not extend Airmen who have failed the ADAPT Program.)		
20	Complete period of probation and rehabilitation. See AFI 36-3208	the Airman requires an extension of 12 months or less to complete probation and rehabilitation.		**R**
21	Complete suspended punishment pursuant to Article 15, UCMJ	limit extension to minimum number of months to complete the suspended punishment period plus 30 days.		**S**
22	Complete an investigation by military or civilian authorities, or await disposition of civil court charges, or await the outcome of an involuntary separation action	the Airman requested extension to await the outcome. Limit to minimum number of months as authorized by the Judge Advocate General (JAG).		**T**
APPEALS				
23	Process an SRP appeal, lengthy service Airman determinations, await decision of AF C&PB IAW AFI 31-105 or await SecAF decision;	the Airman has submitted an appeal or has rendered intent to appeal or request to SecAF has been submitted. Limit extensions to one-month increments when appeal authority is at the wing level or below. Limit extensions to three- month increments when the appeal authority is the SecAF. (Refer to paragraph 6.6.5.5.)	The MPS Chief may approve. (**Note:** Commanders may not disapprove.)	**U**
24	Process an extension of enlistment appeal (cancellation or disapproval)	the Airman has submitted an appeal or has rendered intent to appeal. (Limit extensions to one-month increments. Refer to paragraph 6.6.11.) (**Exception**: Initial extension for appeals where the SecAF is the approving authority may be	The MPS Chief may approve. AFPC Reenlistments is the final disapproval authority.	**V**

		completed for three months [additional extensions are in three-month increments].)		
CITIZENSHIP/SECURITY CLEARANCE				
25	Attain US citizenship or to extend to meet retainability requirement for Security Clearance IAW AFI 31-501	the Airman applied for citizenship. (Extension may not be for more than 6 month increments or the projected swear-in date plus one month, whichever is sooner. Refer to paragraph 6.6.5.4.) Extension period combined with the Airman's remaining obligated service will not exceed the minimum period to meet AFI requirements.		**W**
DEMOTION				
26	Process for separation following demotion	is a Second Term or Career Airman serving in the grade of A1C or below (to include those demoted). (The extension may not exceed the last day of the fourth month following the Airman's new date of rank.)		**X**
SEPARATION AT HYT				
27	Separate at HYT date	as a First Term, Second Term or Career Airman serving in the grade of SrA or SSgt and is within two years of HYT date. (Airmen may not extend under this rule if they refused to obtain service-directed retainability.) (Refer to paragraph 6.6.9.6.) Limit extension to HYT plus 1 month.		**Y**

BEST INTEREST OF THE AIR FORCE (cannot be cancelled for any reason *unless otherwise specified*)				
28a	DELETED			
28b	Obtain retainability for 12 Outstanding Airman of the Year	Airman is nominated for 12 Outstanding Airman of the Year. (**Note**: Extension may be cancelled if Airman is not selected.)		**8**

28c	Obtain retainability for any reason (Personal Convenience)	First Term Airmen with approved CJRs and selected for reenlistment may request a one-time extension under this rule (for any reason) if it is their first extension. Extensions are for 12 months (waivers to the number of months are not be considered). This rule may be suspended when CJR constrained AFSCs exist.		**8**
28d	Extend for any reason in the best interest of the Air Force	no other rule in this table applies to the Airman's situation. Reenlistment eligible Airmen may request an extension under this rule. (See paragraph 6.6.8.4.)	AFPC Reenlistments is the *final* approval authority	**8**

GI BILL OR CONTINUATION PAY				
	Qualify for transfer of benefits under the Post-9/11 GI Bill	The Airman has served at least 6 years TAFMS and has eligible dependents in Defense Enrollment Eligibility Reporting System (DEERS).		**9**
29	Qualify for Continuation Pay under the Blended Retirement System	The Airman has served at least 8 years TAFMS and not more than 12 years TAFMS		
Note*:* Airmen are ineligible to extend under rules 12, 13, and 14 unless they possess RE codes 1#, 2R, 2S, 2T, 2U, 3C, 3I, or 4D, and are otherwise eligible.				

6.7. Extension of Enlistment in the AFR . Voluntary Extension Restrictions**. (T-0).** (**Note:** Reference 6.7.2. as well.)

6.7.1. Period of Voluntary Extension. Voluntary extensions are for whole month periods needed to serve their purpose. **Exception**: Members extending to their HYTD may extend for exact years, months, and days.

6.7.1.1. The total of all extensions of a current enlistment may not exceed four years (48 months), (10 USC § 509). This **cannot** be waived.

6.7.1.2. Convenience of the member is not grounds for extension.

6.7.1.3. Member may not extend an enlistment in order to become eligible for the incentive program.

6.7.2. Eligibility for Voluntary Extension. **(T-2).** The following may request an extension of enlistment prior to ETS.

6.7.2.1. Members under waiver consideration by AFRC/SG for physical disqualification or hospitalized, temporarily/physically disqualified, and pending medical/physical evaluation board (MEB/PEB). Extensions will be in 6 month increments or the minimum time necessary for waiver determination, or MEB determination, whichever is sooner.

6.7.2.2. Inactive Status List Reserve Section (ISLRS) members whose enlistment expires. ARPC/DPT will determine if retention is in the best interest of the Air Force.

6.7.2.3. Members applying for transfer or assignment to the Retired Reserve under AFI 36-3209. The member must request an extension for an unspecified period contingent on transfer to the Retired Reserve. **(T-2).** If approved, ARPC/DPT extends enlistment for an unspecified period. This extension takes effect on the date the member transfers to the Retired Reserve. (AF Form 1411 is not required.)

6.7.2.4. Selectees for the US Air Force Academy Preparatory School. Members may extend if their enlistment will expire before they complete their required period of active service.

6.7.2.5. Career AGRs are authorized to extend up to 4 years to meet retainability required to achieve certain milestones such as current DOS, 20-year active duty date, or HYT. However, if more than 4 years is required to satisfy retainability to reach any of those milestones, members are advised to reenlist.

6.7.2.6. Member who has been nonselected for reenlistment may extend enlistment for the time necessary to allow for due process of the member's appeal.

6.7.2.7. Members who are applying for benefits under the Reserve Montgomery GI Bill, Kicker Program, Post 9-11 GI Bill, or other education benefits may extend up to 4 years in order to qualify for these benefits. If more than 4 years is required to satisfy retainability requirements, members are advised to reenlist.

6.7.2.8. Members unable to participate in or failing to achieve minimum passing score on the Fitness Assessment (AFI 36-2905). The commander can either select the member for reenlistment or authorize a 7- or 12-month extension. When opting to extend the enlistment, the commander will complete the AF Form 418 to render the member ineligible to reenlist rather than denying reenlistment by specifying "ineligibility" vs. nonselection on the form. In the remarks section of the AF Form 418, write the following statement, "Member is rendered ineligible to reenlist in accordance with AFI 36-2905. I am authorizing the member a 7- or 12-month (as applicable) extension to allow for fitness improvement." (**Note**: Attach the AF Form 418 to the extension (AF Form 1411) after updating the extension, send to AFRC/A1K. If the member is later allowed to reenlist, the commander will submit another AF Form 418 selecting the member for reenlistment.

6.7.2.9. Members who have 18 but fewer than 20 satisfactory years for Reserve retirement. Commanders cannot deny extensions of enlistment requested by these personnel.

6.7.2.10. Members being processed for involuntary discharge for cause or physical disqualification according to AFI 36-3209. If the member's ETS will not afford sufficient time for the member to appeal the discharge case, the commander must provide the member

the opportunity to voluntarily extend their enlistment to allow for due process. **(T-2).** Ensure documentation of member's election is included in the discharge case. If the member elects to extend their enlistment, ensure a copy of the AF Form 1411, is included in the discharge case.

6.7.2.11. Members deploying or going TDY. Ensure members have enough retainability to complete the established TDY tour length, (IAW AFI 10-401*, Air Force Operations Planning and Execution* and AFI 36-3802, *Personnel Readiness Operations*), plus an additional 60 days.

6.7.2.12. Members retraining. Extend members to ensure three years retainability from the effective date of retraining.

6.7.2.13. Members incurring an Air Force Reserve Service Commitment (RSC). Extend members in accordance with retainability requirements in AFRCI 36-2102, *Air Force Reserve Service Commitment Date Program*.

6.7.2.14. Members under consideration for promotion under the Stripes for Exceptional Performers II (STEPII). Individuals must have 24 months retainability before being considered for promotion to E-7 to E-9 under the STEP II program. **(T-2).**

6.7.2.15. Members who are found temporarily medically unfit. Any AFR member profiled 4, duty limiting condition, code 31, 37, 81 (previously 4T) may not perform military duty for pay or points. Extend members until the expiration date of the medical profile.

6.7.2.16. AGR. Extend members for retainability to qualify for the AGR program.

6.7.2.17. Members attending technical school. Extend members for the amount of time necessary for retainability.

6.7.2.18. Members who need extensions to meet their HYTD. A member may request an extension of their enlistment at any time for this purpose. Extend enlistment for the exact years, months, and days needed.

6.7.2.19. All extension requests will be requested PRIOR to the member’s ETS, no after-the-fact requests will be honored.

6.7.3. Extension Approval Authorities **(T-2):**

6.7.3.1. Unit Commander. The unit commander or equivalent (for Individual Reservist, RegAF, Joint or sister service unit of assignment commander) makes the final decision on any request for voluntary extension. The unit commander or equivalent may also cancel or terminate a voluntary extension.

6.7.3.2. ARPC/DPT. This office may direct, process (for IRR members), or cancel involuntary extensions.

6.7.4. Completing Documentation for Extensions **(T-2):**

6.7.4.1. The MPS signs Section VIII of the AF Form 1411 on extension requests. The CAA may designate an alternate service representative in their absence.

6.7.4.2. MPS sends the original AF Form 1411 to ARMS. (For IMA and PIRR members, RIO Detachment sends the AF Form 1411 to ARPC/DPT for update.) The personnel system is updated accordingly. Provide a copy of AF Form 1411 to the member. IRR

Bonus Recipients: A commissioned officer or notary public may sign extensions for IRR Bonus recipients.

6.7.5. Cancelling an Extension. **(T-2).** Cancel extensions the member has not yet entered if:

6.7.5.1. The Air Force cannot meet the terms on which it agreed to extend service (thus completion of the extension would be unfair to the member).

6.7.5.2. The member is eligible and wants to reenlist on original ETS instead of entering the extension.

6.7.5.3. Documentation for Canceling or Terminating an Extension**.** Use an AF Form 1411-1 to effect the cancellation, obtain the commander's signature, and make distribution of the form.

6.7.6. Terminating an Extension. **(T-2).** Terminate extensions the member has already begun serving if:

6.7.6.1. The member wants to reenlist and the new contract is sufficient to cover the extension period.

6.7.6.2. The member meets fitness standards according to applicable AFI and is now eligible to reenlist.

6.7.6.3. The unit commander's recommendation of non-selection for reenlistment has been upheld.

6.8. Extension of Enlistment in the ANG . General Information. (**Note**: Also reference para 6.7.2.)

6.8.1. When conditions preclude reenlistment, Airmen may qualify for extension of enlistment.

6.8.1.1. No extension will be granted without approval of the Airmen's immediate commander.

6.8.1.2. For unique situations or circumstances not contained within this instruction, refer to Attachment 3, Procedures for submitting a Waiver Request or an ETP.

6.8.2. Voluntary Extension of Enlistment**.**

6.8.2.1. To determine the authorized terms for extension of enlistment, refer to Table 6.3.

6.8.2.2. More than one extension is authorized on a current enlistment contract; however, the total of all such extensions on the current enlistment contract will not exceed four years per 10 USC § 509. **(T-3).**

6.8.2.3. Extension is effective on day following current ETS.

6.8.2.4. Extension will not be granted in order to qualify for the ANG Incentive Program.

6.8.3. Eligibility for Voluntary Extension. **(T-2).** The following categories of personnel are eligible to request an extension of their current enlistment.

6.8.3.1. Members under waiver consideration by AFRC/SG for physical disqualification or hospitalized, temporarily/physically disqualified, and pending medical/physical

evaluation board (MEB/PEB). Extensions will be in 6 month increments or the minimum time necessary for waiver determination, or MEB determination, whichever is sooner.

Table 6.3. Terms of Extension to Enlistment in the Air National Guard.

RULE	A	B	C
	Are selected by their commander and applicant is:	**Then extend for:**	**Notes:**
1	Selected for service commitment that requires specific retainability.	Exact years, months, and days needed	1, 2, 3
2	An Airman who accepts a Statutory/AGR Tour. Accepts a subsequent Statutory/AGR Tour. EAD Tour application approved by AFPC.	A period that will coincide with an AD tour that will not exceed four years.	3
		For AD tours over four years see Table 5.12., item 1.	3
		For AFPC approved EAD tours: Time required by AFPC, not to exceed the member's HYT.	3
3	Ineligible for reenlistment based on failure to attain physical fitness standards as outlined in AFI 36-2905	Minimum extension period is six months and maximum extension period is twelve months provided Commander concurs. If the commander non-concurs, separate at ETS.	
4	MGIB-SR	The number of years, months, and days that total a 6 year SR commitment from the date of eligibility.	1, 2, 3
5	MGIB-SR Kicker	The number of years, months, and days that total a 6 year SR commitment from the date of eligibility.	1, 2, 3
6	MGIB-Chapter 33	The number of years, months, and days that total a 4 year SR commitment from the date of eligibility.	1, 2, 3
7	An individual who will not be qualified for retirement upon reaching age 60, but will qualify before attaining age 62	Waiver must be submitted to TAG for consideration.	3, 4
8	An individual who is a technician who is extending beyond age 60 for the purpose of qualifying for a technician annuity.	Waiver must be submitted to TAG for approval prior to entering into any period of extension.	3

9	An Airman who's ETS occurs while under investigation or awaiting trial for violation of the UCMJ or State Military Code.	Involuntarily extend for a period sufficient to allow for conclusion of the trial or investigation.	3
10	Affected by "Stop-loss" Provision (10 USC § 12305).	Member will be involuntarily extended. (See paragraph 6.8.7.2.)	3, 5
11	An Airman who is hospitalized, temporarily physically disqualified, or pending Disability Evaluation System (DES), MEB or PEB.	A period that coincides with approved Medical Hold from NGB/SG.	3, 4
12	An Airman who requires retainability for deployment.	A period that includes the estimated tour length, accrued leave, reconstitution time, plus 30 days IAW AFI 10-403 or 6 months, whichever is longer.	3
13	Extension for any provision not included in this instruction	Submit request through State TAG to NGB/A1PP for consideration.	3

Notes:
1. Member is required to complete an ANG Service Commitment Agreement.
2. Member may extend ANG enlistment for a period of at least 6 months to coincide with the MSO.
3. No extensions may be executed for a period of less than 6 months.
4. For a member whose medical condition will extend beyond their 60th birthday, the extension request must be forwarded through the chain of command to TAG for approval.
5. Members affected by Stop-Loss must be released from an involuntary extension immediately upon the lifting of the Stop-Loss Provision (10 USC § 12305). **(T-0).**

6.8.4. Extension of Enlistment due to Air Force Fitness Program, Airmen Medically Disqualified or Airmen in RI 9A000/9A100/9A200/9A300. **(T-3).**

6.8.4.1. Fitness Program.

6.8.4.1.1. Airman approaching ETS who are not selected for reenlistment may submit a request for extension of enlistment to their unit commander for consideration.

6.8.4.1.2. Approval of an extension period is the Commander's prerogative.

6.8.4.1.3. Extension period is limited to a minimum of six but no more than twelve months to allow Fitness Assessment.

6.8.4.1.4. All such requests are subject to the 4-year maximum period limitation of all extensions to any one enlistment under 10 USC § 509.

6.8.4.1.5. Separate Airman on ETS who are not approved for extension of enlistment.

6.8.4.2. Airmen disqualified and in RI 9A000 or 9A100 may execute a one-time extension for a total period of 12 months to qualify/compete for retraining/Special Duty.

6.8.4.2.1. Under no circumstances will the extension period combined with the remaining obligated service exceed 12 months.

6.8.4.2.2. The length of the extension, if any is based on the date of the formal disqualification approval not to exceed 12 months.

6.8.4.2.3. If the Airman is not approved for retraining or Special Duty during this period, he/she will separate on their DOS.

6.8.4.3. Airmen in RI 9A200/9A300 will separate on DOS unless the commander initiates early separation or subsequently completes requirements to retain the Airman.

6.8.5. Air National Guard Enlisted Mandatory Separation Date (MSD**)**: Enlisted retention beyond age 60 is not authorized if a member is qualified for retired pay without prior approval from the SecAF (10 USC § 12308*)* **(T-3)**.

6.8.5.1. Airmen may be approved for retention beyond age 60, but no later than age 62 by the TAG in the following situations:

6.8.5.1.1. Enlisted with Waiver for Qualification for Retirement under 10 USC **Chapter 1223**. Airmen who were enlisted in the ANG under an approved waiver to be retained beyond age 60 to qualify for retirement under 10 USC **Chapter 1223** may be extended for the number of years, months, and days required to qualify for retirement.

6.8.5.1.2. Enlisted members with 18 but less than 20 years of satisfactory service may request retention beyond age 60 to qualify for a Reserve Retirement provided the member did not waive retirement eligibility upon enlistment and extenuating circumstances precluded eligibility before the member reached his or her sixtieth birthday.

6.8.5.1.3. Qualifying for Technician Annuity. Enlisted members serving as dual status technicians may request retention beyond age 60 to qualify for a civil service annuity. Requests for extension must include verification of civil service annuity eligibility date from the state Human Resource Office.

6.8.5.2. Airmen will only receive pay, not points, for service beyond age 60. **(T-2).**

6.8.5.3. Requests will be forwarded to the TAG for consideration prior to the member entering into an extension of enlistment and Airman will not enter the extension period without TAG approval.

6.8.6. Medical Hold

6.8.6.1. Airmen who are hospitalized, temporarily physically disqualified, or pending Individual Disability Evaluation System (IDES) processing may be retained beyond age 60 provided they are in an approved Medical Hold status. (Refer to AFI 36-3212 *Physical Evaluation for Retention, Retirement, and Separation*.)

6.8.6.2. Presumption of Fitness. The existence of a physical defect or condition does not, of itself, justify continuance in service. Refer to AFI 41-210, *Tricare Operations and Patient Administration Functions* for conditions that warrant retention beyond ETS.

6.8.6.3. Justification for extension shall be submitted through the unit commander to TAG, in letter format and include the Medical Hold approved by NGB/SG in accordance with AFI 41-210. **(T-2).**

6.8.6.4. Extension of enlistment will match the approved Medical Hold period established by NGB/SG. **(T-2).**

6.8.6.5. Members applying for extension under the Medical Hold provision will only receive pay, (no points), for service beyond age 60.

6.8.7. Administrative or Involuntary Extension of Enlistment**.** These extensions do not consider the member's desire. (**Note**: This does not include Medical Hold extensions unless the member is incapacitated and unable to submit a voluntary statement.)

6.8.7.1. UCMJ or the State Military Code action. Enlisted members can be administratively extended for the purpose of allowing sufficient time for conclusion of a trial or investigation for a violation of the UCMJ or the State Military Code.

6.8.7.2. STOP LOSS. Involuntary extension guidance resulting from STOP LOSS actions will be included in the instructional guidance from NGB/A1PP.

6.8.7.2.1. Any extension executed for STOP LOSS will be annotated "STOP LOSS" in the remarks section of the AF Form 1411.

6.8.7.3. Administrative Extension. Airmen may be administratively extended in service to allow finalization of investigative and disciplinary action(s). Do not involuntarily retain Airmen for the processing of administrative discharge action.

6.8.7.4. Grievance Adjudication. Members may be extended, at the discretion of TAG, when a member has been denied reenlistment and has a pending complaint or grievance in their behalf that will not be adjudicated prior to their ETS. In this instance, the member will be extended for six months or until adjudication is received.

6.8.8. Cancellation of Extension of Enlistment.

6.8.8.1. Complete AF Form 1411-1to document cancellation of extensions of enlistments.

6.8.8.2. Request must be approved prior to entry into an extension period. **(T-2).**

6.8.8.3. Cancellation will result in the ETS reverting to its previous date.

6.8.8.4. Members may request cancellation provided they have not entered the extension period.

6.8.8.5. Unit commanders may cancel extensions to enlistment when the original reason for extension no longer exists provided they have not entered the extension period.

6.8.8.6. In the event a member has entered into an extension period, refer to AFI 36-3209, Section 3C, Voluntary Separations.

6.8.9. Disposition of Extension Documents. Refer to Table 6.4.

Table 6.4. Disposition of Extension Documents.

Form or Document	Copies	Disposition
AF Form 1411 *Extension of Enlistment in the Air Force*	3	**Original**—ARMS **1st copy**--MPS copy. Review ARMS to ensure a copy is available then destroy after 3 months. **2nd copy**--Airman's copy. (as directed by the RDS)
AF Form 1411-1 *Cancellation of Extensions of Enlistment in the Air Force*	3	Original—ARMS

Chapter 7

ENLISTED CRITICAL SKILLS RETENTION BONUS PROGRAM IN THE REGULAR UNITED STATES AIR FORCE (*REGAF ONLY*)

7.1. Background : The Enlisted CSRB is an Office of the Secretary of Defense (OSD)-driven requirement and is applicable to Airmen assigned in the RegAF. It does not apply to Airmen assigned to the Air Force Reserve or Air National Guard.

7.2. Program Overview : This is a financial incentive paid to Airmen who reenlist or agree to continue serving on active duty for at least one additional year in a military skill designated as critical by the PDUSD (P&R). The intent of the bonus is to provide a financial incentive to influence retention decisions of Service Airmen in designated CSRB-AFSCs taking into consideration current or projected manning shortages, skill imbalances, and high training costs or high replacement costs, in cases where less costly methods are inadequate or impractical. The CSRB program set forth in this Chapter is subject to authorization under 37 USC § 355, DoDD 1304.21, *Policy on Enlistment Bonuses, Accession Bonuses for New Officers in Critical Skills, Selective Reenlistment Bonuses and Critical Skills Retention Bonuses for Active Members* and DoDI 1304.29 *Administration of Enlistment Bonuses, Accession Bonuses for New Officers in Critical Skills, Selective Reenlistment Bonuses, and Critical Skills Retention Bonuses for Active Members*, for such bonuses. The combined CSRB and SRB received during a career cannot exceed $200,000 unless specifically authorized as an exception by the PDUSD (P&R).

7.3. Eligibility Criteria/Qualifications :

7.3.1. At a minimum, Airmen must be in the designated AFSC and enlisted grade as designated by PDUSD (P&R) and published in the Implementation Guidance, must have completed at least 19 years of service and be otherwise eligible to reenlist. **(T-1).**

7.3.2. Eligible Airmen are authorized to reenlist at any time during their current enlistment and the remaining obligated service is waived. Otherwise Airmen must have a service-directed reason IAW Table 5.9 or meet current Air Force reenlistment policy. **(T-1).**

7.3.3. Airmen are allowed to project their reenlistment 6 months in advance provided the reenlistment occurs on the actual day or after the Airman reaches 19 years of TAFMS. (**Note**: Airmen receiving a bonus from a previous contract will not have the remaining obligated service waived and ADSC will be extended to coincide with the length of the bonus, i.e., SRB.)

7.3.4. Contracts can be no less than 1 year and CSRB payments can be paid in lump sum or installments at the amount as indicated by PDUSD (P&R) and published in the Implementation Guidance.

7.3.5. Eligible Airmen are authorized to extend to receive this bonus, provided the Airman has a service-directed reason to extend as shown in Table 6.2. Airmen may elect to extend for longer periods even though less retainability is required in order to qualify for the CSRB. (**Note**: Airmen will not receive the bonus until they enter their extension.)

7.3.6. Airmen will serve in the CSRB skill for the full period of the reenlistment or extension contract agreement, and incur an ADSC for that reenlistment or extension contract. **(T-1).** The ADSC will be based on the years reenlisting.

7.3.7. HYT for mandatory retirements may be waived for Airmen authorized a CSRB, who agree to serve in the designated specialty under a CSRB contract. Once the Airman has completed the appropriate contract, the MPS or equivalent will be required to email AFPC Reenlistments requesting the Airman's HYT be adjusted. AFPC Reenlistments coordinates with AFPC Retirements for approval. Once HYT has been adjusted by AFPC, the MPS or equivalent can then process the reenlistment/extension.

7.3.8. Airmen may withdraw their retirement to reenlist and accept this bonus provided PCS funds were not expended.

7.4. Required Documentation :

7.4.1. Reenlistment: The AF Form 901 documents the CSRB participation and entitlement (insert specific dollar amount of bonus from Implementation Guidance).

7.4.2. Extension: The AF Form 1411 documents the CSRB participation and entitlement. The MPS documents the remarks Section XIV by inserting ―Airman is authorized $___ (insert specific dollar amount of bonus from Implementation Guidance) in conjunction with the Critical Skills Retention Bonus Program.

7.4.3. The MPS will:

7.4.3.1. Forward all requests (to include the required documentation) to AFPC/ADSC OPS via current processing procedures. **(T-1).** Follow contract disposition schedule as outlined in Table 5.10.

7.4.3.2. Select "Critical Skills Ret Bonus (Enlisted)" for case type. **(T-1).**

7.4.3.3. Annotate in the remarks "Member is authorized $_____ in conjunction with the Enlisted CSRB Program." The MPS will also state whether Airman requested lump sum or installments. **(T-1).**

7.4.3.4. Indicate the ADSC end date. **(T-1).** This date equals DOE plus TOE years (months are not added). (**Note**: The ADSC will include the full term and any remaining obligation from a previous Zone E/CSRB.)

7.4.3.5. Include current reenlistment date and whether the Airman was in a combat zone during the month in which the reenlistment took place. **(T-1).**

7.5. Recoupment : When conditions warrant, any unearned CSRB may be recouped, terminated, or suspended, as applicable, applying rules in DoDFMR.

7.6. Active Duty Service Commitment : Once an Airman accepts the CSRB program, AFPC/ADSC OPS will update ADSC 69. **(T-1).** AFPC/ADSC OPS will forward to AFPC Reenlistments for verification and processing to DFAS. **(T-1).** The only ADSC waiver for retirement that is applicable is for "hardship" as stated in AFI 36-3203. (**Note:** see AFI 36-3203, paragraph 2.8.2, 2.10 and Table 2.2.)

Chapter 8

AIR FORCE RESERVE HIGH YEAR OF TENURE (HYT) PROCEDURES (*AFR ONLY*)

8.1. HYT Program . (T-2). It is designed to improve grade ratios, ensure sustained promotion opportunity, and maintain readiness by providing a force fit for the rigors of war.

8.2. Service Limitation. (T-2). The HYT program limits participation for TRs, IMAs, PIRRs, and AGRs. HYTD is the first day of the month following member's pay date plus 33 years of creditable service for military pay (CSMP) or one day prior to age 60, whichever occurs first. An ART's service is limited to 33 years of CSMP or the date eligible for an unreduced civil service retirement, whichever date is later – not to exceed one day prior to age 60.

8.3. Computing HYTD. (T-2). See Attachment 2 for HYTD computation.

8.4. Update HYTD. (T-2). ARPC/DPT is the only agency authorized to update TRs, IMAs, PIRRs, and ARTs HYTD. ARPC/DPA is the only agency authorized to update AGRs HYTD.

8.4.1. The servicing MPS (Unit Program), RIO Detachments (IMA and PIRR Program) must notify ARPC/DPT, if they believe a HYTD is incorrect. Notification will occur by e-mail.

8.5. Adjustment of HYTD. (T-2). A member's HYTD is adjusted pursuant to sanctuary provisions (18 but less than 20 years of satisfactory service at HYTD) or when a member vacates or enters into ART status.

8.5.1. Adjustment of HYTD pursuant to sanctuary provisions. Members with 18 but less than 20 years of satisfactory service at their HYTD will have their HYTD adjusted to the first day following the month the member will obtain 20 years of satisfactory service. However, during this time the member cannot have had an unsatisfactory year. Commander input is not required to adjust their HYTD, because the adjustment of HYTD is pursuant to sanctuary provisions.

8.5.1.1. A HYTD adjusted to allow a member to obtain 20 years satisfactory service will not be further adjusted, unless the member was precluded from satisfactory participation during the adjusted period due to circumstances beyond the member's control.

8.5.2. Adjustment of HYTD based on member vacating ART status to enter AGR tour. Member's HYTD is adjusted to first day of the month following member's pay date plus 33 years of CSMP or one day prior to age 60, whichever occurs first.

8.5.2.1. ARPC/DPT must adjust member's HYTD.

8.5.2.2. During processing of an ART's application for an AGR tour, ARPC/DPT must ensure member's adjusted HYTD is not a past date.

8.5.2.3. If the adjusted HYTD is a past date, then ARPC/DPT must process a request for extension of HYTD to AFRC/CC (approval authority) for decision. The request must be approved before the member enters AGR tour.

8.5.3. Adjustment of HYTD based on member vacating ART status but remaining as a TR. Member's HYTD is adjusted to first day of the month following member's pay date plus 33 years of CSMP or one day prior to age 60, whichever occurs first.

8.5.3.1. The servicing MPS must notify ARPC/DPT to adjust member's HYTD. Notification will provide the date member vacated ART status. Notification shall occur by email.

8.5.3.2. If the adjusted HYTD is a past date, the member is not authorized to participate after the date member vacated ART status and the member must separate or retire, if eligible, not later than 120 days from the date member vacated ART status.

8.5.4. Adjustment of HYTD based on member entering ART status. Member's HYTD is adjusted to one of the following three options: first day of the month following member's pay date plus 33 years of CSMP or one day prior to age 60, whichever occurs first, Service Computation Date (SCD) plus 30 years, or DOB plus minimum civil service retirement age, whichever date is later – not to exceed one day prior to age 60.

8.5.4.1. Servicing MPS must notify ARPC/DPT to adjust member's HYTD. Notification will provide the date member entered ART status. Notification shall occur by email.

8.6. Notification to Member and Commander of Approaching HYTD. (T-2). Fourteen months prior to member's HYTD, the servicing MPS (Unit Program), RIO Detachments (IMA and PIRR) or ARPC/DPA (AGR Program) must notify the member and the member's commander of the member's approaching HYTD. The servicing MPS (Unit Program) must also notify the servicing Civilian Personnel Office (CPO) of an ART's approaching HYTD so the CPO can enroll the ART in the DOD Priority Placement Program. All notifications must be in writing.

8.6.1. Upon notification of member's approaching HYTD, the unit commander determines if a rare situation exists that warrants favorable consideration for extension of member's HYTD to maintain unit readiness.

8.6.2. The commander notifies the member and servicing MPS, RIO, or ARPC/DPA of the decision. Both notifications must be in writing no later than 12 months before the member's HYTD.

8.7. Extension of HYTD. (T-2). Members are considered for extension of HYTD on a case-by-case basis only when rare circumstances deem the member's continued service essential to unit readiness. Extensions are granted in one year increments not to exceed a combined total of 3 years or to one day prior to age 60, whichever occurs first.

8.7.1. Requests for extension of a member's HYTD will be initiated no later than 12 months before member's HYTD and must arrive not later than 6 months prior to member's HYTD. Request for TRs, IMAs, PIRRs and ARTs are sent to ARPC/DPT. Request for AGRs are sent to ARPC/DPA.

8.7.2. AFRC/CC is the approval authority for extension of a member's HYTD. Any commander in a member's chain of command can disapprove a request for extension of HYTD. The decision is final and cannot be appealed.

8.7.3. Commanders must fully substantiate why the member's service is essential to unit readiness. The commander must provide unit and overall wing manning by grade (TSgt – CMSgt), by ART and non-ART, number of personnel in or awaiting formal school, and number of personnel in upgrade training to the 5- and 7-skill level.

8.7.4. Requests for extension of HYTD are processed through the member's chain of command, to include the NAF for TRs and ARTs.

8.7.5. ARPC/DPT (for TRs, IMAs, PIRRs and ARTs) and ARPC/DPA (for AGRs) obtains AFRC/CC's decision, updates approved extension to HYTD, and notifies the servicing military personnel agency of AFRC/CC's decision.

8.7.6. The servicing MPS, RIO Detachment, or ARPC/DPT will notify the member and the member's commanders of AFRC/CC's decision.

8.8. Withdrawal of Approved Extension of HYTD. (T-2). An approved extension of TRs, IMAs, PIRRs or AGRs HYTD can be withdrawn if the member has not entered into the HYTD extension.

8.8.1. AFRC/CC is the approval authority for withdrawal of a member's approved extension of HYTD. Any commander in a member's chain of command can disapprove a request for withdrawal of an approved extension of HYTD. The decision is final and cannot be appealed.

8.8.2. Commanders must fully substantiate why the member's approved extension of HYTD must be withdrawn.

8.8.3. Requests for withdrawal of an approved extension of HYTD are processed through the member's chain of command, to include the NAF for TRs and ARTs, to ARPC/DPTTS (for TRs, IMAs, PIRRs and ARTs) or ARPC/DPA (for AGRs).

8.8.4. ARPC/DPT or ARPC/DPA obtains AFRC/CC's decision; updates the previous HYTD in MilPDS if request is approved, and notifies the servicing military personnel agency of AFRC/CC's decision.

8.8.5. The servicing MPS, RIO Detachment, or ARPC/DPT will notify the member and the member's commanders of AFRC/CC's decision.

8.8.6. Enlisted members may not take part in the Selected Reserve past their HYTD. Members will be transferred to the Retired Reserve, if eligible, or separated at their HYTD.

8.8.7. TRs, IMAs, PIRRs, and AGRs eligible for a Reserve Retirement at HYTD will be automatically transferred (transfer without member's application for retirement) to the Retired Reserve. ARPC/DPT mails all retirement orders and certificates to the member's home address.

DANIEL R. SITTERLY
Acting Assistant Secretary of the Air Force
(Manpower and Reserve Affairs)

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Title 5 USC § 552, *Public information; agency rules, opinions, orders, records, and proceedings*

Title 10 USC § 508, *Reenlistments: qualifications*

Title 10 USC § 509, *Voluntary extensions of enlistments: periods and benefits*

Title 10 USC § 1176(a), *Enlisted members: retention after completion of 18 or more, but less than 20, years of service*

Title 10 USC § 1552 (a) (2), *Correction of military records: claims incident thereto*

Title 10 USC § 12301, *Reserve components generally*

Title 10 USC § 8013, *Secretary of the Air Force*

Title 10 USC § 8251, *Definition: In this chapter, the term "enlistment" means original enlistment or reenlistment.*

Title 10 USC § 12302, *Ready Reserve*

Title 10 USC § 12305, *Authority of President to suspend certain laws relating to promotion, retirement and separation*

Title 10 USC § 12308, *Retention after becoming qualified for retired pay*

Title 10 USC § 12731, *Age and service requirements*

Title 37 USC § 331, *General bonus authority for enlisted members.*

Title 37 USC § 355*, Special pay: retention incentives for members qualified in critical military skills or assigned to high priority units*

Title 44 USC § 3101, *Records management by agency heads; general duties.*

System of Records Notice F036 AF PC C, *Military Personnel Records Systems*

System of Records Notice F036 AF PC G, *Selective Reenlistment Consideration*

System of Records Notice F036 AFPC D, *Selective Reenlistment Bonus and/or Advance Payment Request*

System of Records Notice F036 AFPC L, *Unfavorable Information File (UIF)*

AFPD 36-26, *Total Force Development,* 22 December 2015

AFMAN 33-363, *Management of Records,* 1 March 2008

AFI 10-401, *Air Force Operations Planning and Execution*, 7 December 2006

AFI 10-403, *Deployment Planning and Execution*, 20 September 2012

AFI 31-105, *Air Force Corrections System*, 15 June 2015

AFI 31-501, *Personnel Security Program Management*, 27 January 2005

AFI 33-360, *Publications and Forms Management*, 1 December 2015

AFI 36-2002, *Regular Air Force and Special Category Accessions,* 7 April 1999

AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted),* 25 June 2013

AFI 36-2110, *Assignments,* 22 September 2009

AFI 36-2301, *Developmental Education,* 16 July 2010

AFI 36-2624, *The Career Assistance Advisor, First Term Airmen Center and Enlisted Professional Enhancement Programs,* 15 October 2009

AFI 36-2626, *Airman Retraining Program,* 3 June 2013

AFI 36-2905, *Fitness Program,* 21 October 2013

AFI 36-3003, *Military Leave Program*, 11 May 2016

AFI 36-3203, *Service Retirements,* 18 September 2015

AFI 36-3208, *Administrative Separation of Airmen,* 9 July 2004

AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*, 14 April 2005

AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*, 2 February 2006

AFI 36-3802, *Personnel Readiness Operations,* 23 February 2009

AFI 41-210, *Tricare Operations and Patient Administration Functions, 6* June 2012

AFI 48-123, *Medical Examination and Standards*, 5 November 2013

AFI 51-604, *Appointment to and Assumption of Command, 11 February 2016*

ANGI 36-2101, *Assignments within the Air National Guard,* 10 April 2012

DoD Financial Management Regulation (DoDFMR) Volume 7A, *Military Pay Policy – Active Duty and Reserve Pay*, **Chapter 2**, *Repayment of Unearned Portion of Bonuses and Other Benefits,* April 2016

DoDI 1304.21, *Policy on Enlistment Bonuses, Accession Bonuses for New Officers in Critical Skills, Selective Reenlistment Bonuses and Critical Skills Retention Bonuses for Active Members, 31 January 2005*

DoDI 1304.29, Administration of Enlistment Bonuses, Accession Bonuses for New Officers in Critical Skills, Selective Reenlistment Bonuses and Critical Skills Retention Bonuses for Active Members, 15 December 2004

DoDI 1304.31, *Enlisted Bonus Program,* 12 March 2013

DoDD 1332.41, *Boards for Correction of Military Records (BCMRs) and Discharge Review Boards (DRBs)*, 8 March 2004

Executive Order 9397, *Numbering System for Federal Accounts Relating to Individual Persons*

Executive Order 13478, *Amendments to Executive Order 9397 Relating to Federal Agency Use of Social Security Numbers*

Prescribed Forms

AF Form 418, *Selective Reenlistment Program Consideration for Airmen*

AF Form 901, *Reenlistment Eligibility Annex to DD Form 4*

AF Form 1089, *Leave Settlement Option*

AF Form 1411, *Extension of Enlistment in the Air Force*

AF Form 1411-1, *Cancellation of Extensions of Enlistment in the Air Force*

Adopted Forms

AF Form 108, *Physical Fitness Education and Intervention Processing*

AF Form 158, *USAFR Contact and Counseling Record*

AF Form 679, *Air Force Publication Compliance Item Waiver Request/Approval*

AF Form 847, *Recommendation for Change of Publication*

AF Form 1137, *Unfavorable Information File Summary*

AF Form 2030, *USAF Drug and Alcohol Abuse Certificate*

DD Form 4/1 and 4/2, *Enlistment/Reenlistment Document Armed Forces of the United State*s

DD Form 256AF, *Honorable Discharge Certificate*

NGB Form 22*, National Guard Report of Separation and Record of Service*

NGB Form 3621*, ANG Eligibility Checklist for Enlistment, Reenlistment, or Extension of Enlistment*

Abbreviations and Acronyms

AD—Active Duty

ADAPT—Alcohol and Drug Abuse Prevention and Treatment Program

ADSC—Active Duty Service Commitment

ADT—Active Duty for Training

AECP—Airman Education and Commissioning Program

AFBCMR—Air Force Board for Correction of Military Records

AF C&PB—Air Force Clemency and Parole Board

AFPC—Air Force Personnel Center

AFQT—Air Force Qualification Test

AFR—Air Force Reserve

AFROTC—Air Force Reserve Officer Training Corps

AFRAT—Air Force Reading Abilities Test

AFRC—Air Force Reserve Command

AFRIMS RDS—Air Force Records Information Management System Records Disposition Schedule

AFSC—Air Force Specialty Code

AGR—Active Guard Reserve

ALC—Assignment Limitation Code

ANG—Air National Guard

ARC—Air Reserve Component

ARMS—Automated Records Management System

ARPC—Air Reserve Personnel Center

ART—Air Reserve Technician

AWOL—Absent Without Leave

BOP—Base of Preference

BTZ—Below the Zone

CAA—Career Assistance Advisor

CAFSC—Control Air Force Specialty Code

CSD—Class Start Date

CFM—Career Field Manager

CGD—Class Graduation Date

CJR—Career Job Reservation

CONUS—Continental United States

CPO—Civilian Personnel Office

CSMP—Creditable Service for Military Pay

CSRB—Critical Skills Retention Bonus

CSS—Commander's Support Staff

DAFSC—Duty Air Force Specialty Code

DAS—Date Arrived on Station

DEERS—Defense Enrollment Eligibility Reporting System

DEROS—Date Eligible to Return from Overseas

DES—Disability Evaluation System

DFAS—Defense Finance and Accounting Service

DFR—Drop From Rolls

DIEUS—Date Initial Entry Uniformed Services

DJMS-AC—Defense Joint Military Pay System - Active Component (Formerly JUMPS)

DoD—Department of Defense

DoDFMR—Department of Defense Financial Management Regulation

DoDI—Department of Defense Instruction

DOE—Date of Enlistment

DOS—Date of Separation

DOR—Date of Rank

DP—Director of Personnel

DRU—Direct Reporting Unit

DS-Air—Director of Staff, Air

DSD—Developmental Special Duty

DSG—Drill Status Guardsman

DUI—Driving Under the Influence

EAD—Extended Active Duty

ERB—Enlisted Retention Board

EPR—Enlisted Performance Report

ETP—Exception to Policy

ETS—Expiration Term of Service

FM—Financial Management

FOA—Field Operating Agency

FSS—Force Support Squadron

FTA—First Term Airman

FY—Fiscal Year

GCAA—Group Career Assistance Advisor

GSU—Geographically Separated Unit

HSB—Human Resource Management Strategic Board

HYT—High Year of Tenure

HYTD—High Year of Tenure Date

IAW—In Accordance With

IMA—Individual Mobilization Augmentee

ID—Informed Decision

IDES—Individual Disability Evaluation System

IDT—Inactive Duty for Training

ISLRS—Inactive Status List Reserve Section

IR—Individual Reservist

IRR—Individual Ready Reserve

JAG—Judge Advocate General

MAJCOM—Major Command

MCM—Manual for Courts Martial

MEB—Medical Evaluation Board

MGIB—Montgomery GI Bill

MilPDS—Military Personnel Data System

MMPA—Master Military Pay Account

MPMO—Military Personnel Management Officer

MPS—Military Personnel Section

MSO—Military Service Obligation

MTF—Master Test File

NAF—Numbered Air Force

NARS—Non-Affiliated Reserve Section

NGB—National Guard Bureau

NLT—Not Later Than

NCO—Noncommissioned Officer

NCORP—Noncommissioned Officer Retraining Program

NCS—National Call to Service

NJP—Nonjudicial Punishment

OAY—Outstanding Airman of the Year

OJT—On-the-Job-Training

OSI—Office of Special Investigations

OPR—Office of Primary Responsibility

ORS—Obligated Reserve Section

OSD—Office of the Secretary of Defense

OTS—Officer Training School

P&R—Probation and Rehabilitation

PCA—Permanent Change of Assignment

PCM—Primary Care Manager

PCS—Permanent Change of Station

PDS—Personnel Data System

PDUSD (P&R)—Principal Deputy Under Secretary of Defense for Personnel and Readiness

PEB—Physical Evaluation Board

PERSCO—Personnel Support for Contingency Operations

PIRR—Participating Individual Ready Reservist

PME—Professional Military Education

PSDG—Personnel Services Delivery Guide

PSM—Personnel Systems Management

PTSD—Post Traumatic Stress Disorder

QFRB—Quality Force Review Board

RB—Retention Bonus

RDS—Records Disposition Schedule

RE—Reenlistment Eligibility

RegAF—Regular Air Force

RESSRP—Reserve Selection Retention Process

R—Reporting Identifier

RIO—Readiness and Integration Organization

RIP—Report on Individual Personnel

ROM—Retention Office Manager

ROTC—Reserve Officer Training Corps

RRPS—Ready Reinforcement Personnel Section

RSC—Reserve Service Commitment

RRNCO—Recruiting and Retention Non-commissioned Officer

RRS—Recruiting and Retention Superintendent

RTDP—Return to Duty Program

SecAF—Secretary of the Air Force

SCD—Service Computation

SJA—Staff Judge Advocate

SR—Selected Reserve

SRB—Selective Retention Bonus

SRP—Selective Reenlistment Program

SSB—Special Separation Benefit

STEP—Stripes for Exceptional Performers

STEP II—Stripes for Exceptional Performers II

TAFMS—Total Active Federal Military Service

TAFMSD—Total Active Federal Military Service Date

TAG—The Adjutant General

TEB—Transfer of Education Benefits

TDY—Temporary Duty

TIG—Time in Grade

TOE—Term of Enlistment

UCA—Unit Career Advisor

UCMJ—Uniform Code of Military Justice

UIF—Unfavorable Information File

UMD—Unit Manning Document

UOTHC—Under Other than Honorable Conditions

USC—United States Code

UTA—Unit Training Assemblies

VSI—Voluntary Separation Incentive

VSP—Voluntary Separation Pay

Terms

Active Duty (AD)—Full-time duty in the active military service of the United States. This includes Airmen of the Reserve Components serving on active duty or full-time training duty, but does not include full-time National Guard duty.

Active Duty for Training (ADT)—A tour of active duty used for training Airmen of the Reserve Components to provide trained units and qualified persons to fill the needs of the Armed Forces in time of war or national emergency and such other times as the national security requires. The Airman is under orders that provide for return to non-active status upon completion of the period of active duty for training. It includes annual training, special tours of active duty for training, school tours, and the initial duty for training performed by non-prior service enlistees.

Career Airmen—Airmen serving on a third or subsequent term of enlistment, other than ADT, in any component of military service.

Career Job Reservation (CJR)—A reenlistment quota.

Civilian Director—A civilian employee designated to lead a unit, who performs all functions normally performed by a commander and who is the director of that unit/organization.

Commander—A commander, including section commanders, on G-Series orders. IAW AFI 38-101, *Air Force Organization* and AFI 51-604, *Appointment to and Assumption of Command*, civilian directors can perform tasks assigned to commanders unless a law or DoD regulation prohibits them from doing so. See AFI 51-604, Attachment 2 for a list of examples.

Crime of Domestic Violence—Means an offense that has its factual basis, the use or

attempted use of physical force or threatened use of deadly weapon; committed by current or former spouse, parent, or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabiting with or has cohabitated with the victim as a spouse, parent or guardian; or by a person similarly situated to a spouse, parent or guardian of the victims.

Date of Enlistment (DOE)—Actual reenlistment date; date entering extension (this changes on Master Military Pay Account (MMPA) only, it does not change on MilPDS)

Date of Separation (DOS)—The last day Airmen are obligated to serve in the Air Force including the current enlistment, plus approved extensions. DOS is changed upon reenlistment, extension, or cancellation or if an Airman has lost time.

Enlistment—Voluntary entry into the service in an enlisted status.

Expiration Term of Service (ETS)—Date individual's enlistment, reenlistment, or extension of enlistment expires.

Extended Active Duty (EAD)—For purposes of this AFI, a tour of AD, (normally for more than 90 days) performed by an Airman of the Air Reserve components (ARC). Active duty for training and active duty in a service academy or Armed Forces preparatory school are not creditable as EAD.

Extension of Enlistment—A change to an enlistment document that increases total obligated active service.

Field Operating Agency (FOA)—One of the subdivisions of the Air Force directly subordinate to HAF. A FOA has the procedural responsibilities of a major command, but its mission does not fit into the mission of any major command. There are similar organizations at MAJCOM level and they are called MAJCOM FOAs.

First Term Airmen (FTA)—Individuals who are on their: (1) first enlistment (including Airmen who have extended their enlistments), or; (2) first EAD tour, or; (3) first enlistment with prior active service of less than 24 months.

First Term Airmen Retraining—First Term Airman (FTA) Retraining Program. The FTA Retraining Program is designed to retrain FTA in conjunction with a reenlistment, into skills where shortages exist and additionally, allows a limited number of Airmen the opportunity to pursue other career paths in the Air Force.

High Year of Tenure (HYT) Date—The maximum date an Airman may remain in active service, based on grade and years of service, as determined by the Secretary of the Air Force.

Immediate Reenlistment—Voluntary reentry into an enlisted status within 24 hours after separation.

Individual Mobilization Augmentee (IMA)—An individual reservist attending drills who receives training and is preassigned to an Active Component organization, a Selective Service System, or a Federal Emergency Management Agency billet that must be filled on, or shortly after, mobilization, Also called IMA. (JP 4-05)

Individual Reservist (IR)—References both the Individual Mobilization Augmentees (IMAs) and Participating Individual Ready Reserve (PIRR) members.

Installment Payment—A second or subsequent payment of the SRB made on the reenlistment anniversary date.

Lengthy-Service Airman—A reenlistment-ineligible Airman with a DOS that will permit completion of at least 18 years TAFMS, but less than 20 years TAFMS, and the Airman did not refuse to get service-directed retainability

Major Command (MAJCOM)—A major subdivision of the Air Force assigned a major part of the Air Force Mission. Major commands report directly to HAF.

Medical Hold—Method of retaining a service member beyond an established retirement or separation date for reason of disability processing, for conditions when presumption of fitness does not apply. The Medical Standards Branch (AFPC/DPAMM) may place a member on medical hold when he/she is within 60 days of the scheduled non-disability separation or retirement date and undergoing disability process. Refer to AFI 36-3212.

National Call to Service (NCS) Airman—Airman authorized to enlist in RegAF for a period of 15 months beginning date arrived station.

Obligated Service (Additional)—Obligated service is that time in excess of 29 calendar days from the discharge date (day prior to Date of Enlistment - DOE) to the Date of Separation (DOS) - any partial month of 29 calendar days or less will not be considered in the total obligated service as outlined in DoDFMR Volume 7A.

Participating Individual Ready Reserve (PIRR)—consists of Individual Reservists who are not in the SelRES and are in a non-pay training program. Members in this category are attached to an active duty or Reserve unit. PIRR encompasses Admissions Liaison Officers (ALO), Civil Air Patrol (CAP) and Ready Reinforcement Personnel Section (RRPS).

Reenlistment—For the RegAF, voluntary entry into the RegAF in an enlisted status within 24 hours from a RegAF enlistment. For AFR/ANG, voluntary entry into an enlisted status after a previous enlistment.

Reenlistment Eligibility (RE) Status Code— Code 1 in first position means eligible for immediate reenlistment and prior service enlistment

- Code 2 in first position means ineligible for immediate reenlistment and prior service enlistment
- Code 3 in first position means ineligible for immediate reenlistment, but eligible for prior service enlistment, with an approved waiver. Includes Airmen separated from active duty before completing 36 months TAFMS on initial enlistment (4-year or 6-year enlistees), and who have no known disqualifying factors except grade and skill level;
- Code 4 in first position means ineligible for immediate reenlistment, but eligible for prior service enlistment with an approved waiver.

Second Term Airmen—(1) Airmen who are serving on their Second Term of enlistment or EAD tour or a combination thereof (includes Airmen serving on their first enlistment in the USAF having 24 or more months prior active federal military service);

(2) Airmen with one prior service term of enlistment totaling 24 or more months with other military departments;
(3) Former AFR or ANG Airmen who enlist into the RegAF during a period of EAD;
(4) Former AFR or ANG Airmen who enlist into the RegAF, through prior service programs, with EAD totaling 24 or more months.

Selective Retention Bonus (SRB)—The primary Air Force monetary incentive to attain the number of reenlistments necessary to support the Career Airmen force in designated specialties.

Selective Reenlistment Program (SRP)—A program designed to permit the reenlistment of qualified and needed Airmen who have shown they have the capability and dedication to adapt to future mission requirements. The SRP applies to all enlisted personnel; however, SRP is administered separately within each component.

Senior Host Commander—Senior commander or the deputy on the base or installation, having a MPS under their jurisdiction. The wing commander or deputy would normally be the senior host commander.

Stop-Loss—Involuntary extension of a service member's active duty service under the enlistment contract in order to retain them beyond their initial ETS date and up to their contractually agreed-upon EOS date.

Unit—A military organization constituted by HQ USAF or designated by a MAJCOM, FOA or DRU (for provisional units only). A unit is either named or numbered.

Attachment 2

AFR HYTD COMPUTATION

A2.1. TRs, IRs, and AGRs. HYTD is the member's pay date plus 33 years, first date of the following month, not to exceed age 60. If pay date plus 33 years exceeds age 60, the member's HYTD is one day prior to age 60.

A2.2. ARTs. HYTD is the latest of the following, not to exceed age 60. If any of the following computations exceed age 60, the member's HYTD is one day prior to age 60.

- Pay date plus 33 years, first day of the following month
- Service Computation Date (SCD) plus 30 years
- If employed under the Civil Service Retirement System (CSRS), date of birth pl
- If employed under the Federal Employee Retirement System (FERS), date of bi minimum age listed in the following chart.

Year of Birth	Minimum Age
Before 1948	55
1948	55 years, 2 months
1949	55 years, 4 months
1950	55 years, 6 months
1951	55 years, 8 months
1952	55 years, 10 months
1953 – 1964	56 years
1965	56 years, 2 months
1966	56 years, 4 months
1967	56 years, 6 months
1968	56 years, 8 months
1969	56 years, 10 months
1970 and after	57 years

Attachment 3

ANG ROUTING OF WAIVER REQUESTS AND EXCEPTIONS TO POLICY

A3.1. Definition .

A3.1.1. A request for waiver is a request for a one-time deviation to an established policy or procedure as stated in an ANGI/AFI.

A3.1.2. A request for an ETP is a request to execute a personnel action (or actions) that are otherwise prohibited, not addressed, and/or there are no provisions for a waiver specifically allowed in AFI/ANGI.

A3.2. Approving Authority. The approving authority for waivers and exceptions to policy contained within this instruction is the National Guard Bureau, Force Management Branch (NGB/A1PP).

A3.2.1. Each request must be routed through command echelons to the Air Division in the Office of the TAG for a decision, or a written recommendation of approval or disapproval as required. **(T-2).**

A3.2.2. The Director of Staff-Air (DS-Air) or Military Personnel Management Officer (MPMO) will ensure each request has been properly routed and contains a written endorsement prior to forwarding the waiver or ETP to the approval authority.

A3.3. National Guard Bureau Office of Primary Responsibility (OPR):

A3.3.1. OPR for all reenlistment/extension of enlistment policy is NGB/A1PP, 3500 Fetchet Avenue, Joint Base Andrews, MD 20762. Email: **usaf.jbanafw.ngb-a1.mbx.a1pp@mail.mil**.

A3.3.2. OPR for all Retention policy is the National Guard Bureau Retention Operations Branch (NGB/A1YR), 3500 Fetchet Avenue, Joint Base Andrews, MD 20762. Email: **usaf.jbanafw.ngb-a1.mbx.a1yr-ngbslrp@mail.mil**.

A3.4. Documentation required for Submittal of Requests for Waiver/ETP .

A3.4.1. Memorandum formatted IAW Figure A3.1 and routed through applicable command echelon.

A3.4.2. Supporting documents, as required.

Figure A3.1. Mandatory Format for ANG Reenlistment/Extension Waivers or Exceptions to Policy.

(LETTERHEAD)

MEMORANDUM FOR Unit Commander or FSS Commander — Date
Wing/GSU Commander
State/Territory Approving Authority
NGB/A1P (if required)
IN TURN

FROM: Unit Commander or FSS Officer

SUBJECT: Exception to Policy - JOHN H. DOE

1. The following request submitted to permit the (reenlistment or extension) of (name), to fill the vacant position of E-4 SrA, Personnel Accounting Symbol (PAS): XX123456, AFSC 3S0X1.

2. Current Wing/GSU manning in this AFSC is XX authorized / XX assigned.

3. The following information is provided:

a. Prior Service (*if applicable, then list branch, component and periods of service. Include any inactive reserve time*):

Branch	Component	Periods of Service
USAF	ANG	01 Jul 04 - 15 Aug 05

b. Satisfactory Service: # years, # months, and #days
c. Projected enlistment grade: E-4
d. AFQT score and mental category: 58, Mental Category III (as required)
e. Current Military Status: None-Civilian Traditional AGR Technician
f. Current DOE: (Date of last DD4, for requests pertaining to extensions or reenlistments)
g. Current ETS:

4. State exactly what is to be waived, the authority to waive the requirement (cite table/paragraph listed in this instruction), and a complete and detailed justification for the request (see also AFI 33-360, para 1.9.).

5. Point of contact is MSgt John A. Doe, 165 AW/DP, E-Mail address, Voice DSN 111-1111.

6. After an extensive interview and to the best of my knowledge, the individual named herein is otherwise qualified for reenlistment/extension into the Air National Guard.

Signature of Commander or FSS Officer

Attachments: (list each separately)

Notes:
1. Each waiver will be signed by the gaining unit commander or the FSS Commander and endorsed by each echelon of command.
2. Each request will include all supporting documentation and reference the applicable chapter, paragraph, table and note.
3. State Joint Force Headquarters (JFHQ) Military Personnel Management Office (MPMO) will submit TAG-endorsed requests to NGB.

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 44-178

4 MARCH 2014
Certified Current 28 June 2016
Medical

HUMAN IMMUNODEFICIENCY VIRUS PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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(Brig Gen Charles E. Potter)

Pages: 44

Supersedes: AFI48-135, 7 August 2006

This instruction implements AFPD 44-1, *Medical Operations,* and Department of Defense (DoD) Instruction 6485.01, *Human Immunodeficiency Virus*, June 7, 2013. It outlines the Air Force Human Immunodeficiency Virus (HIV) Program including responsibilities and procedures for identification, surveillance, and administration of Active Duty Air Force personnel. The Air National Guard (ANG) and Headquarters Air Force Reserve Command (HQ AFRC) utilize this instruction along with supplements to provide specific guidelines for the administration of Air Reserve Component (ARC) personnel infected with HIV. Headquarters Air Reserve Personnel Center (HQ ARPC) utilizes AFI 44-175 as guidance for Individual Mobilization Augmentees (IMAs), with local MTFs as the notifying agent. This instruction requires collecting and maintaining information protected by the Privacy Act of 1974. This is authorized by 10 U.S.C., Chapter 55, *Medical and Dental Care*, 10 U.S.C., Sec. 8013, *Power and Duties of the Secretary of the Air Force,* and Executive Order 9397 (SSN) as amended by Executive Order 13478, Amendments to Executive Order 9397 Relating to Federal Agency Use of Social Security Numbers, November 18, 2008. Systems Record Notices F044 AF SG E, *Electronic Medical Records System*, and R, *Reporting of Medical Conditions of Public Health and Military Significance*, apply. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to AFMSA/SG3PM. See **Attachment 1** for a glossary of

references, abbreviations, acronyms, and terms. This publication may be supplemented at any level, but all direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include condensed sections describing the requirements for a positive HIV test and algorithms for determining HIV infection which reference current guidelines by the American Public Health Laboratories (APHL) and Centers for Disease Control (CDC). The location of the USAF HIV Medical Evaluation Unit was updated to San Antonio Military Medical Center (SAMMC) and the location of HIV laboratory testing was updated to the USAF School of Aerospace Medicine (USAFSAM) HIV Testing Services, Wright-Patterson Air Force Base. The clinical evaluation visit structure was modified, with HIV evaluations performed at SAMMC for initial visits, followed by a second visit in 6 months, then yearly thereafter while the patient remains on active duty (AD) status. Interim clinical visits will be performed as necessary in the local area based on recommendations from the USAF HIV Medical Evaluation Unit. The sections detailing the components of HIV clinical evaluations have been condensed with all elements of HIV clinical evaluations to be performed according to current clinical guidelines.

Chapter 1

ROLES AND RESPONSIBILITIES

1.1. HQ USAF/SG. Provides facilities, manpower, and funds to collect HIV testing specimens of Air Force (AF) personnel, to medically evaluate all HIV positive AD members including IMAs, and to ensure spouses and contacts of HIV infected AD members are notified, counseled, and tested appropriately.

1.2. HQ AFRC/SG. Ensures reserve personnel are HIV tested and spouses and contacts of HIV infected reserve personnel are notified appropriately.

1.3. HQ ANG/SG. Ensures ANG personnel are HIV tested and spouses and contacts of HIV infected ANG personnel are notified appropriately.

1.4. HQ AFMC/SG. Provides facilities, funds, and manpower to the USAFSAM HIV Testing Services to perform HIV testing and epidemiological analysis of all HIV tests performed on ADAF personnel and their dependents. Provides support to the DoD Serum Repository.

1.5. HQ AETC/SG. Provides facilities, funds, and manpower to medically evaluate all HIV positive ADAF members.

1.6. USAF HIV MEDICAL EVALUATION UNIT. Located in the Joint Infectious Disease Service at SAMMC, medically evaluates all ADAF HIV positive members initially, at 6 months, and then every 12 months thereafter while on active duty. (T-1)

Chapter 2

HIV PROGRAM

2.1. General. The AF tests all members for human immunodeficiency virus, medically evaluates all AD infected members, and educates members on means of prevention.

2.2. Populations Tested.

2.2.1. Accessions. All applicants for enlistment or appointment to the ADAF or ARC are screened for evidence of HIV infection (**Attachment 3**). Applicants infected with HIV are ineligible for enlistment or appointment to the ADAF and the ARC. Waiver for HIV infection is not authorized.

2.2.2. ADAF personnel. All ADAF personnel are screened for serological evidence of HIV infection every two years, preferably as part of their Preventive Health Assessment (PHA). They are also tested for clinically indicated reasons, when newly diagnosed with active tuberculosis, during pregnancy, when diagnosed with a sexually transmitted infection (STI), upon entry to drug or alcohol treatment programs, or prior to incarceration. HIV testing is conducted IAW **Attachment 3**. (T-1)

2.2.3. ARC personnel. Air Force Reserve personnel are screened for serological evidence of HIV infection every two years, preferably during their PHA (Preventive Health Assessment). ARC members will have a current HIV test within two years of the date on which they are called to active duty for 30 days or more.HIV testing is conducted IAW **Attachment 3**. (T-1)

2.2.4. DoD Civilians. DoD Civilian employees are tested for serological evidence of HIV to comply with host nation requirements for screening of DoD employees (**Attachment 6**) and after occupationally related exposures. (T-1)

2.3. Initial Procedures for Positive Tests. All ADAF personnel testing positive are counseled by a physician regarding the significance of a positive test. They are given information on modes of transmission, appropriate precautions to mitigate transmission, and prognosis. ADAF members are administered an order to follow preventive medicine requirements as described in **Attachment 7**. ARC members will also be administered this order. The preventive medicine requirements/order will not be delayed pending any administrative action. All eligible beneficiaries are offered counseling. Contacts of HIV-infected members are notified of potential exposure to HIV infection according to state or local law. (T-0)

2.4. Clinical Evaluation, to Include Evaluation for Continued Military Service. All ADAF members, as well as ARC members on extended active duty, who test positive for HIV are referred to SAMMC for medical evaluation. Per AFI 48-123 and AFI 41-210, HIV-positive personnel must undergo medical evaluation for the purpose of determining status for continued military service. ARC members who are not on extended active duty or who are not on full-time National Guard duty, and who show serologic evidence of HIV infection, will be referred for a medical evaluation of fitness for continued service in the same manner as service members with other chronic or progressive illnesses in accordance with DoDI 1332.38. In the case of an ANG member, it is only required if the state identifies a nonmobility, nondeployable position in which the member can be retained. All ADAF members will have an initial evaluation at SAMMC, followed by a visit at 6 months, then yearly thereafter while remaining on AD status. ARC and

ANG members whose condition is determined to meet Line of Duty requirements may have initial and/or annual HIV evaluations performed at regional military facilities. ARC and ANG members not meeting Line of Duty requirements will have an initial evaluation by a civilian HIV specialist. The medical evaluation follows the standard clinical protocol outlined in **Attachment 8** and utilizes procedures for evaluating T-helper cell counts described in **Attachment 12**. ARC members not on extended active duty must obtain a medical evaluation that meets the requirements of **Attachment 8** from their civilian healthcare provider (in the case of the ANG, only if the state identifies a nonmobility, nondeployable position in which the member can be retained). An epidemiological assessment (including sexual contacts and history of blood transfusions or donations) is conducted to determine potential risk of HIV transmission (see **Attachment 11**). (T-1)

2.4.1. Outcome of Evaluation for Continued Military Service. HIV seropositivity alone is not grounds for medical separation or retirement for ADAF members. Members shall be retained or separated as outlined in **Attachment 9**. (T-1)

2.4.2. Periodic Re-evaluation. HIV infected ADAF members retained on active duty and ARC members retained in the Selected Reserve must be medically evaluated annually at SAMMC. Such personnel must be assigned within the continental United States (CONUS). Alaska, Hawaii, and Puerto Rico are also acceptable. ARC HIV infected members may not be deployed outside of CONUS (except for Alaska, Hawaii, and Puerto Rico). HIV-infected members shall not be assigned to OCONUS mobility positions, and those on flying status must be placed on Duty Not Including Flying (DNIF) status pending medical evaluation/waiver determination. Waivers are considered using normal procedures established for chronic diseases. Aeromedical waivers are considered according to the Aerospace Medicine Waiver Guide. Members on the Personnel Reliability Program (PRP) or other security sensitive positions shall evaluated for suspension or temporary decertification during medical evaluation, as determined by their Certifying Official/Unit Commander on the advice of a Competent Medical Authority. The Secretary of the Air Force may, on a case-by-case basis, further limit duties and assignment of members to protect the health and safety of the HIV-infected member or other members. Submit such requests to Office of the Secretary of the Air Force, Air Force Pentagon,Washington, DC 20330-1670. (T-1)

2.5. Limitations of Use of Information. Commanders and other personnel comply with limitations on the use of information obtained during the epidemiological assessment of HIV-infected members as outlined in **Attachment 10**. (T-1)

2.6. Public Health. Provides HIV education to all ADAF members, offers education to other eligible beneficiaries, maintains a list of HIV positive personnel to be gained, reports to gaining bases departing HIV positive personnel, and educates HIV positive members and their dependents. (T-1)

2.7. USAFSAM. USAFSAM performs HIV testing (PHE) of submitted specimens and conducts epidemiological surveillance (PHR) of HIV infection in Air Force members and dependents. (T-1)

2.8. AF Blood Centers. AF Blood Centers follow policies of the Armed Services Blood Program Office, Food and Drug Administration (FDA), and the accreditation requirements of the American Association of Blood Banks (AABB). (T-0)

2.9. Combat Zone Procedures. Routine HIV testing is suspended in declared combat zones, defined as those areas where hostile pay is authorized.

2.10. Work Restrictions. Force-wide, HIV-infected employees are allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace. If performance or safety problems arise, managers and supervisors address such problems using existing personnel policies and instructions. HIV-infected healthcare workers, however, should be relieved from patient care responsibilities until an expert review panel has met to advise the healthcare worker on work restrictions. Recommendations to the panel will be made by HIV treatment experts during the individual's initial HIV evaluation at SAMMC in accordance with the most recent guidelines from the Centers for Disease Control and Society for Health Care Epidemiology of America. The panel should be encouraged to contact SAMMC for advice (via telephone conference call) to ensure organizational consistency. (T-1)

Chapter 3

HIV TESTING MEASUREMENT

3.1. HIV Testing Measurement. The AF's goal is to reduce the incidence of HIV infection in its personnel. USAFSAM tracks trends of HIV incidence in AF members. AF labs that do their own HIV testing must communicate test results and ship corresponding serum specimens to USAFSAM so they may ship samples to the DoD serum repository, and track trends. (T-1)

Chapter 4

FORMS

4.1. Forms. AF Form 1762, *HIV Log/Specimen Transmittal*, will be used for requesting HIV testing and specimen transmittal for those sites that do not have CHCS access (see **Attachment 4**). AF Form 3844, *HIV Testing Notification Form*, will be used to notify personnel of required HIV testing. AF Form 3845, *Preventive Medicine Counseling Record*, will be used to record counseling provided for HIV positive individuals. AF Form 74, *Communication Status Notice/Request*, is sent to MTF/CCs and Reserve Medical Unit (RMU)/CCs along with a copy of the patient's positive HIV testing screen and confirmation testing results. The MTF/CC and RMU/CC will document on AF Form 74 that the patient has been notified of the positive HIV results, then return the form to USAFSAM. Positive HIV results will not be finalized until USAFSAM/PHE receives the AF Form 74. (T-1)

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References.

Title 29, United States Code, Section 794, *Non-Discrimination Under Federal Grants and Programs,* current edition

DoD Directive 1332.18, *Separation or Retirement for Physical Disability*, 4 November 1996

DoD Instruction 1332.38, *Physical Disability Evaluation*, *CH 2*, 10 April 2013

DoD Instruction 6485.01, *Human Immunodeficiency Virus,* 7 June 2012

DoD Regulation 5210.42, *Nuclear Weapons Personnel Reliability Program,* 16 July 2012.

AFPD 48-1, *Aerospace Medicinel Enterprise,* 23 August 2011.

AFI 36-3212*, Physical Evaluation for Retention, Retirement, and Separation, IC 2,* 27 November 2009 AFI 48-123, *Medical Examination and Standards*, *GM1*, 31 January 2011

AFI-41-210, *Tricare Operations and Patient Administration Functions,* 6 June 2012

AFI 44-108, *Infection Control Program,* 1 March 2012

CDC. HIV Prevention through Early Detection and Treatment of Other Sexually Transmitted Diseases--United States Recommendation of the Advisory Committee for HIV and STD Prevention. *MMWR.* 1998;47(RR12):1-24.

CDC. Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures. *MMWR*. 1991;40(RR08).

CDC. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR.* 2006;55(RR14):1-17.

CDC. Sexually Transmitted Diseases Treatment Guidelines, 2010. *MMWR.* 2010;59(RR12):1-116.

Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, 2013. Infect Control Hosp Epidemiol. 2013;34(9):875-92.

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1 infected adults and adolescents. Department of Health and Human Services. January 10, 2011;1-66. Available at **http://www.aidsinfo.nih.gov/ContentFiles**/AdultandAdolescentGL.pdf. Accessed May 27, 2011.

SHEA. Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus,and/or Human Immunodeficiency Virus Infection Control and Hospital Epidemiology 2010;. 31, no. 3.

APHL. HIV Testing Algorithms A Status Report: aPublication from the Association of Public Health Laboratories and the Centers for Disease Control & Prevention. April 2009 with update January 2011.

Adopted Forms.

AF Form 1762, HIV Log/Specimen Transmittal

AF Form 3844, HIV Testing Notification Form

AF Form 3845, Preventive Medicine Counseling Record

AF Form 74, Communication Status Notice/Request

Abbreviations and Acronyms.

AABB—American Association of Blood Banks

ADAF—Active Duty Air Force

AETC—Air Education and Training Command

AFMC—Air Force Materiel Command

AFMOA—Air Force Medical Operations Agency

AFMOA/SGOC—Air Force Medical Operations Agency, Surgeon General's Office of Consultants

AFPC—Air Force Personnel Center

AFPC/DPANM—Air Force Personnel Center/Medical Retention Standards Branch

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AIDS—Acquired Immunodeficiency Syndrome

ANGB—Air National Guard Bureau

APHL—American Public Health Laboratories

ARC—Air Reserve Component (Air Force Reserve and Air National Guard)

ASD—Assistant Secretary of Defense

CDC—Centers for Disease Control and Prevention

CHCS—Composite Healthcare System

CHN—Community Health Nurse

CONUS—Continental United States

COT—Consecutive Overseas Tour

CPO—Civilian Personnel Office

DAF—Department of the Air Force

DBMS—Director, Base Medical Services

DoD—Department of Defense

DoDSR—Department of Defense Serum Repository

DNIF—Duty Not Including Flying

DSN—Defense Switched Network

FDA—Food and Drug Administration

FM—Flight Medicine

FM & P—Force Management and Personnel

FMP—Family Member Prefix

HBV—Hepatitis B virus

HIV—Human Immunodeficiency Virus (the virus that causes AIDS)

HQ AETC—Headquarters Air Education and Training Command

HQ AFRC/SG—Headquarters Air Force Reserve Command Surgeon

HQ ANG/SG—Headquarters Air National Guard Command Surgeon

HQ USAF—Headquarters US Air Force

ICD-9—International Classification of Diseases, Revision 9

IMA—Individual Mobilization Augmentee

I-RILO—Initial Review in Lieu of Medical Board

MAJCOM—Major Command

MEB—Medical Evaluation Board

MTF/CC—Medical Treatment Facility Commander

MPF—Military Personnel Flight

MTF—Medical Treatment Facility

NGB—National Guard Bureau

OB—Obstetrics

OI—Opportunistic Infection

OS—Overseas

OSHA—Occupational Safety and Health Association

OTS—Officer Training School

PCS—Permanent Change of Station

PE—Physical Examination

PES—Physical Examination Section

PH—Public Health

PQAM—Program Quality Assurance Monitor

PRP—Personnel Reliability Program

ROTC—Reserve Officer Training Corps

SAF—Secretary of the Air Force

SAMMC—San Antonio Military Medical Center

SF—Standard Form

SG—Surgeon General

SHEA—Society for Healthcare Epidemiology of America

SSN—Social Security Number

STI—Sexually Transmitted Infection

TDY—Temporary Duty

USA—United States Army

USCG—United States Coast Guard

USMC—United States Marine Corps

USN—United States Navy

UCMJ—Uniform Code of Military Justice

USAFSAM—United States Air Force School of Aerospace Medicine

USUHS—Uniformed Services University of the Health Sciences

Terms.

Air Reserve Component—Air Force Reserve and Air National Guard components of the Air Force

Department of Defense Civilian Employees—Current and prospective DoD US civilian employees. Does not include members of the family of DoD civilian employees, employees of, or applicants for, positions with contractors performing work for DoD, or their families.

Enzyme Linked Immunosorbent Assay—A screening test read as 'reactive' if the results are above a calculated cutoff.

Epidemiological Assessment—The process by which personal and confidential information on the possible modes of transmission of HIV are obtained from an HIV-infected person. This information is used to determine if previous, present, or future contacts of the infected individual are at risk for infection with HIV and to prevent further transmission of HIV.

Host Nation—A foreign nation to which DoD US civilian employees are assigned to perform their official duties.

Human Immunodeficiency Virus—The virus that causes AIDS.

Positive—A true positive test is an indicator of a condition being present

Reactive—Reacts with the reagent antibody test to produce a visible result

Serologic Evidence of HIV Infection—A reactive result given by a FDA approved serologic test for HIV detection, such as an enzyme-linked immunosorbent assay (ELISA) or

Chemiluminescent Immunoassay (ChLIA) that is confirmed in by additional testing in a validated testing algorithm, for example by a diagnostic HIV Western Blot immunoelectrophoresis. For Western Blot tests with indeterminate results, an alternative FDA approved test can be used to resolve indeterminates such as a viral load-based assay (APTIMA).

Western Blot Test—A qualitative assay for the detection and identification of antibodies of HIV-1 contained in human serum. It is intended for use with persons of unknown risk as an additional more specific test on human serum specimens found to be repeatedly reactive using a screening procedure such as ELISA.

Attachment 2

PROCEDURES FOR SCREENING APPLICANTS

A2.1. Screen applicants to the USAF or ARC for serologic evidence of HIV infection. Test and interpret results, using the procedures in **Attachment 3**. Counsel applicants on the significance of test results and the need to seek treatment from a civilian physician. (T-1)

A2.2. Screen applicants for enlisted service at the Military Entrance Processing Stations (MEPS) or the initial point of entry to military service. Applicants who enlist under a delayed enlistment program who exhibit serologic evidence of HIV infection before entry on active duty may be discharged due to erroneous enlistment. (T-1)

A2.3. Screen applicants accepted for the Air Force Academy as part of the processing for entry into the Academy and again as part of their medical screening prior to appointment as officers. Screen other officer candidates during their preappointment or precontracting physical examination. (T-1)

A2.4. Screen applicants for ARC during the normal entry physical examinations or in the preappointment programs established for officers. Those individuals with serologic evidence of HIV infection, who must meet accession medical fitness standards to enlist or be appointed, are not eligible for service with the ARC. (T-1)

A2.5. Take the following actions on officer applicants who are ineligible for appointment due to serologic evidence of HIV infection:

A2.5.1. Disenroll enlisted members who are candidates for appointment through Officer Training School (OTS) programs immediately from the program. If OTS is the individual's initial entry training, discharge the individual. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable or entry-level discharge, as appropriate. A candidate who has completed initial entry training during the current period of service before entry into candidate status shall be administered in accordance with Service directives for enlisted personnel. (T-1)

A2.5.2. Disenroll individuals in preappointment programs, such as Reserve Officer Training Corps (ROTC) and Health Professions Scholarship Program (HPSP) participants. The head of the Military Service concerned, or the designated representative, may delay disenrollment until the end of the academic term in which serologic evidence of HIV infection is confirmed. Disenrolled participants retain any financial support through the end of the academic term in which the disenrollment takes place. Financial assistance received in these programs is not subject to recoupment, if the sole basis for dis-enrollment is serologic evidence of HIV infection. (T-1)

A2.5.3. Separate Air Force Academy cadets and personnel attending the Uniformed Services University of the Health Sciences (USUHS) from the Academy or USUHS and discharge them. The superintendent of the Academy may delay separation to the end of the current academic year. A cadet granted such a delay in the final academic year, who is otherwise qualified, may graduate without commission and then is discharged. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable discharge. (T-1)

A2.5.4. Disenroll commissioned officers in DoD-sponsored professional education programs leading to appointment in a professional military specialty (including medical, dental, chaplain, and legal or judge advocate) from the program at the end of the academic term in which serologic evidence of HIV infection is confirmed. Except when laws specifically prohibit it, waive any additional service obligation incurred by participation in such programs; do not recoup any financial assistance received in these programs. Apply the time spent by the officers in these programs towards satisfaction of any preexisting service obligation. (T-1)

A2.5.5. Counsel people disenrolled from officer programs who are to be separated; include preventive medicine counseling and advise the individual to seek treatment from a civilian physician. (T-1)

Attachment 3

AIR FORCE HIV TESTING PROCEDURES

A3.1. Responsibilities:

A3.1.1. Medical Treatment Facility Commander (MTF/CC). Is responsible for the HIV testing program. Appoints an HIV designated physician (and one or more alternates, if alternates are desired); ensures HIV positive individuals are notified and counseled as soon as possible following receipt of the positive test result; and ensures AD members are referred to SAMMC within 60 days of receipt of the HIV positive results notification from the USAFSAM HIV Testing Services to the base. Reserve medical unit commanders will immediately notify wing/unit commanders of any positive HIV test results. (T-1)

A3.1.2. Clinical Laboratory Manager**.** Draws, processes, and ships specimens for HIV testing. All specimens for HIV testing should be sent to USAFSAM HIV Testing Services, Epidemiology Laboratory Service, USAFSAM/PHE, 2510 Fifth Street, Bldg 20840, Wright-Patterson, OH 45433-7951 (DSN 798-4140). If, because of time considerations, local contract HIV testing is done for needlestick exposure, the laboratory manager must also ship a corresponding serum specimen, with HIV test request, to USAFSAM HIV Testing Services. If testing is done by an approved USAF laboratory, the laboratory manager must also ship corresponding serum specimen and results to USAFSAM HIV Testing Services. Upon completion of testing, USAFSAM HIV Testing Service will ship AD, Guard and Reserve samples to the Department of Defense Serum Repository (DoDSR). (T-1)

A3.1.3. Primary Care Management Team**.** Ensures HIV testing is accomplished in conjunction with appropriate Preventive Health Assessment or physical examinations (as described in paragraph **A3.2**). (T-1)

A3.1.4. Public Health (PH). Coordinates with MTF/CC's designee to ensure proper notification of the individual member. Is responsible for monitoring HIV positive ADAF members. Receives and reports to gaining public health personnel when HIV positive personnel are transferred. Informs the requesting laboratory of positive results so they can close out the test status in the computer system. The SAMMC HIV community liaison nurse performs additional case contact interviews, epidemiological follow-ups, and disease reporting procedures during SAMMC HIV evaluation visits. (T-1)

A3.1.5. HIV Testing Point of Contact. MTF shipping and receiving technician is responsible for shipping specimens; identifying supply deficiencies; maintaining results; and acting as the liaison with USAFSAM HIV Testing Services. (T-1)

A3.1.6. Civilian Personnel Office (CPO). Notifies by letter the clinical laboratory manager of any Department of the Air Force civilian employee requiring HIV testing. (T-1)

A3.1.7. Major Commands (MAJCOM). Deputy Command Surgeon (MAJCOM/SGP) or designee acts as liaison between USAFSAM HIV Testing Services and MTFs within the command.

A3.1.8. **USAFSAM**. Monitors and ensures that all active duty, guard and reserve positive HIV tests, as well as positive tests on dependants in the San Antonio area are reported to the HIV Program at SAMMC. Ensures that DoD mandated epidemiological studies are

accomplished on a periodic basis. The USAF HIV Medical Evaluation Unit Director or designee ensures that referred personnel on active orders are scheduled for evaluation within 30 days after being contacted by the referring base. (T-1)

A3.1.9. Reserve Medical Unit**.** Contacts the epidemiology lab to confirm positive test results before release of information, conducting counseling, or determining need for spousal or contact notification. (T-1)

A3.2. Preventive Health Assessment (PHA): Primary Care Manager ensures HIV testing is accomplished per the clinical testing requirements in the PHA for AD members or ARC members. (T-1)

A3.3. Sexually Transmitted Infection (STI) Clinic Testing:

A3.3.1. Providers counsel all STI patients regarding the need for HIV testing. Immediate HIV testing and follow-up testing IAW the most recent CDC recommendations. Informed consent laws are followed for dependents and civilians. (T-1)

A3.3.2. Providers refer all STI patients to PH for case contact interviews as soon as identified. (T-1)

A3.3.3. Test specimens IAW **A3.1.2** (T-1)

A3.3.4. MTF/CC or designee ensures all HIV positive individuals are properly notified and counseled, and all ADAF members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. RMU/CC or designee ensures all HIV positive Reservists are properly notified and counseled, and all Reservists eligible for evaluation at the HIV Medical Evaluation Unit at SAMMC for medical evaluation are referred to the Unit for evaluation. (T-1)

A3.4. Drug and/or Alcohol Treatment Testing:

A3.4.1. The Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program Manager or designee notifies all AD members entering treatment programs of required HIV testing and provides the member with AF Form 3844. Local and state laws dictate availability of testing for family members and use of informed consent. Their testing is not mandatory. Individuals who are not DoD military health care beneficiaries (for example, civilian employees) are not HIV tested. (T-1)

A3.4.2. The treatment entrant reports to the MTF laboratory with AF Form 3844.

A3.4.3. Laboratory personnel obtain an HIV specimen and complete Part 2 of AF Form 3844.

A3.4.4. Accomplish the HIV testing IAW **A3.1.2** (T-1)

A3.4.5. The clinical laboratory manager forwards the completed AF Form 3844 to the ADAPT Program Manager or designee who ensures all AD members entering treatment have been HIV tested.

A3.4.6. MTF/CC or designee ensures all HIV positive individuals are properly notified and counseled, and all AD members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. (T-1)

A3.5. Clinical Testing:

A3.5.1. All health care providers order HIV testing for those patients with clinical indications of HIV related diseases (e.g. active tuberculosis, incident HBV and HCV cases) and for patients with potential exposure to the virus. A confirmed positive result on a urinalysis drug test is a clinical indication for HIV testing. Providers inform patients of HIV testing for clinical indications. Local state informed consent laws are followed for family members and other beneficiaries (for example, retirees). Informed consent is not required for AD members. (T-0)

A3.5.2. Providers ordering HIV testing ensure test results are reviewed, HIV positive patients are counseled, and HIV positive AD members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. Normally, the HIV designated physician in conjunction with public health personnel, provide counseling and referral services. (T-1)

A3.5.3. Providers will not routinely order HIV testing on all patients. (T-1)

A3.5.4. Clinical testing is accomplished IAW **A3.1.2** (T-1)

A3.6. Occupational Exposure Testing.

A3.6.1. Employees report to PH for occupational exposure testing and follow up IAW OSHA Blood-borne Pathogen Final Rule as implemented in the facility Infection Control Program/Employee Health Program. (T-0)

A3.6.2. Follow the latest CDC guidelines for blood and body fluid exposures to bloodborne pathogens as stated in the facility Infection Control Program/ Employee Health Program/Bloodborne Pathogen Program. Refer to AFI 44-108, *Infection Control Program*. (T-0)

A3.6.3. Personnel who perform exposure-prone procedures (to include, but not limited to, surgeons, pathologists, dentists, dental technicians, phlebotomists, emergency medical technicians, and physicians, nurses and technicians working in the emergency room, intensive care, surgery, and labor/ delivery) should know their HIV antibody status.

A3.6.4. Follow local state laws on HIV testing and informed consent for non-active duty individuals, including employees and patients. Informed consent is not required for active duty personnel. (T-0)

A3.6.5. Personnel testing is accomplished IAW **A3.1.2** (T-1)

A3.7. Prenatal Testing:

A3.7.1. Screen all AD obstetrics (OB) patients for evidence of HIV infection regardless of previous testing. (T-1)

A3.7.2. Encourage nonactive duty OB patients to be tested. Follow local state laws on informed consent for nonactive duty patients.

A3.7.3. Submit additional specimens as clinical specimens, not as OB specimens.

A3.7.4. Accomplish testing IAW **A4.1.2** (T-1)

A3.8. Results Reporting:

A3.8.1. Active Duty. The USAFSAM HIV Testing Services reports negative test results usually electronically to the submitting MTF within three workdays. First time positive notification letters are sent via FedEx Priority Overnight or by encrypted e-mail to the MTF/CC and base PH. Enclosed in each notification letter is an AF Form 74. The MTF/CC and PH officer write on their respective cards the date results were received, complete blocks (phone number, date and sign/organization/installation), document notification of the patient, and return to USAFSAM HIV Testing Services either by mail or by encrypted e-mail. Once the signed AF Form 74 is returned to the USAFSAM HIV Testing Service, the result will be certified in CHCS. Known positive patient's results are made available within 7 working days. (T-1)

A3.8.2. Air National Guard and Air Force Reserve. USAFSAM HIV Testing Services results for Air National Guard and Air Force Reserve units are reported the same as for Active Duty except that units not attached to an MTF with CHCS lab interoperability must log into the Wright-Patterson CHCS platform remotely to retrieve their results. (T-1)

A3.8.3. Clinical and Civilian Employee Samples. The USAFSAM HIV Testing Services report negative test results to the submitting MTF Laboratory Services within 3 working days. If positive, a notification letter is sent via FedEx Priority Overnight within seven workdays to PH. The letter has an AF Form 74 enclosed. The PH officer will write on AF Form 74 the date results were received, complete blocks (phone number, date and sign/organization/installation), document notification of the patient, and return to USAFSAM HIV Testing Services. (T-1)

A3.8.4. Results of HIV Testing Performed at DoD Labs Other Than Air Force**.** Occasionally, HIV testing will be done at Army or Navy laboratories on active duty Air Force personnel. When USAFSAM HIV Testing Services obtain first time positive results from other services, notification on AF members, USAFSAM HIV Testing Service will contact the submitting MTF's PH to ensure that notification has been performed. If notification has not been accomplished, USAFSAM HIV Testing Service will initiate notification as outlined in **A3.9.1**. (T-1)

A3.9. Blood Bank Testing. If a military member is identified as HIV positive through blood donation or other blood bank or outside laboratory testing, a specimen must be sent to USAFSAM HIV Testing Services for confirmation. (T-1)

A3.9.1. All military members with a positive HIV screening test should be referred to public health for appropriate counseling and follow-up instructions regarding further testing. (T-0)

A3.10. Problem Resolution:

A3.10.1. Inform USAFSAM HIV Testing Services of difficulties obtaining supplies or test results.

A3.10.2. The USAFSAM HIV Testing Services handles all test inquiries.

NOTE: Assess HIV risk at every preventive health assessment (PHA) and screen for serologic evidence of HIV infection during their PHA as required (minimum testing every 2 years). ARC personnel are screened during their periodic long flying physical every three years or nonflying physical every five years or as per the PHA clinical testing requirements. DoD mandated testing continues to include sexually transmitted disease (STI) clinic patients, drug and alcohol treatment entrants, prior to PCS OS assignments, prenatal patients, and host country requirements before deployment. (T-1)

Attachment 4

COMPLETION OF FORMS FOR REQUESTING HIV TESTING AND SPECIMEN TRANSMITTAL

A4.1. Composite Healthcare System.

A4.1.1. Submitting labs with Composite Healthcare System (CHCS) have the capability to create and send a list of specimens which can be sent to the receiving lab.

A4.1.1.1. Create a shipping/transmittal list in Composite Healthcare System (CHCS).

A4.1.1.2. Include a copy of the shipping/transmittal list in each specimen package sent to the receiving lab.

A4.1.1.3. Send the shipping/transmittal list electronically (if applicable) to the receiving lab through CHCS.

A4.2. AF FORM 1762 Completion (to be used ONLY by sites without CHCS access):

A4.2.1. AF Form 1762 is used to request HIV Screen Testing when CHCS is not available. The following information is mandatory: the facility/organization and address at the top of each form submitted. If not, specimens will be processed as NBI (no base identification) which will delay results until submitting activity can be ascertained. (T-1)

A4.2.2. For each request**,** the Full Name (last name, first name, middle initial) not nick-names, Full SSN (not last 4) with an FMP, Date of Birth (dates are to be entered as DD-MMM-YY, e.g., October 19, 1948 = 19 Oct 48), Duty Code (see **A5.3**) and Source Code (see **A5.4**). [Force Testing no longer exists. All periodic testing is done in conjunction with **"**P" (physicals) unless meeting one of the other source codes. See **A5.4** Source Codes.] (T-1)

A4.2.3. Testing will not proceed until all information is provided. Additionally, the individual being tested will not receive a test date in the master AFPC records if the name, FMP/SSN, or date of birth, do not match. (T-1)

A4.2.4. Fill out forms LEGIBLY. If entered by hand, the individual responsible for verifying the identity of personnel being screened, not the person being drawn, will print the information. Typewritten or computer generated forms are preferred. If you have computer support, call USAFSAM HIV Testing Services for available software programs to help produce a computer generated AF Form 1762. The AF Form 1762 is available through e-Publishing (**http://www.e-publishing.af.mil/shared/media/epubs/af1762.xfd**).

A4.2.5. At the bottom of the form, fill in date shipped, name of shipping person, or someone USAFSAM HIV Testing Services can contact if there are problems, and a DSN phone number or commercial number only if DSN is unavailable.

A4.2.6. MTF's that use the Composite Healthcare System (CHCS), refer to ADHOC A98 1011, Automated HIV Shipping Form, which can be downloaded from the Brooks web site: **http://www.tmssc.brooks.af.mil**.

A4.2.7. Guard and Reserve bases not utilizing CHCS can use developed software from US AFI HIV Testing Service (phone number DSN 240-8934). Guard and Reserve sites that access the Wright-Patterson CHCS remotely will use the CHCS ad hoc "ASL" (USAFSAM (Epi) Lab Referral Shipping List) function to generate their shipping list(s). This ad hoc

function is given to all Guard and Reserve users who request CHCS access through the Epidemiology Laboratory Information Systems Department.

A4.2.8. Common Errors in filing out AF Form 1762:

A4.2.8.1. Not putting Base ID/Submitting Activity at the top of each form

A4.2.8.2. Name - incomplete or not legible. Has name recently changed or is there a suffix (e.g. "Jr." or "III") after the name?

A4.2.8.3. SSN - more or less than 9 digits; not legible. Failure to include FMP with SSN.

A4.2.8.4. No Duty Code, no Source Code, or entry of unauthorized code.

A4.2.8.5. No Date or Shipping official to contact in case of problems.

A4.2.8.6. No DSN phone or commercial number if DSN unavailable.

A4.2.8.7. Failure to retain copy of AF Form 1762. A4.2.9. Forward the first two copies of the AF Form 1762 to USAFSAM HIV Testing Services along with the specimens. Keep the third copy in the laboratory for MTF record keeping purposes to track timely return of results. If test results have not been received within three days, contact USAFSAM HIV Testing Services for assistance.

A4.2.8.8. The MTF/CC reviews the reports and provides copies of positive results to the physician designated to advise and counsel HIV antibody positive individuals. (T-1)

A4.2.8.9. DoD laboratories authorized to perform HIV antibody clinical screening in-house use AF Form 1762 as a log for all HIV antibody ELISA screenings performed. All five items of information are to be completed. By the fifth working day of the month, forward all results from the previous month electronically or by floppy disc to USAFSAM HIV Testing Services. Forward specimens tested negative to USAFSAM HIV Testing Services marked “DoDSR” for placement in the DoDSR. Forward a specimen from each individual who screens positive for HIV in local testing to USAFSAM HIV Testing Services for confirmatory testing. (T-1)

A4.3. AF Form 4 is used only to request Western Blot Confirmation Testing. Do not use this form for HIV screening requests; use an AF Form 1762 as required in section **A5.1.1** For bases who perform local clinical testing and MTF Blood Banks that screen donors, all specimens that screen positive must be sent to the HIV Testing Services for FDA confirmation algorithm testing. Complete the form as follows: Fill out the top of the form with **all** required information. Blocks 13 and 14 must be completed with Duty Code and Source Code or testing will delayed until information is obtained.

A4.4. Duty Codes: To obtain the most accurate information possible, submitting laboratories must use the patient category code (pat cat code) from CHCS for duty codes on the AF Form 1762 to identify the status of the individual being tested. This is an Alpha, two numeric code which is a mandatory field when registering members into CHCS. Therefore, this information should be available to download to an ADHOC report when computer generating the CHCS AF Form 1762. These codes closely emulate the DEERS codes for status of individual member being tested. For submitting activities not on CHCS, use the Pat Cat that closely defines the status of the individual. The following are the most commonly used:

PAT CATs DEFINITION.

A11 Army, Active Duty A12 Army, Reserve A13 Army, Recruits A14 Army, Academy Cadet A15 Army, National Guard

PAT CATs DEFINITION.

A21 Army, ROTC A23 Army National Guard A26 Army, Applicants-Enlistment's A31 Army, Retired A41 Army, Dependent of Active Duty A43 Army, Dependent of Retiree A45 Army, Dependent of Deceased Active Duty A47 Army, Dependent of Deceased Retiree A48 Army, Unmarried former Spouse

F11 Air Force, Active Duty F12 Air Force, Reserve F13 Air Force, Recruits F14 Air Force, Academy Cadet F15 Air Force, National Guard F21 Air Force, ROTC F23 Air Force National Guard F26 Air Force, Applicants-Enlistment's F31 Air Force, Retired F41 Air Force, Dependent of Active Duty F43 Air Force, Dependent of Retiree F45 Air Force, Dependent of Deceased Active Duty F47 Air Force, Dependent of Deceased Retiree F48 Air Force, Unmarried former Spouse M11 Marine Corps, Active Duty M12 Marine Corps, Reserve M13 Marine Corps, Recruits M14 Marine Corps, Academy-midshipmen M21 Marine Corps, ROTC M26 Marine Corps, Applicants-Enlistment's M31 Marine Corps, Retired M41 Marine Corps, Dependent of Active Duty M43 Marine Corps, Dependent of Retiree M45 Marine Corps, Dependent of Deceased Active Duty M47 Marine Corps, Dependent of Deceased Retiree M48 Marine Corps, Unmarried former Spouse

N11 Navy, Active Duty N12 Navy, Reserve N13 Navy, Recruits N14 Navy, Academy-Midshipmen N21 Navy, ROTC N26 Navy, Applicants-Enlistment's N31 Navy, Retired N41 Navy, Dependent of Active Duty N43 Navy, Dependent of Retiree N45 Navy, Dependent of Deceased Active Duty N47 Navy, Dependent of Deceased Retiree N48 Navy, Unmarried former Spouse

C11 Coast Guard, Active Duty C12 Coast Guard, Reserve

PAT CATs DEFINITION

C31 Coast Guard, Retired C41 Coast Guard, Dependent of Active Duty C43 Coast Guard, Dependent of Retiree

P11 Public Health Svs, Active Duty P12 Public Health Svs, Reserve P31 Public Health Svs, Retired P41 Public Health Svs, Dependent of Active Duty P43 Public Health Svs, Dependent of Retiree

K53 Civil Service Employee/Other Federal Agencies K57 Civilian Employee, Occupational

Health K59 Federal Government Employees, Overseas K61 VA Sharing Agreement/VA beneficiary K64 Other Federal Agency (DAF employee) K66 Federal Prisoners

Table A4.1. PAT CATs Definition.

A11	Army, Active Duty
A12	Army, Reserve
A13	Army, Recruits
A14	Army, Academy Cadet
A15	Army, National Guard
A21	Army, ROTC
A23	Army National Guard
A26	Army, Applicants-Enlistment's
A31	Army, Retired
A41	Army, Dependent of Active Duty
A43	Army, Dependent of Retiree
A45	Army, Dependent of Deceased Active Duty
A47	Army, Dependent of Deceased Retiree
A48	Army, Unmarried former Spouse

F11	Air Force, Active Duty
F12	Air Force, Reserve
F13	Air Force, Recruits
F14	Air Force, Academy Cadet
F15	Air Force, National Guard
F21	Air Force, ROTC
F23	Air Force National Guard
F26	Air Force, Applicants-Enlistment's
F31	Air Force, Retired
F41	Air Force, Dependent of Active Duty
F43	Air Force, Dependent of Retiree
F45	Air Force, Dependent of Deceased Active Duty
F47	Air Force, Dependent of Deceased Retiree
F48	Air Force, Unmarried former Spouse

M11	Marine Corps, Active Duty
M12	Marine Corps, Reserve
M13	Marine Corps, Recruits
M14	Marine Corps, Academy -midshipmen
M15	Marine Corps, National Guard
M21	Marine Corps, ROTC
M23	Marine Corps National Guard
M26	Marine Corps, Applicants-Enlistment's
M31	Marine Corps, Retired
M41	Marine Corps, Dependent of Active Duty
M43	Marine Corps, Dependent of Retiree
M45	Marine Corps, Dependent of Deceased Active Duty
M47	Marine Corps, Dependent of Deceased Retiree
M48	Marine Corps, Unmarried former Spouse

N11	Navy, Active Duty
N12	Navy, Reserve
N13	Navy, Recruits
N14	Navy, Academy Cadet
N15	Navy, National Guard
N21	Navy, ROTC
N23	Navy National Guard
N26	Navy, Applicants-Enlistment's
N31	Navy, Retired
N41	Navy, Dependent of Active Duty
N43	Navy, Dependent of Retiree
N45	Navy, Dependent of Deceased Active Duty
N47	Navy, Dependent of Deceased Retiree
N48	Navy, Unmarried former Spouse

C11	Coast Guard, Active Duty
C12	Coast Guard, Reserve
C31	Coast Guard, Retired
C41	Coast Guard, Dependent of Active Duty
C43	Coast Guard, Dependent of Retiree

K53	Civil Service Employee/Other Federal Agencies
K57	Civilian Employee, Occupational Health
K59	Federal Government Employees, Overseas
K61	VA Sharing Agreement/VA beneficiary
K64	Other Federal Agency (DAF employee)
K66	Federal Prisoners

P11	Public Health Svs, Active Duty
P12	Public Health Svs, Reserve
P31	Public Health Svs, Retired

P41	Public Health Svs, Dependent of Active Duty
P43	Public Health Svs, Dependent of Retiree

A4.5. Source Code. The only authorized codes used in the appropriate block on the AF Form 1762 are listed below. These codes identify the reason that the individual is being screened. They were adopted for use throughout DoD by the Reportable Disease Data Base (RDDB) Working Group. A single code is entered on the AF Form 1762. Multiple codes for an individual are not authorized:

Table A4.2. Source Codes.

A	Alcohol and Drug Treatment
B	Blood Donor (Authorized for use on specimens or confirmation specimens)
C	Contact Testing (Referral)
F	Force Screening (routine screening of personnel)
I	Indicated for Clinical Reasons
J	Prisoners or Detained Persons
M	Medical Admissions (Including Psychiatric)
N	Pre-deployment
O	OB Clinic/Pregnancy Related
P	Physical Examinations
R	Requested by Individual
S	Surgical Admission (Including Invasive Procedures and ER)
T	Post-deployment
V	STI Clinic Visit
X	Any Other Source (used only in extremely rare cases)

A4.6. Shipment of Specimen Requirements.

A4.6.1. Ship specimens using instructions provided by USAFSAM HIV Testing Services. It is very important that the MTFs follow these instructions. Deviation could cause rejection of a shipment and necessitate redrawing each individual.

A4.6.2. USAFSAM HIV Testing Services will only accept 12x75 mm polypropylene tubes. If the whole shipment arrives in anything other than these type tubes, the shipment will be returned to the submitting MTF at their expense to process in the correct tubes. Single specimens will have to be redrawn. Tubes and caps can be ordered from most laboratory supply catalogues (see below) or can be obtained by completing a supply order form and submitting to our Customer Service Team via email at **usafsam.phe.cst@wpafb.af.mil.** This order form can be found on our website at **https://kx.afms.mil/epi.calling** the Epidemiology Laboratory Services at DSN 240-8751 or 8378. If the submitting MTF's stock runs out, it will have to hold specimens until a supply of the correct tubes are received.

Test Tubes, 12x75 mm, polypropylene, round bottom

FSN 6640-01-264-2362

Curtin-Matheseon Scientific (CMS) #289-657

S/P-Baxter T-1226-12

Plug Cap for 12x75 test tubes

FSN 6640-01-2222963

CMS #148-346

S/P-Baxter T1226-32

Tubes and caps in one order

S/P-Baxter T1226-42

Double sided Plastic Bags

Fisher Cat #01-824 Lab Safety Supply Cat #TL-23805

VWR Cat #11216-783

A4.6.3. Label tubes with a CHCS generated label. If CHCS is unavailable, write FULL NAME **(**Last name, first name, middle initial), and the FULL SSN with FMP, and collection date on label, then place label long-wise without covering the bottom of tube. (Pre/Post deployment specimens need draw date). Secure with a plastic plug cap. DO NOT USE PARAFILM.

A4.6.4. Place patient samples in a foam tube rack in the order listed on the shipping/transmittal list or AF Form 1762. Wrap foam tube rack containing specimens in absorbent material and place in a large plastic shipping bag. Place patient samples (amount for 1 AF Form 1762/no more than 22) with absorbent material in large portion of plastic shipping bag. Place one copy of the shipping/transmittal list or one copy and original of AF Form 1762. Place original and one copy of AF Form 1762 inside the outer pouch of the shipping bag corresponding to samples and tear off plastic strip covering the adhesive and to SEAL THE BAG. If foam tube racks are not available, place no more than 10 specimens in a small plastic shipping bag containing absorbent material. Place one copy of the shipping/transmittal list or one copy and original of AF Form 1762 in the outer pouch of the shipping bag and SEAL THE BAG. Repeat for each batch of 10 specimens. In shipping

HIVs specimens with other EPI specimens, place HIV specimens in a separate ziplock plastic shipping bag marked: “HIV”

A4.6.5. The following common errors could be avoided if a quality control program exists.

A4.6.6. Common errors in Specimen Preparation:

A4.6.6.1. Not spinning specimen down causing hemolyzed specimens

A4.6.6.2. Putting specimens in the wrong tubes; only polypropylene 12x75 mm will be accepted.

A4.6.6.3. Over-filling tubes, causing tube cap to come off when the specimen is frozen.

A4.6.6.4. Not putting tube caps on tightly.

A4.6.6.5. Tape or parafilm around the cap of the tube.

A4.6.6.6. Omitting the individual's full name/full SSN on tube

A4.6.6.7. Only last four of SSN on the transport tube.

A4.6.6.8. Name on tube does not match name on shipping/paperwork transmittal list or AF Form 1762.

A4.6.6.9. No shipping/transmittal list or AF Form 1762 accompanying the specimen tube.

A4.6.7. Common Errors in Specimen Packaging:

A4.6.7.1. Not wrapping tubes with absorbent paper material.

A4.6.7.2. Not maintaining a cold environment (use ice, cold packs, or dry ice as appropriate).

A4.6.7.3. Not separating shipping/transmittal lists or AF Forms 1762 from specimens, causing forms to get wet if leakage occurs.

A4.6.7.4. Not sealing the shipping bag completely causing specimens to be lost in transit.

A4.6.7.5. Not packing specimens in foam shipping rack or separating them into batches of ten.

Attachment 5

HIV TESTING AND INTERPRETATION OF RESULTS

A5.1. Laboratories:

A5.1.1. Use only approved MTF laboratories or the USAFSAM HIV Testing Services to perform the initial screening test on specimens collected from Service members. (T-1)

A5.1.2. All approved Air Force MTF laboratories that perform in-house HIV testing must send a serum sample for testing to USAFSAM HIV Testing Services IAW **A3.1.2** This sample will be forwarded to the DoD serum repository after testing by the USAF HIV Testing Service. (T-1)

A5.1.3. The USAFSAM HIV Testing Services, USAFSAM, Wright-Patterson Air Force Base, maintains specimens for seven days after testing then discarded. Specimens from Reserve and Guard units are sent to the DoD serum repository. (T-1)

A5.2. Specimen Collection and Handling:

A5.2.1. Collect blood samples with appropriate vacutainer tubes.

A5.2.2. Label tubes with a CHCS generated label. As a minimum, each sample is labeled with three unique patient identifiers such as; the individual's full name, FMP/SSN, date of birth or a laboratory assigned number. Also include the date and time of collection.

A5.2.3. Samples are centrifuged and serum separated within six hours of collection.

A5.2.4. Specimens should be refrigerated before the initial test. If the initial test is cannot be conducted within seven days, or the date at which the sample was collected is unknown, the specimen must be frozen (≤ -20°C).

A5.2.5. Use cold packs to keep specimens at refrigerated temperatures (2 – 8°C) or shipped on dry ice if the samples are frozen (≤ -20°C) during transit between laboratories.

A5.2.6. Ship specimens according to US (or foreign) biological agent shipping requirements.

A5.3. Initial Test:

A5.3.1. Conduct the initial test using a FDA-approved screening test. Interpret results according to the manufacturer's package insert.

A5.3.2. The laboratory establishes an internal quality control program.

A5.3.3. All controls will be 100 percent correct before the entire batch results are considered acceptable.

A5.4. Supplemental/Confirmatory Tests:

A5.4.1. All HIV testing will follow an APHL/CDC-approved algorithm. (T-0)

A5.4.2. Perform a FDA-approved confirmatory test, such as a Western Blot (WB) test. For Western Blot tests with indeterminate results, an alternative FDA approved test can be used to resolve indeterminates such as a viral load-based assay (APTIMA) or other FDA approved testing platform. (T-0)

A5.4.3. The laboratory validates its procedure using a protocol that establishes accuracy, precision, and reproducibility.

Attachment 6

HIV TESTING OF DOD CIVILIAN EMPLOYEES

A6.1. Direct requests for authority to screen DoD civilian employees for HIV to the Assistant Secretary of Defense (ASD)/Force Management and Personnel (FM&P). Only requests that are based on a host nation HIV screening requirement are accepted. Requests based on other concerns, such as sensitive foreign policy or medical health care issues, are not considered under this instruction. Approvals are provided in writing by the ASD/FM&P and apply to all the DoD Components that may have activities located in the host nation. (T-0)

A6.2. Specific HIV screening requirements may apply to DoD civilian employees currently assigned to positions in the host nation and to prospective employees. When applied to prospective employees, HIV screening is considered a requirement imposed by another nation, that must be met before the final decision to select the individual for a position, or before approving temporary duty or detail to the host nation. Individuals who refuse to cooperate with HIV screening requirements or those who cooperate and are diagnosed as HIV seropositive, may not be considered further for employment in host nations with HIV screening requirements. (T-0)

A6.3. DoD civilian employees who refuse to cooperate with the screening requirements are treated, as follows:

A6.3.1. Those who volunteered for the assignment, whether permanent or temporary, are retained in their official position without further action and without prejudice to employee benefits, career progression opportunities, or other personnel actions to which those employees are entitled under applicable law or instruction.

A6.3.2. Those who are obligated to accept assignment to the host nation under the terms of an employment agreement, regularly scheduled tour of duty, or similar and/or prior obligation may be subjected to an appropriate adverse personnel action under the specific terms of the employment agreement or other authorities that may apply.

A6.3.3. Host nation screening requirements, which apply to DoD civilian employees currently located in that country, must be observed. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges to comply with the requirements. (T-0)

A6.4. Individuals who are not employed in the host nation, who accept the screening, and who are evaluated as HIV seropositive shall be denied the assignment on the basis that evidence of seronegativity is required by the host nation. If denied the assignment, such DoD employees shall be retained in their current positions without prejudice. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges, on DoD civilian employees currently located in the host nation. In all cases, employees shall be given proper counseling and shall retain all the rights and benefits to which they are entitled, including accommodations for the handicapped as in the applicable ASD/FM&P Memorandum, and for employees in the United States (29 U.S.C. 794). Non-DoD employees are referred to appropriate support service organizations. (T-0)

A6.5. Some host nations may not bar entry to HIV seropositive DoD civilian employees, but may require reporting of such individuals to host nation authorities. In such cases, DoD civilian employees who are evaluated as HIV seropositive shall be informed of the reporting

requirements. They shall be counseled and given the option of declining the assignment and retaining their official positions without prejudice or notification to the host nation. If assignment is accepted, the requesting authority shall release the HIV seropositive result, as required. Employees currently located in the host nation may also decline to have seropositive results released. In such cases, they may request and shall be granted early return at government expense or other appropriate personnel action without prejudice to employee rights and privileges. (T-0)

A6.6. A positive HIV screening test must be confirmed by an FDA approved confirmatory test according to an APHL/CDC approved algorithm. A civilian employee may not be identified as HIV antibody positive, unless the confirmatory test is positive. The clinical standards in this instruction shall be observed during initial and confirmatory testing. (T-0)

A6.7. Provide tests at no cost to the DoD civilian employees, including applicants. (T-0)

A6.8. Counsel DoD civilian employees infected with HIV. (T-0)

Attachment 7

GUIDELINES FOR ADMINISTERING THE ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS TO INDIVIDUALS INFECTED WITH HIV

A7.1. After the member is notified by a health care provider that he or she has tested positive for HIV infection, and the significance of such a test, the MTF/CC expeditiously notifies the member's unit commander of the positive test results. For active duty members, the member's unit commander issues an order to follow preventive medicine requirements. For unit assigned reservists, this order is issued only after their immediate commander determines the member will be retained in the Selected Reserve. When the order is given, a credentialed provider is present to answer any medical concerns of the member. Use the order at **Attachment 13**. It is signed and dated by the commander and member. If the member refuses to sign, the commander notes that the member refused to sign in the acknowledgment section. The order is securely stored to protect the member's privacy and confidentiality. A copy of the order is provided to the member. Upon the individual's reassignment, the unit commander forwards the order in a sealed envelope to the gaining commander. The envelope is marked "To Be Opened By Addressee Only." Upon the individual's separation from the Air Force, the order is destroyed. (T-1)

A7.2. AD members testing positive for HIV infection undergo a complete medical evaluation at SAMMC. Upon arrival, all HIV positive members are counseled by a health care provider or by the HIV Community Health Nurse (CHN) assigned to the HIV Medical Evaluation Unit at SAMMC. Use AF Form 3845, **Preventive Medicine Counseling Record,** or similar form. The CHN signs the form. The member signs the counseling record acknowledging receipt of the counseling. One copy of the record is given the member and one copy filed in the records of the HIV CHN. (T-1)

A7.3. If the member is returned to duty from the HIV Medical Evaluation Unit to a different unit from which he or she came, the gaining unit commander issues an additional order to follow preventive medicine requirements to the member. A copy of this order is given to the member. Use the order at **Attachment 13**. The commander may request the MTF/CC or other health care provider is present when the order is administered to answer any medical concerns of the member. The commander and member sign and date the order. If the member refuses to sign, the commander notes the member refused to sign in the acknowledgment section. Securely store the order to protect the member's privacy and confidentiality. (T-1)

A7.4. It is unnecessary to recall members issued orders under former procedures. HIV seropositive members, who have not been previously issued preventive medicine requirement orders, must be counseled by a health care provider assigned to the local medical facility on AF Form 3845 and issued an order (**Attachment 13**) by his or her unit commander. (T-1)

NOTE: DoD requested the Military Departments standardize the administration of the order to follow preventive medicine requirements to individuals infected with HIV. The guidelines above standardize and simplify procedures.

Attachment 8

STANDARD CLINICAL PROTOCOL

A8.1. Medical Evaluation:

A8.1.1. Accomplish a complete medical evaluation of AF personnel with HIV infection with an initial visit, a second visit at 6 months, and subsequent visits every 12 months at SAMMC as long as the member is retained on active duty. HIV disease will be staged according to current CDC guidelines for every clinical visit. Interim medical visits will be performed as necessary in the member's local area in accordance with current DHHS Guidelines for Management of Adult HIV Infections. For unit assigned reservists not on extended active duty, this evaluation is not accomplished until after the commander's decision to retain the member. If the member is retained, the evaluation must be accomplished and documented IAW AFI 48-123, AFI 41-210, and AFRC medical guidance on nonduty related medical conditions. (T-1)

A8.1.2. Maintain a frozen serum specimen on all HIV positive individuals at a central serum bank for at least three years at -70 degrees Celsius. (T-1)

A8.1.3. Seek psychiatric consultation if there are concerns about fitness for duty or if the screening evaluation suggests more detailed psychiatric evaluation is needed. If the patient has persistent evidence of diminished intellectual skills, personality changes, and motor impairment, more specialized studies (neurologic studies, computed tomography or magnetic resonance imaging, lumbar puncture, psychiatric examination, and neuropsychiatric testing) may be required to evaluate the possible presence of a HIV-related mental or neurological syndrome. (T-1)

A8.1.4. Perform additional testing in both initial and follow-up epidemiologic/clinical assessments as indicated to maintain compliance with changes in accepted standards of care for management of HIV infection. (T-1)

A8.2. Medical Record Coding of HIV-1 Infections. Follow current ICD CM coding guidelines for medical record coding of HIV infection.

A8.3. Disposition of Members Infected:

A8.3.1. DoD Directive 1332.18, Separation From the Military Service by Reason of Physical Disability, November 4, 1996, and AFI 41-210, Medical Evaluations Boards (MEB) and Continued Military Service, provides guidelines for fitness for duty determinations. However, MEB pre-screening will occur with an Initial Review in Lieu of an MEB (I-RILO) under the guidelines of AFI 41-210, chapter 4, section 4k. This guidance provides I-RILO screening procedures for both ADAF members Air Reserve Component members. (T-0)

A8.3.2. Refer AD members infected with HIV for I-RILO in accordance with AFI 41-210, immediately following the initial evaluation. However, while I-RILOs usually require a letter from the member's Commander indicating the impact of a member's condition upon his/her duty performance, such a letter is not required in the case of HIV seropositive members because of the risk of Privacy Act violations while routing such letters through the Commander's support staff. I-RILOs will only be submitted from the HIV Medical

Evaluation Unit at SAMMC and individual home bases are not to submit I-RILOs or annual ALC-C RILOs for HIV infection. (T-1)

Attachment 9

RETENTION AND SEPARATION

A9.1. Retention:

A9.1.1. Members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection. (T-0)

A9.1.2. HIV-infected members who have been evaluated for continued military service and are retained will receive an Assignment Limitation Code (ALC-C). Please refer to AFI 41-210 for ALC-C stratifications and for a list of waiver authorities for OCONUS TDY and/or assignment. (T-1)

A9.2. Separation:

A9.2.1. AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation,* provides guidance for separation or retirement of AD members who are determined to be unfit for further duty.

A9.2.2. AD and Reserve members with laboratory evidence of HIV infection found not to have complied with lawfully ordered preventive medicine procedures are subject to administrative and disciplinary action, which may include separation.

A9.2.3. Separation of AD members with laboratory evidence of HIV infection under the plenary authority of the Secretary of the Air Force, if requested by the member, is permitted.

A9.2.4. The immediate commander of ARC members not on extended active duty who show serologic evidence of HIV infection will determine if the member can be utilized in the Selected Reserve. If the member cannot be utilized, he/she may be transferred involuntarily to the Standby Reserve or separated. If separated, the characterization of service shall never be less than that warranted by the member's service record. (T-1)

A9.2.5. Air Force members determined to have been infected with HIV at the time of enlistment or appointment are subject to discharge for erroneous enlistment or appointment. (T-1)

Attachment 10

LIMITATIONS ON THE USE OF INFORMATION FROM EPIDEMIOLOGICAL ASSESSMENTS

A10.1. Limitations of Results:

A10.1.1. Laboratory tests results performed under this instruction may not be used as the sole basis for separation of a member. The results may be used to support a separation based on physical disability or as specifically authorized by any section in this instruction. This instruction shall not preclude use of laboratory test results in any other manner consistent with law or instruction. (T-1)

A10.1.2. Laboratory test results confirming evidence of HIV infection may not be used as an independent basis for any adverse administrative action or any disciplinary action, including punitive actions under the Uniform Code of Military Justice (UCMJ) (10 U.S.C. 47, reference [j]). (T-1) However, such results may be used for other purposes including, but not limited to, the following:

A10.1.2.1. Separation under the accession testing program.

A10.1.2.2. Voluntary separation for the convenience of the Government.

A10.1.2.3. Other administrative separation action authorized by Air Force policy.

A10.1.2.4. In conducting authorized Armed Services Blood Program Look Back activities.

A10.1.2.5. Other purposes (such as rebuttal or impeachment) consistent with law or instruction (e.g., the Federal or Military Rules of Evidence or the Rules of Evidence of a State), including to establish the HIV seropositivity of a member when the member disregards the preventive medicine counseling or the preventive medicine order or both in an administrative or disciplinary action based on such disregard or disobedience.

A10.1.3. HIV infection is an element in any permissible administrative or disciplinary action, including any criminal prosecution (e.g., as an element of proof of an offense charged under the UCMJ or under the code of a State or the United States).

A10.1.4. HIV infection is a proper ancillary matter in an administrative or disciplinary action, including any criminal prosecution (e.g., as a matter in aggravation in a court-martial in which the HIV positive member is convicted of an act of rape committed after being informed that he or she is HIV positive).

A10.2. Limitations on the Use of Information Obtained in the Epidemiological Assessment Interview:

A10.2.1. Information obtained from a member during, or as a result of, an epidemiological assessment interview may not be used against the member in the following situations:

A10.2.1.1. A court-martial.

A10.2.1.2. Line of duty determination.

A10.2.1.3. Nonjudicial punishment.

A10.2.1.4. Involuntary separation (other than for medical reasons).

A10.2.1.5. Administrative or punitive reduction-in-grade.

A10.2.1.6. Denial of promotion.

A10.2.1.7. An unfavorable entry in a personnel record.

A10.2.1.8. A denial to reenlistment.

A10.2.1.9. Any other action considered by the Secretary of the Air Force concerned to be an adverse personnel action.

A10.2.2. The limitations in paragraph **A10.2.1** do not apply to the introduction of evidence for appropriate impeachment or rebuttal purposes in any proceeding, such as one in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the member or to disciplinary or other action based on independently derived evidence.

A10.2.3. The limitations in paragraph **A10.2.1** do not apply to nonadverse personnel actions on a case-by-case basis, such as: A10.2.3.1. Reassignment. A10.2.3.2. Disqualification (temporary or permanent) from a personnel reliability program. A10.2.3.3. Denial, suspension, or revocation of a security clearance. A10.2.3.4. Suspension or termination of access to classified information.

A10.2.4. Removal (temporary or permanent) from flight status or other duties requiring a high degree of stability or alertness, including explosive ordnance disposal or deep-sea diving.

A10.3. Entries in Personnel Records: Except as authorized by this instruction, if any such personnel actions are taken because of, or are supported by, serologic evidence of HIV infection or information described in paragraph **A10.1.2**, no unfavorable entry may be placed in a personnel record for such actions. Recording a personnel action is not an unfavorable entry in a personnel record. Additionally, information reflecting an individual's serologic or other evidence of infection with HIV is not grounds for an unfavorable entry in a personnel record.

Attachment 11

PERSONNEL NOTIFICATION, MEDICAL EVALUATION, AND EPIDEMIOLOGICAL INVESTIGATION

A11.1. Personnel Notification:

A11.1.1. Once a health care authority has been notified of an individual with serologic or other laboratory/clinical evidence of HIV infection, public health and or the HIV designated physician shall undertake preventive medicine intervention. The CHN and physician staff at the SAMMC HIV Medical Evaluation Unit will assist military and civilian blood bank organizations and preventive medicine authorities with blood donor look back tracing and referral and refer case-contact information to the appropriate military or civilian health authority. (T-0)

A11.1.2. All individuals with serologic evidence of HIV infection who are military healthcare beneficiaries shall be counseled by a physician or a designated healthcare provider on the significance of a positive antibody test. They shall be advised as to the mode of transmission, the appropriate precautions and personal hygiene measures required to minimize transmission through sexual activities and/ or intimate contact with blood or blood products, and of the need to advise any past or future sexual partners of their infection. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies. The individuals shall be informed that they are ineligible to donate blood, sperm, organs or tissues and shall be placed on a permanent donor deferral list. (T-0)

A11.1.3. Service members identified to be at risk shall be counseled and tested for serologic evidence of HIV infection. Other DoD beneficiaries, such as retirees and family members, identified to be at risk, shall be informed of their risk and offered serologic testing, clinical evaluation, and counseling. The names of individuals identified to be at risk who are not eligible for military healthcare shall be referred to civilian health authorities in the local area where the index case is identified, unless prohibited by the appropriate State or host-nation civilian authority. Anonymity of the HIV index case shall be maintained, unless reporting is required by civil authorities. (T-0)

A11.1.4. Blood donors who demonstrate repeatedly reactive screening tests for HIV, but for whom confirmatory test(s) are negative or indeterminate are not eligible for blood donor pool, shall be appropriately counseled. (T-0)

A11.2. Medical Evaluation:

A11.2.1. Active duty personnel and ARC members on extended active duty who have tested positive for HIV shall be sent to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. All DoD directed evaluations will be completed as an outpatient, coordinated by the HIV Evaluation Unit staff. All Active Duty HIV patients undertaking their initial evaluation will undergo mental health status screening by a SAMMC mental health provider. (T-1)

A11.2.2. Physically or mentally unstable HIV patients should have their conditions addressed and stabilized sufficiently for outpatient management prior to transport. Upon arrival, those patients exhibiting an active process requiring physician attention during non-duty hours will be admitted to the appropriate inpatient service. (T-1)

A11.2.3. SAMMC HIV Medical Evaluation Unit staff will conduct a confidential patient epidemiologic interview, repeat the contact notification process, and verify blood donation "lookback" process. The HIV Evaluation Unit CHN or designee will provide the disease education and risk reduction counseling during the patient interview, and complete two copies of the standardized medical counseling form ("Prevention Medicine Counseling Record"). One copy is given to the patient, and the other copy maintained in the HIV CHN's confidential patient files. If the patient refuses to sign, SAMMC Directorate of Medical Law will be notified. The "Order to Follow Preventive Medicine Requirements" is issued by the unit commander of an HIV infected person prior to the patient's initial evaluation by the HIV unit. (T-1)

A11.2.4. All HIV infected active duty and TDRL personnel arriving at SAMMC will receive medical evaluation and staging of their HIV disease by an assigned HIV unit staff physician. The physician will also provide disease specific patient education and appropriate treatment recommendations, and serve as liaison with consulting or inpatient services when necessary. The HIV unit physician will be available to the patient's primary care provider for ongoing patient management and any issues concerning scheduled reevaluations. (T-1)

A11.3. Epidemiological Investigation:

A11.3.1. Epidemiological investigation shall attempt to determine potential contacts of patients who have serologic or other laboratory or clinical evidence of HIV infection. The patient shall be informed of the importance of case-contact notification to interrupt disease transmission and shall be informed that contacts shall be advised of their potential exposure to HIV. Individuals at risk of infection include sexual contacts (male or female); children born to infected mothers; recipients of blood, blood products, organs, tissues, or sperm; and users of contaminated intravenous drug paraphernalia. At risk individuals who are eligible for healthcare in the military medical system shall be notified. The Secretaries of the Military Departments shall designate all spouses (regardless of the Service affiliation of the HIV infected Reservist) who are notified under this provision to receive serologic testing and counseling on a voluntary basis from MTFs under the Secretaries' of the Military Departments jurisdiction. (T-0)

A11.3.2. Communicable disease reporting procedures shall be followed consistent with this Directive through liaison between the public health authorities and the appropriate local, State, Territorial, Federal, or host-nation health jurisdiction. (T-0)

Attachment 12

PROCEDURE FOR EVALUATING T-HELPER CELL COUNT

A12.1. Analytical Procedure:

A12.1.1. Determine the percentage of CD4+ and CD3+ positive lymphocytes by immunophenotyping blood cells using flow-cytometry instrumentation per applicable CDC guidelines. Each laboratory performing T-helper cell counts maintains a current and complete standard operating procedure manual. The absolute T-helper cell count is a product of the percentage of T-helper cells (defined as CD4+ and CD3+ positive lymphocytes) and the absolute lymphocyte level.

A12.2. Internal Quality Control Program:

A12.2.1. Each laboratory maintains a comprehensive internal quality control program. Minimally, on each day of operation monitor the following flow-cytometry procedures or reagents:

A12.2.1.1. Optical focusing and alignment of all lenses and light paths for forward-angle light scatter, right-angle light scatter, red fluorescence, and green fluorescence if these functions are adjustable on the instrument.

A12.2.1.2. Standardize fluorescent intensity beads, particles, or cells with fluorescence in the range of biological samples.

A12.2.1.3. Verify fluorescent compensation beads, particles, or cells with fluorescence in the range of biological samples.

A12.2.1.4. A human blood control sample or equivalent.

A12.2.2. Each laboratory establishes tolerance limits for each of the procedures or reagents in paragraph **A12.1** Take corrective action and document when any quality control reagent exceeds established tolerance limits. Accomplish routine maintenance and function verification checks. The laboratory director regularly reviews corrective and quality control records.

A12.3. External Quality Control Program: The Army establishes and operates an external quality control program to evaluate the results reported by the flow-cytometry laboratories. The external quality control program includes a hematology survey to monitor the performance of the absolute lymphocyte count and a flow-cytometry survey to monitor the performance of each immunophenotyping procedure.

A12.4. Recording and Reporting Data: The laboratory director reviews and verifies the reported results. The laboratory report contains data from which absolute and relative values may be calculated for each lymphocyte subpopulation along with locally derived normal ranges inclusive of the fifth and ninety-fifth percentiles. The laboratory maintains permanent files of patient reports, internal and external quality control records, and instrument maintenance and performance verification checks.

A12.5. Personnel Qualifications:

A12.5.1. Properly train all personnel involved with the flow-cytometry instrumentation.

A12.5.2. Director of the flow-cytometry laboratory holds a doctoral degree in a biologic science or is a physician and possesses experience in immunology or cell biology.

A12.5.3. Technical supervisor holds a bachelor's degree in a biological science and has at least two years of experience in flow-cytometry.

A12.6. Safety: All laboratories comply with the CDC biosafety level 2 standards. All procedures having the potential to create infectious aerosols shall be conducted within the confines of a Class II biological safety cabinet. Although certain specimen processing procedures may inactivate infectious agents, all material is treated as infectious throughout all procedures. Decontaminate all material generated in the processing and evaluation of blood specimens and dispose of using established hazardous waste disposal policies.

Attachment 13

ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS

Because of the necessity to safeguard the overall health, welfare, safety, and reputation of this command and to ensure unit readiness and the ability of the unit to accomplish its mission, certain behavior and unsafe health procedures must be proscribed for members who are diagnosed as positive for HIV infection.

As a military member who has been diagnosed as positive for HIV infection, you are hereby ordered:

(1) to verbally inform sexual partners that you are HIV positive prior to engaging in sexual relations. This order extends to sexual relations with other military members, military dependents, civilian employees of DoD components or any other persons;

(2) to use proper methods to prevent the transfer of body fluids during sexual relations, including the use of condoms providing an adequate barrier for HIV (e.g. latex);

(3) in the event that you require emergency care, to inform personnel responding to your emergency that you are HIV positive as soon as you are physically able to do so.

(4) when seeking medical care, you may wish to inform the provider that you have HIV so that the provider can use that information to optimize your evaluation and treatment;

(5) not to donate blood, sperm, tissues, or other organs.

Violating the terms of this order may result in adverse administrative action or punishment under the Uniform Code of Military Justice for violation of a lawful order.

_____

Signature of Commander and Date

ACKNOWLEDGMENT

I have read and understand the terms of this order and acknowledge that I have a duty to obey this order. I understand that I must inform sexual partners, including other military members, military dependents, civilian employees of DoD components, or any other persons, that I am HIV positive prior to sexual relations; that I must use proper methods to prevent the transfer of body fluids while engaging in sexual relations, including the use of condoms providing an adequate barrier for HIV; that if I need emergency care I will inform personnel responding to my emergency that I am HIV positive as soon as I am physically able to do so; that when I seek medical or dental care I may wish to inform the provider that I have HIV in order to optimize my evaluation and treatment; and that I must not donate blood, sperm, tissues, or other organs. I understand that violations of this order may result in adverse administrative actions or punishment under the Uniform Code of Military Justice for violation of a lawful order.

_____

Signature of Member and Date

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

OFFICE OF THE ASSISTANT SECRETARY

JUN 0 6 2018

MEMORANDUM FOR AIR FORCE PERSONNEL CENTER/CC
AIR FORCE MEDICAL STANDARDS BRANCH
AIR FORCE MEDICAL OPERATIONS AGENCY/CC

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Appropriate Evaluation of Fitness for Continued Service for Airmen with Asymptomatic Human Immunodeficiency Virus (HIV)

This memo will provide guidance for the Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for the evaluation for fitness for Airmen with asymptomatic HIV.

In order to treat every Airman equitably and with dignity and respect, the appropriate treatment and medical evaluation of fitness for continued service for asymptomatic HIV Airmen will be accomplished in the same manner as any Airman with a chronic and/or progressive disease, and IAW with DoDI 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members,* dated 7 June 2013. Asymptomatic HIV alone is not unfitting for continued service. Airmen will not be referred into IDES unless the criteria for referral, in accordance with DoDI 1332.18, *Disability Evaluation System*, Enclosure 3, Appendix 1, paragraph 2, are met.

Our point of contact is Col Karen Downes at karen.m.downes2.mil@mail.mil or 703-697-8822.

Shon J. Manasco
Assistant Secretary
(Manpower and Reserve Affairs)

DEPARTMENT OF THE AIR FORCE
WASHINGTON, D.C. 20330-1000

SEP 2 6 2018

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR AIR FORCE REVIEW BOARDS AGENCY
AIR FORCE PERSONNEL CENTER
AIR FORCE MEDICAL STANDARDS BRANCH
AIR FORCE MEDICAL OPERATIONS AGENCY

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Airmen with Asymptomatic Human Immunodeficiency Virus (HIV) Disposition

References: (a) Department of Defense Instruction 1332.18 *Disability Evaluation System,* dated 5 Aug 2014, Incorporating Change 1, 17 May 2018
(b) Department of Defense Instruction 6490.07, *Deployment –Limiting Medical Conditions for Service Members and DoD Civilian Employees,* dated 5 Feb 2010
(c) Department of Defense Instruction 6485.1 *Human Immunodeficiency Virus (HIV) in Military Service Members,* dated 7 June 2013
(d) *Appropriate Evaluation of Fitness for Continued Service for Airman with Asymptomatic Human Immunodeficiency Virus (HIV) Memorandum,* dated 6 June 2018

1. This memo provides additional guidance for the evaluation of fitness for duty for Airman with asymptomatic HIV.

2. Airmen identified with asymptomatic HIV will be evaluated through the Medical Retention Standards office (AFPC/DP2NP) and, based on the determination of DP2NP, will either be referred to the Integrated Disability Evaluation System (IDES) or returned to duty with an assignment limitation code.

3. When evaluating Airman with any chronic and/or progressive condition (to include HIV), the decision authority or boards will use the criteria in DoDI 1332.18, Enclosure 3, Appendix 1 and 2 as well as an assessment of the current career point of the Airman. Additionally, further evaluate the disability to see if it (1) represents a decided medical risk to the health of the member or to the welfare or safety of other members; or (2) the Airman's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

4. Airmen with Asymptomatic HIV may be retained or separated on a case by case basis in accordance with DoDI 1332.18, *Disability Evaluation System* and DoDI 6485.1 *Human Immunodeficiency Virus.*

5. The phrase "asymptomatic HIV alone is not unfitting for continued Service" in Reference (d), is not a policy statement that asymptomatic HIV Airman are not to be referred into DES.

Referral into the DES system requires a further determination that the member is unfit for continued Service under the criteria in DoDI 1332.18.

6. Our point of contact is Col Karen Downes at 703-697-8822 or via email at karen.m.downes2.mil@mail.mil.

Shon J. Manasco
Assistant Secretary
(Manpower and Reserve Affairs)

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

11 Oct 17

MEMORANDUM FOR AFPC/CC

FROM: HQ USAF/A1P

SUBJECT: Retention of Airmen with Asymptomatic HIV

Airmen with asymptomatic HIV infection, defined as laboratory evidence of Human Immunodeficiency Virus (HIV) infection without the presence of progressive clinical illness or immunological deficiency, shall be referred to Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for a case review.

AFPC/DP2NP will determine if the Airman may be returned to duty with an Assignment Limitation Code (ALC-C) or if medically necessary, be referred to the Integrated Disability Evaluation System (IDES). Asymptomatic HIV alone is not unfitting for continued service.

Airmen with laboratory evidence of HIV infection and with the presence of progressive clinical illness or immunological deficiency shall be referred into the IDES.

Our points of contact are Lt Col Matthew Huibregtse, AF/A1PPP (703-571-0827, matthew.j.huibregtse.mil@mail.mil) and Col Patrick Danaher, AFMOA/SGHM, (210-395-9140, patrick.j.danaher6.mil@mail.mil).

ROBERT D. LABRUTTA
Major General, USAF
Director, Military Force Management Policy

cc:
AFMOA/CC

USCENTCOM 231245Z MAR 17 MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

UNCLASSIFIED//

SUBJ/MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY//

REF/A/MSG/CDRUSCENTCOM/SG/032024ZOCT2001//
AMPN/ORIGINAL USCINCCENT INDIVIDUAL PROTECTION AND INDIVIDUAL UNIT DEPLOYMENT POLICY MESSAGE//

REF/B/MSG/CDRUSCENTCOM/SG/021502ZDEC2013//
AMPN/MOD TWELVE TO USCENTCOM INDIVIDUAL PROTECTION AND UNIT DEPLOYMENT POLICY MESSAGE. MOD TWELVE IS NO LONGER VALID AND IS SUPERSEDED BY MOD THIRTEEN//

REF/C/DOC/USD(P&R)/11AUG2006, CERTIFIED 30SEP2011//
AMPN/DODI 6490.03/DEPLOYMENT HEALTH//

REF/D/DOC/USD(P&R)/09JUN2014//
AMPN/DODI 6025.19/INDIVIDUAL MEDICAL READINESS//

REF/E/DOC/COMDT CG/22AUG2014//
AMPN/COMDTINST M6000.1F/COAST GUARD MEDICAL MANUAL//

REF/F/DOC/SECAF/AS UPDATED 27AUG2015//
AMPN/AFI 48-123/MEDICAL EXAMINATIONS AND STANDARDS //

REF/G/DOC/HQDA/14DEC2007 WITH RAR 04AUG2011//
AMPN/AR 40-501/STANDARDS OF MEDICAL FITNESS//

REF/H/DOC/BUMED/11JUN2015//
AMPN/NAVMED P-117/MANUAL OF THE MEDICAL DEPARTMENT//

REF/I/DOC/USD(P&R)/05FEB2010//
AMPN/DODI 6490.07/DEPLOYMENT-LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES//

REF/J/DOC/USD(P&R)/20DEC2011//
AMPN/DODI 3020.41/OPERATIONAL CONTRACT SUPPORT//

REF/K/ORD/CFC/010458ZJUL2006//
AMPN/CFC FRAGO 09-1038/CONTRACTOR CARE IN THE USCENTCOM AOR//

REF/L/DOC/USD(P&R)/23JAN2009//
AMPN/DODD 1404.10/DOD CIVILIAN EXPEDITIONARY WORKFORCE//

REF/M/DOC/ASD(FMP)/11MAR2002, AS AMENDED 26DEC2002//
AMPN/DODI 1100.21/VOLUNTARY SERVICES IN THE DEPARTMENT OF DEFENSE//

REF/N/DOC/DEPSECDEF/12OCT2006//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/ANTHRAX VACCINE IMMUNIZATION PROGRAM//

REF/O/DOC/ASD(P&R)/09OCT2004//
AMPN/DODD 6200.04/FORCE HEALTH PROTECTION (FHP)//

REF/P/DOC/USD(P&R)/09FEB2006//
AMPN/UNDER SECRETARY OF DEFENSE MEMO/POLICY GUIDANCE FOR MEDICAL DEFERRAL PENDING DEPLOYMENT TO THEATERS OF OPERATION//

REF/Q/DOC/HQDA/BUMED/SECAF/07OCT2013//
AMPN/AR 40-562, BUMEDINST 6230.15B, AFI 48-110 IP, CG COMDTINST M6230.4G/ IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES//

REF/R/DOC/DEPSECDEF/12NOV2015//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/CLARIFYING GUIDANCE FOR SMALLPOX AND ANTHRAX VACCINE IMMUNIZATION PROGRAMS//

REF/S/DOC/ASD(HA)/31JUL2009//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL POLICY FOR THE ADMINISTRATION OF THE ANTHRAX VACCINE ABSORBED//

REF/T/DOC/USD(P&R)/07JUN2013//
AMPN/DODI 6485.01/HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN MILITARY SERVICE MEMBERS//

REF/U/DOC/ASD(HA)/14MAR2006//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/POLICY FOR PRE AND POST DEPLOYMENT SERUM COLLECTION//

REF/V/DOC/ASD(P&R)/17JUL2015//
AMPN/DODI 6465.1/ERYTHROCYTE GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G6PD) AND SICKLE CELL TRAIT SCREENING PROGRAMS//

REF/W/DOC/ASD(HA)/12DEC2015//
AMPN/DODI 5154.30/ARMED FORCES INSTITUTE OF PATHOLOGY OPERATIONS//

REF/X/DOC/ASD(HA)/20APR2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDELINE FOR TUBERCULOSIS SCREENING AND TESTING//

REF/Y/DOC/ASD(HA)/26JUL2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/IMPLEMENTATION OF REVISED DEPARTMENT OF DEFENSE FORMS 2795, 2796 AND 2900//

REF/Z/DOC/USD(P&R)/11SEP2015//

AMPN/DODI 6490.13/COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES//

REF/AA/USD(P&R)/ 26FEB2013, AS AMENDED 25JAN2017//
AMPN/DODI 6490.12/MENTAL HEALTH ASSESSMENT FOR SERVICE MEMBERS DEPLOYED IN CONNECTION WITH A CONTINGENCY OPERATION//

REF/BB/USD(I)/20MAR2009, AS AMENDED 02SEP2014//
AMPN/DODI 6420.01/NATIONAL CENTER MEDICAL INTELLIGENCE (NCMI)//

REF/CC/DOC/ASD(HA)/15APR2013//
AMPN/GUIDANCE ON MEDICATIONS FOR THE PROPHYLAXIS OF MALARIA//

REF/DD/DOC/ASD(HA)/12AUG2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/NOTIFICATION FOR HEALTHCARE PROVIDERS OF MEFLOQUINE BOX WARNING//

REF/EE/DOC/ASD(HA)/18MAY2007//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/UPDATED POLICY FOR PREVENTION OF ARTHROPOD-BORNE DISEASES AMONG DEPARTMENT OF DEFENSE PERSONNEL DEPLOYED TO ENDEMIC AREAS//

REF//FF/DOC/J4/02NOV2007//
AMPN/MCM-0028-07/PROCEDURES FOR DEPLOYMENT HEALTH SURVEILLANCE//

REF/GG/DOC/CC/08MAR2016//
AMPN/CCR 40-2/DEPLOYMENT FORCE HEALTH PROTECTION//

REF/HH/DOC/AFHSC/MAR2012//
AMPN/ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES & CASE DEFINITIONS//

REF/II/ DOC/CENTCOM/OCT2012//
AMPN/UNITED STATES CENTRAL COMMAND HEALTHCARE INFORMATION SYSTEM USE POLICY//

REF/JJ/DOC/USD(P&R)/18SEP2012//
AMPN/DODI 6490.11/DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/ AND CONCUSSION IN THE DEPLOYED SETTING//

REF/KK/DOC/ASD(HA)/07OCT2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL PRACTICE GUIDELINES FOR DEPLOYMENT LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS//

RMKS/1. (U) THIS IS MODIFICATION THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY. IN SUMMARY, MODIFICATIONS HAVE BEEN MADE TO PARAGRAPH 15 FROM MOD TWELVE, REF B.
1.A. PARAGRAPH 15 REQUIRED NUMEROUS CHANGES; THEREFORE, IT IS BEING REPUBLISHED IN ITS ENTIRETY. MOD 13 SUPERSEDES ALL PREVIOUS VERSIONS.
1.B. PARAGRAPH 15 OF REF A HAS BEEN TOTALLY REWRITTEN AS FOLLOWS:
15.A. DEFINITIONS.

15.A.1. DEPLOYMENT. FOR MEDICAL PURPOSES, THE DEFINITION OF DEPLOYMENT IS TRAVEL TO OR THROUGH THE USCENTCOM AREA OF RESPONSIBILITY (AOR), WITH EXPECTED OR ACTUAL TIME IN COUNTRY (PHYSICALLY PRESENT, EXCLUDING IN-TRANSIT OR TRAVEL TIME) FOR A PERIOD OF GREATER THAN 30 DAYS, EXCLUDING SHIPBOARD OPERATIONS, AS DEFINED IN REF C.

15.A.2. TEMPORARY DUTY (TDY). TDY MISSIONS ARE THOSE MISSIONS WITH TIME IN COUNTRY OF 30 DAYS OR LESS.

15.A.3. PERMANENT CHANGE OF STATION (PCS). PCS PERSONNEL, INCLUDING EMBASSY PERSONNEL, WILL COORDINATE WITH THEIR RESPECTIVE SERVICE COMPONENT MEDICAL PERSONNEL FOR MEDICAL GUIDANCE AND REQUIREMENTS FOR PCS TO SPECIFIC COUNTRIES IN THE USCENTCOM AOR. AUTHORIZED DEPENDENTS MUST PROCESS THROUGH THE OVERSEAS SCREENING PROCESS AND EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP), IF REQUIRED. ALL PERSONNEL MUST BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND DOD TRAVEL GUIDELINES IAW REF C. HOST NATION IMMUNIZATION AND MEDICAL SCREENING REQUIREMENTS APPLY. PORTIONS OF MOD 13 WILL APPLY AS DELINEATED IN TAB B.

15.A.4. **SHIPBOARD PERSONNEL.** ALL SHIPBOARD PERSONNEL WHO DEPLOY INTO THE AOR MUST HAVE CURRENT SEA DUTY SCREENING AND REMAIN FULLY MEDICALLY READY FOLLOWING ANNUAL PERIODIC HEALTH ASSESSMENT (PHA). DEPLOYMENT HEALTH ASSESSMENT PER 15.H APPLIES IF DEPLOYED TO OCONUS FOR GREATER THAN 30 DAYS WITH NON-FIXED U.S. MEDICAL TREATMENT FACILITIES (MTFS).

15.B. APPLICABILITY. THIS MOD APPLIES TO U. S. MILITARY PERSONNEL, TO INCLUDE ACTIVATED RESERVE AND NATIONAL GUARD PERSONNEL, DOD CIVILIANS, DOD CONTRACTORS, DOD SUB-CONTRACTORS, VOLUNTEERS, AND THIRD COUNTRY NATIONALS (TCN) TRAVELING OR DEPLOYING TO THE CENTCOM AOR AND WORKING UNDER THE AUSPICES OF THE DOD. LOCAL NATIONALS (LN) SHOULD MEET THE MINIMAL MEDICAL STANDARDS ADDRESSED IN SECTION 15.C.1.F.

15.C. MEDICAL DEPLOYABILITY. DEPLOYED HEALTH SERVICE SUPPORT INFRASTRUCTURE IS DESIGNED AND PRIORITIZED TO PROVIDE ACUTE AND EMERGENCY SUPPORT TO THE EXPEDITIONARY MISSION. ALL PERSONNEL (UNIFORMED SERVICE MEMBERS, GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, DOD CONTRACTOR EMPLOYEES) TRAVELING TO THE CENTCOM AOR MUST BE MEDICALLY, DENTALLY AND PSYCHOLOGICALLY FIT. INDIVIDUALS DEEMED UNABLE TO COMPLY WITH CENTCOM DEPLOYMENT REQUIREMENTS ARE DISQUALIFIED FOR DEPLOYMENT IAW SERVICE POLICY AND MOD 13. PERSONNEL FOUND TO BE MEDICALLY NON-DEPLOYABLE WHILE OUTSIDE OF THE CENTCOM AOR FOR ANY LENGTH OF TIME WILL NOT ENTER OR RE-ENTER THE THEATER UNTIL THE NON-DEPLOYABLE CONDITION IS COMPLETELY RESOLVED OR AN APPROVED WAIVER FROM A CENTCOM WAIVER AUTHORITY IS OBTAINED. SEE REF D, E, F, G AND H. DOD CIVILIAN EMPLOYEES ARE COVERED BY THE REHABILITATION ACT OF 1973. AS SUCH, AN APPARENTLY DISQUALIFYING MEDICAL CONDITION NEVERTHELESS REQUIRES THAT AN INDIVIDUALIZED ASSESSMENT BE MADE TO DETERMINE WHETHER THE EMPLOYEE CAN PERFORM THE ESSENTIAL FUNCTIONS OF THEIR POSITION IN THE DEPLOYED ENVIRONMENT, WITH OR WITHOUT REASONABLE ACCOMMODATION, WITHOUT CAUSING UNDUE HARDSHIP. IN EVALUATING UNDUE HARDSHIP, THE NATURE OF THE ACCOMMODATION AND THE LOCATION OF THE DEPLOYMENT MUST BE CONSIDERED. FURTHER, THE EMPLOYEE'S MEDICAL CONDITION MUST NOT POSE A SUBSTANTIAL RISK OF SIGNIFICANT HARM TO THE EMPLOYEE OR OTHERS WHEN TAKING INTO ACCOUNT THE CONDITIONS OF THE RELEVANT DEPLOYED ENVIRONMENT. SEE REF I. THE FINAL AUTHORITY OF WHO MAY DEPLOY TO THE CENTCOM AOR RESTS WITH THE CENTCOM SURGEON AND/OR THE SERVICE COMPONENT SURGEON'S WAIVER AUTHORITY, NOT THE

INDIVIDUAL'S MEDICAL EVALUATING ENTITY OR DEPLOYING PLATFORM.

15.C.1. MEDICAL FITNESS, INITIAL AND ANNUAL SCREENING.

15.C.1.A. MEDICAL READINESS PROCESSING. THE MEDICAL SECTION OF THE DEPLOYMENT SCREENING SITE MAY PUBLISH GUIDANCE, IAW MOD13 AND SERVICE STANDARDS, TO ASSIST IN DETERMINING MEDICAL DEPLOYMENT FITNESS. DEPLOYING PERSONNEL MUST HAVE AN EVALUATION BY A MEDICAL PROVIDER TO DETERMINE IF THEY CAN SAFELY DEPLOY AND OBTAIN AN APPROVED WAIVER FOR ANY DISQUALIFYING MEDICAL CONDITION(S) FROM THE COMPONENT SURGEON OR CENTCOM SURGEON PRIOR TO DEPLOYING.

15.C.1.B. FITNESS INCLUDES, BUT IS NOT LIMITED TO, THE ABILITY TO ACCOMPLISH ALL REQUIRED TASKS AND DUTIES, BY SERVICE REQUIREMENTS OR DUTY POSITION, CONSIDERING THE ENVIRONMENTAL AND OPERATIONAL CONDITIONS OF THE DEPLOYED LOCATION. AT A MINIMUM, PERSONNEL MUST BE ABLE TO WEAR BALLISTIC, RESPIRATORY, SAFETY, CHEMICAL, AND BIOLOGICAL PERSONAL PROTECTIVE EQUIPMENT; USE REQUIRED PROPHYLACTIC MEDICATIONS; AND INGRESS/EGRESS IN EMERGENCY SITUATIONS WITH MINIMAL RISK TO THEMSELVES OR OTHERS.

15.C.1.C. EXAMINATION INTERVALS. AN EXAMINATION WITH ALL MEDICAL ISSUES AND REQUIREMENTS ADDRESSED WILL REMAIN VALID FOR A MAXIMUM OF 15 MONTHS FROM THE DATE OF THE PHYSICAL, OR 12 MONTHS FOLLOWING DEPLOYMENT, WHICHEVER IS FIRST. SEE TAB A AND REF D, J, K, L AND M FOR FURTHER GUIDANCE. GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, AND DOD CONTRACTOR PERSONNEL DEPLOYED FOR MULTIPLE OR EXTENDED TOURS OF MORE THAN 12 MONTHS MUST BE RE-EVALUATED FOR FITNESS TO STAY DEPLOYED. ANNUAL IN-THEATER RESCREENING MAY BE FOCUSED ON HEALTH CHANGES, VACCINATION CURRENCY, AND MONITORING OF EXISTING CONDITIONS RATHER THAN BEING COMPREHENSIVE, BUT SHOULD CONTINUE TO MEET ALL MEDICAL GUIDANCE AS PRESCRIBED IN MOD 13. UNLESS SPECIFICALLY OBLIGATED BY CONTRACTUAL ARRANGEMENT, EXPEDITIONARY MILITARY MEDICAL ASSETS ARE NOT TO BE USED FOR RE-EVALUATION TO STAY DEPLOYED. IF INDIVIDUALS ARE UNABLE TO ADEQUATELY COMPLETE THEIR MEDICAL SCREENING EVALUATION IN THE AOR, THEY SHOULD BE REDEPLOYED TO ACCOMPLISH THIS YEARLY REQUIREMENT. PERIODIC HEALTH SURVEILLANCE REQUIREMENTS AND PRESCRIPTION NEEDS ASSESSMENTS SHOULD REMAIN CURRENT THROUGH THE DEPLOYMENT PERIOD.

15.C.1.D. SPECIALIZED GOVERNMENT CIVILIAN EMPLOYEES WHO MUST MEET SPECIFIC PHYSICAL STANDARDS (E.G., FIREFIGHTERS, SECURITY GUARDS, POLICE, AVIATORS, AVIATION CREW MEMBERS, AIR TRAFFIC CONTROLLERS, DIVERS, MARINE CRAFT OPERATORS, COMMERCIAL DRIVERS, ETC.) MUST MEET THOSE STANDARDS WITHOUT EXCEPTION, IN ADDITION TO BEING FOUND FIT FOR THE SPECIFIC DEPLOYMENT BY A MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 13. CERTIFICATIONS MUST REMAIN VALID THROUGHOUT THE ENTIRETY OF THE DEPLOYMENT. IT IS UP TO THE INDIVIDUAL TO PLAN FOR AND RECERTIFY THEIR RESPECTIVE REQUIREMENTS.

15.C.1.E. DOD CONTRACTOR EMPLOYEES MUST MEET SIMILAR STANDARDS OF FITNESS AS MILITARY AND DOD CIVILIAN PERSONNEL, AND MUST BE DOCUMENTED TO BE FIT FOR THE PERFORMANCE OF THEIR DUTIES, WITHOUT LIMITATIONS, BY MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 13. CONTRACTORS MUST COMPLY WITH REF J AND SPECIFICALLY ENCLOSURE 3 FOR MEDICAL REQUIREMENTS. EVALUATIONS SHOULD BE COMPLETED PRIOR TO ARRIVAL AT THE DEPLOYMENT PLATFORM.

15.C.1.E.1. PREDEPLOYMENT AND/OR TRAVEL MEDICINE SERVICES FOR CONTRACTOR EMPLOYEES, INCLUDING COMPLIANCE WITH IMMUNIZATION, DNA, AND PANOGRAPH REQUIREMENTS, EVALUATION OF FITNESS, AND ANNUAL SCREENING ARE THE RESPONSIBILITY OF THE CONTRACTING AGENCY PER THE CONTRACTUAL REQUIREMENTS.

QUESTIONS SHOULD BE SUBMITTED TO THE SUPPORTED COMMAND'S CONTRACTING AND MEDICAL AUTHORITY. SEE TAB A AND REF J FOR FURTHER GUIDANCE.

15.C.1.E.2. ALL CONTRACTING AGENCIES ARE RESPONSIBLE FOR PROVIDING THE APPROPRIATE LEVEL OF MEDICAL SCREENING FOR THEIR EMPLOYEES. SCREENING MUST BE COMPLETED BY A MEDICAL PROVIDER LICENSED IN A COUNTRY WITH OVERSIGHT AND ACCOUNTABILITY OF THE MEDICAL PROFESSION, AND A COPY OF THE COMPLETED MEDICAL SCREENING DOCUMENTATION, IN ENGLISH, MUST BE MAINTAINED BY THE CONTRACTOR. DOCUMENTATION MAY BE REQUESTED BY BASE OPERATIONS CENTER PERSONNEL PRIOR TO ISSUANCE OF ACCESS BADGES AS WELL AS BY MEDICAL PERSONNEL FOR COMPLIANCE REVIEWS. INSTALLATION COMMANDERS, IN CONCERT WITH THEIR LOCAL MEDICAL ASSETS AND CONTRACTING REPRESENTATIVES, MAY CONDUCT QUALITY ASSURANCE AUDITS TO VERIFY THE VALIDITY OF MEDICAL SCREENINGS.

15.C.1.E.3. CONTRACTOR EXPENSE. IAW REF J, CONTRACTORS WILL PROVIDE PREDEPLOYMENT MEDICAL AND DENTAL EVALUATIONS. ANNUAL IN THEATER RESCREENING, IF REQUIRED, WILL BE AT CONTRACTOR EXPENSE. REQUIRED IMMUNIZATIONS OUTLINED IN THE FOREIGN CLEARANCE GUIDE (HTTPS://WWW.FCG.PENTAGON.MIL) FOR THE COUNTRIES TO BE VISITED, AS WELL AS THOSE OUTLINED IN PARAGRAPH 15.F. OF THIS MOD, WILL BE DONE AT CONTRACTOR EXPENSE. THE SOLE EXCEPTION TO THIS POLICY IS ANTHRAX VACCINE, WHICH WILL BE PROVIDED AT MILITARY EXPENSE. SEE REF C, J, AND N. A DISQUALIFYING MEDICAL CONDITION, AS DETERMINED BY AN IN-THEATER COMPETENT MEDICAL AUTHORITY, WILL BE IMMEDIATELY REPORTED TO THE CONTRACTOR EMPLOYEE'S CONTRACTING OFFICER WITH A RECOMMENDATION THAT THE CONTRACTOR BE IMMEDIATELY REDEPLOYED AND REPLACED AT CONTRACTOR EXPENSE UNLESS AN APPROVED WAIVER IS OBTAINED. ALL THE ABOVE EXPENSES WILL BE COVERED BY THE CONTRACTOR UNLESS OTHERWISE SPECIFIED IN THE CONTRACT.

15.C.1.F. LN AND TCN EMPLOYEES. MINIMUM SCREENING REQUIREMENTS INCLUDE:

15.C.1.F.1. PRE-EMPLOYMENT AND ANNUAL MEDICAL SCREENING OF LN AND TCN EMPLOYEES IS NOT TO BE PERFORMED IN MILITARY MTFS. LOCAL CONTRACTING AGENCIES MUST KEEP DOCUMENTATION IAW PARA. 15.C.1.E.1.

15.C.1.F.2. ALL LN AND TCN EMPLOYEES WHOSE JOB REQUIRES CLOSE OR FREQUENT CONTACT WITH NON-LN/TCN PERSONNEL (E.G., DINING FACILITY WORKERS, SECURITY PERSONNEL, INTERPRETERS, ETC.) MUST BE SCREENED FOR TUBERCULOSIS (TB) USING AN ANNUAL SYMPTOM SCREEN. A TUBERCULIN SKIN TEST (TST) IS UNRELIABLE AS A STAND-ALONE SCREENING TEST FOR TB DISEASE IN LN/TCN PERSONNEL AND SHOULD NOT BE USED. SPECIFIC QUESTIONS REGARDING APPROPRIATE SCREENING OF DETAINEES, PRISON GUARDS AND OTHER HIGHER RISK POPULATIONS SHOULD BE REFERRED TO THE THEATER PREVENTIVE MEDICINE CONSULTANT THROUGH UNIT MEDICAL PERSONNEL.

15.C.1.F.3. LN AND TCN EMPLOYEES INVOLVED IN FOOD SERVICE, WATER, AND ICE PRODUCTION MUST BE SCREENED ANNUALLY FOR SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE. CONTRACTORS MUST ENSURE EMPLOYEES RECEIVE TYPHOID AND HEPATITIS A VACCINATIONS AND THIS INFORMATION MUST BE DOCUMENTED IN THE EMPLOYEES' MEDICAL RECORD / SCREENING DOCUMENTATION.

15.C.1.F.4. FURTHER GUIDANCE REGARDING MEDICAL SUITABILITY OR FORCE HEALTH PROTECTION MAY BE PROVIDED BY THE LOCAL TASK FORCE COMMANDER OR EQUIVALENT IN CONSULTATION WITH THEIR MILITARY MEDICAL ASSETS.

15.C.2. UNFIT PERSONNEL. CASES OF IN-THEATER/DEPLOYED PERSONNEL IDENTIFIED AS UNFIT, IAW THIS MOD 13, DUE TO CONDITIONS THAT EXISTED PRIOR TO DEPLOYMENT WILL BE FORWARDED TO THE APPROPRIATE COMPONENT SURGEON FOR DETERMINATION REGARDING POTENTIAL MEDICAL WAIVER OR REDEPLOYMENT. FINDINGS/ACTIONS WILL BE

FORWARDED TO THE CENTCOM SURGEON AT CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL.

15.C.3. MEDICAL WAIVERS.

15.C.3.A. MEDICAL WAIVER APPROVAL AUTHORITY.

15.C.3.A.1. MEDICAL WAIVER APPROVAL AUTHORITY LIES AT THE COMBATANT COMMAND SURGEON LEVEL IAW REF I, O, AND P, AND IS DELEGATED TO THE USCENTCOM COMPONENT SURGEONS FOR ALL DEPLOYING PERSONNEL WITHIN THEIR RESPECTIVE COMPONENT FOR ALL HEALTH CONDITIONS, EXCLUDING BEHAVIORAL HEALTH CONDITIONS. BEHAVIORAL HEALTH WAIVERS WILL INITIALLY BE EVALUATED BY THE RESPECTIVE SERVICE COMPONENT, BUT THE FINAL DETERMINATION FOR APPROVAL RESIDES WITH THE CENTCOM SURGEON. SENDING UNIT COMMANDERS ARE NOT AUTHORIZED TO OVERRIDE A MEDICAL DEPLOYABILITY DETERMINATION, HOWEVER, COMMAND ENDORSEMENT OF SERVICE MEMBER WAIVERS IS REQUIRED PRIOR TO SUBMISSION.

15.C.3.A.2. CONTRACTORS' AND SUB CONTRACTORS' RESPECTIVE SERVICE AFFILIATION IS DETERMINED BY THE 'CONTRACTOR ISSUING AGENCY' BLOCK ON THEIR 'LETTER OF AUTHORIZATION', AND WAIVERS SHOULD BE SENT TO THE APPROPRIATE SERVICE COMPONENT WAIVER AUTHORITY. SEE SECTION 15.C.3.C. THE CENTCOM SURGEON IS THE WAIVER AUTHORITY FOR DOD CIVILIANS, CONTRACTORS, AND ORGANIZATIONS SUCH AS DEFENSE INTELLIGENCE AGENCY, AMERICAN RED CROSS, ETC., WHO ARE NOT DIRECTLY ASSOCIATED WITH A PARTICULAR CENTCOM COMPONENT.

15.C.3.A.3. EXCEPT IN THE CASE OF DOD CIVILIAN EMPLOYEES WHO ARE COVERED BY THE REHABILITATION ACT OF 1973, AN INDIVIDUAL MAY BE DENIED DEPLOYMENT BY THE LOCAL MEDICAL AUTHORITY OR CHAIN OF COMMAND. AN INDIVIDUALIZED ASSESSMENT IS STILL REQUIRED FOR DOD. SEE PARA. 15.C AND REF I. AUTHORITY TO APPROVE DEPLOYMENT OF ANY PERSON (UNIFORMED OR CIVILIAN) WITH DISQUALIFYING MEDICAL CONDITIONS LIES SOLELY WITH THE CENTCOM SURGEON AND THE CENTCOM SERVICE COMPONENT SURGEONS WHO HAVE BEEN DELEGATED THIS AUTHORITY BY THE CENTCOM SURGEON.

15.C.3.A.4. ALL ADJUDICATING SURGEONS WILL MAINTAIN A WAIVER DATABASE AND RECORD ALL WAIVER REQUESTS.

15.C.3.A.5. ADJUDICATION SHOULD ACCOUNT FOR SPECIFIC MEDICAL SUPPORT CAPABILITIES IN THE LOCAL REGION OF THE AOR. THE COMPONENT SURGEON WILL RETURN THE SIGNED WAIVER FORM TO THE REQUEST ORIGINATOR FOR INCLUSION IN THE PATIENT'S DEPLOYMENT MEDICAL RECORD AND THE ELECTRONIC MEDICAL RECORD (EMR).

15.C.3.B. WAIVER PROCESS. IF A MEDICAL WAIVER IS DESIRED, LOCAL MEDICAL PERSONNEL WILL INFORM THE NON-DEPLOYABLE INDIVIDUAL AND THE UNIT COMMAND/SUPERVISOR ABOUT THE WAIVER PROCESS AS FOLLOWS.

15.C.3.B.1. AUTHORIZED AGENTS (LOCAL MEDICAL PROVIDER, COMMANDER/SUPERVISOR, REPRESENTATIVE, OR INDIVIDUAL MEMBER) WILL FORWARD A COMPLETED MEDICAL WAIVER REQUEST FORM (TAB C), TO BE ADJUDICATED BY THE APPROPRIATE SURGEON IAW PARAGRAPH 15.C.3.C. WAIVER SUBMISSION BY OR THROUGH A MEDICAL AUTHORITY IS STRONGLY ENCOURAGED TO AVOID UNNECESSARY ADJUDICATION DELAYS DUE TO INCOMPLETE INFORMATION. UNIFORMED PERSONNEL MUST OBTAIN COMMAND ENDORSEMENT OF THE WAIVER PRIOR TO SUBMISSION. THE CASE SUMMARY PORTION OF THE WAIVER SHOULD INCLUDE A SYNOPSIS OF THE CONCERNING CONDITION(S) AND ALL SUPPORTING DOCUMENTATION TO INCLUDE THE PROVIDER'S ASSESSMENT OF ABILITY TO DEPLOY.

15.C.3.B.2. DISAPPROVALS MUST BE DOCUMENTED AND SHOULD NOT BE GIVEN TELEPHONICALLY.

15.C.3.B.3. A CENTCOM WAIVER DOES NOT PRECLUDE THE NEED FOR SERVICE-SPECIFIC MEDICAL WAIVERS (E.G., SMALL ARMS WAIVERS) OR OCCUPATIONAL MEDICAL WAIVERS (E.G., AVIATORS, COMMERCIAL TRUCK DRIVERS, ETC.) IF REQUIRED.
15.C.3.B.4. APPEAL PROCESS. IF THE SENDING UNIT DISAGREES WITH THE COMPONENT SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED TO THE CENTCOM SURGEON. IF THE DISAGREEMENT IS WITH THE CENTCOM SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED THROUGH THE CHAIN OF COMMAND TO THE CENTCOM CHIEF OF STAFF.
15.C.3.B.5. WAIVERS ARE APPROVED FOR A MAXIMUM OF 12 MONTHS OR FOR THE TIMEFRAME SPECIFIED ON THE WAIVER (TAB C). WAIVER COVERAGE BEGINS ON THE DATE OF THE INITIAL DEPLOYMENT AND REMAINS IN EFFECT FOR EITHER THE TIME PERIOD SPECIFIED ON THE WAIVER OR A MAXIMUM TIME OF 12 MONTHS.
15.C.3.B.6. WAIVERS MAY BE APPROVED, AT THE WAIVER AUTHORITY'S SOLE DISCRETION, FOR PERIODS OF TIME (E.G. 90 DAYS) SHORTER THAN THE SCHEDULED DEPLOYMENT DURATION IN ORDER TO REQUIRE REASSESSMENT OF A MEDICAL CONDITION. SUCH WAIVERS WILL INCLUDE RESUBMISSION INSTRUCTIONS. ALL LABS, ASSESSMENTS, ETC. REQUIRED FOR RESUBMISSION ARE THE RESPONSIBILITY OF THE EMPLOYEE TO OBTAIN AND SUBMIT.
15.C.3.C. CONTACTS FOR WAIVERS
15.C.3.C.1. CENTCOM SURGEON. CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL;
CML: 813.529.0361; DSN: 312.529.0361
15.C.3.C.2. AFCENT SURGEON. USCENTAFSG.ORGBOX@AFCENT.AF.MIL;
CML: 803.717.7101; DSN: 313.717.7101
15.C.3.C.3. ARCENT SURGEON. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@MAIL.MIL;
CML: 803.885.7946; DSN: 312.889.7946
15.C.3.C.4. MARCENT SURGEON. FORCE.SURGEON@MARCENT.USMC.MIL;
CML: 813.827.7175; DSN: 312.651.7175
15.C.3.C.5. NAVCENT SURGEON. CUSNC.MEDWAIVERS@ME.NAVY.MIL;
CML: 011.973.1785.4558; DSN: 318.439.4558
15.C.3.C.6. SOCCENT SURGEON. SOCCENT.SG@SOCCENT.CENTCOM.MIL;
CML: 813.828.4351; DSN: 312.968.4351
15.D. PHARMACY.
15.D.1. SUPPLY. PERSONNEL WHO REQUIRE MEDICATION AND WHO ARE DEPLOYING TO THE CENTCOM AOR WILL DEPLOY WITH NO LESS THAN A 180 DAY SUPPLY (OR APPROPRIATE AMOUNT FOR SHORTER DEPLOYMENTS) OF THEIR MAINTENANCE MEDICATIONS WITH ARRANGEMENTS TO OBTAIN A SUFFICIENT SUPPLY TO COVER THE REMAINDER OF THE DEPLOYMENT USING A FOLLOW-ON REFILL PRESCRIPTION. TRICARE ELIGIBLE PERSONNEL WILL OBTAIN FOLLOW-ON REFILL PRESCRIPTIONS FROM THE TRICARE MAIL ORDER PHARMACY (TMOP) DEPLOYED PRESCRIPTION PROGRAM (DPP) OR EXPRESS SCRIPTS. INFORMATION ON THIS PROGRAM MAY BE FOUND AT HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML .
15.D.2. EXCEPTIONS. EXCEPTIONS TO THE 180 DAY PRESCRIPTION QUANTITY REQUIREMENT INCLUDE:
15.D.2.A. PERSONNEL REQUIRING MALARIA CHEMOPROPHYLACTIC MEDICATIONS (DOXYCYCLINE, ATOVAQUONE/PROGUANIL, ETC.) WILL DEPLOY WITH EITHER ENOUGH MEDICATION FOR THEIR ENTIRE DEPLOYMENT OR WITH ENOUGH TO COVER APPROXIMATELY HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER (EXCLUDING PRIMAQUINE FOR TERMINAL PROPHYLAXIS) BASED ON UNIT PREFERENCE. UNITS WILL DISTRIBUTE TERMINAL PROPHYLAXIS UPON REDEPLOYMENT. THE DEPLOYMENT PERIOD WILL BE CONSIDERED TO INCLUDE AN ADDITIONAL 28 DAYS AFTER

LEAVING THE MALARIA RISK AREA (FOR DOXYCYCLINE) OR 7 DAYS (FOR MALARONE) TO ACCOUNT FOR REQUIRED PRIMARY PROPHYLAXIS. TERMINAL PROPHYLAXIS WITH PRIMAQUINE FOR 14 DAYS SHOULD BEGIN ONCE THE INDIVIDUAL MEMBER HAS LEFT THE AREA OF MALARIA RISK.

15.D.2.B. PSYCHOTROPIC MEDICATION MAY BE DISPENSED FOR UP TO A 180 DAY SUPPLY WITH NO REFILL.

15.D.2.B.1. IF REQUIRED, THE PROVIDER MAY PRESCRIBE A LIMITED QUANTITY (I.E., AT LEAST A 90 DAY SUPPLY) WITH NO REFILLS TO FACILITATE CLINICAL FOLLOW-UP IN THEATER.

15.D.2.B.2. PSYCHOTROPIC MEDICATIONS AUTHORIZED FOR UP TO A 180 DAYS SUPPLY INCLUDE, BUT ARE NOT LIMITED TO; ANTI-DEPRESSANTS, ANTI-ANXIETY (NON CONTROLLED SUBSTANCES), NON-CLASS 2 (CII) STIMULANTS, AND ANTI-SEIZURE MEDICATIONS USED FOR MOOD DISORDERS. THIS TERM ALSO ENCOMPASSES THE GENERIC EQUIVALENTS OF THE ABOVE MEDICATION CATEGORIES WHEN USED FOR NON-PSYCHOTROPIC INDICATIONS.

15.D.2.C. ALL FDA CONTROLLED SUBSTANCES (SCHEDULE I-V) ARE LIMITED TO A 90 DAY SUPPLY WITH NO REFILLS. AN APPROVED WAIVER MUST BE OBTAINED FROM THE CENTCOM WAIVER AUTHORITY PRIOR TO DEPLOYMENT, AND WILL BE REQUIRED FOR ALL RENEWALS. CLINICAL FOLLOW-UP IN THEATER SHOULD BE SOUGHT AT THE EARLIEST OPPORTUNITY TO OBTAIN MEDICATION RENEWALS.

15.D.3. PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART). SOLDIER READINESS PROCESSING (SRP) AND OTHER DEPLOYMENT PLATFORM PROVIDER/PHARMACY AND UNIT MEDICAL OFFICER PERSONNEL WILL MAXIMIZE THE USE OF THE PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART) TO SCREEN DEPLOYING PERSONNEL FOR HIGH-RISK MEDICATIONS, AS WELL AS TO IDENTIFY MEDICATIONS WHICH ARE TEMPERATURE-SENSITIVE, OVER THE COUNTER (FOR SITUATIONAL AWARENESS REGARDING MEDICATION INTERACTION), OR NOT AVAILABLE ON THE CENTCOM FORMULARY AND/OR THROUGH THE TMOP/DPP. CONTACT THE DHA PHARMACY ANALYTICS SUPPORT SECTION AT 1.866.275.4732 OR USARMY.JBSA.MEDCOM-AMEDDCS.MBX.PHARMACOECONOMIC-CENTER@MAIL.MIL FOR INFORMATION ON HOW TO OBTAIN A PMART REPORT. INFORMATION REGARDING PMART AS WELL AS THE CENTCOM FORMULARY CAN BE FOUND AT THE HEALTH.MIL WEBSITE AT: WWW.HEALTH.MIL/PMART.

15.D.4. TRICARE MAIL ORDER PHARMACY (TMOP). PERSONNEL REQUIRING ONGOING PHARMACOTHERAPY WILL MAXIMIZE USE OF THE TMOP/DPP SYSTEM (TO INCLUDE MEDICATIONS LISTED IN 15.D.2.B AND 15.D.2.C) WHEN POSSIBLE. THOSE ELIGIBLE FOR TMOP WILL COMPLETE ON-LINE ENROLLMENT AND REGISTRATION PRIOR TO DEPLOYMENT IF POSSIBLE. INSTRUCTIONS CAN BE FOUND AT HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML

15.E. MEDICAL EQUIPMENT.

15.E.1. PERMITTED EQUIPMENT. PERSONNEL WHO REQUIRE MEDICAL EQUIPMENT (E.G., CORRECTIVE EYEWEAR, HEARING AIDS) MUST DEPLOY WITH ALL REQUIRED ITEMS IN THEIR POSSESSION TO INCLUDE TWO PAIRS OF EYEGLASSES, PROTECTIVE MASK EYEGLASS INSERTS, BALLISTIC EYEWEAR INSERTS, AND HEARING AID BATTERIES. SEE REF D

15.E.2. NON-PERMITTED EQUIPMENT. PERSONAL DURABLE MEDICAL EQUIPMENT (NEBULIZERS, SCOOTERS, WHEELCHAIRS, CATHETERS, DIALYSIS MACHINES, INSULIN PUMPS, IMPLANTED DEFIBRILLATORS, SPINAL CORD STIMULATORS, CEREBRAL IMPLANTS, ETC.) IS NOT PERMITTED. MEDICAL MAINTENANCE, LOGISTICAL SUPPORT, AND INFECTION CONTROL PROTOCOLS FOR PERSONAL MEDICAL EQUIPMENT ARE NOT AVAILABLE AND ELECTRICITY IS OFTEN UNRELIABLE. A WAIVER FOR A MEDICAL CONDITION REQUIRING PERSONAL DURABLE MEDICAL EQUIPMENT WILL ALSO BE CONSIDERED APPLICABLE TO THE EQUIPMENT. DURABLE MEDICAL EQUIPMENT THAT IS NOT MEDICALLY COMPULSORY BUT USED FOR RELIEF OR

MAINTENANCE OF A MEDICAL CONDITION WILL REQUIRE A WAIVER. WAIVERS SHOULD COMPELLINGLY ARGUE FOR CONTINUED READINESS DESPITE PRESUMED FAILURE OF THE EQUIPMENT. MAINTENANCE AND RESUPPLY OF NON-PERMITTED EQUIPMENT IS THE RESPONSIBILITY OF THE INDIVIDUAL.

15.E.3. CONTACT LENSES.

15.E.3.A. ARMY, NAVY, AND MARINE PERSONNEL WILL NOT DEPLOY WITH CONTACT LENSES EXCEPT IAW SERVICE POLICY.

15.E.3.B. AIR FORCE PERSONNEL (NON-AIRCREW) WILL NOT DEPLOY WITH CONTACT LENSES UNLESS WRITTEN AUTHORIZATION IS PROVIDED BY THE DEPLOYING UNIT COMMANDER. CONTACT LENSES ARE LIFE SUPPORT EQUIPMENT FOR USAF AIRCREWS AND THEREFORE ARE EXEMPT IAW SERVICE GUIDELINES. AIR FORCE PERSONNEL DEPLOYING WITH CONTACT LENSES MUST RECEIVE PRE-DEPLOYMENT EDUCATION IN THE SAFE WEAR AND MAINTENANCE OF CONTACT LENSES IN THE DEPLOYED ENVIRONMENT. THEY MUST ALSO DEPLOY WITH TWO PAIRS OF EYEGLASSES AND A SUPPLY OF CONTACT LENS MAINTENANCE ITEMS (E.G., CLEANSING SOLUTION) ADEQUATE FOR THE DURATION OF THE DEPLOYMENT.

15.E.4. MEDICAL WARNING TAGS. DEPLOYING PERSONNEL REQUIRING MEDICAL WARNING TAGS (MEDICATION ALLERGIES, G6PD DEFICIENCY, DIABETES, SICKLE CELL DISEASE, ETC.) WILL DEPLOY WITH RED MEDICAL WARNING TAGS WORN IN CONJUNCTION WITH THEIR PERSONAL IDENTIFICATION TAGS.

15.E.4.A. MEDICAL PERSONNEL IDENTIFY NEED FOR MEDICAL WARNING TAGS AND PREPARE DOCUMENTATION.

15.E.4.B. INSTALLATION OR ORGANIZATION COMMANDERS WILL DIRECT EMBOSSING ACTIVITIES TO PROVIDE TAGS IAW SERVICE PROCEDURES.

15.F. IMMUNIZATIONS.

15.F.1. ADMINISTRATION. ALL IMMUNIZATIONS WILL BE ADMINISTERED IAW REF Q. REFER TO THE DHA-IMMUNIZATION HEALTHCARE BRANCH WEBSITE HTTP://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR OR CONTACT THE CENTCOM DHA-IMMUNIZATION HEALTHCARE BRANCH ANALYST BRIAN.D.CANTERBURY.CIV@MAIL.MIL FOR QUESTIONS AND CLARIFICATIONS.

15.F.2. REQUIREMENTS. ALL PERSONNEL (TO INCLUDE PCS AND SHIPBOARD PERSONNEL) TRAVELING FOR ANY PERIOD OF TIME TO THE THEATER WILL BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND SERVICE INDIVIDUAL MEDICAL READINESS (IMR) REQUIREMENTS IAW REF C. CURRENT DOD IMMUNIZATIONS REQUIREMENTS AND RECOMMENDATIONS CAN BE FOUND AT THE DEFENSE HEALTH AGENCY WEBSITE, ON THE CENTCOM TAB, AT HTTP://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR . IN ADDITION, ALL TDY PERSONNEL MUST COMPLY WITH FOREIGN CLEARANCE GUIDELINES FOR THE COUNTRIES TO OR THROUGH WHICH THEY ARE TRAVELING. MANDATORY VACCINES FOR DOD PERSONNEL (MILITARY, CIVILIAN & CONTRACTORS) TRAVELING FOR ANY PERIOD OF TIME IN THEATER ARE:

15.F.2.A. TETANUS/DIPHTHERIA. RECEIVE A ONE-TIME DOSE OF TDAP IF NO PREVIOUS DOSE(S) RECORDED. RECEIVE TETANUS (TD) IF ≥ 10 YEARS SINCE LAST TDAP OR TD BOOSTER.

15.F.2.B. VARICELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1980 (HEALTH CARE WORKERS MAY NOT USE THIS EXEMPTION), DOCUMENTED PREVIOUS INFECTION (CONFIRMED BY EITHER EPIDEMIOLOGIC LINK OR LABORATORY RESULT), SUFFICIENT VARICELLA TITER, OR DOCUMENTED ADMINISTRATION OF VACCINE (2 DOSES).

15.F.2.C. MEASLES / MUMPS / RUBELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1957, DOCUMENTATION OF EFFECTIVE IMMUNITY BY TITER, OR DOCUMENTED ADMINISTRATION OF 2 LIFETIME DOSES OF MMR.
15.F.2.D. POLIO. REQUIRED FOR TRAVEL TO/THROUGH **AFGHANISTAN OR PAKISTAN FOR ≥4 WEEKS**.
15.F.2.D.1 BOOSTER DOSE OF EITHER ORAL (OPV) OR INACTIVATED (IPV) VACCINE (IPV IS THE ONLY POLIO VACCINE CURRENTLY AVAILABLE IN THE UNITED STATES) BETWEEN 4 WEEKS AND 12 MONTHS OF DEPARTURE FROM AFGHANISTAN OR PAKISTAN.
15.F.2.D.2. IMMUNIZATION SHOULD BE DOCUMENTED ON THE CDC-731 CERTIFICATE OF VACCINATION OR PROPHYLAXIS (YELLOW SHOT RECORD) IN ADDITION TO THE DD2766C TO MEET INTERNATIONAL STANDARDS.
15.F.2.D.3. MEDICAL ASSUMED (MA) AND MEDICAL IMMUNE (MI) EXEMPTIONS ARE NOT ACCEPTED FOR THIS REQUIREMENT.
15.F.2.D.4. IAW WORLD HEALTH ORGANIZATION (WHO) OR ACIP DISEASE OUTBREAK GUIDANCE, MORE STRINGENT VACCINATION REQUIREMENTS MAY BE RECOMMENDED.
15.F.2.E. SEASONAL INFLUENZA (INCLUDING EVENT-SPECIFIC INFLUENZA, E.G., H1N1).
15.F.2.F. HEPATITIS A. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.
15.F.2.G. HEPATITIS B. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.
15.F.2.H. TYPHOID. BOOSTER DOSE OF TYPHIM VI VACCINE IF GREATER THAN TWO YEARS SINCE LAST VACCINATION WITH INACTIVATED / INJECTABLE VACCINE OR GREATER THAN FIVE YEARS SINCE RECEIPT OF LIVE / ORAL VACCINE. ORAL VACCINE IS AN ACCEPTABLE OPTION ONLY IF TIME ALLOWS FOR RECEIPT AND COMPLETION OF ALL FOUR DOSES PRIOR TO DEPLOYMENT.
15.F.3. ANTHRAX. PERSONNEL WITHOUT A MEDICAL CONTRAINDICATION TRAVELING IN THE CENTCOM THEATER FOR 15 DAYS OR MORE WILL COMPLY WITH THE MOST CURRENT DOD ANTHRAX REQUIREMENTS, CURRENTLY A SERIES OF 5 VACCINES AND ANNUAL BOOSTER. SEE REF N, R, AND S AND EXCEPTIONS FOR VACCINATION IN 15.F.6.
15.F.3.A. MILITARY PERSONNEL. REQUIRED.
15.F.3.B. DOD CIVILIANS. REQUIRED AT GOVERNMENT EXPENSE, FOR EMERGENCY ESSENTIAL PERSONNEL IAW REF N.
15.F.3.C. DOD CONTRACTORS. REQUIRED AT GOVERNMENT EXPENSE AS DIRECTED IN THE CONTRACT.
15.F.3.D. VOLUNTEERS. VOLUNTARY AT GOVERNMENT EXPENSE.
15.F.4. SMALLPOX. AS OF 16 MAY 2014, SMALLPOX VACCINATION IS NO LONGER REQUIRED FOR THE CENTCOM AOR. SEE REF R.
15.F.5. RABIES. PRE-EXPOSURE VACCINATION SHOULD BE ACCOMPLISHED AS BELOW, OR OTHERWISE CONSIDERED FOR PERSONNEL WHO ARE NOT REASONABLY EXPECTED TO RECEIVE PROMPT MEDICAL EVALUATION AND RISK-BASED RABIES POST-EXPOSURE PROPHYLAXIS WITHIN 72 HOURS OF EXPOSURE TO A POTENTIALLY RABID ANIMAL. FOR ALREADY-VACCINATED PERSONNEL, BOOSTER DOSES ARE REQUIRED EVERY TWO YEARS OR WHEN TITERS INDICATE. EXCEPTIONS MAY BE IDENTIFIED BY UNIT SURGEONS.
15.F.5.A. HIGH RISK PERSONNEL: PRE-EXPOSURE VACCINATION IS REQUIRED FOR VETERINARY PERSONNEL, MILITARY WORKING DOG HANDLERS, ANIMAL CONTROL PERSONNEL, CERTAIN SECURITY PERSONNEL, CIVIL ENGINEERS AT RISK OF EXPOSURE TO RABID ANIMALS, AND LABORATORY PERSONNEL WHO WORK WITH RABIES SUSPECT SAMPLES.

15.F.5.B. SPECIAL OPERATIONS FORCES (SOF)/SOF ENABLERS: ALL PERSONNEL DEPLOYING IN SUPPORT OF SOF WILL BE ADMINISTERED THE PRE-EXPOSURE RABIES VACCINE SERIES AS INDICATED BELOW.
15.F.5.B.1. AFGHANISTAN. PERSONNEL WITH PRIMARY DUTIES OUTSIDE OF FIXED BASES.
15.F.5.B.2. PAKISTAN. ALL PERSONNEL.
15.F.5.B.3. OTHER AREAS. PER USSOCOM SERVICE-SPECIFIC POLICIES. CONTACT USSOCOM PREVENTIVE MEDICINE OFFICER AT DSN (312) 299-5051 FOR MORE INFORMATION.
15.F.6. EXCEPTIONS. REQUIRED IMMUNIZATIONS WILL BE ADMINISTERED PRIOR TO DEPLOYMENT, WITH THE FOLLOWING POSSIBLE EXCEPTIONS:
15.F.6.A. THE FIRST VACCINE IN A REQUIRED SERIES MUST BE ADMINISTERED PRIOR TO DEPLOYMENT WITH ARRANGEMENTS MADE FOR SUBSEQUENT IMMUNIZATIONS TO BE GIVEN IN THEATER.
15.F.6.B. IAW REF S, ANTHRAX MAY BE ADMINISTERED UP TO 120 DAYS PRIOR TO DEPLOYMENT. IT IS HIGHLY ADVISABLE TO GET THE FIRST TWO ANTHRAX IMMUNIZATIONS OR SUBSEQUENT DOSE/BOOSTER PRIOR TO DEPLOYMENT IN ORDER TO AVOID UNNECESSARY STRAIN ON THE DEPLOYED HEALTHCARE SYSTEM.
15.F.7. ADVERSE MEDICAL EVENTS RELATED TO IMMUNIZATIONS SHOULD BE REPORTED THROUGH REPORTABLE MEDICAL EVENTS (RME) IF CASE DEFINITIONS ARE MET. ALL IMMUNIZATION RELATED UNEXPECTED ADVERSE EVENTS ARE TO BE REPORTED THROUGH THE VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) AT HTTP://WWW.VAERS.HHS.GOV.
15.F.8. USCENTCOM AND COMPONENTS WILL MONITOR IMMUNIZATION COMPLIANCE VIA THE COCOM IMMUNIZATION REPORTING DATABASE. SUBORDINATE COMMANDS WILL REQUEST ACCESS TO THE COCOM IMMUNIZATION REPORTING DATABASE BY CONTACTING CCSG AT BRIAN.CANTERBURY2@CENTCOM.MIL OR CCSG-PMO@CENTCOM.SMIL.MIL.
15.G. MEDICAL / LABORATORY TESTING.
15.G.1. HIV TESTING. HIV LAB TESTING, WITH DOCUMENTED NEGATIVE RESULT, WILL BE WITHIN 120 DAYS PRIOR TO DEPLOYMENT OR DEPARTURE FOR ANY REQUIRED DEPLOYMENT TRAINING IF TRAINING IS EN ROUTE TO DEPLOYMENT LOCATION. IAW REF I AND T, THE COGNIZANT COMBATANT COMMAND SURGEON SHALL BE DIRECTLY CONSULTED IN ALL INSTANCES OF HIV SEROPOSITIVITY BEFORE MEDICAL CLEARANCE FOR DEPLOYMENT.
15.G.2. SERUM SAMPLE. SAMPLE WILL BE TAKEN WITHIN THE PREVIOUS 365 DAYS. IF THE INDIVIDUAL'S HEALTH STATUS HAS RECENTLY CHANGED OR HAS HAD AN ALTERATION IN OCCUPATIONAL EXPOSURES THAT INCREASES HEALTH RISKS, A HEALTH CARE PROVIDER MAY CHOOSE TO HAVE A SPECIMEN DRAWN CLOSER TO THE ACTUAL DATE OF DEPLOYMENT. SEE REF U.
15.G.3. G6PD TESTING. DOCUMENTATION OF ONE-TIME GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY TESTING IS IAW REF V. ENSURE RESULT IS IN MEDICAL RECORD OR DRAW PRIOR TO DEPARTURE. PRE-DEPLOYMENT MEDICAL SCREENERS WILL RECORD THE RESULT OF THIS TEST IN THE SERVICE MEMBER'S PERMANENT MEDICAL RECORD, DEPLOYMENT MEDICAL RECORD (DD FORM 2766) AND SERVICE SPECIFIC ELECTRONIC MEDICAL RECORD. (REF V) IF AN INDIVIDUAL IS FOUND TO BE G6PD-DEFICIENT, THEY SHOULD BE ISSUED MEDICAL WARNING TAGS (SEE 15.E.4.) THAT STATE "G6PD DEFICIENT: NO PRIMAQUINE". IF PRIMAQUINE IS GOING TO BE ISSUED TO A DOD CIVILIAN OR DOD CONTRACTOR, COMPLETE THE TESTING AT GOVERNMENT EXPENSE.
15.G.4. HCG. REQUIRED WITHIN 30 DAYS OF DEPLOYMENT FOR ALL WOMEN, AS WELL THOSE FEMALE TO MALE TRANSGENDERED INDIVIDUALS WHO HAVE RETAINED FEMALE ANATOMY. ABOVE INDIVIDUALS WITH A DOCUMENTED HISTORY OF A HYSTERECTOMY ARE EXEMPT. PREGNANCY WILL BE RULED OUT PRIOR TO ANY IMMUNIZATION (EXCEPT INFLUENZA) AND

MEDICAL CLEARANCE FOR DEPLOYMENT.

15.G.5. DNA SAMPLE. REQUIRED FOR ALL DOD PERSONNEL, INCLUDING CIVILIANS AND CONTRACTORS. OBTAIN SAMPLE OR CONFIRM SAMPLE IS ON FILE BY CONTACTING THE DOD DNA SPECIMEN REPOSITORY (COMM: 301.319.0366, DSN: 285; FAX 301.319.0369); HTTP://WWW.AFMES.MIL . SEE REF C, D, AND W.

15.G.6. TUBERCULOSIS (TB) TESTING. SEE REF X.

15.G.6.A. TUBERCULOSIS TESTING FOR SERVICE MEMBERS WILL BE PERFORMED AND DOCUMENTED IAW SERVICE POLICY. CURRENT POLICY IS TO AVOID UNIVERSAL TESTING, AND INSTEAD USE TARGETED TESTING BASED UPON RISK ASSESSMENT, USUALLY PERFORMED WITH A SIMPLE QUESTIONNAIRE. DEPLOYMENT TO TB ENDEMIC COUNTRIES, EVEN FOR PERIODS IN EXCESS OF A YEAR, HAS NOT BEEN SHOWN TO BE A RISK FACTOR FOR TB FOR MOST AVERAGE-RISK SERVICE MEMBERS. TB TESTING FOR DOD CIVILIANS, CONTRACTORS, VOLUNTEERS, AND OTHER PERSONNEL SHOULD BE SIMILARLY TARGETED IAW CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES, WITH TESTING FOR TB TO BE ACCOMPLISHED WITHIN 90 DAYS OF DEPLOYMENT IF INDICATED. IF TESTING IS PERFORMED TUBERCULIN SKIN TEST (TST) OR AN INTERFERON-GAMMA RELEASE ASSAY MAY BE USED UNLESS OTHERWISE INDICATED.

15.G.6.B. POSITIVE TB TESTS WILL BE HANDLED IAW SERVICE POLICY AND CDC GUIDELINES. PERSONNEL WITH A POSITIVE TB TEST SHOULD BE EVALUATED AND COUNSELED. EVALUATION WILL INCLUDE AT LEAST A SYMPTOM QUESTIONNAIRE FOR ACTIVE TB DISEASE, EXPOSURE HISTORY, AND CHEST X-RAY.

15.G.6.C. THE DECISION TO TREAT LTBI IN U.S. FORCES AND CIVILIANS DURING DEPLOYMENT INSTEAD OF AFTER REDEPLOYMENT SHOULD INCLUDE CONSIDERATION OF THE RISKS AND BENEFITS OF TREATMENT DURING DEPLOYMENT, INCLUDING: RISK OF TB ACTIVATION, RISK OF ADVERSE EVENTS FROM LTBI TREATMENT, TIME REMAINING IN DEPLOYMENT, AVAILABILITY OF MEDICAL PERSONNEL TRAINED IN LTBI TREATMENT, AVAILABILITY OF FOLLOW-UP DURING TREATMENT, AND AVAILABILITY OF MEDICATION. LACK OF TREATMENT FOR LTBI IS NOT A CONTRAINDICATION FOR DEPLOYMENT INTO THE CENTCOM AOR AND NO WAIVERS ARE REQUIRED FOR A DIAGNOSIS OF LTBI IF APPROPRIATE EVALUATION AND COUNSELING, AS NOTED ABOVE, IS COMPLETED.

15.G.6.D. UNIT-BASED / LARGE GROUP OR INDIVIDUAL LTBI TESTING SHOULD NOT BE PERFORMED IN THE AOR EXCEPT AMONG CLOSE CONTACTS OF CASES OF KNOWN TB DISEASE.

15.G.6.E. U.S. FORCES AND DOD CIVILIANS WITH TB DISEASE WILL BE EVACUATED FROM THEATER FOR DEFINITIVE TREATMENT. EVALUATION AND TREATMENT OF TB AMONG U.S. CONTRACTORS, LOCAL NATIONALS (LN) AND THIRD COUNTRY NATIONAL (TCN) EMPLOYEES WILL BE AT CONTRACTOR EXPENSE. EMPLOYEES WITH SUSPECTED OR CONFIRMED PULMONARY TB DISEASE WILL BE EXCLUDED FROM WORK UNTIL CLEARED BY THE THEATER PREVENTIVE MEDICINE CONSULTANT FOR RETURN TO WORK.

15.G.7. OTHER LABORATORY TESTING. OTHER TESTING MAY BE PERFORMED AT THE CLINICIAN'S DISCRETION COMMENSURATE WITH RULING OUT OR MONITORING NON-DEPLOYABLE CONDITIONS AND ENSURING PERSONNEL MEET STANDARDS OF FITNESS IAW PARAGRAPH 15.C.2.

15.H. HEALTH ASSESSMENTS.

15.H.1. HEALTH ASSESSMENTS AND EXAMS. PERIODIC HEALTH ASSESSMENTS MUST BE CURRENT IAW SERVICE POLICY AT TIME OF DEPLOYMENT AND SPECIAL DUTY EXAMS MUST BE CURRENT FOR THE DURATION OF TRAVEL OR DEPLOYMENT PERIOD. SEE REF D, J.

15.H.2. PRE-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2795).

15.H.2.A. ALL DOD PERSONNEL (MILITARY, CIVILIAN, CONTRACTOR) TRAVELING TO THE

THEATER FOR MORE THAN 30 DAYS WILL COMPLETE OR CONFIRM AS CURRENT A PRE-DEPLOYMENT HEALTH ASSESSMENT WITHIN 120 DAYS OF THE EXPECTED DEPLOYMENT DATE IAW REF Y. THIS ASSESSMENT WILL BE COMPLETED ON A DD FORM 2795 IAW REF C. THIS DOES NOT APPLY TO PCS PERSONNEL, SHIPBOARD PERSONNEL, OR PERSONNEL LOCATED WITH A DHP FUNDED FIXED MEDICAL TREATMENT FACILITY (E.G. BAHRAIN) IAW REF C.

15.H.2.A.1. PERSONNEL TRAVELING TO THE THEATER FOR 15 TO 30 DAYS MAY CONSIDER COMPLETING A PRE-DEPLOYMENT HEALTH ASSESSMENT IN ORDER TO DOCUMENT THEIR HEALTH STATUS AND ADDRESS ANY HEALTH CONCERNS PRIOR TO TRAVEL TO THEATER. THIS IS ESPECIALLY RELEVANT TO THOSE WHOSE POSITION REQUIRES FREQUENT TRAVEL TO THE AOR. THESE INDIVIDUALS ARE ENCOURAGED TO COMPLETE AT LEAST ONE PRE-DEPLOYMENT HEALTH ASSESSMENT EACH YEAR, ALONG WITH A CORRESPONDING POST-DEPLOYMENT HEALTH ASSESSMENT FOR THE SAME YEAR.

15.H.2.B. FOLLOWING COMPLETION OF THE DEPLOYER PORTION OF THE DD FORM 2795, THE DEPLOYER WILL HAVE A PERSON-TO-PERSON DIALOGUE WITH A TRAINED AND CERTIFIED HEALTH CARE PROVIDER (PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES TECHNICIAN) TO COMPLETE THE ASSESSMENT.

15.H.2.C. THE COMPLETED ORIGINAL DD FORM 2795 WILL BE PLACED IN THE DEPLOYER'S PERMANENT MEDICAL RECORD, A PAPER COPY IN THE DEPLOYMENT MEDICAL RECORD (DD FORM 2766), AND AN ELECTRONIC COPY TRANSMITTED TO THE DEFENSE MEDICAL SURVEILLANCE SYSTEM (DMSS) AT THE ARMED FORCES HEALTH SURVEILLANCE CENTER (AFHSC). CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2795; A PAPER VERSION WILL SUFFICE.

15.H.3. AUTOMATED NEUROPSYCHOLOGICAL ASSESSMENT METRIC (ANAM).

ALL SERVICE MEMBERS AS DESIGNATED IN REF Z WILL UNDERGO ANAM TESTING WITHIN 12 MONTHS PRIOR TO DEPLOYMENT. ANAM TESTING WILL BE RECORDED IN APPROPRIATE SERVICE DATABASE AND ELECTRONIC MEDICAL RECORD. CONTRACTORS, PCS AND SHIPBOARD PERSONNEL ARE NOT REQUIRED TO UNDERGO ANAM TESTING.

15.H.4. POST-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2796).

15.H.4.A. ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT ON A DD FORM 2796. THE POST-DEPLOYMENT HEALTH ASSESSMENT MUST BE COMPLETED NO EARLIER THAN 30 DAYS BEFORE EXPECTED REDEPLOYMENT DATE AND NO LATER THAN 30 DAYS AFTER REDEPLOYMENT.

15.H.4.A.1. INDIVIDUALS WHO WERE NOT REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT, BUT WHO COMPLETED ONE TO COVER MULTIPLE TRIPS TO THEATER EACH OF 30 DAYS OR LESS DURATION, SHOULD COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT AT LEAST ONCE A YEAR TO DOCUMENT ANY POTENTIAL EXPOSURES OF CONCERN RESULTING FROM ANY SUCH TRAVEL AND THE POTENTIAL NEED FOR MEDICAL FOLLOW-UP.

15.H.4.A.2. INDIVIDUALS WHO WERE NOT REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT MAY BE REQUIRED (BY THE COMBATANT COMMANDER, SERVICE COMPONENT COMMANDER, OR COMMANDER EXERCISING OPERATIONAL CONTROL) TO COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT IF ANY HEALTH THREATS EVOLVED OR OCCUPATIONAL AND/OR CBRN EXPOSURES OCCURRED DURING THE DEPLOYMENT THAT WARRANT MEDICAL ASSESSMENT OR FOLLOW-UP. (SEE REF C).

15.H.4.B. ALL REDEPLOYING PERSONNEL WILL UNDERGO A PERSON-TO-PERSON HEALTH ASSESSMENT WITH AN INDEPENDENT PRACTITIONER. THE ORIGINAL COMPLETED COPY OF

THE DD FORM 2796 MUST BE PLACED IN THE INDIVIDUAL'S MEDICAL RECORD AND TRANSMIT AN ELECTRONIC COPY TO THE DMSS AT THE AFHSC. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2796; A PAPER VERSION WILL SUFFICE.

15.H.5. MENTAL HEALTH ASSESSMENT. ALL SERVICE MEMBERS WILL UNDERGO A PERSON-TO-PERSON MENTAL HEALTH ASSESSMENT WITH A LICENSED MENTAL HEALTH PROFESSIONAL OR TRAINED AND CERTIFIED HEALTH CARE PERSONNEL (SPECIFICALLY A PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES TECHNICIAN). ASSESSMENTS WILL BE ACCOMPLISHED WITHIN 120 DAYS PRIOR TO DEPLOYMENT, ONCE DURING EACH 180-DAY PERIOD DURING WHICH A MEMBER IS DEPLOYED (IN-THEATER MENTAL HEALTH ASSESSMENT), AND AFTER REDEPLOYMENT WITHIN 3 TIMEFRAMES (3-6, 7-18, AND 18-30 MONTHS AFTER REDEPLOYMENT), OR AS REQUIRED BY SERVICE POLICY. ASSESSMENTS WILL BE ADMINISTERED AT LEAST 90 DAYS APART. CURRENTLY ADMINISTERED PERIODIC AND OTHER PERSON-TO-PERSON HEALTH ASSESSMENTS, SUCH AS THE POST-DEPLOYMENT HEALTH REASSESSMENT, WILL MEET THE TIME REQUIREMENTS IF THEY CONTAIN ALL PSYCHOLOGICAL AND SOCIAL QUESTIONS IAW REF AA.

15.H.5.A. IN-THEATER MENTAL HEALTH ASSESSMENTS WILL BE CONDUCTED BY PERSONNEL IN DEPLOYED UNITS WHOSE RESPONSIBILITIES INCLUDE PROVIDING UNIT HEALTH CARE SERVICES IF SUCH PERSONNEL ARE AVAILABLE AND THE USE OF SUCH PERSONNEL FOR THE ASSESSMENTS WOULD NOT IMPAIR THE CAPACITY OF SUCH PERSONNEL TO PERFORM HIGHER PRIORITY TASKS.

15.H.5.A.1. PERSONNEL CONDUCTING ASSESSMENTS MUST MEET REQUIREMENTS IN PARAGRAPH 15.H.5.

15.H.5.A.2. SCHEDULING IN-THEATER MENTAL HEALTH ASSESSMENTS MUST BE MADE IN CONSIDERATION OF AND SEEK TO LESSEN POTENTIAL IMPACTS ON THE OPERATIONAL MISSION.

15.H.5.B. MENTAL HEALTH ASSESSMENT GUIDANCE DOES NOT DIRECTLY APPLY TO DOD CONTRACTORS UNLESS SPECIFIED IN THE CONTRACT OR THERE IS A CONCERN FOR A MENTAL HEALTH ISSUE. ALL RELATED MENTAL HEALTH EVALUATIONS WILL BE AT THE CONTRACTOR'S EXPENSE.

15.H.6. POST-DEPLOYMENT HEALTH RE-ASSESSMENT (DD FORM 2900). ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH REASSESSMENT (DD FORM 2900) 90 TO 180 DAYS AFTER RETURN TO HOME STATION. SEE WWW.PDHEALTH.MIL FOR ADDITIONAL INFORMATION ON PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENTS. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2900; A PAPER VERSION WILL SUFFICE.

15.I. MEDICAL RECORD. SEE REF C.

15.I.1. DEPLOYED MEDICAL RECORD. THE DD FORM 2766, ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET, OR EQUIVALENT, WILL BE USED INSTEAD OF DEPLOYING AN INDIVIDUAL'S ENTIRE MEDICAL RECORD. THE DEPLOYED DD FORM 2766 SHOULD BE RE-INTEGRATED INTO THE MAIN MEDICAL RECORD AS PART OF THE REDEPLOYMENT PROCESS.

15.I.1.A. DEPLOYED PERSONNEL (MORE THAN 30 DAYS). DD2766 IS REQUIRED.

15.I.1.B. TDY PERSONNEL (15 – 30 DAYS). DD FORM 2766 IS HIGHLY ENCOURAGED, ESPECIALLY FOR THOSE WHO TRAVEL FREQUENTLY TO THEATER, TO DOCUMENT THEATER-SPECIFIC VACCINES AND CHEMOPROPHYLAXIS, AS REQUIRED.

15.I.1.C. TDY PERSONNEL (LESS THAN 15 DAYS). DD2766 IS NOT REQUIRED.

15.I.1.D. PCS PERSONNEL. FOLLOW SERVICE GUIDELINES FOR MEDICAL RECORD MANAGEMENT.

15.I.2. MEDICAL INFORMATION. THE FOLLOWING HEALTH INFORMATION MUST BE PART OF AN ACCESSIBLE ELECTRONIC MEDICAL RECORD FOR ALL PERSONNEL (SERVICE MEMBERS, CIVILIANS AND CONTRACTORS), OR BE HAND-CARRIED AS PART OF A DEPLOYED MEDICAL RECORD:
15.I.2.A. ANNOTATION OF BLOOD TYPE AND RH FACTOR, G6PD, HIV, AND DNA.
15.I.2.B. CURRENT MEDICATIONS AND ALLERGIES. INCLUDE ANY FORCE HEALTH PROTECTION PRESCRIPTION PRODUCT (FHPPP) PRESCRIBED AND DISPENSED TO AN INDIVIDUAL.
15.I.2.C. SPECIAL DUTY QUALIFICATIONS.
15.I.2.D. ANNOTATION OF CORRECTIVE LENS PRESCRIPTION.
15.I.2.E. SUMMARY SHEET OF CURRENT AND PAST MEDICAL AND SURGICAL CONDITIONS.
15.I.2.F. MOST RECENT DD FORM 2795, PREDEPLOYMENT HEALTH ASSESSMENT.
15.I.2.G. DOCUMENTATION OF DENTAL STATUS CLASSES I OR CLASS II.
15.I.2.H. IMMUNIZATION RECORD. MEDICAL DEPLOYMENT SITES WILL ENTER IMMUNIZATION DATA INTO SERVICE ELECTRONIC TRACKING SYSTEMS, (ARMY-MEDPROS, AIR FORCE-AFCITA, COAST GUARD-MRRS, NAVY-MRRS (ASHORE) OR SAMS (AFLOAT) AND MARINE CORPS-MRRS).
15.I.2.I. ALL APPROVED MEDICAL WAIVERS.
15.J. PRE-DEPLOYMENT TRAINING. SEE REF C.
15.J.1. SCOPE. GENERAL ISSUES TO BE ADDRESSED. INFORMATION REGARDING KNOWN AND SUSPECTED HEALTH RISKS AND EXPOSURES, HEALTH RISK COUNTERMEASURES AND THEIR PROPER EMPLOYMENT, PLANNED ENVIRONMENTAL AND OCCUPATIONAL SURVEILLANCE MONITORING, AND THE OVERALL OPERATIONAL RISK MANAGEMENT PROGRAM.
15.J.2. CONTENT. SHOULD INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING AREAS: COMBAT/OPERATIONAL STRESS CONTROL AND RESILIENCE; POST-TRAUMATIC STRESS AND SUICIDE PREVENTION; MILD TRAUMATIC BRAIN INJURY RISK, IDENTIFICATION AND TRACKING; NUCLEAR, BIOLOGICAL, CHEMICAL THREATS; ENDEMIC PLANT, ANIMAL, REPTILE AND INSECT HAZARDS AND INFECTIONS; COMMUNICABLE DISEASES; VECTORBORNE DISEASES; ENVIRONMENTAL CONDITIONS; SAFETY; OCCUPATIONAL HEALTH.
15.K. MEDICAL CBRN DEFENSE MATERIEL (MCDM) / CHEMICAL BIOLOGICAL RADIOLOGICAL NUCLEAR (CBRN) RESPONSE.
15.K.1. MCDM ITEMS. CJTF-OIR, USFOR-A, AND USCENTCOM SERVICE COMPONENT COMMANDS WILL DETERMINE MCDM AVAILABILITY REQUIREMENTS, BASED UPON BEST ESTIMATES OF RISK AND COMMAND POLICY, FOR ALL FORCES THAT FALL UNDER THEIR RESPECTIVE FORCE PROTECTION AUTHORITIES AS IDENTIFIED IN ANNEX J OF USCENTCOM OPORD 05-02, IN THE FOLLOWING MINIMUM ESSENTIAL QUANTITIES. CONTRACTORS WILL RECEIVE THESE ITEMS PER THEIR CONTRACT.
15.K.1.A. ANTIDOTE TREATMENT NERVE AGENT AUTOINJECTOR (ATNAA) (6505-01-362-7427); RECOMMEND THREE EACH PER AFFECTED INDIVIDUAL.
15.K.1.B. DIAZEPAM INJECTION (CONVULSANT ANTIDOTE NERVE AGENT - CANA) (6505-01-274-0951); RECOMMEND ONE EACH PER AFFECTED INDIVIDUAL.
15.K.1.C. M291A SKIN DECONTAMINATION KIT OR REACTIVE SKIN DECONTAMINATION LOTION (RSDL). RECOMMEND ONE M291A KIT OR ONE POUCH CONTAINING 3 PACKETS OF RSDL PER AFFECTED INDIVIDUAL.
15.K.1.D. CIPROFLOXACIN 500MG TABS OR DOXYCYCLINE 100MG TABS; RECOMMEND SIX TABS (BLISTER PACKS PREFERABLE) PER AFFECTED INDIVIDUAL OF EITHER MEDICATION.TO COVER INITIAL DOSAGE AND SUPPORT PROPHYLAXIS AND/OR TREATMENT FOR THREE DAYS PER INDIVIDUAL. AVAILABILITY OF COMPLETE 30-DAY COURSE OF MEDICATION (60 TABLETS) SHOULD BE CONSIDERED GIVEN MISSION REQUIREMENTS. INDIVIDUALS USING DOXYCYCLINE FOR MALARIA PROPHYLAXIS MAY BE CONSIDERED TO BE COVERED FOR THESE REMAINING DOSES.

15.K.1.E. INDIVIDUAL DEPLOYERS RECEIVING MCDM MEDICATIONS AND/OR EQUIPMENT DURING PRE-DEPLOYMENT PROCESSING SHOULD TURN IN THESE ITEMS TO THEIR UNIT UPON ARRIVAL IN THE AOR.

15.K.2. CBRN COUNTERMEASURES.

15.K.2.A. TO PROTECT AGAINST POSSIBLE AND POTENTIALLY INDICATED CBRN THREATS WITHIN THE AOR, SERVICE COMPONENTS WILL BPT ACQUIRE AND ISSUE, IAW SERVICE POLICY OR ON ORDER FROM THE CENTCOM COMMANDER, THE FOLLOWING TYPES AND QUANTITIES OF MCDM ITEMS FOR THEIR IN-THEATER FORCES.

15.K.2.B. PYRIDOSTIGMINE BROMIDE (PB) 30MG TABS (SOMAN NERVE AGENT PRETREATMENT PYRIDOSTIGMINE - SNAPP); 42 TABLETS PER AFFECTED INDIVIDUAL.

15.K.2.B.1. POTASSIUM IODIDE (KI) TABLETS (FOR BETA/GAMMA RADIATION EXPOSURE); 14 TABS PER AFFECTED INDIVIDUAL.

15.K.2.B.2. SERVICE COMPONENTS AND/OR JTFS WITH BASE OPERATING SUPPORT (BOS) RESPONSIBILITY FOR BASES IN THEATER THAT ARE KEY TRANSPORTATION AND SUPPORT NODES WILL ENSURE ADEQUATE AMOUNTS OF THE MCDM ITEMS LISTED IN PARAGRAPH 15.K. ARE PRE-POSITIONED AND STORED TO SUPPORT THE TRANSIENT POPULATION (NON DEPLOYERS, PCS PERSONNEL, ETC.) THAT MAY RESIDE OR BE PRESENT AT THESE LOCATIONS FOR ANY PERIOD OF TIME AND ANY INDIVIDUAL DEPLOYERS NOT ATTACHED TO A TROOP UNIT MOVEMENT.

15.L. THEATER FORCE HEALTH PROTECTION.

15.L.1. DISEASE RISK ASSESSMENT.

15.L.1.A. MALARIA RISK ASSESSMENT AND GUIDELINES. IN THE ABSENCE OF A LOCAL RISK ASSESSMENT CONDUCTED IAW THE GUIDANCE PROVIDED IN PARAGRAPH 15.L.1.B., THE FOLLOWING COUNTRIES AND TIMEFRAMES REQUIRE CHEMOPROPHYLAXIS. THESE ARE MINIMUM REQUIREMENTS.

15.L.1.A.1. AFGHANISTAN: YEAR ROUND.

15.L.1.A.2. PAKISTAN: YEAR ROUND.

15.L.1.A.3. TAJIKISTAN: APRIL THROUGH OCTOBER.

15.L.1.A.4. YEMEN: YEAR ROUND.

15.L.1.B. LOCAL COMPONENT/JTF SURGEONS ARE ENCOURAGED TO CONDUCT EVIDENCE-BASED ENTOMOLOGICAL AND EPIDEMIOLOGICAL ASSESSMENTS OF MALARIA RISK AT FIXED BASES WHERE SIGNIFICANT NUMBERS OF PERSONNEL ARE ASSIGNED FOR PROLONGED PERIODS. IN CONDUCTING SUCH A RISK ASSESSMENT, SURGEONS SHOULD REVIEW THE MOST RECENT ASSESSMENTS AND RISK MAPS PRODUCED BY THE NATIONAL CENTER FOR MEDICAL INTELLIGENCE (NCMI) AT HTTPS://WWW.NCMI.DETRICK.ARMY.MIL/ (UNCLASSIFIED) OR HTTPS://WWW.NCMI.DIA.SMIL.MIL (CLASSIFIED).

15.L.1.B.1. BASED ON NCMI RISK ASSESSMENTS AND IN CONSULTATION WITH THE THEATER PREVENTIVE MEDICINE CONSULTANT, RECOMMENDATIONS FOR MODIFIED CHEMOPROPHYLAXIS POLICY MAY BE PROVIDED TO COMMANDERS USING REF BB OR SIMILAR RISK ANALYSIS.

15.L.1.B.2. MANEUVER FORCES WITH INTERMITTENT AND UNPREDICTABLE EXPOSURES TO RISK AREAS SHOULD EMPLOY CHEMOPROPHYLAXIS BASED ON THE HIGHEST RISK AREAS. UNITS AND INDIVIDUALS WITH VERY SHORT TERM EXPOSURE (I.E., AIRCREW NOT STATIONED IN THE AOR) SHOULD HAVE RISK AND CHEMOPROPHYLAXIS USE DETERMINED IAW SERVICE POLICY.

15.L.2. MALARIA CHEMOPROPHYLAXIS UTILIZATION.

15.L.2.A. ALL THERAPEUTIC/CHEMOPROPHYLACTIC MEDICATIONS, INCLUDING ANTIMALARIALS AND MCDM WILL BE PRESCRIBED IAW FDA GUIDELINES, REF C, BB, CC, AND DD.

15.L.2.B. DOXYCYCLINE OR ATOVAQUONE/PROGUANIL (MALARONE®) ARE GENERALLY ACCEPTABLE AS A PRIMARY MALARIA CHEMOPROPHYLACTIC AGENT. MEFLOQUINE SHOULD BE CONSIDERED THE DRUG OF LAST RESORT FOR PERSONNEL WITH CONTRAINDICATIONS TO DOXYCYCLINE OR MALARONE®, SHOULD BE USED WITH CAUTION IN PERSONS WITH A HISTORY OF TBI OR PTSD, AND IS CONTRAINDICATED IN PERSONNEL WITH PSYCHIATRIC DIAGNOSES. EACH MEFLOQUINE PRESCRIPTION WILL BE ISSUED WITH A WALLET CARD AND CURRENT FDA SAFETY INFORMATION INDICATING THE POSSIBILITY THAT THE NEUROLOGIC SIDE EFFECTS MAY PERSIST OR BECOME PERMANENT IAW REF DD. OTHER FDA APPROVED AGENTS MAY BE USED TO MEET SPECIFIC SITUATIONAL REQUIREMENTS.
15.L.2.C. PERSONNEL SHOULD DEPLOY WITH EITHER THEIR ENTIRE PRIMARY PROPHYLAXIS COURSE IN HAND (EXCLUDING TERMINAL PRIMAQUINE) OR WITH ENOUGH MEDICATION TO COVER HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER BASED ON UNIT PREFERENCE. TERMINAL PROPHYLAXIS (PRIMAQUINE) SHOULD BE DISTRIBUTED UPON REDEPLOYMENT AND ONLY AFTER VERIFYING G6PD STATUS (SEE 15.G.3.). A COMPLETE COURSE OF PRIMARY PROPHYLAXIS BEGINS 2 DAYS PRIOR TO ENTERING THE RISK AREA FOR DOXYCYCLINE AND MALARONE®(2 WEEKS FOR MEFLOQUINE)AND COMPLETES AFTER 4 WEEKS OF DOXYCYCLINE OR MEFLOQUINE AFTER LEAVING THE AT RISK AREA, OR (1 WEEK OF MALARONE®). TERMINAL PROPHYLAXIS IS REQUIRED AND CONSISTS OF TAKING PRIMAQUINE FOR 2 WEEKS AFTER LEAVING THE RISK AREA. INDIVIDUALS WHO ARE NOTED TO BE G6PD-DEFICIENT, IAW PARAGRAPH 15.G.3., WILL NOT BE PRESCRIBED PRIMAQUINE.
15.L.2.D. MISSING ONE DOSE OF MEDICATION OR NOT USING THE DOD INSECT REPELLENT SYSTEM WILL PLACE PERSONNEL AT INCREASED RISK FOR MALARIA.
15.L.2.E. COMMANDERS AND SUPERVISORS AT ALL LEVELS WILL ENSURE THAT ALL INDIVIDUALS FOR WHOM THEY ARE RESPONSIBLE HAVE TERMINAL PROPHYLAXIS ISSUED TO THEM IMMEDIATELY UPON REDEPLOYMENT FROM THE AT RISK MALARIA AREA(S).
15.L.3. PERSONAL PROTECTIVE MEASURES. A SIGNIFICANT RISK OF DISEASE CAUSED BY INSECTS AND TICKS EXISTS YEAR-ROUND IN THE AOR. THE THREAT OF DISEASE WILL BE MINIMIZED BY USING THE DOD INSECT REPELLANT SYSTEM AND BED NETS; HTTP://WWW.AFPMB.ORG. SEE REF EE.
15.L.3.A. PERMETHRIN TREATMENT OF UNIFORMS. UNIFORMS ARE AVAILABLE FOR ISSUE WHICH ARE FACTORY-TREATED WITH PERMETHRIN. THE UNIFORM LABEL INDICATES WHETHER IT IS FACTORY TREATED. UNIFORMS WHICH ARE NOT FACTORY TREATED SHOULD BE TREATED WITH THE INDIVIDUAL DYNAMIC ABSORPTION (IDA) KIT (NSN: 6840-01-345-0237) OR 2 GALLON SPRAYER PERMETHRIN TREATMENT. BOTH ARE EFFECTIVE FOR APPROXIMATELY 50 WASHINGS. A MATRIX OF WHICH UNIFORMS MAY BE EFFECTIVELY TREATED IS AVAILABLE ON THE AFPMB WEBSITE AT HTTP://WWW.AFPMB.ORG .
15.L.3.B. APPLY DEET CREAM (NSN: 6840-01-284-3982) TO EXPOSED SKIN. ONE APPLICATION LASTS 6-12 HOURS; MORE FREQUENT APPLICATION IS REQUIRED IF HEAVY SWEATING AND/OR IMMERSION IN WATER. A SECOND OPTION IS 'SUNSECT CREAM' (20% DEET/SPF 15), NSN: 6840-01-288-2188.
15.L.3.C. WEAR TREATED UNIFORM PROPERLY TO MINIMIZE EXPOSED SKIN (SLEEVES DOWN AND PANTS TUCKED INTO BOOTS).
15.L.3.D. USE PERMETHRIN TREATED BEDNETS PROPERLY IN AT RISK AREAS TO MINIMIZE EXPOSURE DURING REST/SLEEP PERIODS. PERMETHRIN TREATED POP UP BEDNETS ARE AVAILABLE: NSN 3740-01-516-4415
15.L.4. HEALTH SURVEILLANCE. SEE REF C AND FF.
15.L.4.A. JOINT MEDICAL WORKSTATION (JMEWS) THROUGH MSAT AT HTTPS://MSAT.FHP.SMIL.MIL/PORTAL

15.L.4.A.1. DEPLOYED UNITS WILL USE JMEWS AS THE PRIMARY DATA ENTRY POINT FOR DISEASE AND INJURY (DI) REPORTING. UNITS WILL ENSURE ALL SUBORDINATE UNITS COMPLETE JOINING AND DEPARTING REPORTS AS REQUIRED WITHIN JMEWS. SHIPBOARD UNITS SHOULD UTILIZE SAMS OR TMIP-M FOR DI REPORTING AND FIXED MTF'S SHOULD UTILIZE AHLTA.
15.L.4.A.2. UNITS WILL COORDINATE JMEWS TRAINING PRIOR TO DEPLOYMENT FOR APPROPRIATE PERSONNEL TO THE MAXIMUM EXTENT POSSIBLE. CURRENTLY, THE ARMY USES MC4 TRAINERS TO TRAIN JMEWS, THE AIR FORCE USES THEATER MEDICAL INFORMATION PROGRAM (TMIP-AF). INFORMATION MANAGERS, OTHER SERVICES DO NOT HAVE DIRECTED TRAINERS AT THIS TIME.
15.L.4.B. DI SURVEILLANCE, SEE REF GG.
15.L.4.B.1. THE LIST OF DI REPORTING CATEGORIES, THEIR DEFINITIONS, AND THE ESSENTIAL ELEMENTS OF THE STANDARD DI REPORT CAN BE FOUND IN ENCLOSURE C OF REF FF.
15.L.4.B.2. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AOR ARE COLLECTING THE PRESCRIBED DI DATA AND REPORTING THAT DATA THROUGH THE JMEWS OR OTHER STANDARDIZED REPORTING PROCESSES ON A WEEKLY BASIS.
15.L.4.B.3. MEDICAL PERSONNEL AT ALL LEVELS WILL ANALYZE THE DI DATA FROM THEIR UNIT AND THE UNITS SUBORDINATE TO THEM AND MAKE CHANGES AND RECOMMENDATIONS AS REQUIRED TO REDUCE DI AND MITIGATE THE EFFECTS OF DI UPON OPERATIONAL READINESS.
15.L.4.C. OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE (OEHSA)
15.L.4.C.1. AUTHORITY. AN OEHSA IS A JOINT APPROVED PRODUCT USED TO PROVIDE A COMPREHENSIVE ASSESSMENT OF BOTH OCCUPATIONAL AND ENVIRONMENTAL HEALTH HAZARDS ASSOCIATED WITH DEPLOYMENT LOCATIONS AND ACTIVITIES AND MISSIONS THAT OCCUR THERE ESTABLISHED BY REF D AND FF.
15.L.4.C.2 TIMEFRAME. AN OEHSA IS INITIATED WITHIN 30 DAYS OF DATE OF ESTABLISHMENT AND COMPLETED WITHIN THREE MONTHS FOR ALL PERMANENT AND SEMI-PERMANENT BASE CAMPS. OEHSA ARE CONDUCTED TO VALIDATE ACTUAL OR POTENTIAL HEALTH THREATS, EVALUATE EXPOSURE PATHWAYS, AND DETERMINE COURSES OF ACTION AND COUNTERMEASURES TO CONTROL OR REDUCE THE HEALTH THREATS AND PROTECT THE HEALTH OF DEPLOYED PERSONNEL.
15.L.4.C.3. CLASSIFICATION/PUBLICATION/ACCESS. OEHSA WILL BE SENT BY THE COMPLETING UNIT THROUGH THE DESIGNATED SERVICE COMPONENT OR JTF PM/FHP OFFICER FOR REVIEW AND SUBMITTED DIRECTLY TO THE DEFENSE OCCUPATIONAL AND ENVIRONMENTAL READINESS SYSTEM (DOEHRS) AT HTTPS://DOEHRS-IH.CSD.DISA.MIL/. SEE APPENDIX J TO REFERENCE EE FOR DOEHRS REQUIREMENTS. IF THE SUBMITTER DOES NOT HAVE ACCESS TO DOEHRS SUBMIT THE OEHSA TO THE MILITARY EXPOSURE SURVEILLANCE LIBRARY (MESL) HTTPS://MESL.APGEA.ARMY.MIL/MESL/. IF THE MESL IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS.DATA@US.ARMY.MIL. CLASSIFIED EXPOSURE DATA SHOULD BE SUBMITTED DIRECTLY TO MESL-S HTTPS://MESL.CSD.DISA.SMIL.MIL. IF ACCESS TO THE MESL-S IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS@USACHPPM.ARMY.SMIL.MIL.
15.L.4.C.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR APPROVING OEHSA COMPLETION AND WILL SUBMIT A MONTHLY REPORT IAW PROCEDURES OUTLINED IN REFERENCE GG.
15.L.4.D. PERIODIC OCCUPATIONAL AND ENVIRONMENTAL MONITORING SUMMARY (POEMS).
15.L.4.D.1. AUTHORITY. POEMS IS A JOINT APPROVED PRODUCT USED TO ADDRESS ENVIRONMENTAL EXPOSURE DOCUMENTATION REQUIREMENTS ESTABLISHED BY REF D AND FF.

15.L.4.D.2. TIMEFRAME. POEMS WILL BE CREATED AND VALIDATED FOR EVERY MAJOR DEPLOYMENT SITE AS SOON AS SUFFICIENT DATA IS AVAILABLE. IN GENERAL, POEMS ARE A SUMMARY OF INFORMATION REFLECTING A YEAR OR MORE OF ENVIRONMENTAL AND OCCUPATIONAL HEALTH DATA TO ENSURE ADEQUATE COLLECTION OF EXPOSURE INFORMATION.
15.L.4.D.3. CLASSIFICATION/PUBLICATION/ACCESS. POEMS WILL BE UNCLASSIFIED BUT POSTED ON THE PASSWORD PROTECTED DEPLOYMENT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA PORTAL AT HTTPS://MESL.APGEA.ARMY.MIL/MESL/ WHERE JOINT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA AND REPORTS ARE STORED. THE POEMS TEMPLATE CAN BE FOUND AT HTTP://PHC.AMEDD.ARMY.MIL.
15.L.4.D.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR ENSURING POEMS ARE COMPLETED FOR SITES IN THEIR RESPECTIVE AOR. THEY SHOULD DEVELOP SITE PRIORITIZATION LISTS AND ENLIST THE SUPPORT OF SERVICE PUBLIC HEALTH ORGANIZATIONS (E.G., U.S. ARMY PUBLIC HEALTH CENTER (USAPHC)) TO DRAFT THE CONTENT OF A SITE POEMS. THE USAPHC OVERSEES THE DATA ARCHIVAL WEBSITE FOR PUBLICATION OF FINAL POEMS AND ASSOCIATED DOCUMENTS; HOWEVER, APPROVAL OF "FINAL" POEMS MUST COME FROM THE SERVICE COMPONENT/JTF FHP OFFICER WITH INPUT FROM PREVENTIVE MEDICINE RESOURCES IN DIRECT OR GENERAL AREA SUPPORT.
15.L.5. REPORTABLE MEDICAL EVENT (RME) SURVEILLANCE. SEE REF O, GG.
15.L.5.A. THE LIST OF DISEASES AND CONDITIONS THAT MUST BE REPORTED CAN BE FOUND IN THE TRI-SERVICE REPORTABLE EVENTS GUIDELINES AND CASE DEFINITIONS AT HTTP://WWW.AFHSC.MIL OR REF HH.
15.L.5.B. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AO ARE COLLECTING THE APPROPRIATE RME DATA AND REPORTING THAT DATA THROUGH THEIR SERVICE SPECIFIC REPORTING MECHANISMS.
15.L.5.B.1. IT IS ONLY REQUIRED TO COPY CCSG FOR THE FOLLOWING RMES AT CCSG-PMO@CENTCOM.SMIL.MIL OR CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL: ANTHRAX; BOTULISM; CBRN AND TOXIC INDUSTRIAL CHEMICAL/MATERIAL (TIC/TIM) EXPOSURE; SEVERE COLD WEATHER/HEAT INJURIES; DENGUE FEVER; HANTAVIRUS DISEASE; HEMORRHAGIC FEVER; HEPATITIS B OR C, ACUTE; HIV; MALARIA; MEASLES; MENINGOCOCCAL DISEASE; MIDDLE EASTERN RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV); NOROVIRUS; OUTBREAK OR DISEASE CLUSTER; PLAGUE; PNEUMONIA, EOSINOPHILIC; Q- FEVER; RABIES, HUMAN; SEVERE ACUTE RESPIRATORY INFECTIONS (SARI); STREPTOCOCCUS, INVASIVE GROUP A; TETANUS; TUBERCULOSIS, ACTIVE; TULAREMIA; TYPHOID FEVER; VARICELLA
15.L.5.C. RME REPORTING IS TO OCCUR AS SOON AS REASONABLY POSSIBLE AFTER THE EVENT HAS OCCURRED. EVENTS WITH BIOTERRORISM POTENTIAL OR RAPID OUTBREAK POTENTIAL ARE CONSIDERED URGENT RME AND IMMEDIATE REPORTING IS REQUIRED (WITHIN FOUR HOURS).
15.L.6. HEALTH RISK COMMUNICATION. SEE REF C.
15.L.6.A. DURING ALL PHASES OF DEPLOYMENT, PROVIDE HEALTH INFORMATION TO EDUCATE, MAINTAIN FIT FORCES, AND CHANGE HEALTH RELATED BEHAVIORS FOR THE PREVENTION OF DISEASE AND INJURY DUE TO RISKY PRACTICES AND UNPROTECTED EXPOSURES.
15.L.6.B. CONTINUAL HEALTH RISK ASSESSMENTS ARE ESSENTIAL ELEMENTS OF THE HEALTH RISK COMMUNICATION PROCESS DURING THE DEPLOYMENT PHASE. MEDICAL PERSONNEL AT ALL LEVELS WILL PROVIDE WRITTEN AND ORAL RISK COMMUNICATION PRODUCTS TO

COMMANDERS AND DEPLOYED PERSONNEL FOR MEDICAL THREATS, COUNTERMEASURES TO THOSE THREATS, AND THE NEED FOR ANY MEDICAL FOLLOW-UP.

15.L.6.C. DI, RME, AND OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) RISK ASSESSMENTS WITH RECOMMENDED COUNTERMEASURES WILL BE PROVIDED TO COMMANDERS AND DEPLOYED PERSONNEL ON A REGULAR BASIS AS WELL AS A SITUATIONAL BASIS WHEN A SIGNIFICANT CHANGE IN ANY ASSESSMENT OCCURS.

15.L.7. HEALTH CARE MANAGEMENT.

15.L.7.A. JOINT TRAUMA SYSTEM (JTS) CLINICAL PRACTICE GUIDELINES (CPGS) MAY BE OBTAINED AT THE UNITED STATES ARMY INSTITUTE OF SURGICAL RESEARCH (USAISR) WEBSITE AT HTTP://WWW.USAISR.AMEDD.ARMY.MIL/CPGS.HTML.

15.L.7.B. DOCUMENTATION OF ALL MEDICAL AND DENTAL CARE RECEIVED WHILE DEPLOYED WILL BE IAW CENTCOM MEDICAL INFORMATION MANAGEMENT GUIDELINES. SEE REF II.

15.L.7.C. IT IS A COMMANDER'S RESPONSIBILITY TO ENSURE THAT ALL PERSONNEL POTENTIALLY AFFECTED BY A BLAST OR OTHER POTENTIALLY CONCUSSIVE EVENT (PCE) ARE EVALUATED FOR TRAUMATIC BRAIN INJURY (TBI) BY A MEDICAL PROVIDER AND DOCUMENTATION IS COMPLETED IAW REF JJ.

15.L.8. UNIT MASCOTS AND PETS.

15.L.8.A. PER CENTCOM GENERAL ORDER 1.C, DEPLOYED PERSONNEL WILL AVOID CONTACT WITH LOCAL ANIMALS (E.G., LIVESTOCK, CATS, DOGS, BIRDS, REPTILES, ARACHNIDS, AND INSECTS) IN THE DEPLOYED SETTING AND WILL NOT FEED, ADOPT, OR INTERACT WITH THEM IN ANY WAY.

15.L.8.B. ANY CONTACT WITH LOCAL ANIMALS, WHETHER INITIATED OR NOT, THAT RESULTS IN A BITE, SCRATCH OR POTENTIAL EXPOSURE TO THE ANIMAL'S BODILY FLUIDS (SALIVA, VENOM, ETC.) WILL BE IMMEDIATELY REPORTED TO THE CHAIN OF COMMAND AND MEDICAL PERSONNEL FOR EVALUATION AND FOLLOW-UP.

15.L.9. FOOD AND WATER SOURCES.

15.L.9.A. ALL WATER (INCLUDING ICE) IS CONSIDERED NON-POTABLE UNTIL TESTED AND APPROVED BY APPROPRIATE MEDICAL PERSONNEL (ARMY OR NAVY PREVENTIVE MEDICINE, AIR FORCE BIOENVIRONMENTAL ENGINEERING, INDEPENDENT DUTY MEDICAL TECHNICIAN/CORPSMAN). COMMERCIAL SOURCES OF DRINKING WATER MUST ALSO BE APPROVED BY THE U.S. ARMY PUBLIC HEALTH CENTER.

15.L.9.B. NO FOOD SOURCES WILL BE UTILIZED UNLESS INSPECTED AND APPROVED BY U.S. ARMY PUBLIC HEALTH CENTER (I.E. VETERINARY PERSONNEL).

15.L.9.C. COMMANDERS WILL ENSURE THE NECESSARY SECURITY TO PROTECT WATER AND FOOD SUPPLIES AGAINST TAMPERING BASED ON RECOMMENDATIONS PROVIDED IN FOOD/WATER VULNERABILITY ASSESSMENTS. MEDICAL PERSONNEL WILL PROVIDE CONTINUAL VERIFICATION OF QUALITY AND PERIODIC INSPECTION OF STORAGE AND PREPARATION FACILITIES.

15.L.10. ENVIRONMENTAL EXPOSURES OF CONCERN.

15.L.10.A. COLD INJURY RISK WILL DEPEND ON THE SPECIFIC REGION. HYPOTHERMIA, A LIFE-THREATENING CONDITION, MOSTLY OCCURS UP TO 55 DEGREES FAHRENHEIT AIR TEMPERATURE. RISK OF COLD INJURY INCREASES FOR PERSONS WHO ARE IN POOR PHYSICAL CONDITION, DEHYDRATED, WET, OR AT INCREASED ALTITUDE. COUNTERMEASURES INCLUDE PROPER WEAR OF CLOTHING AND COVER. EXPOSED SKIN IS MORE LIKELY TO DEVELOP FROSTBITE. ENSURE CLOTHING IS CLEAN, LOOSE, LAYERED, AND DRY. COVER THE HEAD TO CONSERVE HEAT.

15.L.10.B. HEAT STRESS/ SOLAR INJURIES/ILLNESS. HEAT INJURIES MAY BE THE GREATEST OVERALL THREAT TO MILITARY PERSONNEL DEPLOYED TO WARM CLIMATES. ACCLIMATIZATION TO INCREASED TEMPERATURE AND HUMIDITY MAY TAKE 10 TO 14 DAYS.

HEAT INJURIES CAN INCLUDE DEHYDRATION, SUNBURN, HEAT SYNCOPE, HEAT EXHAUSTION AND HEAT STROKE. ENSURE PROPER WORK-REST CYCLES, ADEQUATE HYDRATION, AND COMMAND EMPHASIS ON HEAT INJURY PREVENTION. ENSURE AVAILABILITY AND USE OF INDIVIDUAL PROTECTION SUPPLIES AND EQUIPMENT SUCH AS SUNSCREEN, LIP BALM, SUN GOGGLES/GLASSES, AND POTABLE WATER.

15.L.10.C. ALTITUDE. OPERATIONS AT HIGH ALTITUDES (OVER 9888 FT) CAN CAUSE A SPECTRUM OF ILLNESSES, INCLUDING ACUTE MOUNTAIN SICKNESS; HIGH ALTITUDE PULMONARY EDEMA, HIGH ALTITUDE CEREBRAL EDEMA, OR RED BLOOD CELL SICKLING IN SERVICE MEMBERS WITH SICKLE CELL TRAIT. ASCEND GRADUALLY, IF POSSIBLE. TRY NOT TO GO DIRECTLY FROM LOW ALTITUDE TO >9,888 FT (3,013 M) IN ONE DAY. A HEALTH CARE PROVIDER MAY PRESCRIBE ACETAZOLAMIDE (DIAMOX) OR DEXAMETHASONE (DECADRON) TO SPEED ACCLIMATIZATION IF ABRUPT ASCENT IS UNAVOIDABLE. TREAT AN ALTITUDE HEADACHE WITH SIMPLE ANALGESICS; MORE SERIOUS COMPLICATIONS REQUIRE OXYGEN AND IMMEDIATE DESCENT.

15.L.10.D. GOOD FIELD SANITATION PRACTICES ARE ESSENTIAL TO MAINTAIN FORCE HEALTH. THEY INCLUDE: FREQUENT HANDWASHING, PROPER DENTAL CARE, CLEAN AND DRY CLOTHING (ESPECIALLY SOCKS, UNDERWEAR, AND BOOTS), BATHING AND DENTAL CARE WITH WATER FROM A POTABLE SOURCE. CHANGE SOCKS FREQUENTLY, FOOT POWDER HELPS PREVENT FUNGAL INFECTIONS.

15.M. ALL OTHER INSTRUCTIONS AND GUIDANCE SPECIFIED IN INITIAL POLICY MESSAGE REMAIN IN EFFECT. MOD TWELVE IS NOW INVALID.

15.N. THE USCENTCOM POC FOR PREVENTIVE MEDICINE/FORCE HEALTH PROTECTION IS CCSG, DSN 312-529-0345; COMM: 813-529-0345; SIPR: CCSG-PMO@CENTCOM.SMIL.MIL OR KEVIN.CRON@CENTCOM.SMIL.MIL; NIPR: CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL OR KEVIN.M.CRON.MIL@MAIL.MIL//

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

SEP 22 2014

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

The DoD and the Military Services have policies in place to address the management of individuals with these conditions. The policies were established with an understanding of these diseases and the impact on the individual and the risk to other individuals. Health care providers in the Military Health System have appropriate training to manage the acute and long-term health needs of individuals with these conditions. The enclosed report reviews the policies for accession, retention, deployment, discharge, and adverse actions. The review found that the policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, reflect standard of care medical practices, and have been reviewed regularly and updated as practices, guidelines, and standard of care have evolved.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

SEP 22 2014

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

SEP 22 2014

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

SEP 22 2014

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

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Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

Report to Congressional Defense Committees on Department of Defense Personnel Policies Regarding Members of the Armed Forces with HIV or Hepatitis B

2014

The estimated cost of report for the
Department of Defense is approximately
$5100.00
This includes $4,500.00 in expenses and
$600.00 in DoD labor.
Generated on July 30, 2014

EXECUTIVE SUMMARY

INTRODUCTION: This report responds to section 572 the National Defense Authorization Act (NDAA) for Fiscal Year 2014 (Public Law 113-66), which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

DATA COLLECTION: DoD and Service policies were reviewed to develop this report.

POLICIES PERTAINING to HIV and HBV:

1. Individuals under consideration for appointment, enlistment, or induction into the Military Services with evidence of HIV or HBV infection do not meet accession standards, which require healthy recruits free of communicable diseases or medical conditions that may require excessive time lost for treatment or probably will result in separation for medical unfitness. Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions.

2. Service members already serving who have laboratory evidence of HIV or HBV infection:
   - Are referred for appropriate treatment and managed in the same manner as a Service member with other chronic or progressive illnesses. If determined to be unfit for duty, the Service member will be separated or retired.
   - May not deploy without a waiver and the approval of the Combatant Commander. The factors considered ensure the Service member will be able to perform duties.
   - May not be subjected to adverse personnel action solely due to infection status. However, a Service member with laboratory evidence of HIV infection who disobeys an order to inform current or potential sexual partners of their infected status or to engage in safe sex practices may be subject to disciplinary action.

DISCUSSION: This review found that current DoD HIV and HBV policies are:

1. Established to maintain military readiness and based on international, national and federal guidelines, and professional organization recommendations for prevention, identification and treatment of HIV and HBV.

2. Evidence-based, medically accurate and reviewed regularly by subject matter experts.

3. Established to ensure applicants can complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military without jeopardizing their health, the health of their unit, or the health of the inhabitants of the lands where our forces are deployed.

4. In support of retention of DoD personnel already serving unless there is evidence of deteriorating health or other factors that make the individual unable or unfit to perform their duties.

5. Implemented to ensure that infection with HIV or HBV will not be the basis for adverse personnel actions.

CONCLUSION: The policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, and are reviewed regularly and updated as practices, guidelines, and standards of care evolve.

INTRODUCTION:

Section 572 of NDAA for FY 2014, which was signed into law on December 26, 2013, required the Secretary of Defense to submit a report on DoD personnel policies regarding members of the Armed Forces infected with HIV or HBV to the congressional defense committees not later than 180 days after enactment of the act. The statute states: "The report shall include the following:

(1) A description of policies addressing the enlistment or commissioning of individuals with these conditions and retention policies, deployment policies, discharge policies, and disciplinary policies regarding individuals with these conditions.

(2) An assessment of these policies, including an assessment of whether the policies reflect an evidence-based, medically accurate understanding of how these conditions are contracted, how these conditions can be transmitted to other individuals, and the risk of transmission."

An interim report dated April 30, 2014 was sent to the chairpersons of the defense committees.

DATA COLLECTION:

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) requested each of the Military Departments to provide a summary addressing the requirements in section 572 of the NDAA for FY 2014. The ASD(HA) reviewed DoD-level policies for enlistment or commissioning, retention, deployment, discharge and discipline of individuals infected with HIV or HBV. This report combines the Service data with the DoD assessment to provide a summary addressing the two requirements in the NDAA language.

POLICIES PERTAINING TO HIV AND HBV:

1. Enlistment or Commissioning

Standards for enlistment or commissioning of individuals into the Armed Services are stated in DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in The Military Services." Paragraph 4 states "It is DoD policy to ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that probably will endanger the health of other personnel.
(2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
(3) Medically capable of satisfactorily completing required training.
(4) Medically adaptable to the military environment without the necessity of geographical area limitations.
(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions."

Applicants with the following specific medical conditions do not meet accession standards:

- Presence of HIV or serologic evidence of infection or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing, or
- Current acute or chronic hepatitis carrier state, hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function

In accordance with DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs will be tested for laboratory evidence of HIV within 72 hours of arrival to the program and denied entry to the program if such test is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV not later than during their commissioning physical examination, and denied a commission if they test positive.

Service accession policies are in compliance with DoDI 6130.03 and DoDI 6485.01.

2. Retention

Once a Service member has been trained, the goal is to retain members who acquire HIV or HBV who are still capable of performing their duties in the rigorous military environment and to deploy wherever the military serves. If any member incurs a medical condition that limits their ability to continue performing their military occupation, the Department's Disability Evaluation System (DES) provides for the member to have a fair and full review to determine fitness for duty (see paragraph 4 below for a discussion of DES).

The screening policies for HIV and HBV identify Service members who have been infected since accession into the military. In the Army and Air Force, HBV screening for Service members is performed if clinically indicated. SECNAVINST 5300.30E currently requires all AD personnel to receive, in addition to accession testing, an HBV test every 25 months. However, since it has been determined that there is no medical or force readiness indication for such frequent testing, the Secretary of the Navy has issued a temporary deferral from this requirement. Navy is currently revising SECNAVINST 5300.30E to remove this needlessly stringent requirement. Additional screening will be in accordance with the US Preventive Task Force Recommendation Statement, "Screening for Hepatitis B Virus Infection in Non-pregnant Adolescents and Adults," and as medically indicated.

DoDI 6485.01 requires all Service members to be screened periodically for laboratory evidence of HIV infection.

- AD and Reserve Component (RC) Selected Reserve (SELRES) personnel are screened every 2 years unless more frequent screenings are clinically indicated.

- Members of the SELRES are screened at least once every 2 years. RC personnel are screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.[1]

Testing for laboratory evidence of HIV for pre- and post-deployment is conducted in accordance with DoDI 6025.19, "Individual Medical Readiness" and DoDI 6490.03, "Deployment Health." (The requirements for screening in DoDI 6025.19 and DoDI 6490.03 are listed under the deployments section.)

The U.S. Preventive Services Task Force (USPSTF) makes recommendations for screening for HIV that are patient specific. In addition, the 2013 recommendations noted that there are no definitive data supporting specific screening intervals. These recommendations are reviewed by the subject matter experts when reviewing DoD policy for currency. It is important to note that DoD policy is population based screening based upon unique operational military requirements. For example, the safety of the U.S. military blood supply is a primary factor in determining the policy for screening. The DoD screening policy supports early detection and treatment. The USPSTF 2013 recommendations also noted that there is direct evidence of the benefits of early antiretroviral therapy for HIV infected persons and its effectiveness in preventing HIV transmission.

An AD Service member with laboratory evidence of HIV or HBV infection is evaluated and managed in the same manner as a Service member with other chronic or progressive illnesses. A treatment plan is established, any indicated treatment is initiated. The member may be allowed to continue to serve in a manner that ensures ongoing access to appropriate medical care provided that she or he is fit for duty Infected RC members who are fit for duty are also managed in the same manner as those with chronic or progressive illnesses and their medical condition is monitored periodically.

3. Deployment

DoDI 6025.19 requires that an HIV test result, completed within the last 24 months, be on file prior to deployment.

DoDI 6490.03 requires pre-deployment serum specimens and HIV testing (or as required by HIV threat or country requirements) for all deployments greater than 30 days to areas outside the contiguous United States (OCONUS) with non-fixed Military Treatment Facilities (MTFs). The combatant command (COCOM) Commander, Service component commander, or commander exercising operational control determines requirements for serum testing and HIV testing for all OCONUS deployments less than 30 days; OCONUS deployments to areas with fixed U.S. MTFs; and deployments within the contiguous United States (CONUS). When required, pre-deployment HIV tests must have been collected within 2 years of deployment (or more recently, based on country entry requirements). HIV serum samples that are not more than 12 months old

[1] "RC personnel" includes all members of the RC not in the SELRES. For example, a member in the Individual Ready Reserve is not routinely screened; however, the member is screened when ordered to AD for more than 30 days.

stored in the DoD Serum Repository may satisfy the pre-deployment specimen requirement. DoDI 6490.03 requires notification of Service members if a pre- or post-deployment serum sample will be tested for HIV.

In accordance with DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Service members with the following medical conditions may not deploy unless a waiver is granted:

- Known blood-borne diseases that may be transmitted to others in a deployed environment.
- Presence of HIV seropositivity with the presence of progressive clinical illness or immunological deficiency.

The Combatant Command surgeon must be consulted in all instances of HIV seropositivity and active HBV infection for consideration of a medical clearance for deployment. The Combatant Commander is the final approval authority for waivers.

AR 40-501, "Standards of Medical Fitness," directs that HIV infected members will not be deployed to a combat theater of operations. However, waivers may be granted to HIV infected individuals to serve in OCONUS duty assignments. AR 40-501 is currently under revision and will address the availability of medical care in OCONUS for members with HIV or HBV who are granted a waiver. The revised policy will direct that medical services available in the assignment area must provide the same standard of care as in CONUS.

In 2012, based on advances in medical treatment which have significantly simplified the disease management of individuals with HIV, the Navy updated its policies to allow individuals with HIV, who have had appropriate evaluation and medical clearance, to operationally deploy aboard select naval vessels. These personnel are considered to have controlled HIV infection as manifested by an unimpaired immune system, no current viremia, an established history of compliance with medical treatment, and a history of professional attitude. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of infection in normal daily activities.
- An investment in training of these individuals has been made.
- The previous policy of denying deployments was making this subset of personnel less competitive in achieving career milestones or warrior qualifications.

The Air Force (AF) policy states that HIV-infected Service members cannot deploy or be stationed OCONUS without a waiver. The AF is continuing to develop guidance for non-permanent change of station (PCS) extended duty tours and/or travel to areas with increasing military operations tempo (such as United States Africa Command or United States Pacific Command).

4. Discharge From Duty or Retirement

A Service member infected with HIV or HBV is not retired or separated solely on the basis of being infected. However, an infected member whose condition deteriorates and interferes with the successful performance of their military occupation may be referred to the Disability Evaluation System (DES) for a physical disability evaluation, which provides for a fair and full review to determine fitness for duty.

DoDI 1332.18, "Physical Disability Evaluation," DoD Manual 1332.18, Vol 1, "Disability Evaluation System Manual: General Information and Legacy DES (LDES) Time Standards," and DoD Manual 1332.18, Vol 2: Disability Evaluation System Manual: Integrated Disability Evaluation System (IDES)" establish policy for determining fitness for duty and for retiring or separating Service members due to physical disability. A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history, appropriate physical examination, indicated medical tests and their results, medical and surgical consultations as necessary, diagnoses, ongoing or recommended treatment, and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty, the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Have one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating including those duties remaining on a Reserve obligation for more than 1 year after diagnosis;

- Have a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

- Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

In all cases, competent medical authorities will refer into the DES eligible Service members who meet the criteria within 1 year of diagnosis.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to reasonably perform the duties of her or his office, grade, rank, or rating to include duties during a remaining period of Reserve obligation. For members determined unfit due to duty-related medical impairments, the PEB determines their entitlement to benefits under Chapter 61 of 10 U.S.C. Members found unfit are separated or retired in accordance with the guidance in DoDI 1332.18.

A revision of DoDI 1332.18 and the supporting Manuals were published on 5 August 2014. As a result, the Military Services will need to review Service policies for disability evaluation to ensure compliance with the revised DoD policy.

5. Adverse Personnel Action

HIV or HBV infection may not be the sole cause for adverse personnel actions. DoDI 6485.01 directs that information obtained as a result of an epidemiologic assessment interview will not be used to support any adverse personnel action against the Service member.

The Services use a strategy of aggressive disease surveillance and health education programs to help control the transmission of HIV or HBV. An infected Service member receives training on the prevention of further transmission of HIV or HBV infection to others and the potential legal consequences of exposing others to HIV infection. All Services hold HIV infected members accountable under the Uniform Code of Military Justice (UCMJ) if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

DISCUSSION:

International, national and federal guidelines and professional organization recommendations are considered in the development of DoD and Service policies and during the periodic reviews and updates. These guidelines and recommendations are evidence-based, and take into consideration the epidemiology and pathophysiology of how HIV and HBV are contracted and transmitted. DoD policies for HIV and HBV are consistent with the current guidelines and recommendations of the Centers for Disease Control and Prevention. Service policies are in compliance with the DoD policies. The health information and privacy of infected Service members are protected by DoD privacy policies and programs, with which the Services are also in compliance.

The Heads of the DoD Components must ensure that each issuance for which they are the office of primary responsibility is reviewed annually. The policy must be certified as current or revised, changed, or cancelled as appropriate. The DoD policy on HIV in military Service members was revised most recently on June 7, 2013 and was reviewed in June 2014 for currency.

All Department of the Army (DA) administrative publications must be no more than 5 years old. All DA Publications more than 5 years old must be updated to reflect current policies and procedures. The Army reported that their personnel policies are reviewed every 5 years at a minimum to ensure currency and that they reflect standard of care practices. AR40-501 is being revised in light of the advances in care and treatment for HIV, and normal life expectancy for those with adequate access to care and compliance with treatment recommendations. Army reports, for example, that a current policy that prevents the assignment of HIV infected soldiers to military-sponsored educational programs that would result in an additional service obligation is being reconsidered.

The Navy reported that its guidance for evaluation, diagnosis, and management options for HIV and HBV undergoes frequent and significant updates as medical capabilities, technologies, and evidence based practices evolve. Navy policy incorporates best practices to maintain a fit and ready force capable of carrying out the Navy's mission in its unique operational milieu.

Therefore, policies undergo review and revision to ensure maximum readiness at least every five years. When specific issues arise, policies are amended as needed on a case by case basis.

Recognizing the similarities in the transmission of, and risk factors for HIV and HBV infection, Department of the Navy medical, manpower and personnel policies reflect current knowledge of the natural history of these infections, the risks to the infected individual incident to continued military service, the risk of transmission of these viruses to non-infected personnel, the effect of infected personnel on commands and the mission, and the safety of military blood supplies.

The AF Medical Service reported that their HIV and HBV policies are assessed every two years to ensure they accurately reflect current evidence-based practice. Air Force Instruction 48-135, "Human Immunodeficiency Virus Program," was rewritten in 2014 in consultation with the Air Force Medical Service Infectious Disease physician and HIV point of contact at San Antonio Military Medical Center to ensure clinical accuracy. Similarly, HBV policies are reviewed by both Infectious Disease and Gastroenterology subject matter experts to ensure accuracy and adherence to up to date evidence-based practices.

To prevent hepatitis B, DoD began vaccinating all new recruits in 2002. Tri-service vaccination policy is contained in Army Regulation 40-562, *BUMEDINST 6230.15B, AFI 48–110, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases." Current policy continues vaccination of basic trainees and other accessions (unless sero-immune) during initial entry training. The hepatitis B vaccine is also provided for susceptible personnel who are at risk of potential exposure to blood-borne pathogens. For military purposes, this includes occupational specialties involving health care workers, emergency medical technicians, mortuary affairs personnel, search and rescue specialists, correctional facility staff, and designated special operations forces. Members deploying for more than 30 days to areas of high hepatitis B Service members who may have been exposed to Hepatitis B are evaluated and receive post-exposure prophylaxis, if appropriate.

There is no vaccine currently available to prevent HIV infection, but the Army is engaged in clinical research. Post-exposure prophylaxis is available and is provided for Service members, as appropriate, based upon the nature and timing of the exposure.

In summary, this review found that current DoD and Service policies for accession, retention, deployment, discharge, and discipline of DoD personnel with HIV or HBV:

- are based on international, national and federal guidelines, and professional organization recommendations for prevention, identification, and treatment of HIV and HBV;
- are evidence based and medically accurate in accordance with how HIV and HBV are contracted and transmitted;
- are reviewed regularly by subject matter experts at the DoD and Service level, and are updated as guidelines and recommendations evolve or new medical information becomes available;
- are consistent with national guidelines, consistently implemented across DoD, and that Service policies are in compliance with DoD-level policies;

- support retention of DoD personnel unless there is evidence of deteriorating health or other factors that make the individual unable or unfit to perform their duties;
- direct that infection with HIV or HBV will not be the sole basis for adverse actions; and
- protect the privacy of an infected individual.

Service policies reflect frequent changes and updates as medical capabilities, technologies, and evidence-based practices have evolved. The AF, which has the most recently revised policies for HIV and HBV, believes its current policies are appropriate, reflect the most current evidence-based practice, and are medically accurate based on how these conditions are contracted and transmitted. The Army and the Navy are currently revising the policies governing the management of Service members infected with HIV or HBV.

CONCLUSIONS:

DoD accession policies are consistent with the need of the military Services to recruit healthy personnel who are able to participate in demanding military training and capable of deploying to harsh and austere environments without deterioration in their health.

For those who become infected with HIV or HBV after accession, DoD policy is evidence-based and in accordance with state-of-the-art clinical guidelines. The emphasis is upon retention if the medical condition is stable with appropriate treatment.

A waiver is required for Service members with HIV or HBV infection to deploy. As with other medical conditions requiring a waiver, many factors that the Service member will encounter during the deployment are considered to determine whether it is likely the medical condition will limit the Service member's performance or cause the medical condition to deteriorate.

Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV or HBV infection) may be evaluated for either duty limitations or medical discharge.

Adverse personnel actions based solely on HIV or other infection are precluded by DoD and Service policy. However, as with any direct order, a Service member, who violates the order to inform sexual partners of their HIV or HBV status or fails to use safe sexual practices, may be subject to disciplinary action.

The policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, reflect standard of care medical practices, and have been reviewed regularly and updated as practices, guidelines, and standard of care have evolved.

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

AUG 27 2018

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

The enclosed report includes the following: (1) a description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition; (2) an update on the status of the Department of the Army's HIV policy; (3) an assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted, how this condition can be transmitted to other individuals, the risk of transmission, and treatment regimens available; and (4) the feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

Thank you for your continued support of our Service members. A similar letter is being sent to the Chairman of the Senate Committee on Armed Services.

Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

AUG 27 2018

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

The enclosed report includes the following: (1) a description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition; (2) an update on the status of the Department of the Army's HIV policy; (3) an assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted, how this condition can be transmitted to other individuals, the risk of transmission, and treatment regimens available; and (4) the feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

Thank you for your continued support of our Service members. A similar letter is being sent to the Chairman of the House Committee on Armed Services.

Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus:

Report to the Committees on the Armed Services of the Senate and House of Representatives

August 2018

The estimated cost of this report or study for the Department of Defense is approximately $18,000 for the 2018 Fiscal Year.
This includes $100 in expenses and $18,000 in DoD labor.
Generated on 2018Apr27 RefID: D-13AF836

EXECUTIVE SUMMARY

INTRODUCTION: House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018, requested that the Department of Defense (DoD) submit a report to the Committees on Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV). Specifically, the Committee requested DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Enlistment and Commissioning (i.e., Accession): Grounded in statutory requirements for accessions of able-bodied and physically qualified individuals, recently reissued Department of Defense Instruction (DoDI) 6130.03, "Medical Standards for Appointment, Enlistment, or Induction into the Military Services," May 6, 2018, establishes DoD policy to ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

- Free of contagious diseases that may endanger the health of other personnel.
- Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.
- Medically capable of satisfactorily completing required training and initial period of contracted service.

- Medically adaptable to the military environment without geographical area limitations.
- Medically capable of performing duties without aggravating existing physical defects or medical conditions.

That instruction also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. The instruction addresses 29 body systems, and lists for each of those a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. Thus, HIV infection is a disqualifying medical condition for entry into the military service. Both prior service and non-prior service applicants undergo screening for HIV prior to entrance. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver.

2. Retention and Discharge: DoD and Service policies restrict involuntary separation of a Service member solely due to being HIV positive. Service members who acquire HIV after joining the military are ensured access to appropriate medical care: DoD policy requires they receive counseling and treatment consistent with the standard of care, evidence-based HIV clinical practice standards, and medical management guidelines. HIV positive Service members receive a referral for medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses. Service members with HIV may continue their service as long as they are able to perform their military duties, taking into account the nature of their position. If they develop a disability, HIV-positive Service members undergo evaluation of fitness for continued service by the same process as those who are HIV-negative. Active duty (AD) and Reserve Component (RC) Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty undergo separation or retirement. Military Departments and Combatant Commands (CCMD) limit assignments of HIV-infected individuals based on expert medical review, determination regarding the individual's fitness for duty, and the nature and location of the duties performed, in accordance with operational requirements.

3. Deployment: DoD policy establishing deployment-limiting medical conditions sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness requirements, or Combatant Commander needs may involve additional restrictions. HIV antibody positive status is a deployment-limiting medical condition precluding contingency deployment.

DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Enclosure 3, dated February 5, 2010, provides that individuals with a diagnosis of "human immunodeficiency virus (HIV) antibody positive with the presence of progressive [HIV related] clinical illness or immunological deficiency" shall not deploy unless a waiver is granted. All Service policies preclude HIV positive Service members from deploying to combat areas or in support of contingency operations due to the potential lack of access to needed medical care or medications in austere environments, as well as the military risks inherent in the mission assigned that could lead to illness exacerbation and compromise unit readiness and mission completion. For purposes of this report, a contingency deployment is one that is outside the continental United States (OCONUS), more than 30 days in duration, and in a

location with medical support from only non-fixed (temporary) military medical treatment facilities. A contingency deployment also includes the relocation of forces and materiel to an operational area in a situation requiring military operations in response to natural disasters, terrorists, or as otherwise directed.

All Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or to be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations. A waiver may be recommended on a case-by-case basis after review of the individual Service member's health and consideration of factors including the climate, altitude, rations, housing, nature of the duty assignment proposed, and medical services available in the location to which deployment or assignment is proposed. Further, the condition must not pose a significant risk of substantial harm to the individual or others, taking into account the condition of the deployed environment. The following table outlines the Service-specific policies for grant of a waiver to permit an HIV positive Service member to deploy for other than combat or a contingency, or to be assigned for duty in an overseas location:

Army	Waivable?	Yes
	By Whom?	Combatant Commander
	Under what conditions?	Soldier is determined to be fit and free of HIV-related illness.
	Host nation rules apply?	Yes, but deployments may be permitted ***only*** to Europe and Korea.
Navy/ Marine Corps	Waivable?	Yes
	By Whom?	Sailors: Treating HIV Evaluation and Treatment Unit (HETU), Navy Bloodborne Infection Management Center, PERS-82, and receiving command. Marines: Deputy Commandant. Manpower & Reserve Affairs and receiving command.
	Under what conditions?	Agreement by all organizations/officials listed above and receiving command (including the CCMD, as appropriate). Sailors/Marines who have no viremia (i.e., there is no virus present in the bloodstream), do have an established history of medical compliance, and possess a professional attitude, may be considered on a case-by-case basis for large ship platform tours and OCONUS deployment/assignment.
	Host nation rules apply?	Yes
Air Force	Waivable?	Yes
	By Whom?	Air Force Medical Support Agency, with favorable coordination from receiving commander and CCMD approval.
	Under what conditions?	No HIV-related illness.
	Host nation rules apply?	Yes

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the Disability Evaluation System (DES) or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary: DoD policy provides that a HIV positive status is not a punishable offense and cannot be used as a sole basis for disciplinary action against an individual. DoD policy also prohibits the use of information obtained as a result of an epidemiologic assessment interview to support any adverse personnel action against a Service member. However, Service members with laboratory evidence of HIV infection may be subject to disciplinary action if they disobey an order to inform current or potential sexual partners of their infected status or do not engage in safe sex practices.

ARMY POLICY STATUS UPDATE: Initiated in 2015, a working group has reviewed Army Regulation (AR) 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF PERSONNEL POLICIES: Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. Broad consensus regarding published medical evidence supports the notion that people living with HIV on antiretroviral therapy (ART) who have an undetectable viral load in their blood, have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for an individual's viral load to reach an undetectable level. Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure, but also on providing evidence-based care and support for Service members living with HIV, with the goal to maintain a Service member's fitness for duty, optimize retention and quality of life, and help avoid disease progression of HIV-positive Service members into potential disability. Recognizing the risk factors for HIV infection and transmission, DoD- and Service-level personnel policies intend to reflect current knowledge of: how HIV is contracted and transmitted to HIV-naïve individuals; the ability of an HIV-positive individual to continue service without exacerbating his or her condition or risking the military mission; the effect of

infected personnel on commands; and the safety of military blood supplies. Medical literature pertaining to HIV medicine rapidly evolves. Subject matter experts across the Military Services are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion.

FEASIBILITY OF ALLOWING ENLISTED SERVICE MEMBERS TO BECOME COMMISSIONED OFFICERS AND RESTRICTIONS DIFFERENT FOR OFFICERS: DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for this difference is that once a member has been fully trained and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service compared to one without such service, in minimizing any risk of inability to perform satisfactorily in the commissioned officer position due to medical conditions. Yet, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION: The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces. Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.

- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, including combat against enemy forces, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.

- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.

- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.

- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.

- Ensure that a Service member infected with HIV but able to fully perform duties is not retired or involuntarily separated solely based on being infected.

- Direct the protection of health information and privacy of HIV-infected personnel.

- Reflect existing evidence and adhere to current nationally-accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.

- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS: DoD- and Service-level personnel policies pertaining to members of the Armed Forces infected with HIV are evidence-based in accordance with current clinical guidelines and are reviewed and updated to align with evolving medical capabilities, technologies, evidence-based practices, and current scientific understanding of the nature of HIV infection, transmission, and management. Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the Military Health System (MHS) to sustain the health of Service members and restore the health and return to duty of Service members who become ill or injured, whenever possible. Once a Service member completes training, the goal is to retain members who acquire HIV and who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (e.g., access to quality care, counseling, support and educational services, privacy protections, option to continue service, if desired). As such, existing DoD- and Service-level personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

INTRODUCTION:

In House Report 115-200, page 148-149, to accompany H.R. 2810, NDAA for FY 2018 (Public Law 115-91), the Committee on Armed Services of the House of Representatives requested that the DoD submit a report to the Committees on the Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with HIV. Specifically, the Committee requested that DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

The Committee indicated that the Department's previous report, submitted to Congress in response to section 572 of the NDAA for FY 2014, did outline the current DoD policies; however, it failed to include how current policies reflect the evidence base and medical advances in the field of HIV. The Committee also stated the report fell short in describing the criteria guiding the implementation of these policies throughout different branches and among commanding officers.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the OASD(HA).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Accession (Enlistment or Commissioning)

Accession standards require healthy recruits who are free of communicable diseases or medical conditions that will likely endanger the health of other personnel, require excessive time lost from duty for necessary treatment or hospitalization, or likely result in separation from service due to medical unfitness. DoDI 1304.26, "Qualification Standards for Enlistment, Appointment,

and Induction," provides basic entrance qualification standards "designed to ensure that individuals under consideration for enlistment, appointment, or induction are able to perform military duties successfully, and to select those who are the most trainable and adaptable to Service life." Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions. DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," states that individuals under consideration for appointment, enlistment, or induction into the Military Services must be:

- Free of contagious diseases that probably will endanger the health of other personnel.
- Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- Medically capable of satisfactorily completing required training.
- Medically adaptable to the military environment without the necessity of geographical limitations.
- Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

DoDI 6130.03 also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. This instruction addresses 29 body systems and lists for each a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013, reiterates that individuals with laboratory evidence of HIV infection are denied eligibility for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03. All applicants for appointment, enlistment, or individuals being inducted into the Military Services are screened for laboratory evidence of HIV infection. Applicants do not meet accession standards if they present with HIV or serologic evidence of infection, or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing. Thus, HIV infection is a disqualifying medical condition for military service, and persons infected with HIV are neither enlisted nor commissioned into military service. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver pursuant to DoDI 6130.03.

Additionally, DoDI 6485.01 requires applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs undergo testing for laboratory evidence of HIV within 72 hours of arrival to the program, and denies entry to the program if the test result is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV no later than during their commissioning physical examination, and are denied a commission if they test positive.

Applicants for active and reserve enlisted service undergo HIV testing typically at U.S. Military Entrance Processing Command Military Entrance Processing Stations (MEPS) or other authorized locations. Applicants not tested at the MEPS undergo testing as part of the physical examination conducted prior to accession.

Service accession policies comply with DoDI 6130.03 and DoDI 6485.01. Applicable Service policies are set forth in the following: AR 600-110 and AR 40-501for the Army; Secretary of the Navy Instruction (SECNAVINST) 5300.30E for the Navy and Marine Corps; and Air Force Instruction (AFI) 48-123 for the Air Force.

DoD medical accession standards are reviewed periodically by the Accession Medical Standards Working Group (AMSWG), which evaluates and recommends updates to maintain the currency and validity of those standards. The AMSWG is co-chaired by representatives from the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (M&RA) and OASD(HA). It includes a voting representative from each of the five Military Services, with additional support from the following DoD components/offices: Joint Staff Surgeon; Surgeons General of the Army, Navy, and Air Force; medical officers of the Coast Guard and National Guard Bureau; and personnel chiefs of the Army, Navy, Air Force, Marine Corps, Joint Staff, and National Guard Bureau. Among the functions of the AMSWG are to perform evidence-based assessments of the accession standards and provide direction in research initiatives for the Accession Medical Standards Research Activity, including evidence-based research in support of medical standards assessments.

Supported by the work of the medical and personnel experts of the AMSWG, the DoDI 6130.03 disqualification for accession for HIV infection does not reflect disagreement with the medical consensus that modern medication management of HIV infection produces very positive results. However, in the context of the extraordinary challenges of many aspects of military service, including potential mission needs under highly stressful combat conditions or in extremely austere and dangerous places worldwide, even well-managed HIV infection carries risks of complications and comorbidities, possibly with latent effects, immune system dysregulation, neurocognitive impairments (NCI) (discussed further below), disrupted medication maintenance and necessary monitoring for potential side-effects, possible military vaccination adverse effects, and potential communicability, including in circumstances of buddy-aid to a seriously injured member in combat and emergency whole blood battlefield transfusions. In view of these risks, the needs of the Service incline toward maintaining the longstanding medical standard disallowing accession of HIV infected individuals.

2. Retention/Discharge

Once a Service member completes initial training, the policy is to retain members who acquire HIV and are still capable of performing their duties in the rigorous military environment. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection is conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

DoDI 6485.01 specifically addresses HIV in Service members, and prescribes procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV. An AD Service member with laboratory evidence of HIV infection is referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, in accordance with DoDI 1332.18, "Disability Evaluation System." AD Service members with laboratory evidence of HIV infection determined to be fit for duty are allowed to serve in a manner that ensures access to appropriate medical care.

A RC Service member with laboratory evidence of HIV infection is referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for AD for a period of more than 30 days is denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members, either who are not on AD for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, are transferred involuntarily to the Standby Reserve only if they cannot be used in the Selected Reserve.

In accordance with DoDI 6485.01, the privacy of a Service member with laboratory evidence of HIV infection is protected consistent with DoD 5400.11-R, "Department of Defense Privacy Program" and DoD 6025.18-R, "DoD Health Information Privacy Regulation."

A Service member infected with HIV but able to fully perform their duties is not retired or separated solely based on being infected. However, Service members, including those infected with HIV, whose condition deteriorates or otherwise interferes with their ability to perform their military occupation successfully, may be referred to the DES. The DES provides for the member to have a fair and full review to determine fitness for duty. The following DoD issuances establish policy for determining fitness for duty, and for retiring or separating Service members due to physical disability: Department of Defense Manual (DoDM) 1332.18, Vol 1, "Disability Evaluation System (DES) Manual: General Information and Legacy DES (LDES) Time Standards;" DoDM 1332.18, Vol 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES);" and DoDM 1332.18, Vol 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)."

A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history; appropriate physical examination; indicated medical tests and their results; medical and surgical consultations as necessary; diagnoses; ongoing or recommended treatment; and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty (MOS), the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Having one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of his or her office, grade, rank, or rating, including those duties remaining on a Reserve obligation for more than one year after diagnosis;

- Having a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

- Having a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to perform the duties of her or his office, grade, rank, or rating reasonably, to include duties during a remaining period of Reserve obligation. AD and RC Service members with laboratory evidence of HIV infection who, because of their disease progression, are determined to be unfit for further duty are medically separated or retired pursuant to DoDI 1332.18.

Service retention and discharge policies comply with the retention and discharge DoD policies described above.

Retention/Discharge - Army:
AR 600-110 stipulates that individuals confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains. Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information.

In AR 600-110, there is no medical reason for HIV-infected Soldiers' duties to change solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination is made by a MEB as to the Soldier's fitness to perform his or her duties. In the case of HIV-infected health care providers, their duties may be restricted if they present a risk of transmitting HIV to their patients. An expert medical review committee designated by the deputy commander for clinical services makes this determination. This committee makes recommendations on a case-by-case basis to the Medical and Dental Activity/United States Army Medical Center (MEDCEN)/Dental Activity commander per AR 40–68, "Clinical Quality Management," regarding the restriction of duties of HIV infected health care providers. The restriction may only apply until the risk is eliminated. In all other instances, HIV infected

Soldiers are utilized in their primary MOS, per normal utilization criteria contained in Army personnel regulations and the assignment limitations specified in AR 600-110.

Infectious disease specialists medically evaluate HIV-infected Soldiers at a participating MEDCEN supporting the health service region to determine their infection status. HIV infected Soldiers who meet medical retention standards outlined in AR 40-501, and who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations (every six months or as directed), are not involuntarily separated solely based on HIV status.

HIV-infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 and be found fit for duty. RC Soldiers are required to obtain the fit for duty medical examination from the civilian medical community at no expense to the Government. The required medical procedures are provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation. Medical follow-up and evaluation are conducted every six months and as directed by the infectious disease physician for all HIV infected Soldiers.

Except for those identified during the accession testing program, HIV infected AD Soldiers able to perform duties fully who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations are not involuntarily separated solely because they are HIV infected. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and are evaluated for physical disability processing under AR 635–40, "Disability Evaluation for Retention, Retirement, or Separation." AR 600-110 specifies procedures for officers (paragraph 6-13) and for enlisted personnel (paragraph 6-14). In accordance with AR 40-501, HIV-infected Soldiers who demonstrate progressive clinical illness or immunological deficiency are referred to a MEB. For Active Army Soldiers and RC Soldiers on AD for more than 30 days (except for training under 10 U.S.C. § 10148), a MEB must be accomplished and, if appropriate, the Soldier must be referred to a Physical Evaluation Board (PEB) under AR 635–40. For RC Soldiers not on AD for more than 30 days or on AD for training under 10 U.S.C. § 10148, referral to a PEB will be determined under AR 635–40. Records of official medical diagnoses provided by civilian medical providers concerning the presence of progressive clinical illness or immunological deficiency in RC Soldiers may be used as a basis for administrative action under, for example, AR 135–133, "Ready Reserve Screening, Qualification Records System, and Change of Address Reporting," AR 135–175, "Separation of Officers," AR 135–178, "Enlisted Administrative Separations," or AR 140–10, "Assignments, Attachments, Details, and Transfers," as appropriate. Additionally:

- Soldiers identified as HIV infected within 180 days of initial entry on AD are separated under the provisions of AR 635–200 for failure to meet accession medical fitness standards.

- HIV infected Army National Guard (ARNG) Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards are processed under AR 40–501 and

National Guard Regulation (NGR) 600–200, "Enlisted Personnel Management," or NGR 635–101, "Efficiency and Physical Fitness Boards," as appropriate.

- HIV infected United States Army Reserve Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 are processed in accordance with AR 135–178 (enlisted) or AR 135–175 (officer).

The Army National Guard implements guidance as prescribed by the AR 600-110 and AR 40-501 with regard to HIV positive personnel. AR 600-110 is administered by the G1 (Army Personnel) section; however, Army National Guard – Office of the Chief Surgeon (ARNG-CSG) has oversight with regard to monitoring the implementation of laboratory testing and re-testing of HIV positive Soldiers). HIV positive Soldiers are retained in current MOS/Area of Concentration, as long as medical fitness standards are maintained in accordance with AR 40-501. ARNG-CSG relies highly on the input of Army Directives, the U.S. Army Public Health Center, and the Centers for Disease Control and Prevention (CDC) when considering medical retentions.

Retention/Discharge - Navy and Marine Corps:
If an AC Sailor or Marine tests HIV antibody positive during routine screening, he or she is directed by the Chief, Bureau of Medicine and Surgery to an appropriate medical facility for evaluation and determination of fitness for duty, like all Service members with a chronic medical condition, in accordance with SECNAVINST 1850.4E, "Navy Disability Evaluation Manual," and Chapter 18 of Naval Medical Command (NAVMED) P-117, "Manual of the Medical Department," which pertains to DES. Members with HIV undergo additional evaluation in accordance with DoDI 6485.01. If found fit for full duty (i.e., physically qualified to remain on AD), they are referred, evaluated, treated, and followed by an HETU, and are subsequently retained, deployed, and returned to their unit for duty. Further, they are eligible for reenlistment following normal reenlistment procedures. RC Sailors undergo evaluation by their civilian providers, and are also evaluated for fitness for duty in the same manner as all RC members with a chronic medical condition. Marine Corps Order (MCO) 1300.8, "Marine Corps Personnel Assignment Policy," is in accordance with SECNAVINST 5300.30E regarding the referral for medical evaluation for continued service, appropriate treatment, and determination of fitness for duty.

In SECNAVINST 5300.30E, if a Sailor or Marine is found unfit for continued service, he or she is processed for medical separation through the physical disability system and discharged. Sailors and Marines who have tested HIV positive also have the option to undergo voluntary separation, and are afforded the option of requesting a voluntary discharge under honorable conditions, unless there are other factors involved. Retention or discharge decisions are based on the determination of competent medical authority regarding fitness of service. SECNAVINST 5300.30E is currently under revision.

MCO 1900.16 Chapter 1, "Separation and Retirement Manual," refers to SECNAVINST 5300.30E for voluntary separation of Marines who have tested positive for HIV. In MCO 1001R.1L, "Reserve Administration Manual," Reserve Marines identified as HIV positive and

who, although deemed medically fit for duty, are unable to fill an appropriate billet within the Selected Reserve and are placed in the Standby Reserve-Inactive Status List. Under this status, such Marines are not eligible to participate, receive pay or retirement point credit, are not eligible for promotion consideration, and are not accountable for purposes of end strength or controlled grades.

SECNAVINST 5300.30E and DoDI 6485.01 permit members of the Marine Corps Ready Reserve who are HIV positive to continue to serve within the Marine Corps Reserve, barring any medically assessed unfitting conditions, such as immunologic deficiency, neurological deficiency, progressive clinical or laboratory abnormalities associated with HIV, or diagnosis of Acquired Immune Deficiency Syndrome (AIDS)-defining conditions.

Retention/Discharge - Air Force:
AFI 44-178, "Human Immunodeficiency Virus Program," instructs that "members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection." AFI 48-123 stipulates that HIV is potentially a cause for denying continued service and requires a retention decision through a MEB or similar review."

AFI 44-178 guides the management of AD Service members with HIV and screening protocol routinely employed by the Air Force. In accordance with AFI 44-178, all AD Airmen with asymptomatic HIV are seen annually at the Air Force HIV Medical Evaluation Unit (MEU) in San Antonio. The MEU completes a narrative summary (NARSUM) for each Airman with HIV infection, which is forwarded to the Air Force Personnel Center (AFPC) for adjudication regarding retention.

In an effort to treat every Airman equitably and with dignity and respect, the Air Force refers Airmen with asymptomatic HIV infection into the DES in the same manner and process as any other Airman with a chronic medical condition. As outlined above, current Air Force policy requires that all Airmen with HIV have a NARSUM reviewed annually by AFPC. AFPC is the only entity that can assign Airmen an Assignment Limitation Code-C (ALC-C), which restricts permanent and temporary duty assignments to areas where appropriate medical care is available to the HIV-positive Service member. The intent of the ALC-C is to protect such members from being placed in environments where adequate medical care is not available. The benefit of assigning an ALC-C is that it ensures visibility at all levels that an Airman will require a waiver for OCONUS assignment or deployment.

3. Deployment
DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," includes HIV antibody positive diagnosis with the presence of progressive clinical illness or immunological deficiency as a medical condition that usually precludes contingency deployment. In all instances of HIV seropositivity, the policy requires that the cognizant CCMD surgeon be consulted before medical clearance for deployment. The Combatant Commander is the final approval authority for waivers. The medical standards in DoDI 6490.07 are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. DoD personnel with existing medical conditions may deploy based upon a medical assessment, if the following conditions are met:

(1) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

(2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

(3) Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the MHS. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g., heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

(4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

DoDI 6490.07 sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness needs, or CCMD requirements may involve additional deployment restrictions. Additionally, DoDI 6485.01 instructs compliance with host-nation requirements for screening and related matters for Service members. As outlined below, all Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations.

Deployment - Army:
AR 40-501, paragraph 5-14, "Medical fitness standards for deployment and certain geographical areas," states a general rule that "all Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS)." However, the policy acknowledges, "because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions would ensure these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers."

AR 40-501, paragraph 5-14, lists medical conditions requiring careful review prior to recommending whether the Soldier can deploy to duty in a combat zone or austere isolated area

where medical treatment may not be readily available. In accordance with AR 40-501, HIV infected Soldiers are not permitted to deploy into the combat theater of operations. Additionally, in accordance with AR 600-110 and AR 614-30, "Overseas Service," Soldiers confirmed to be HIV infected while stationed overseas are reassigned to the United States.

However, if found fit by a PEB, HIV infected Soldiers may be considered for overseas deployment to Europe or Korea (host Nation permitting), in accordance with AR 40-501. HIV infected AD Soldiers, including Active Guard and Reserve, are otherwise limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). In the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands), HIV infected Soldiers are not assigned to:

- Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation, provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is three years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made, provided assignment can be made according to normal personnel management and assignment criteria in AR 614–100, "Officer Assignment Policies, Details, and Transfers," and AR 614–200, "Enlisted Assignments and Utilization Management." Reassignment must be to an authorized position for the Soldier's grade and primary or secondary MOS. Installation commanders unable to make appropriate reassignments report the names of HIV infected Soldiers to the Commander, Human Resource Command (HRC), Army Human Resource Command (AHRC)–EPD–I (enlisted), or Total Army Personnel Command (TAPC)–OPD–M (officer).

- Military-sponsored educational programs, regardless of length, but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs are disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to Permanent Change of Station restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs is waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).

- U.S. Army Recruiting Command, Cadet Command, MEPS, ARNG full time recruiting force, or ARNG full time attrition/retention force, if a Soldier's medical condition requires frequent medical follow-up (as determined by medical authorities), and if the Soldier's projected duty station is geographically isolated from an Army military treatment facility capable of providing that follow-up. These organizations report HIV-

infected Soldiers who cannot be assigned under this policy to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer), for assignment instructions.

AR 600-110 stipulates that commanders may not change the assignment or use of HIV-infected Soldiers solely because of their infection, unless required by that regulation or the Soldier's medical condition. Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

HIV infected Service members may transfer to the Active Army from another Armed Force (inter-Service transfer), if they meet medical retention standards in AR 40–501. However, Service members who are HIV infected may not be transferred to the Army from another Armed Force, if they are required to meet accession medical standards in AR 40–501, except as specifically permitted in the Accession Testing Program, as described in AR 600-110.

Deployment - Navy/Marine Corps:
Deployment determinations for HIV-infected Service members are based on guidance articulated in DoDI 6490.07 and in CCMD Area of Responsibility specific Force Health Protection policies. SECNAVINST 5300.30E permits certain personnel on a case-by-case basis to be considered for OCONUS or large ship platform tours, in consultation with the treating HETU, Navy Bloodborne Infection Management Center, and PERS-82 (Temporary Disability Retirement List] (for Sailors), or the United States Marine Corps M&RA (for Marines). These cases apply to personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance, and a history of professional attitude). This placement requires the receiving command's acceptance. These personnel are not considered for overseas individual augmentee tours, given the austere environments in which they potentially could be placed. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of disease in normal daily activities.
- An investment in training of these members has been made.
- The previous policy of denying deployments has made this subset of personnel less competitive in achieving career milestones or warrior qualifications.

MCO 1300.8 is in accordance with SECNAVINST 5300.30E regarding assignment of HIV infected personnel.

Deployment - Air Force:
AFI 48-123 indicates, "conditions, which may seriously compromise the near-term well-being if an individual were to deploy, are disqualifying for mobility status or deployment duty." In accordance with DoDI 6490.07, AFI 48-123 also indicates, "medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable." However, AFI 48-123 also states, "in general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days."

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the DES or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary

In and of itself, being HIV positive is not a punishable offense and cannot be used as a basis for disciplinary action against the individual. DoDI 6485.01 directs that information obtained during or primarily as a result of an epidemiologic assessment interview, (which is defined in DoDI 6485.01 as the "questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes"), cannot be used to support any adverse personnel action against the Service member, in accordance with section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986. DoDI 6485.01 defines "adverse personnel action" as "a court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons."

DoDI 6485.01 also requires aggressive disease surveillance and implementation of health education programs for Service members. A Service member with laboratory evidence of HIV infection receives training on how to prevent further transmission of HIV infection to others, and the legal consequences of exposing others to HIV infection. In compliance with this policy, the Services provide counseling and training to Service members with HIV infection regarding the prevention of disease transmission to others and the legal consequences of intentional exposure to others, or failure to disclose status to sexual partners or blood donation centers.

However, infected Service members retained on AD who fail to comply with the directives given during preventive medicine counseling are subject to appropriate disciplinary actions for their disregard or disobedience. All Services hold HIV infected members accountable under the Uniform Code of Military Justice if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high-risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

STATUS UPDATE ON THE DEPARTMENT OF THE ARMY'S HIV POLICY:
Initiated in 2015, a working group has reviewed AR 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF POLICIES:
Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. As such, the Department takes every effort to protect the health and well-being of Service members to minimize the risk of exposure to HIV through regular HIV screening and surveillance efforts. DoDI 6485.01 requires that the Secretaries of the Military Departments report HIV test results to the Defense Medical Surveillance System, pursuant to Department of Defense Directive (DoDD) 6490.02E, "Comprehensive Health Surveillance," and directs health care personnel providing medical care to follow the recommendations issued by the CDC for preventing HIV transmission in health-care settings.

DoD health surveillance policy also requires that medical surveillance systems continuously capture data on occupational and environmental exposures to potential and actual health hazards, and link with medical surveillance data to monitor the health of DoD's population and identify potential risks to health. Thus, this policy enables timely implementation of interventions to prevent, treat, or control disease and injury, and reinforces the provision of optimal medical care.

Impact of Antiretroviral Therapy on Disease Management

Viral suppression and AIDS are two ends of the spectrum of HIV infection. Virally-suppressed HIV infection usually requires an individual to take ART, alternatively referred to as combination Antiretroviral Therapy, regularly and to see an infectious disease specialist annually. ART consists of a combination of antiretroviral (ARV) drugs to suppress the HIV virus to undetectable levels and stop HIV disease progression. AIDS is usually the result of long-term non-adherence with medications and can be associated with impairment and disability (e.g., opportunistic infections, cancer, weakness).

There is broad consensus on evidence published in the medical literature to support the notion that people living with HIV on ART with an undetectable viral load in their blood have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for the viral load to become undetectable. "Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits."[1]

However, it is important to emphasize that despite undetectable viral loads, HIV transmission still can occur. According to the U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, "exposure to a source patient with an undetectable serum viral load does not eliminate the possibility of HIV transmission or the need for (post-exposure prophylaxis) PEP and follow-up testing. While the risk of transmission from an occupational exposure to a source patient with an undetectable serum viral load is thought to be very low, PEP

should still be offered. Plasma viral load (e.g., HIV RNA [ribonucleic acid]) reflects only the level of cell-free virus in the peripheral blood; persistence of HIV in latently infected cells, despite patient treatment with ARV drugs, has been demonstrated, and such cells might transmit infection even in the absence of viremia. HIV transmission from exposure to a source person who had an undetectable viral load has been described in cases of sexual and mother-to-child transmissions."[2] It is also important to underscore that an "undetectable" viral load that confers a "negligible risk" of HIV transmission has no application in the setting of blood transfusion or needlestick (occupational) exposures.

Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure for HIV-naïve individuals, but also on providing evidence-based care and support for Service members living with HIV, with the goal to retain and maintain a Service member's fitness for duty, optimize quality of life, as well as avoid any disability that might arise as a result of HIV infectivity.

Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV: Potential Impact on Future Policy

Despite virological suppression, long-term treated patients may experience memory difficulties, mental slowing, attention deficits, and other neurological impairment symptoms. Moreover, neurocognitive damage can occur without HIV-infected individuals experiencing related symptoms or interference in their daily functioning. The impact of HIV-associated neurocognitive disorder and asymptomatic NCI on fitness for duty, including resilience and readiness, is currently unknown.

According to a Department of Defense Infectious Disease Clinical Research Program cross-sectional study of 200 HIV-infected and 50 HIV-uninfected military beneficiaries including AD members, retirees, or dependents, HIV positive patients diagnosed and managed early during the course of HIV infection had a low prevalence of NCI. This is comparable to matched HIV-uninfected persons.[3] Based on these data, the early recognition and management of HIV infection may be important in limiting NCI.

Yet effective ART resulting in viral suppression and asymptomatic infection does not imply absence of HIV-associated injury or impairment. Some HIV-infected, virally suppressed patients on ART will develop illnesses associated with premature aging (e.g., cardiovascular disease, osteoporosis). As the HIV-positive population ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia are becoming risk factors for cognitive impairment in HIV-positive patients on ART.[4]

Common neurocognitive symptoms experienced by HIV-infected patients potentially include changes in memory, concentration, attention, and motor skills, may present challenges for accurate diagnoses and assessments of functional capacity, and often require prolonged observation or reporting.[5,6] Some patients may experience a fluctuating course of NCI over time, including symptom normalization; however, it is unknown whether these changes reflect

biologic alterations induced by responses to (or failures) of ART, or occur independently of viral load and changes to ART regimens.[7] Despite effective systemic viral suppression among HIV-positive individuals on ART, scientific studies have indicated that a small subset of individuals show neurocognitive deterioration with evidence of persistent laboratory and neuroimaging abnormalities in the central nervous system.[8] A longitudinal cohort observation study found that numerous patients with asymptomatic NCI, even with a suppressed plasma viral load, eventually developed symptomatic NCI.[9] The impact of these potential NCIs on a Service member's readiness, resilience, and/or retention is currently unknown.

As the HIV-positive population on ART ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia may become risk factors for cognitive impairment.[10] The future impact of HIV as a chronic disease on readiness, resiliency, and retention, as well as treatment and management approaches, are a part of ongoing DoD health surveillance efforts.

As stipulated in DoDD 6490.02E, DoD requires comprehensive, continuous and consistent health surveillance to enable continuous capture of individual and population data, including health status, occupational exposures, disease, and medical interventions (such as immunizations, treatments and medications), in order to implement early intervention and disease control strategies and reinforce provision of optimal medical care. As such, the policy enables DoD to be well-positioned to update policies and practices to appropriately identify and manage HIV infection among Service members as the HIV-positive population on ART ages.

Military-Unique Considerations

According to the Military Infectious Diseases Research Program (MIDRP), HIV "remains a significant threat to Service members deployed overseas, and is a major source of regional instability in areas of US force protection."[11] Additionally, the MIDRP also recognized that infectious diseases can also impose "a significant burden on the medical logistical system for people requiring treatment" and "loss of personnel to infectious diseases reduces operational readiness and effectiveness by requiring replacement troops." Therefore, the MIDRP indicates, preventing disease is "a force multiplier by keeping people healthy and by enhancing readiness," and DoD must protect its forces from diseases that may compromise its ability to complete missions and to prevent troops from acquiring illnesses. As such, preventing disease through limiting risk of exposure to infectious disease is a key component to enhance military readiness and effectiveness.

It is important to note that DoD HIV screening policy is population-based, and accounts for unique operational military requirements. For example, protecting the safety of the U.S. military blood supply or health of potential donors and recipients (i.e., Service members) is of critical importance to DoD and therefore a central issue. Combat-related injuries, especially during mass casualty situations, require large supplies of blood for transfusions. The need for screening the blood supply is therefore critical. In certain cases, "battlefield transfusions" may be required to resuscitate casualties in life-threatening situations when the inventory of U.S. Food and Drug Administration (FDA)-compliant blood products is depleted in combat zones due to austere operating conditions and irregular resupply. In these cases, the U.S. Army Institute of Surgical

Research Joint Trauma System Clinical Practice Guideline on Fresh Whole Blood indicates that Service members may receive an emergency transfusion of fresh whole blood in life-saving or limb-sparing situations.[12] This Joint Trauma System Clinical Practice Guideline also indicates that even though fresh whole blood undergoes rapid testing for HIV to the greatest extent possible prior to transfusion, the potential risk for HIV transmission remains in battlefield circumstances. HIV infection is among a number of medical conditions that preclude blood donation. Early CDC data demonstrate that the highest risk of transmission of HIV infection is via blood transfusion (92.50 percent transmission rate, or 9250/10000 exposures).[13] Even though this data included cases involving transmission of very high viral loads as well as lower levels of viremia, it is conceivable that a unit of whole blood (as utilized used in a "walking blood bank" scenario) would pose a very high risk of transmission of HIV infection, even if from an HIV-infected Service member with an undetectable viral load.[14] To the extent possible, DoD adheres to FDA blood-borne pathogen screening guidelines requiring all donated blood products be tested for HIV types I and II.[15] DoD ensures the safety of the blood supply through policies of the Armed Services Blood Program Office and the accreditation requirements of the American Association of Blood Banks. However, in emergency battlefield circumstances it is impossible to eliminate all risk of communicability through blood transfusion.

Service Policies

Service policies accurately reflect current medical literature and expert opinion (consensus standards) regarding transmission and treatment of HIV. The U.S. Air Force (USAF) management of Airmen with HIV is highly structured and achieves viral load suppression in over 90 percent of patients. AFI 44-178 is the underpinning of the USAF's HIV management success. AR 600-110, "Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus," and Headquarters, Department of the Army medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection; the risks to the infected individual incident to military service; the risk of transmission of the disease to non-infected personnel; the overall impact of infected personnel in Army units and on readiness posture; and the safety of military blood supplies. The Assistant Secretary of the Navy (M&RA) established SECNAVINST 5300.30E to reflect current knowledge of the natural history of HIV; the risks to the infected individual incident to military service; the risk of transmission of HIV to non-infected personnel; the effect of infected personnel on commands; and the safety of military blood supplies. The Services are currently reviewing and updating several policies, to include SECNAVINST 5300.30E, AFI 44-178, AR 600-110, to reflect changes as medical capabilities, technologies, and evidence-based practices have evolved.

Medical literature pertaining to HIV medicine rapidly evolves. MHS subject matter experts are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion, referenced in, but not limited to the following:

- "National HIV/AIDS Strategy for the United States." U.S. Department of Health & Human Services. Available at: https://www.hiv.gov.

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health

and Human Services. Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf.

- Primary Care Guidelines for the Management of Persons Infected with HIV, issued by expert panel of the HIV Medicine Association of the Infectious Diseases Society of America. Update issued in: Aberg JA, Gallant JE, Ghanem KG, et al. Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV medicine association of the Infectious Diseases Society of America. Clin Infect Dis. 2014;58(1):e1-34. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24235263/.

- CDC. "Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services." MMWR Recomm Rep. 2012;61(RR-5):1-40. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm.

FEASIBILITY OF ALLOWING ENLISTED MEMBERS TO BECOME COMMISSIONED OFFICERS OF THE ARMED FORCES AND RESTRICTIONS DIFFERENT FOR OFFICERS:

DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for the difference is that once a member has been fully trained to perform, and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment, who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service, compared to one without such service, when it comes to minimizing any risk of inability due to medical conditions to perform satisfactorily in the commissioned officer position. However, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION:

The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving

nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces.

Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.
- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.
- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.
- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.
- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.
- Ensure that a Service member infected with HIV is not retired or involuntarily separated solely based on being infected.
- Recognize that in the unique circumstances of military combat operations, there remain significant risks that individuals with even well-controlled HIV infection may suffer adverse health effects and create additional mission risks for the military command.
- Direct the protection of health information and privacy of HIV-infected personnel.
- Reflect existing evidence and adhere to current nationally accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.
- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS:

DoD personnel policy for HIV-positive Service members is evidence-based, in accordance with state-of-the-art clinical guidelines, reviewed for currency, and updated accordingly as medical capabilities, technologies, and evidence-based practices evolve.

DoD accession policies align with the military's requirements to recruit healthy personnel who are able to complete demanding military training and to deploy to austere environments without exacerbating their health or compromising operational effectiveness and mission accomplishment.

For those who acquire HIV after accession, DoD policy emphasizes retention if the medical condition is stable with appropriate treatment and the Service member is found fit for duty. Service members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, cannot be separated solely based on laboratory evidence of HIV infection. Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV infection) may undergo evaluation for either duty limitations or medical discharge.

A waiver is required for HIV-positive Service members to deploy; medical evaluators must consider climate, altitude, rations, housing, duty assignment, and available medical services in theater when deciding whether an individual is deployable. However, current Service policies do not permit HIV-infected Service members to deploy to combat theaters of operation or in support of other contingency operations, given the austere environment, potential exacerbation of illness and lack of access to needed medical care, as well as risk of compromising unit readiness and successful mission completion. Army policy currently allows deployment to Europe and Korea for HIV-infected soldiers found fit by a PEB (host Nation permitting). Navy policy currently permits case-by-case consideration for non-combat OCONUS or large ship platform tours for HIV-infected personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance).

DoD policy prohibits adverse personnel actions based solely on HIV status, assuming ability to perform duties fully. However, as with any direct order, a Service member who violates the order to inform sexual partners of their HIV status or fails to use safe sexual practices, as instructed during face-to-face consultation, may be subject to disciplinary action.

Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the MHS to sustain the health of Service members, restore the health, and return to duty of Service members who become ill or injured, if possible. Once Service members complete training, the goal is to retain members who acquire HIV who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (access to quality care, counseling, support and educational services, privacy protections, and option to continue service, if desired). Existing personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as to help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

ACRONYMS:	
AD	active duty
AFI	Air Force Instruction
AFPC	Air Force Personnel Center
AHRC	Army Human Resource Command
AIDS	Acquired Immune Deficiency Syndrome
ALC-C	Assignment Limitation Code-C
AMSWG	Accession Medical Standards Working Group
AR	Army Regulation
ARNG	Army National Guard
ARNG-CSG	Army National Guard – Office of the Chief Surgeon
ART	antiretroviral therapy
ARV	antiretroviral
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CONUS	continental United States
DES	Disability Evaluation System
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDM	Department of Defense Manual
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HETU	HIV Evaluation and Treatment
HIV	human immunodeficiency virus
HRC	Human Resource Command
IDES	Integrated Disability Evaluation System
IMR	individual medical readiness
LDES	Legacy Disability Evaluation System
M&RA	Manpower and Reserve Affairs
MCO	Marine Corps Order

MEB	Medical Evaluation Board
MEDCEN	United States Army Medical Center
MEPS	Military Entrance Processing Stations
MEU	Medical Evaluation Unit
MHS	Military Health System
MIDRP	Military Infectious Diseases Research Program
MOS	military occupational specialty
MQA	medical quality assurance
NARSUM	narrative summary
NAVMED	Naval Medical Command
NCI	neurocognitive impairment
NDAA	National Defense Authorization Act
NGR	National Guard Regulation
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	outside the continental United States
PEB	Physical Evaluation Board
QAP	Quality Assurance Program
RC	Reserve Component
SECNAVINST	Secretary of the Navy Instruction
TAPC	Total Army Personnel Command
TDA	table of distribution and allowances
USAF	U.S. Air Force

REFERENCED POLICIES:

1. DoD Issuances:
   - DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
   - DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
   - DoDD 6490.02E, "Comprehensive Health Surveillance," February 8, 2012, as amended
   - DoDI 1304.26, "Qualification Standards for Enlistment, Appointment, and Induction," March 23, 2015, as amended
   - DoDI 1332.18, "Disability Evaluation System (DES)," August 5, 2014
   - DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018
   - DoDI 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011, as amended
   - DoDI 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014
   - DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
   - DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013
   - DoDI 6490.03, "Deployment Health," August 11, 2006, as amended
   - DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
   - DoDM 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014
   - DoDM 1332.18, Volume 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES)," August 5, 2014
   - DoDM 1332.18, Volume 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)," November 21, 2014
   - DoDM 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013

2. Department of the Army:
   - AR 40-501, "Standards of Medical Fitness," June 14, 2017
   - AR 40-68, "Clinical Quality Management," Rapid Action Revision Issue Date: May 22, 2009
   - AR 135-133, "Ready Reserve Screening, Qualification Records System, and Change of Address Reporting," December 22, 2016
   - AR 135-175, "Separation of Officers," November 29, 2017
   - AR 135-178, "Enlisted Administrative Separations," November 7, 2017
   - AR 140-10, "Assignments, Attachments, Details, and Transfers," August 15, 2005
   - AR 140-50, "Officer Candidate School, Army Reserve," October 15, 1999
   - AR 350-51, "United States Army Officer Candidate School," June 11, 2001
   - AR 600–8–24, "Officer Transfers and Discharges," Rapid Action Revision Issue Date: September 13, 2011

- AR 600-110, "Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus," April 22, 2014
- AR 614-30, "Overseas Service," December 22, 2016
- AR 614-100, "Officer Assignment Policies, Details, and Transfers," January 10, 2006
- AR 614-200, "Enlisted Assignments and Utilization Management," November 29, 2017
- AR 635-40, "Disability Evaluation for Retention, Retirement, or Separation," January 19, 2017
- AR 635–200, "Active Duty Enlisted Administrative Separations," December 19, 2016

3. Departments of the Army and the Air Force National Guard Bureau:
   - NGR 351-5, "State Military Academies," Incl Change 1, December 16, 1985
   - NGR 600-200, "Enlisted Personnel Management," July 31, 2009
   - NGR 635-101, "Efficiency and Physical Fitness Boards," August 15, 1977

4. Department of the Navy and United States Marine Corps:
   - SECNAVINST 1850.4E, "Department of the Navy (DON) Disability Evaluation Manual," April 30, 2002
   - SECNAVINST 5300.30E, "Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus Infection in the Navy and Marine Corps," August 13, 2012
   - NAVMED P-117, "Manual of the Medical Department (MANMED): Chapter 18: Medical Evaluation Boards," January 10, 2005

5. Department of the Air Force:
   - AFI 44-178, "Human Immunodeficiency Virus Program," March 4, 2014; Certified Current June 28, 2016
   - AFI 48-123, "Medical Examinations Standards," November 5, 2013
   - AFI 48-123 – Air Force Medical Command Supplement (AFMCSUP), "Medical Examinations Standards," October 23, 2014

6. United States Marine Corps-Specific Policies:
   - MCO 1300.8, "Marine Corps Personnel Assignment Policy," September 18, 2014
   - MCO 1900.16 CH 1, "Separation and Retirement Manual," August 7, 2015
   - MCO 1001R.1L, "Marine Corps Reserve Administration Manual," December 23, 2015

ADDITIONAL REFERENCES

[1] Prevention Access Campaign. Risk of Sexual Transmission of HIV from a Person Living with HIV Who Has An Undetectable Viral Load: Messaging Primer and Consensus Statement. Issued July 21, 2016. Endorsements updated January 8, 2018. Available at: https://www.preventionaccess.org/consensus

[2] Kuhar DT, Henderson DK, Struble KA, Heneine W, Thomas V, Cheever LW et al. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. *Infect Control Hosp Epidemiopl.* 2013; 34(9):875-892. Available at: https://www.ncbi.nlm.nih.gov/pubmed/23917901.

[3] Crum-Cianflone NF, Moore DJ, Letendre S et al. Low prevalence of neurocognitive impairment in early diagnosed and managed HIV-infected persons. *Neurology*. 2013;80:371–379. Available at: https://www.ncbi.nlm.nih.gov/pubmed/23303852.

[4] Sacktor N. Changing clinical phenotypes of HIV-associated neurocognitive disorders. *J Neurovirol*. 2018;24(2):141-145. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28752495.

[5] Price RW. HIV-associated neurocognitive disorders: Epidemiology, clinical manifestations, and diagnosis. UpToDate. Literature review current through May 2018. This topic last updated February 14, 2017. Available at: https://www.uptodate.com/contents/hiv-associated-neurocognitive-disorders-epidemiology-clinical-manifestations-and-diagnosis.

[6] De Souza EM, Buoniconti CS, Valim FC, Moura AS. Risk factors for neurocognitive impairment in HIV-infected patients and comparison of different screening tools. *Dementia & Neuropsychologia*. 2016;10(1):42-46. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5674913/.

[7] Antinori A, Arendt G, Becker JT, et al. Updated research nosology for HIV-associated neurocognitive disorders. *Neurology*. 2007;69(18):1789-1799. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4472366/.

[8] Sacktor N. Changing clinical phenotypes of HIV-associated neurocognitive disorders. *J Neurovirol*. 2018;24(2):141-145. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28752495.

[9] Grant I, Franklin DR Jr, Deutsch R, Woods SP, et al. Asymptomatic HIV-associated neurocognitive impairment increases risk for symptomatic decline. *Neurology*. 2014;82:2055–2062. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118496/pdf/NEUROLOGY2013549501.pdf.

[10] Sacktor N. Changing clinical phenotypes of HIV-associated neurocognitive disorders. *J Neurovirol*. 2018;24(2):141-145. Available at: https://www.ncbi.nlm.nih.gov/pubmed/28752495.

[11] U.S. Army Medical Research and Materiel Command. Military Infectious Diseases Research Program (MIDRP). Background and Environment. Available at: http://mrmc.amedd.army.mil/index.cfm?pageid=medical_r_and_d.midrp.overview

[12] U.S. Army Institute of Surgical Research: Joint Trauma System Clinical Practice Guideline: Fresh Whole Blood (FWB) Transfusion. 2012. Available at: http://www.usaisr.amedd.army.mil/cpgs/Fresh_Whole_Blood_Transfusion_24_Oct_12.pdf

[13] Patel P, Borkowf CB, Brooks JT. Et al. Estimating per-act HIV transmission risk: a systematic review. *AIDS*. 2014. doi: 10.1097/QAD.0000000000000298. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24809629.

[14] Patel P, Borkowf CB, Brooks JT. Et al. Estimating per-act HIV transmission risk: a systematic review. *AIDS*. 2014. doi: 10.1097/QAD.0000000000000298. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24809629.

[15] U.S. Department of Health and Human Services, Food and Drug Administration: CFR- Code of Federal Regulations Title 21. Available at https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?CFRPart=1271&showFR=1

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

RICHARD ROE; VICTOR VOE; and OUTSERVE-SDLN, INC., Plaintiffs, v. PATRICK M. SHANAHAN, in his official capacity as Acting Secretary of Defense; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; and the UNITED STATES DEPARTMENT OF DEFENSE, Defendants.	)	No. 1:18-cv-1565-LMB-IDD

DECLARATION OF MS. MARTHA P. SOPER

I, Ms. Martha P. Soper, hereby declare as follows:

1. I work for the Assistant Secretary of the Air Force for Manpower and Reserve Affairs. My office is located within the Deputy Assistant Secretary's office, which is responsible for readiness issues. My specific duties within the office deal with health policy, which includes oversight of the Disability Evaluation System ("DES") within the United States Air Force.

2. DES cases involving airmen with HIV are processed in the same manner as any other case involving an airman with a chronic and progressive medical condition. This is required by DoD Instruction 6485.01, paragraph 2c, and a clarifying memorandum issued by the Assistant Secretary of the Air Force for Manpower and Reserve Affairs on September 26, 2018. Under DoDI 1332.18, airmen are "referred" for evaluation by the DES when one or more of the following conditions are met: 1) the member has one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties

of their office, grade, rank, or rating; 2) has a medical condition that represents an obvious medical risk to the health of the member or to the health and safety of other members; or 3) has a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member. Practically speaking, airmen are typically identified for referral to the DES by medical providers at their local medical treatment facility. Members with HIV are fully evaluated and treated by infectious disease specialists at the San Antonio Military Medical Center, where the Air Force's HIV program is located. After evaluation and treatment these specialists contact the Air Force Personnel Center to begin the process of determining whether the particular case will be referred into the DES.

3. The mere diagnosis of a medical condition does not mean that airmen will necessarily be evaluated through the DES. Before airmen are officially referred into the system the case is evaluated by the Air Force Personnel Center's Medical Retention Standards Office. This office reviews every case in which a potentially unfitting medical condition has been identified and determines whether the condition warrants referral to the DES by applying the standards for referral listed above. If the particular member being evaluated does not have significant limits on his ability to deploy, or is in a career field that does not require deployment and is otherwise reasonably performing the duties of his position, he may be returned to duty via a process called an Initial Review in Lieu of DES processing or "IRILO". The Medical Retention Standards Office, thus, can either return the member to duty or refer him or her for entrance into the DES. The Medical Retention Standards Office reviewed the cases of 31 airmen who were newly diagnosed with HIV in 2018. 10 of these individuals were returned to duty by the IRILO process and 21 were referred into the Disability Evaluation System.

4. Since 2016, the Air Force has reviewed and revised its evaluation of HIV cases through the DES. Prior to 2016, nearly all cases of asymptomatic HIV resulted in a return to duty via the IRILO process administered by the Air Force Personnel Center's Medical Retention Standards Office. Beginning in 2016 the Medical Retention Standards Office began referring certain cases of asymptomatic HIV into the DES in order to treat HIV in the same manner in which it treats all other chronic, progressive illnesses. While our review of DES policies relating specifically to the evaluation of members with asymptomatic HIV was underway, three policy guidance memos were issued. The first was issued by AF/A1 in October 2017. The second and third were issued by the Secretary of the Air Force for Manpower and Reserve Affairs in June 2018, and September 2018, respectively.

5. Most members who are referred for evaluation in the DES, including most members with HIV who are ultimately evaluated by the DES, are referred because they may be unable to reasonably perform the duties of their office, grade, rank or rating. As required by DoDI 1332.18, the Medical Retention Standards Office's determination of whether an airman's medical condition may cause him to be unable to reasonably perform his duties includes a consideration of the following criteria: 1) the member's ability to perform the common military tasks for his office, grade, rank, or rating, such as firing a weapon, performing field duty, or wearing load-bearing or protective gear; 2) whether the member is medically prohibited from taking the service's required physical fitness test; 3) whether the service member is deployable individually or as part of a unit, with or without prior notification to any location specified by the Air Force; and 4) if the medical condition disqualifies the airman for specialized duties whether the specialized duties constitute the member's current duty assignment; if the member has an alternate specialty; or whether reclassification or reassignment is feasible.

6. Asymptomatic HIV has not been found to interfere with airmen's ability to perform the fitness test, or to perform the day to day tasks of most Air Force career fields as long as they are located within the United States. However, asymptomatic HIV does place significant limits on where an airman could be deployed, and may disqualify airmen for some specialized duties.

7. Assuming that the Medical Retention Standards Office finds that the member has a condition that meets one of the criteria for referral into the DES, the next step in the process is for the member to undergo a Medical Evaluation Board ("MEB"). The MEB is a board consisting of two or more physicians who have state licensure and have met criteria to be credentialed to practice medicine at a military treatment facility, and one of the physicians must have detailed knowledge of the medical retention standards. The Air Force physicians review all available medical evidence, to include any examinations completed as part of the DES processing, and document the medical status and duty limitations of airmen who meet the referral criteria. After the MEB makes its recommendation, the airman has an opportunity to make a written rebuttal and to elect to have an impartial medical review of the case performed by a physician who was not involved in the MEB. Prior to the MEB's review, a medical provider prepares a Narrative Summary of the Airman's medical condition which contains a summary of the Airman's medical history and its impact upon the standards for fitness and the considerations involved in the reasonable performance of duties analysis.

8. The Physical Evaluation Board determines the whether airmen with medical conditions are fit to perform their duties, and for members determined to be unfit as a result of a duty related condition, will determine eligibility for benefits. The PEB process includes the Informal Physical Evaluation Board ("IPEB") and the Formal Physical Evaluation Board ("FPEB"). The IPEB reviews every case in which a member is not returned to duty by either the IRILO process

or by a MEB. The IPEB consists of at least two military members (one of whom must be a physician) and reviews all of the information available to the MEB and the Medical Retention Standards office. Specifically, this means that the IPEB reviews the Narrative Summary prepared for the MEB, any rebuttal matters submitted by the Airman, the Airman's complete medical record, and the recommendation of the Airman's immediate commander in determining whether the Airman's condition meets the criteria for unfitness under Appendix 2 to Enclosure 3 of DoDI 1332.18. These standards are: 1) that the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating; 2) that the evidence establishes that the service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or 3) that the evidence establishes that the service member's disability imposes unreasonable requirements on the military to maintain or protect the service member. When considering whether an Airman is able to reasonably perform duties of his or her office, grade, rank, or rating the IPEB considers the same factors (common military tasks, physical fitness test, deployability, and special qualifications) that are considered by the Medical Retention Standards office and the MEB.

9. Once the IPEB has reached its decision, it makes a written recommendation as to whether the Airman should be discharged, retired, or retained with a succinct explanation of its reasoning on an Air Force Form 356 which is then provided to the Airman. At that point, the Airman may either accept the results or can elect to appeal to the Formal Physical Evaluation Board (FPEB).

10. All DES adjudicators are required by DoDI 1332.18 to uniformly consider deployability as a factor in making a fitness determination. The IPEB typically finds that members who are unable to deploy without waivers (and for whom waivers are unlikely to be approved) unfit, regardless of the condition which causes the deployment restriction. The IPEB and all subsequent levels of

review do, however, consider mitigating factors such as whether the Airman's career field is required to deploy infrequently, if the airman is likely to deploy, whether the airman is likely to deploy to locations that do not require a medical waiver for the condition at issue, and the airman's career point as more junior airmen generally deploy at higher rates than more senior airmen. Adjudicators at all levels consider deployment rates in each individual airman's career that is obtained from the Military Personnel Data System in making fitness determinations.

11. For the past two decades 80% of the Air Force's deployment taskings have been to the United States Central Command's Area of Responsibility. While CENTCOM's current guidance allows for the theoretical possibility of a waiver for an individual with asymptomatic HIV to deploy there, the considerations noted in CENTCOM's policy make it extremely unlikely that such a waiver would ever be granted. In fact, CENTCOM has never granted a waiver for an HIV positive service member to enter the AOR. The inability to deploy to CENTCOM, while extremely important, is not always outcome determinative when mitigating factors such as a low likelihood of deployment, specialized skillsets, or length of service weigh in the airman's favor. Adjudicators at all levels must weigh these factors when considering the specific merits of each case.

12. Airmen who do not accept the results of the IPEB and elect to appeal their cases to the FPEB are afforded an in person hearing before the FPEB at Joint Base San Antonio – Randolph, TX. Airmen who appear before the FPEB are entitled to representation, free of charge, by military attorneys assigned to the Office of Airmen's Counsel. Airmen can also be represented by civilian counsel of their own choice, at their own expense. The FPEB is comprised of 3 members, one physician and two line of the Air Force officers or civilian equivalent. The FPEB review includes the material submitted to the IPEB. At the hearing, the airman is entitled to

testify under oath or by unsworn statement, present any relevant witnesses, and any documentary evidence relevant to the case. After the hearing the FPEB deliberates and issues a written recommendation with a succinct explanation of its reasoning on an Air Force Form 356. The FPEB is required to provide the Air Force Form 356 to the member. Airmen who are unsatisfied with the recommendations of the FPEB are able to appeal to the Air Force Personnel Board ("AFPB") of the Secretary of the Air Force Personnel Council ("SAFPC").

13. The SAFPC serves as the decision authority for a wide array of personnel decisions made by the Air Force. One of the SAFPC's responsibilities is to serve as, effectively, the final appeal authority for Airmen evaluated by the DES prior to their separation from Active Duty. Airmen are entitled to review the SAFPC's decisions in DES cases by the Air Force Board for Correction of Military Records ("AFBCMR"). However, the SAFPC's decisions are not stayed pending the AFBCMR's review of the case, and case processing times at the AFBCMR make it virtually impossible that the AFBCMR would be able to review an SAFPC decision prior to an airman's disability separation or retirement. Airmen who receive relief from the AFBCMR may correct the airman's record to reflect reinstatement depending upon the circumstances of their individual case. The plaintiffs in this case have not appealed their cases to the AFBCMR.

14. Airmen are not entitled to an in person hearing before the SAFPC. Rather, in DES cases, the SAFPC reviews all information that was submitted to the MEB, IPEB, and FPEB, the airmen's current medical records, and any additional submissions or arguments made by the airmen or their counsel. The SAFPC applies the same DoDI 1332.18 standards for unfitness that are applied by the IPEB and FPEB. The SAFPC also analyzes the four criteria that are required to be considered by DoDI 1332.18 in determining whether an individual can reasonably perform the duties of his or her rank grade and position (common military tasks, fitness tests,

deployability, and specialized duties) in addition to other factors such as career field specific deployment rates, time in service, and critical skillsets.

15. The SAFPC decided ten cases of members with asymptomatic HIV during the month of October 2018, after the September 26, 2018 memorandum was issued by the Assistant Secretary of the Air Force for Manpower and Reserve Affairs. These cases included the cases of the two plaintiffs in this lawsuit. Of these cases, six individuals, including the plaintiffs, were found unfit and four were returned to duty. Each member was asymptomatic and had support from their command for retention. Of those who were found unfit all belonged to career fields in which a given individual had a greater than 20% chance of deployment in FY 18, and had at least a 20% likelihood of deployment between FY 15 and FY 17. Additionally, two of the Airmen found unfit were unable to be medically cleared for special flight duties, and one was found to have an unstable condition. Those who were retained, however, had a much lower likelihood of deployment as the highest likelihood of deployment in this cohort was only 12.8% in FY 18 and between 17.1% FYs 15 and 17. Moreover, each of the individuals who were retained were able to perform all of their regular duties without restrictions.

16. There have been eighteen DES cases involving airmen with HIV that have reached a final decision since the last policy guidance was issued in September 2018. Of these eighteen cases, one resulted in a return to duty finding by the FPEB and four resulted in return to duty findings from SAFPC. There were five cases in which the member was found unfit by the IPEB and elected to accept the IPEB's recommendation. There have been six cases, including plaintiffs' in which the member was found unfit by the SAFPC. Of the six members who received unfit findings, four were discharged with disability severance pay, one was medically retired, and one member was administratively separated due to misconduct unrelated to his medical condition.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this __25th_ of January 2019.

Martha P. Soper

Assistant Deputy, Health Policy

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

RICHARD ROE, *et al.*, Plaintiffs, v. PATRICK M. SHANAHAN, *et al.*, Defendants.	No. 1:18-cv-641-LMD-IDD

DECLARATION OF KEVIN CRON IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Kevin Cron, do hereby declare as follows:

1. I currently serve as the Preventive Medicine Officer and primary Waiver Action Officer for U.S. Central Command ("CENTCOM"), a theater-level Unified Combatant Command with responsibility for military operations across North Africa, Central Asia, and the Middle East, including Iraq and Afghanistan, within the Department of Defense ("DoD"). I have held this position since 2015. I act on behalf of the CENTCOM Surgeon to develop and interpret CENTCOM medical readiness standards and advise commanders and units on deployment issues, and have issued determinations for over 14,000 medical waiver applications, including applicants from all branches of the U.S. Armed Forces, as well as a variety of governmental, non-governmental, and contracting agencies. I am responsible for assessing wartime medical and environmental threats, integrating threat analyses into operational and strategic plans, and developing programs to minimize medically-related threats to USCENTCOM personnel, forces, and missions.

2. In the exercise of my duties, I have been made aware of this lawsuit by counsel from the DOD Office of the General Counsel.

3. I submit this declaration in support of the Defendant's Response to the Plaintiffs' January 11, 2018 Motion for a Preliminary Injunction. I base this declaration on my personal knowledge and on information made available to me in the performance of my duties. Unless specifically noted, the opinions in this declaration are my own and relate to my assigned duties within the CENTCOM Surgeon's office.

Purpose of this Declaration

4. This declaration is submitted in support of Defendant's Reply to Plaintiffs' Motion for a Preliminary Injunction. In their November January 11, 2019 Memorandum in Support of Plaintiff's Motion for a Preliminary Injunction, Plaintiffs state "'the military's restrictions on deployability are not rationally related to military effectiveness or readiness, because a person's physical capabilities are not generally affected by an HIV diagnosis."

Deployment Restrictions to the CENTCOM AOR

5. Deployment to the CENTCOM area of responsibility ("AOR") is governed by a variety of regulations, including Department of Defense Instruction ("DoDI") 6490.07 and Modification Thirteen to USCENTCOM Individual Protection and Individual-Unit Deployment Policy ("MOD 13").

6. DoDI 6490.07 (Deployment Limiting Medical Conditions for Service Members and DoD Civilian Employees) puts forth baseline guidance on medical deployability for the DoD. Enclosure 3 states, "In general, individuals with the conditions in paragraphs a. through h. of this enclosure, based upon a medical assessment as described in Enclosure 2 and Reference (l), shall not deploy unless a waiver is granted." Paragraph (e) (2) then states, "A diagnosis of human immunodeficiency (HIV) antibody positive with the presence of progressive clinical illness or immunological deficiency. The cognizant Combatant Command surgeon shall be

consulted in all instances of HIV seropositivity before medical clearance for deployment." Enclosure 4 additionally specifies Combatant Commanders shall "Serve as the final approval authority for exceptions to the medical standards (waivers) made pursuant to the procedures in this Instruction.", and serves as the basis for MOD 13.

8. MOD 13 is a CENTCOM policy, and provides guidance on medical readiness for deployment to the AOR. Paragraph 15.G.1 reiterates that, "the cognizant Combatant Command surgeon shall be directly consulted in all instances of HIV seropositivity before medical clearance for deployment." Tab A, Paragraph 7.C.2. clearly states that "Confirmed HIV infection is disqualifying for deployment". Paragraph 15.C of MOD 13 also notes that "Deployed health service support infrastructure is designed and prioritized to provide acute and emergency support to the expeditionary mission. All personnel (uniformed service members, government civilian employees, volunteers, DoD contractor employees) traveling to the CENTCOM AOR must be medically, dentally and psychologically fit." This is an important caveat that is considered in every waiver decision. MOD 13 also makes clear that "the final authority of who may deploy to the CENTCOM AOR rests with the CENTCOM Surgeon and/or the Service Component Surgeon's waiver authority, not the individual's medical evaluating entity or deploying platform."

9. The CENTCOM AOR presents many medical care challenges. The AOR covers 20 countries and covers more than 4 million square miles. Operations in the AOR are expeditionary in nature, and health service support plans are designed to meet the reasonably anticipated needs of a pre-screened warfighting population without complex medical needs. Conditions requiring highly specialized medical personnel, treatments, or medications cannot be reliably supported. Moreover, contingency deployments and deployment to austere conditions

may place Service members with mandatory medication or treatment regimens at risk because these regimens may be disrupted and may be difficult to replace in a timely manner. In the case of HIV treatment, such a disruption could result in the reactivation of the virus, with acquired resistance to the medication. This situation would place not only the individual Service member at risk, but also medical providers at all levels, including Host Nation and Coalition personnel, who may have to treat the Service member for battlefield injuries. The remaining force must also be considered, due to potential exposure to blood from treating, or being treated for, battlefield trauma, or for those individuals requiring battlefield blood transfusions.

10. In considering a medical waiver, I conduct an individual assessment of the risk each applicant poses to themselves, the deployed force, and, most importantly, the military mission in the CENTCOM AOR. The decision to grant a deployment waiver is a risk calculation that accounts for the applicant's condition, occupation, and time/location of deployment. We consider not only their current condition and stability, but also how they will be impacted by reasonably anticipated contingencies, such as loss, theft, or destruction of medication, how their condition will impact the evaluation of routine medical issues, what secondary effects their treatment may have, and how their condition will influence, and be influenced by, operational activities within active combat zones. It is a necessarily complex process. For a waiver to be granted, the needs of the Service to have the specific Service member or civilian in theater must be great enough to validate taking on this additional risk.

11. In my tenure as the wavier authority for CENTCOM, I have reviewed waiver requests from HIV-positive service members. I have not granted a deployment waiver for a HIV-positive Service member. After conducting a thorough risk assessment for each waiver request and consulting with the CENTCOM Surgeon and Component Surgeons, we determined

in each case that the risks of deploying a HIV-positive Service member were too great to justify waiver approval. It is highly unlikely that either Service member Roe or Voe would be granted a waiver to deploy to the CENTCOM AOR.

12. There are features of HIV which make it difficult to compare to other conditions. Treatment medications are highly specialized, and require constant, diligent compliance to be effective. A resurgent infection may go unnoticed, and must be considered as a possibility when other medical complaints arise. Currently, there is no cure for the disease. Medical conditions all have their own challenges, and must be considered in that context.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

EXECUTED this 25th day of January 2019, Tampa, Florida.

LTC KEVIN CRON, MD, MPH
Preventive Medicine Officer
USCENTCOM/CCSG

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Short Communication
Investigation of Incident HIV Infections Among U.S. Army Soldiers Deployed to Afghanistan and Iraq, 2001–2007

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Abstract

The U.S. Army initiated an investigation in response to observations of a possible increase in HIV incidence among soldiers deployed to combat. Human immunodeficiency virus (HIV)-infected U.S. Army soldiers are not eligible to deploy. Combat presents a health hazard to HIV-infected soldiers and they pose a threat to the safety of the battlefield blood supply and their contacts. All soldiers are routinely screened for HIV every 2 years and those who deploy are also screened both prior to and after deployment. Seroconversion rates were estimated for all soldiers who deployed to Afghanistan or Iraq in the period 2001–2007 and all active duty soldiers who did not. Seroconverters with an estimated date of infection, based on calculation of the midpoint between the last seronegative and first seropositive test date, that was either before or during deployment were eligible for inclusion. Confidential interviews and medical record reviews were conducted to determine the most likely time, geographic location, and mode of infection. Reposed predeployment samples were tested for HIV ribonucleic acid. The HIV seroconversion rate among all soldiers who deployed was less than the rate among those who did not deploy: 1.04 and 1.42 per 10,000 person-years, respectively. Among 48 cases, most were determined to have been infected in the United States or Germany and prior to deployment ($n=20$, 42%) or during rest and relaxation leave ($n=13$, 27%). Seven seronegative acute infections were identified in the predeployment period. Subtype was determined for 40 individuals; all were subtype B infections. All were acquired through sexual contact. These findings can inform development of preventive interventions and refinement of existing screening policy to further reduce HIV-infected deployed soldier person time.

The prevalence of HIV infection in the U.S. Army population remains at approximately 0.02%,[1] and is significantly lower than that of the general U.S. population. The epidemic in the Army is similar to that in the U.S. general population; HIV infection disproportionately affects blacks and males and also disproportionately affects certain regions of the country including the South and Northeast.[2–4] By regulation, all U.S. soldiers are subject to periodic serologic screening for HIV every 2 years. In addition, soldiers who deploy to combat are also screened both prior to and after returning from deployments. HIV-infected soldiers are excluded from overseas missions.[5,6] Requirements for U.S. Army soldiers who deployed to Afghanistan or Iraq from October 2001 to December 2007 were for serologic screening for HIV infection within 365 days before deployment and within 30 days after the end of deployment. HIV force screening began in 1986 with the purpose of enhancing the safety of blood products obtained in urgent donation settings, such as a battlefield, preventing potentially fatal complications from administration of military-required, live vaccines, and monitoring HIV-infected troops for continuing physical qualification for duty.[7]

Approximately 5 years ago observations by Army investigators suggested that there may be an increase in HIV incidence among soldiers associated with combat deployments.[8–10] On July 14, 2007, the U.S. Army Surgeon General ordered an

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investigation to describe the location, time, and mode of transmission of HIV infections among U.S. Army soldiers who had deployed to Afghanistan and Iraq after October 1, 2001.

Soldiers with HIV seroconversions were identified using archived personnel, deployment, and HIV screening surveillance data from the Defense Medical Surveillance System (DMSS).[11] The rate of HIV seroconversion among soldiers who deployed to Afghanistan or Iraq was compared to the rate among active duty soldiers who did not deploy to Afghanistan or Iraq at any time during the study period. The midpoint between the last seronegative and first seropositive test date was estimated to be the date of HIV infection. Soldiers with an HIV-positive test who had deployed to Iraq or Afghanistan at any time during the study period were eligible for inclusion. Those who had a midpoint date either prior to or during deployment were included in this investigation. Soldiers were confirmed as cases after they individually verified their deployment dates.

All confirmed cases were invited to participate in a detailed epidemiologic interview and to permit a review of existing personnel and medical records. Soldiers were reminded of the protections from adverse action and confidentiality of the information obtained as part of epidemiologic interviews required by Army regulation.[5] To avoid the potential for favorable reporting, soldiers were not required to participate. Veterans who had separated from the Army were asked to provide informed consent and permission to release existing medical records. A single military infectious disease physician, who conducted interviews at U.S. Military Treatment Facilities, administered a questionnaire that guided the interviews and elicited individual health, social, and military occupational history including medical encounters and potential exposures to HIV.

For each case, archived serum remaining from the last seronegative HIV test performed prior to deployment was obtained from the Department of Defense Serum Repository (DoDSR)[11] and subjected to confirmatory HIV serologic testing[2,12] and nucleic acid amplification testing (NAAT, Amplicor HIV-1 Monitor v 1.5, Roche). Acute HIV infection (AHI) in an individual was identified by an HIV-seronegative sample that was NAAT positive. Whole blood specimens were collected at the time of epidemiologic interview for genotyping. Nucleic acid was extracted from plasma and serum using the QiAamp Viral RNA mini kit (QIAGEN Inc., Valencia, CA). HIV genotyping and sequence analysis were performed, as previously described, using a multiregion hybridization assay (MHA) for subtype B/non-B (MHAbnb) and partial length sequencing.[2,13]

The most likely time, geographic location, and mode of acquisition of HIV infection were determined using all available data. A timeline of events in the period of risk prior to HIV infection was generated for each participant and included self-assessment of the most likely time, location, and mode of infection; self-reported behavioral and occupational exposures; medical encounter and laboratory test records; and the dates and locations of all deployments, rest and relaxation (R&R) activities, and military assignments. Cases of probable, acute retroviral syndrome were identified using clinical histories and compatible medical encounter data. Where possible, administrative and medical records data were used to validate participant self-reports.

Approval of this investigation was obtained from the Division of Human Subjects Protections and Institutional Review Board of the Walter Reed Army Institute of Research (WRAIR #1678).

Among the 1,134,001 soldiers who deployed to Afghanistan or Iraq during the study period, 131 seroconverted (1.04/10,000 person years). By comparison, 258 of the 1,816,901 soldiers who did not deploy to Afghanistan or Iraq during the study period seroconverted (1.42/10,000 person-years).

Of the 131 seroconverters who deployed, 67 were not included because their midpoint date did not meet the inclusion criteria or due to misclassification of infection status or history of deployment. Of the 64 who were eligible for inclusion, nine declined participation, one was deceased, and one did not respond. Five others were excluded because the actual deployment dates individually verified by the soldier were different from those obtained from archived surveillance data such that their midpoint date was not prior to or during deployment. Thus, 48 confirmed cases participated. Compared to the overall deploying Army, cases were older, of higher rank, and were more frequently black and unmarried (Table 1).

Of the 48 confirmed cases, 20 (42%) were determined to have been infected before deployment, 13 (27%) during leave for R&R, and one (2%) while deployed. Determination of the most likely time of infection for four of the soldiers could be narrowed to only two time periods because exposure histories spanned more than one period. Five (10%) were determined to have been infected in the period between their deployment end date and postdeployment HIV serologic screening. For five other soldiers, there were insufficient existing data or exposure histories obtained in the interview to narrow the most likely time of infection down to even two periods (Fig. 1).

Most were determined to have been infected in the continental United States or Germany. Most (13/20) of the soldiers who were determined to have acquired their HIV-1 infection prior to deployment were infected in the last 6 months prior to departing for Afghanistan or Iraq (Fig. 2). Seven soldiers' predeployment samples were HIV seronegative and NAAT positive. These samples were collected between 290 and 41 days (median 76) prior to deployment. HIV subtype was determined by MHA or partial length sequencing for 40 of 48 participants and all were subtype B. For eight participants, samples were either not available or nontypeable.

High-risk exposures in the period at risk included unprotected sex with opposite and same sex partners; unprotected sex with strangers and other high-risk partners including commercial sex workers, injection drug users, and persons subsequently identified as HIV-infected; unprotected sex with multiple partners; and unprotected sex after alcohol use. None were emergency blood transfusion donors or recipients. One individual refused to provide a history of exposures.

Twenty-three individuals (48%) had a clinically apparent illness consistent with acute retroviral syndrome (ARS). Five were medically evacuated for evaluation of lymphadenopathy and one for evaluation of a febrile illness. Two soldiers contracted a sexually transmitted infection in addition to HIV during the period between when they were determined to have been infected and the end of their deployment. No participant experienced any vaccine adverse events.

This is the first report of HIV infections among U.S. Army soldiers deployed in support of combat operations. Overall, the rate of new HIV infections among those who deployed did

Table 1. Characteristics of HIV-Infected Cases (n=48) Compared to All HIV-Uninfected Active Army Personnel Who Deployed in the Period 2001–2007

Variable	*All deploying active Army personnel* n (%)	*Investigation participants* n (%)
Year of operation		
2002	56,226 (5)	2 (4)
2003	276,178 (24)	16 (33)
2004	230,695 (20)	14 (29)
2005	215,326 (19)	9 (19)
2006	162,507 (14)	6 (13)
2007	186,181 (16)	1 (2)
Age group[a,b]		
20–24	390,256 (34)	8 (17)
25–29	236,806 (21)	14 (29)
30–39	303,381 (27)	16 (33)
40+	138,370 (12)	10 (21)
Sex		
Male	1,019,894 (90)	47 (98)
Female	114,107 (10)	1 (2)
Race[b]		
Black	209,168 (18)	32 (67)
Other	924,869 (82)	16 (33)
Component		
Active	Not applicable	33 (69)
Reserve	Not applicable	15 (31)
Grade[b]		
E1–E4	537,927 (47)	18 (38)
E5+	596,090 (53)	30 (62)
Marital status[b,c]		
Married	590,549 (52)	22 (46)
Single	486,144 (43)	21 (44)
Other	57,344 (5)	5 (10)
Education		
Master degree	Not available	4 (8)
Associate/Bachelor degree		11 (23)
Some College		22 (46)
<High School		11 (23)
Occupation		
Combat arms	Not available	14 (29)
Combat support		23 (48)
Medical		4 (8)
Other support		7 (15)

[a]<20 age group (6% of deploying Army personnel) not shown.
[b]Differences were statistically significant ($p<0.05$, χ^2/Fisher's exact tests).
[c]Other includes divorced, separated, widowed, unknown.

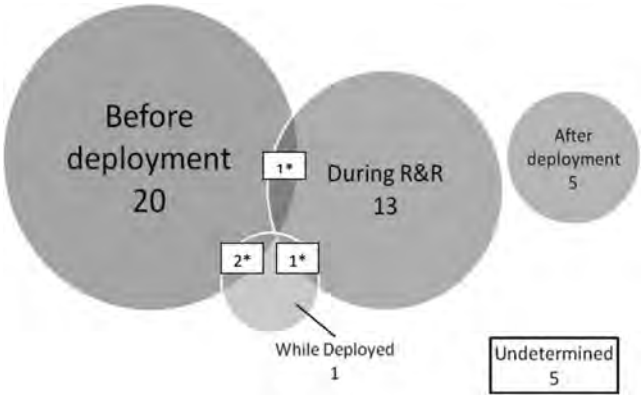

FIG. 1. Numbers of cases with determination of most likely time of infection occurring during particular periods in relation to deployment ($n=48$). R&R locations: 11 continental United States, 1 South America, 1 unknown. *The most likely time of infection could be narrowed to only one of two time periods because exposure histories spanned more than one period.

not exceed the rate among nondeploying soldiers and infection while deployed in Afghanistan and Iraq was extremely rare. Single, male, and black soldiers were overrepresented among the soldiers with new HIV infections who deployed. This was not unexpected as these findings are consistent with those in a previous report of the epidemic of HIV in the U.S. Army and Air Force.[2] However, these data demonstrate that HIV infection results in short-term morbidity and lost duty time in the combat environment. The realities of the current combat environment support the rationale that served as a basis for implementing force-wide screening policies 25 years ago.[7] Deployment and the battlefield present potential exposures to blood-borne pathogens including HIV. In addition to sexual transmission[14,15] there is potential contact with the battlefield supply of non-FDA-approved blood products,[16,17] occupational combat exposures, and casualty care with infection control measures limited by austere field conditions.[18,19] The probability of any transfusion-transmitted (TT) infection in combat settings is relatively low, while the potential impact is high. Underscoring this is a recent report of the first documented case of TT hepatitis C virus infection in a U.S. military recipient of a battlefield transfusion of non-FDA licensed, fresh whole blood,[16] as well as a recent report of TT HIV infection in the United States.[20]

Optimal HIV-related policy development and decision making rely on both knowledge of the current epidemiology and careful consideration of the technical, fiscal, and operational costs associated with each potential strategy. The observed, small number of HIV-infected soldiers in the combat theater of operations suggests that periodic force screening and perideployment screening using serological diagnostic algorithms to identify HIV infection are highly successful and effectively decrease HIV-infected deployed soldier person time. These findings contributed to an interim change in deployment screening policy that shortened the required HIV testing interval from 365 days to 90 prior to deployment in order to increase case finding, referral for clinical care, and exclusion from deployment eligibility. They may also inform further refinement of screening policy and laboratory methodology.

These data identify potential time period targets for the delivery of preventive interventions. As part of soldier readiness processing, soldiers preparing to deploy receive country-specific threat briefs that include information about potential disease, environmental, and occupational health hazards, and individual countermeasures available to stay healthy. These briefs include specific information and prevention messages about HIV/HIV-related infections. These data also reinforce the need to maintain a highly sensitive, readily adaptable, state-of-the-art capacity to determine HIV

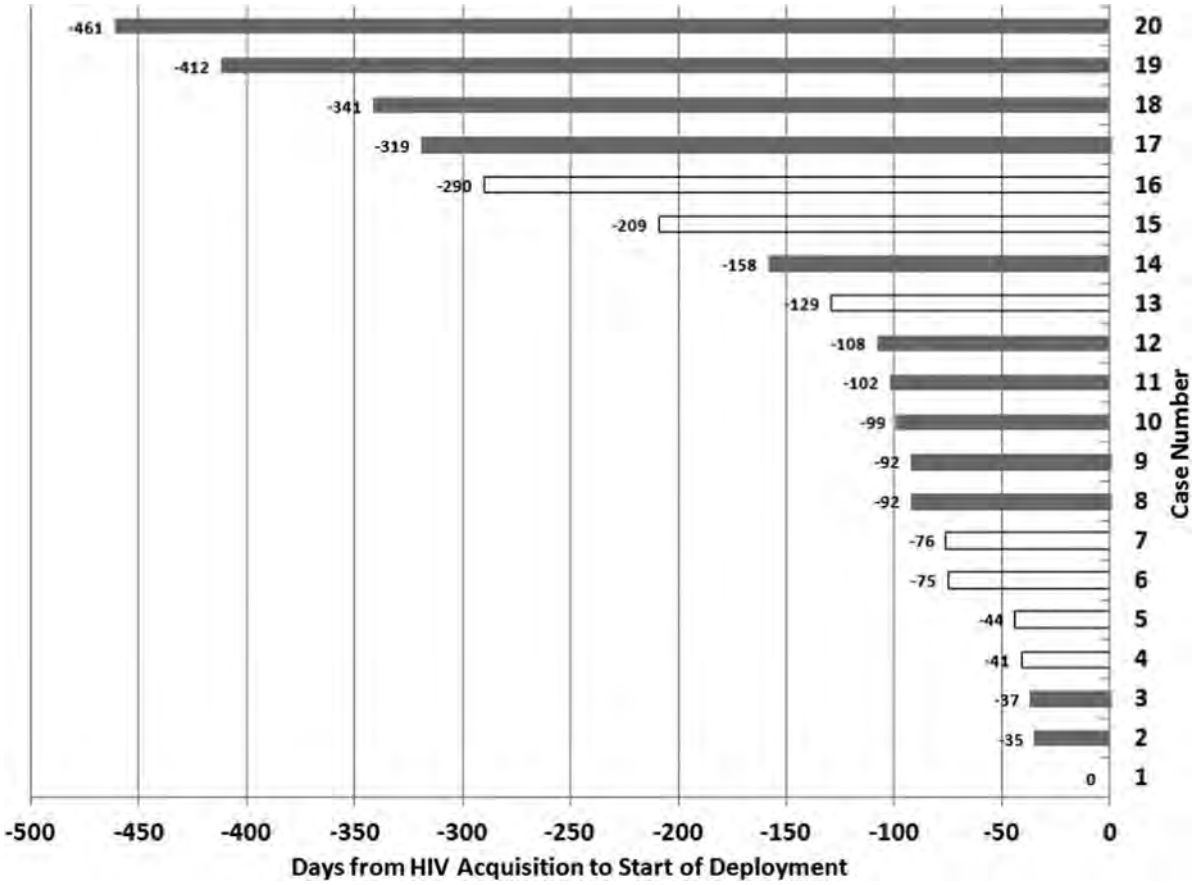

FIG. 2. Days from determination of most likely time of acquisition of HIV infection to start of deployment for soldiers infected prior to deployment ($n = 20$).

infection status when the tempo of military operations is high. Identification of acute HIV infection is a rare event.[21] By using an enhanced diagnostic algorithm that included HIV NAAT testing in this investigation that exceeded the sensitivity and time of earliest detection of the routine deployment serology-only screening diagnostic algorithm in place during the study period, we identified seven HIV infections that were RNA positive and serology negative. These results indicated that infection occurred as early as 5 22 days prior to sample collection.[22] The finding of acute infection occurring in close proximity to predeployment HIV screening suggests that there may be an association between mobilization for deployment and HIV infection acquisition.

Predeployment HIV testing is one part of the soldier readiness processing and training that occurs prior to deployment. This testing, performed in addition to the periodic HIV testing of the entire force, is conducted only among soldiers preparing to deploy. It is possible then that there is a relationship between incident HIV infection and deployment. There was no control group so additional study is warranted to investigate the possibility that deployment is associated with changes in behavior and exposures associated with HIV infection.

Future study is also warranted of soldiers who had incident HIV infections and deployed but were not compliant with deployment screening interval regulations and were not included in this investigation. A limitation of this study is that the inclusion criteria excluded those who have an estimated date of infection that was after the end of deployment. Due to the variability in compliance with predeployment and postdeployment and periodic HIV screening interval requirements, these inclusion criteria potentially excluded soldiers who may have contributed HIV infected person time while deployed and also eliminated description of the epidemiology of postdeployment incident HIV infection. Additional study of those soldiers with deployment exposure and postdeployment HIV infection is warranted. And on-going surveillance efforts of and reporting requirements for HIV screening compliance should continue. Findings from these studies would inform development and optimal timing for delivery of preventive interventions.

This study supports the utility of perideployment HIV screening. The findings of this investigation can advance the objectives of a force-wide HIV screening program to improve individual and force health, prevent the deployment of HIV-infected soldiers, and protect the safety of the battlefield blood supply.

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Author Disclosure Statement

No competing financial interests exist.

Material has been reviewed by the Walter Reed Army Institute of Research. There is no objection to its presentation and/or publication. The opinions or assertions contained herein are the private views of the author, and are not to be construed as official, or as reflecting true views of the Department of the Army or the Department of Defense.

References

1. Armed Forces Health Surveillance Center: Updates: Routine screening for antibodies to HIV 1, civilian applicants for U.S. military service and U.S. Armed Forces, active and reserve components. Medical Surveillance Monthly Report 2010; 17(9):7 18.
2. Singer DE, Bautista CT, O'Connell RJ, *et al.:* HIV infection among U.S. Army and Air Force military personnel: Socio demographic and genotyping analysis. AIDS Res Hum Retroviruses 2010;26(8):889 894.
3. Prejean J, Song R, Hernandez A, *et al.:* Estimated HIV inci dence in the United States, 2006 2009. PLoS One 2011; 6(8):e17502.
4. Centers for Disease Control and Prevention: HIV Surveil lance Report, 2009; vol. 21. Published February, 2011; http:// www.cdc.gov/hiv/topics/surveillance/resources/reports.
5. Department of the Army: Army Regulation 600 110. Personnel General Identification, Surveillance, and Admin istration of Personnel Infected with Human Immunodeficiency Virus (HIV). Washington, DC, July 15, 2005.
6. U.S. Central Command (CENTCOM): Mod[ification] Ten to USCENTCOM Individual Protection and Individual/Unit Deployment Policy: U.S. Central Command (CENTCOM); March 2010.
7. Department of Defense: Memorandum, Subject: Guidance for AIDS Related Rearch in the Department of Defense. Washington, DC, January 16, 1986.
8. Scott P, Schnabel D, Kijak G, *et al.:* HIV 1 Infections among U.S. Army Soldiers Deployed to Combat Operations in Iraq and Afghanistan. Paper presented at the 45th Annual Meeting of IDSA (Infectious Diseases Society of America), 2007, San Diego, CA.
9. Rubertone MV: Current HIV Testing Policy/HIV Incidence in Department of Defense Military Service Members. Report submitted September 27, 2006 to the U.S. Department of Defense (DoD) Armed Forces Epidemiological Board (Cur rently, DoD Defense Health Board). Washington, DC. Un published, 2006.
10. Department of Defense, Armed Forces Epidemiological Board: Transcript of Proceedings, September 27, 2006. http:// www.health.mil/dhb/AFEB Transcripts.cfm.
11. Rubertone MV and Brundage JF: The Defense Medical Surveillance System and the Department of Defense serum repository: Glimpses of the future of public health surveil lance. Am J Public Health 2002;92(12):1900 1904.
12. Renzullo PO, Sateren WB, Garner RP, Milazzo MJ, Birx DL, and McNeil JG: HIV 1 seroconversion in United States Army active duty personnel, 1985 1999. AIDS 2001;15(12):1569 1574.
13. Kijak GH, Tovanabutra S, Sanders Buell E, *et al.:* Distin guishing molecular forms of HIV 1 in Asia with a high throughput, fluorescent genotyping assay, MHAbce v.2. Virology 2007;358(1):178 191.
14. Wright J, Albright TS, Gehrich AP, Dunlow SG, Lettieri CF, and Buller JL: Sexually transmitted diseases in Operation Iraqi Freedom/Operation Enduring Freedom. Mil Med 2006;171(10):1024 1026.
15. Malone JD, Hyams KC, Hawkins RE, Sharp TW, and Daniell FD: Risk factors for sexually transmitted diseases among deployed U.S. military personnel. Sex Transm Dis 1993; 20(5):294 298.
16. Hakre S, Peel SA, O'Connell RJ, *et al.:* Transfusion transmissible viral infections among US military recipients of whole blood and platelets during Operation Enduring Freedom and Operation Iraqi Freedom. Transfusion 2011; 51(3):473 485.
17. Spinella PC: Warm fresh whole blood transfusion for severe hemorrhage: U.S. military and potential civilian applica tions. Crit Care Med 2008;36(7 Suppl):S340 345.
18. Murray CK, Johnson EN, Conger NG, and Marconi VC: Occupational exposure to blood and other bodily fluids at a military hospital in Iraq. J Trauma 2009;66(4 Suppl): S62 68.
19. Hospenthal DR and Crouch HK: Infection control challenges in deployed US military treatment facilities. J Trauma 2009; 66(4 Suppl):S120 128.
20. Centers for Disease Control and Prevention: HIV Trans mission Through Transfusion Missouri and Colorado, 2008. Morbid Mortal Weekly Rep (MMWR) 2010;59(41): 1335 1339.
21. Cohen MS, Shaw GM, McMichael AJ, and Haynes BF: Acute HIV 1 Infection. N Engl J Med 2011;364(20):1943 1954.
22. Fiebig EW, Wright DJ, Rawal BD, *et al.:* Dynamics of HIV viremia and antibody seroconversion in plasma donors: Implications for diagnosis and staging of primary HIV in fection. AIDS 2003;17(13):1871 1879.

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HIV Preexposure Prophylaxis in the U.S. Military Services — 2014–2016

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Human immunodeficiency virus (HIV) infection is a substantial health concern for the U.S. Department of Defense (DoD) and for service members stationed throughout the world. Each year, approximately 350 new HIV infections are diagnosed in members of the U.S. military services, with most infections acquired within the United States (*1*). The DoD populations most affected by HIV mirror those in the U.S. civilian population; the highest rates of new military diagnoses are in men and blacks or African Americans (blacks) (*1*). Blacks are disproportionally affected, and most new diagnoses occur among men who have sex with men (MSM). HIV preexposure prophylaxis (PrEP) is approximately 90% effective in preventing HIV infection when used properly (*2*), and an increasing number of active duty personnel have used HIV prevention services and PrEP in the military health system since the repeal of "Don't Ask, Don't Tell"* in 2011 (*3*). Military health system and service records were reviewed to describe HIV PrEP use among military personnel, and military health care providers were surveyed to assess HIV PrEP knowledge and attitudes. Among 769 service members prescribed PrEP during February 1, 2014–June 10, 2016, 60% received prescriptions from an infectious disease provider, 19% were black men, and 42% were aged >28 years. Half of surveyed military health care providers self-rated their PrEP knowledge as poor. DoD is developing new policy to address access to care challenges by defining requirements and establishing pathways for universal patient access to PrEP.

Charts were reviewed for service members without a diagnosis of HIV infection whose records indicated a prescription for emtricitabine/tenofovir disoproxil fumarate (Truvada, Gilead Sciences, Inc.) during February 1, 2014–June 10, 2016, and data were collected on demographic characteristics, service branch, risk behavior, and MSM risk index (*4*). The MSM risk index is a validated seven-item screening index used to prioritize patients for intensive HIV prevention efforts, including PrEP, with a score ≥10 having a sensitivity and specificity of 84% and 45%, respectively (*5*). Laboratory data were obtained from the Defense Medical Surveillance System (*6*). Infection status was ascertained by negative fourth generation HIV antigen/antibody testing and HIV viral load when clinically indicated. During 2015–2017, surveys were administered to 4,217 primary care and infectious disease providers in the Army, Navy, and Air Force to evaluate knowledge, attitudes, experience, and beliefs related to HIV PrEP.

Among 769 service members without HIV infection who were prescribed Truvada during February 1, 2014–June 10, 2016, 759 (99%) were men, and 320 (42%) were aged

* The 1993 Department of Defense policy that prohibited military personnel from discriminating against service members or applicants who did not disclose their homosexual or bisexual sexual orientation, while barring openly gay, lesbian, or bisexual persons from military service.

INSIDE

Continuing Education examination available at https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.

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>28 years, including 57 aged >40 years (Table) (Figure 1). Blacks accounted for 19% of those prescribed Truvada, compared with 47% who were white. Among the 769 Truvada recipients (including 33 whose education level was unknown), 285 (37%) had at least some college education. The indication for initiating PrEP was most commonly sexual contact with men (87%) and condomless sex (73%); 30% reported exposure to sexual partners with known HIV infection. The MSM risk index score was documented for 156 (20%) PrEP prescription recipients; among those for whom MSM risk index score was available, 72% had scores ≥10.

Service members who received PrEP were assigned to duty locations throughout the United States and several locations overseas; 315 (41%) of all PrEP recipients accessed services at one of three medical centers located in the Maryland/District of Columbia area; Portsmouth, Virginia; and San Diego, California (Figure 2). Of the 769 Truvada recipients, 464 (60%) accessed PrEP at infectious disease clinics. The majority had appropriate laboratory screening; however, 16% did not have an HIV test within 14 days of initiating PrEP, 13% were never evaluated for hepatitis B virus infection, and 20% and 30% did not have kidney function assessed at baseline or within 90 days of PrEP initiation, contrary to recommendations.

Among the 4,217 Army, Navy, and Air Force health care providers who were asked to respond to a web-based survey, 1,599 (38%) responded, including 1,190 (74% of respondents) primary care providers. Overall, 789 (49%) respondents rated their knowledge of PrEP as poor, and 470 (29%) reported ever having prescribed PrEP. Common health care provider concerns included medication adverse effects (915; 57%), compliance (817; 51%), and a need for more clear evidence

TABLE. Number of U.S. military service members (N = 769) without human immunodeficiency virus (HIV) infection who initiated preexposure prophylaxis, by selected characteristics — February 1, 2014–June 10, 2016

Characteristic	No. (%)
Total	**769 (100)**
Sex	
Men	759 (99)
Women	10 (1)
Age group (yrs)	
18–28	449 (58)
29–40	263 (34)
41–48	44 (6)
≥49	13 (2)
Race	
White	361 (47)
Black	149 (19)
Other*	259 (34)
Service branch	
Army	207 (27)
Navy	364 (47)
Air Force	158 (21)
Marine Corps	40 (5)
Education, highest level	
High school or less	451 (59)
Some college	84 (11)
Bachelor's degree	120 (16)
Higher than bachelor's degree	81 (11)
Unknown	33 (4)

* Includes American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and unknown.

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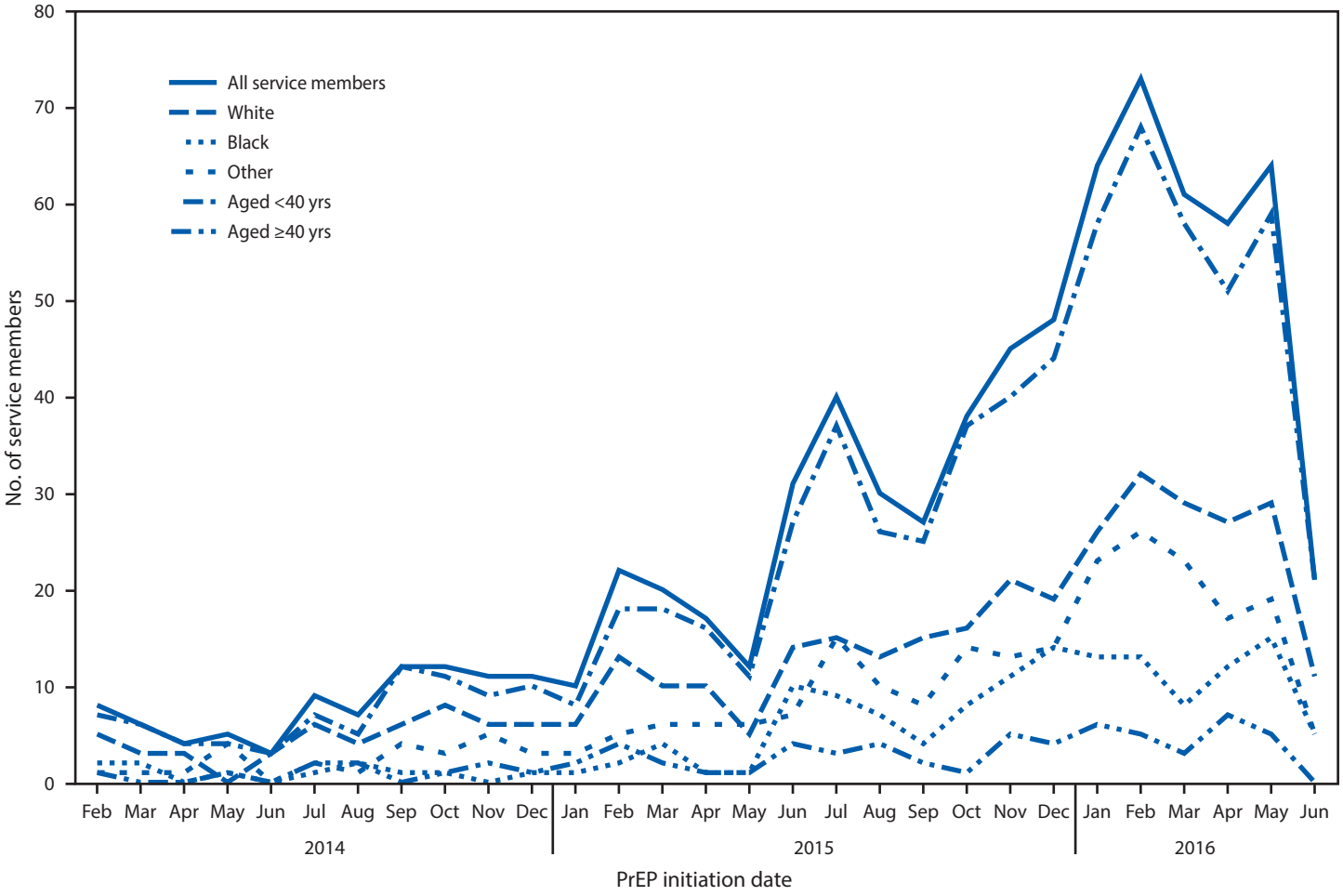
FIGURE 1. Number of military service members who initiated human immunodeficiency virus (HIV) preexposure prophylaxis (PrEP) among U.S. military personnel on active service who did not have HIV infection, by month — 2014–2016*



* Any patient without HIV infection who received an initial prescription for Truvada paid for by the U.S. Department of Defense during February 1, 2014–June 10, 2016, was considered to have received HIV PrEP.

of safety or efficacy (812; 51%). Despite these limitations and concerns, 1,082 (68%) of the responding health care providers endorsed provision of PrEP in the military health care system.

Discussion

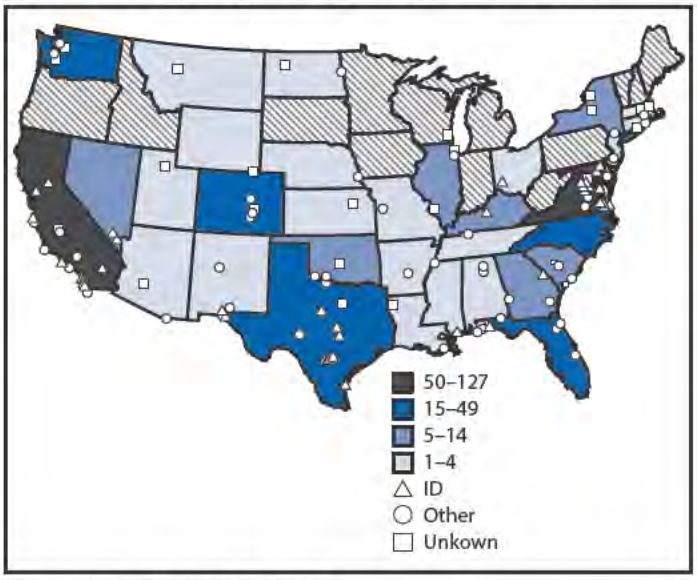
A key goal of the national HIV prevention strategy is effective use of HIV prevention services, including PrEP.[†] As in the U.S. civilian population, in the military, HIV disproportionately affects blacks, who represent 17% of the military force[§] but account for approximately half of all military HIV diagnoses (*7*); during the 2014–2016 study period, only 19% of service members who used PrEP services were black. Further studies are required to learn whether this represents a true disparity and whether improving culturally appropriate efforts will increase PrEP use among black service members who are at increased risk for acquiring HIV infection.

Based on the assumptions that 1) men constitute 85% of the 1.3 million active duty service members, 2) an estimated 4.23% of these men are MSM (including those who self-reported as gay [0.78%], bisexual [2.15%], or other MSM [1.30%]) (*8*), and 3) 25% of MSM have substantially increased risk for HIV (i.e., are candidates for PrEP) (*9*), an estimated 12,000 service members would be eligible for PrEP. However, as of February 2017, approximately 2,000 service members and their beneficiaries had accessed PrEP (Pharmacy Operations Division, Defense Health Agency, unpublished data, 2018). Most patients currently using PrEP are receiving Truvada from major military medical centers after referral to infectious disease specialists. Although a majority of surveyed military

[†] White House Office of National AIDS Policy. National HIV/AIDS strategy for the United States: Updated to 2020; 2016 progress report. December 2016. https://www.whitehouse.gov/sites/whitehouse gov/files/images/nhas-2016-progress-report.pdf.

[§] Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, Department of Defense. 2015 demographics: profile of the military community. http://download.militaryonesource.mil/12038/MOS/Reports/2015-Demographics-Report.pdf.

FIGURE 2. Number of military service members who initiated human immunodeficiency virus (HIV) preexposure prophylaxis (PrEP) among U.S. military personnel on active service who did not have HIV infection, by location of duty and prescribing clinic type — 2014–2016*



Abbreviation: ID = infectious disease.

* Any patient without HIV infection who received an initial prescription for Truvada paid for by the U.S. Department of Defense during February 1, 2014–June 10, 2016, was considered to have received HIV PrEP.

health care providers support the use of PrEP for military beneficiaries, increased capacity through provider education and expanded access to the requisite pharmacy and laboratory support services are necessary to meet the anticipated future demand for PrEP and ensure effective delivery of these services in the primary care setting. The transition to use of a fourth-generation HIV immunoassay for HIV screening throughout the DoD has substantially reduced the failure to diagnose acute HIV infection during the "window period" (i.e., the time between exposure to HIV infection and appearance of the first detectable HIV RNA). However, because of variable access to diagnostic tests, some health care providers expressed concern that patients with acute HIV infection might inappropriately be prescribed PrEP instead of antiretroviral treatment because of unrecognized HIV infection.

The maximum estimated annual cost of PrEP to the military health care system is substantial, and new prescriptions for PrEP are expected to continue to rise. Based on the estimate that approximately 12,000 service members would be eligible for PrEP and the current annual cost of Truvada is $12,000 per user,[¶] the potential maximum annual cost to the military health care system in drug costs alone would exceed $140 million. However, these cost estimates are largely based on assumptions using data from civilian populations and do not account for the lower costs of potential generic prescriptions; further evaluation is needed. In addition, the cost of PrEP services in the DoD can be weighed against the cost savings of preventing HIV infection in the service member; the average lifetime cost of medical care for a person with HIV infection is estimated to be nearly $450,000 (*10*). In addition, indirect costs associated with HIV-infected personnel who are prohibited from combat deployment might have substantial impact on military unit readiness and ability to accomplish specific missions.

Considerations unique to DoD are associated with initiation and maintenance of PrEP services among service members subject to worldwide assignment and deployment. Clinical, pharmacy, and laboratory services are limited in some deployment settings; moreover, access to expedited laboratory testing for HIV infection and the three-site (throat, rectum, and urine) gonorrhea and chlamydia nucleic acid amplification testing (NAAT) recommended by CDC's 2017 PrEP guidelines for MSM is either unavailable or not easily accessible at many smaller military medical treatment facilities in the United States. In addition, because some pharmacies have insufficient stock of medication for use for PrEP, not every service member or family member who needs Truvada can obtain it. Occupational considerations also exist. Historically, pilots and air crew members on flight status were prohibited from using Truvada and all other antiretrovirals.[**] To date, only Navy aviation has formally amended its aeromedical waiver guide to allow PrEP use among pilots and air crew.[††] In addition, adherence to the recommended 3-month follow-up evaluations can be difficult in light of the often unpredictable training and mission schedules. These differences between military policy and clinical practice have the potential to create confusion for both patients and health care providers with regard to implementation of standard PrEP management.

Approximately 28% of PrEP users with documented MSM risk indices had scores <10. The DoD legacy "Don't Ask, Don't Tell" policy and reluctance of service members to disclose MSM status might in part explain why only 20% of PrEP users had a documented MSM risk index score and why 28% of those had scores <10. As a result, in the military setting, the risk index alone might not be a reliable discriminator of candidacy for PrEP services. In addition, sexual relations and physical intimacy between unmarried service members,

[¶] National Acquisition Center and U.S. Department of Veteran Affairs. Pharmaceutical Catalog; 2017 https://www.va.gov/nac/Pharma/List?cboContractNumbers=&cboContractorNames=&txtCriteria1=truvada&TxtNDC=&txtPackage=&cboVAClass=&Sort=1&search=Search.

[**] Official Air Force Aerospace Medicine approved medications. https://www.315aw.afrc.af.mil/Portals/13/Users/096/96/96/Aircrew%20Medication%20List%20June%202017.pdf?ver=2017-07-13-121648-710. Army Regulation 40-501: Standards of Medical Fitness. Updated June 14, 2017. https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN3801_AR40-501_Web_FINAL.pdf.

[††] U.S. Navy Aeromedical Reference and Waiver Guide. http://www.med.navy.mil/sites/nmotc/nami/arwg/Documents/WaiverGuide/18_Medications.pdf.

Summary

What is already known about this topic?

Each year, approximately 350 new human immunodeficiency virus (HIV) infections are diagnosed in U.S. military service members, with most diagnoses occurring among men who have sex with men (MSM).

What is added by this report?

Among 769 service members prescribed preexposure prophylaxis (PrEP) during February 1, 2014–June 10, 2016, 87% were MSM. In a survey of health care providers, 49% rated their knowledge of PrEP as poor, and 29% reported ever having prescribed PrEP.

What are the implications for public health practice?

Strategies for reducing barriers to receipt of HIV prevention and care services include patient self-referrals for PrEP evaluations and development of new health policy to provide universal access to the provider, laboratory, and pharmacy services required for an effective PrEP program.

regardless of sex, in the deployed setting has been historically regarded as unprofessional behavior in a combat environment. The currently accepted practice is to discontinue PrEP because Truvada is considered a nondeployable medication in current combat environments.[§§]

The findings in this report are subject to at least three limitations. First, MSM risk index scores were infrequently documented by health care providers, which might have led to candidacy for PrEP services being misclassified. Second, the reported locations of PrEP initiation were based on uneven availability of PrEP services throughout the military health system, which limits generalizability. Finally, the percentage of survey responses from military health care providers was low, which might have led to misrepresentation of provider knowledge of PrEP.

Despite the universal access to care afforded to service members by the military health care system, there is a recognized need to improve and expand access to PrEP for those patients at highest risk for HIV infection. Currently, the availability of PrEP services is heterogeneous, based on the individual patient's geographic location. If located close to a tertiary care medical center, a patient typically is referred by a primary care provider to an infectious disease specialist to receive PrEP services. To reduce the barrier of requiring a consult to a subspecialty provider, several locations with infectious disease specialists are now allowing patients to self-refer for PrEP evaluations. Patients located closer to smaller military treatment facilities might find it difficult to access PrEP because resources required for PrEP services might be lacking, including three-site gonorrhea and chlamydia NAAT testing and adequate supplies of Truvada at the military pharmacy. In addition, primary care providers with limited knowledge and experience might lack confidence to provide PrEP services. New DoD policy is being developed to address identified gaps through initiatives to improve health care provider education and so ensure universal access to PrEP at the primary care level, and to standardize pharmacy and laboratory service delivery at all military treatment facilities.

[§§] Department of Defense. PPG-Tab A: Amplification of the minimal standards of fitness for deployment to the CENTCOM AOR; to accompany MOD thirteen to USCENTCOM individual protection and individual/unit deployment policy. July 12, 2017. https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Access-to-Healthcare/Pharmacy-Program/Deployment-Prescription-Program.

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Conflict of Interest

Jason Okulicz reports personal fees from Gilead Sciences, outside the submitted work. No other conflicts of interest were reported.

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References

1. Okulicz JF, Beckett CG, Blaylock JM, et al. Review of the U.S. military's human immunodeficiency virus program: a legacy of progress and a future of promise. MSMR 2017;24:2–7.
2. Grant RM, Lama JR, Anderson PL, et al.; iPrEx Study Team. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. N Engl J Med 2010;363:2587–99. https://doi.org/10.1056/NEJMoa1011205
3. Under Secretary of Defense. Memorandum for secretaries of the military departments. Subject: repeal of Don't Ask, Don't Tell and future impact on policy. Washington, DC: US Department of Defense; 2011. http://archive.defense.gov/home/features/2010/0610_dadt/USD-PR-DADT_28Jan11.pdf
4. US Public Health Service, CDC. Preexposure prophylaxis for the prevention of HIV infection in the United States—2017 update: clinical providers' supplement. Atlanta, GA: US Public Health Service, CDC; 2018. https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf

5. Smith DK, Pals SL, Herbst JH, Shinde S, Carey JW. Development of a clinical screening index predictive of incident HIV infection among men who have sex with men in the United States. J Acquir Immune Defic Syndr 2012;60:421–7. https://doi.org/10.1097/QAI.0b013e318256b2f6
6. Rubertone MV, Brundage JF. The Defense Medical Surveillance System and the Department of Defense serum repository: glimpses of the future of public health surveillance. Am J Public Health 2002;92:1900–4. https://doi.org/10.2105/AJPH.92.12.1900
7. Hakre S, Jagodzinski LL, Liu Y, et al. Characteristics of HIV-infected U.S. Army soldiers linked in molecular transmission clusters, 2001–2012. PLoS One 2017;12:e0182376. https://doi.org/10.1371/journal.pone.0182376
8. Hoover KW, Tao KL, Peters PJ. Nationally representative prevalence estimates of gay, bisexual, and other men who have sex with men who have served in the U.S. military. PLoS One 2017;12:e0182222. https://doi.org/10.1371/journal.pone.0182222
9. Smith DK, Van Handel M, Wolitski RJ, et al. Vital signs: estimated percentages and numbers of adults with indications for preexposure prophylaxis to prevent HIV acquisition—United States, 2015. MMWR Morb Mortal Wkly Rep 2015;64:1291–5. https://doi.org/10.15585/mmwr.mm6446a4
10. Farnham PG, Gopalappa C, Sansom SL, et al. Updates of lifetime costs of care and quality-of-life estimates for HIV-infected persons in the United States: late versus early diagnosis and entry into care. J Acquir Immune Defic Syndr 2013;64:183–9. https://doi.org/10.1097/QAI.0b013e3182973966

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Rebound of plasma viremia following cessation of antiretroviral therapy despite profoundly low levels of HIV reservoir: implications for eradication

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Abstract

Objectives—Sustained suppression of plasma viremia in HIV-infected individuals is attainable with antiretroviral therapy (ART); however, eradication of virus that would allow discontinuation of ART has been hampered by the persistence of HIV reservoirs. It is of great interest to identify individuals who had received ART for prolonged periods of time with extremely low or undetectable HIV reservoirs and monitor plasma viremia following discontinuation of therapy.

Methods—We measured the size of HIV reservoirs in $CD4^+$ T cells of individuals on long-term ART and monitored plasma viremia following cessation of ART in one individual with an exceptionally low viral burden after a decade of therapy.

Results—We demonstrated undetectable levels of HIV DNA in the blood of eight of 45 infected individuals on long-term ART. Among those eight individuals, the frequency of cells carrying infectious virus was significantly lower in those who initiated ART during the early versus the chronic phase of infection. One individual with undetectable HIV DNA in both blood and tissue and a profoundly low level of infectious virus experienced plasma viral rebound 50 days following discontinuation of ART.

Conclusions—Our data suggest that a significant reduction in the size of viral reservoirs may be achievable in selected individuals who initiate standard ART early in infection. However, given re-emergence of plasma viremia in an individual with an extraordinarily low viral burden, therapeutic strategies aimed at specifically targeting these extremely rare HIV-infected cells with novel interventions may be necessary in order to achieve eradication of virus.

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Keywords

antiretroviral therapy; discontinuation of therapy; eradication; human immunodeficiency virus; viral reservoirs

Introduction

Despite the development of successful therapeutic strategies [1], it has thus far been impossible to eradicate HIV in infected individuals receiving effective antiretroviral therapy (ART), mainly due to the persistence of viral reservoirs [2–4]. Previous studies have demonstrated the persistence of HIV in $CD4^+$ T cells in blood as well as in gut-associated lymphoid tissue (GALT) of infected individuals receiving ART who had maintained undetectable levels of plasma viremia for significant periods of time [5], an observation that may help explain the relatively rapid rebound of plasma viremia upon treatment interruption [6,7]. In this regard, it has been demonstrated that detectable levels of plasma viremia (>50 copies of HIV RNA per ml) re-emerge on average 9 days following discontinuation of ART in individuals who experienced ART-induced suppression of plasma viremia [7]. However, the vast majority, if not all, of such infected individuals carried readily detectable HIV reservoirs prior to cessation of ART and had received antiretroviral drugs for less than 3–5 years [6,7]. Although viral reservoirs, which persist in spite of clinically effective ART, pose a major impediment to complete eradication of virus, evidence for continual decay of a pool of infected $CD4^+$ T cells has also been demonstrated in a subset of HIV-infected individuals, especially those who initiated ART during the early phase of infection [8,9]. In this regard, it would be of interest to determine if treatment with ART for extended periods of time (up to and longer than a decade) could bring the viral reservoirs to extremely low and possibly undetectable levels, and whether under such conditions the occurrence, timing, and level of viral rebound would be influenced upon discontinuation of therapy. We conducted the present study to address this issue.

Materials and methods

Patient population

Forty-four individuals with documented HIV infection who had received ART for a median of 7.7 years (range 3.0–10.5) and who had achieved prolonged suppression of plasma viremia were studied. One of 44 patients had been reported in a previously published paper [9]. Nine of the 44 individuals initiated ART during the early phase of infection (<6 months after acquisition of HIV). All participants included in this study maintained undetectable levels of plasma viremia (<50 copies/ml) without viral ‘blips’ after initiation of ART as determined by frequent blood sampling (at least three times per year). Any individual with detectable plasma viremia (>50 copies/ml) during the course of ART was excluded from this study. Blood and tissue specimens were collected from the study participants in accordance with protocols approved by the Institutional Review Boards of the University of Toronto, Toronto, Canada, University of Washington, Seattle, and by the Office of Human Subjects Research at the National Institutes of Health.

Isolation of $CD4^+$ T cells in blood and preparation of cells in gut-associated lymphoid tissue

Peripheral blood mononuclear cells (PBMCs) were obtained from blood draw and leukapheresis by Ficoll-Hypaque density gradient centrifugation. $CD4^+$ T cells were isolated from PBMCs of HIV-infected individuals using either a column-based cell or an automated separation technique (StemCell Technologies) as previously described [10]. The purity of

enriched $CD4^+$ T cells was generally greater than 95% assessed by flow cytometry. In order to examine cells in GALT, sigmoidoscopy was conducted in two study participants. Tissue samples (>10 biopsies) were incubated with 0.5 mg/ml collagenase (Type II-S; Sigma) in RPMI containing 5% fetal bovine serum, HEPES, and Pen/Strep at 37°C for 30 min. After frequent pipetting and vortexing, cells were washed and stored on ice and the remaining undigested tissue was treated with 1.0 mg/ml collagenase for an additional 30 min. The cells obtained above were subjected to $CD8^+$ cell depletion (Invitrogen-Dynal).

Quantitative real-time PCR for measurements of HIV DNA

In order to determine the frequency of $CD4^+$ T cells carrying HIV proviral DNA in infected individuals, realtime PCR was carried out on genomic DNA isolated from $1–2 \times 10^6$ purified $CD4^+$ T cells using the Puregene DNA isolation kit according to the manufacturer's specifications (Gentra). 1 μg of DNA was then used as a template for real-time PCR in an iCycler (Bio-Rad). The amplification reaction was carried out in triplicate using 0.5 μmol/l primers, 0.2 μmol/l fluorescent probe, 0.8 mmol/l dNTPs, 5 mmol/l $MgCl_2$, and 2.5 U Platinum Taq Polymerase (Invitrogen) in 50 μl total volume. The following primers were used: 5′-GGTCT CTCTGGTTAGACCAGAT-3′ (5′ primer) and 5′-CTG CTAGAGATTTTCCACACTG-3′ (3′ primer) along with the fluorescent probe 5′-6FAM-AGTAGTGTGTGCCCGTCTGTT-TAMRA-3′. PCR conditions consisted of a denaturation step at 95°C for 3 min followed by 45 cycles of 15 s at 95°C and 1 min at 59°C. Serially diluted ACH-2 DNA (40 000, 8000, 1600, 320, 64, 12.8, 2.56, and 0.56 cell equivalents per well in triplicates) was also subjected to the above PCR to obtain standard curves. The detection limit of the assay was 2.6 copies of HIV DNA. In order to determine the frequency of HIV infection in GALT, approximately 200 000 CD8-depleted cells were lyzed in 10 mmol/l Tris–HCl pH8 containing 100 μg/ml proteinase K (Roche Applied Science) for 1 h at 56°C followed by heat inactivation of the enzyme. Real-time PCR specific for human β-actin DNA (Applied Biosystems) was carried out on the above cell lysates in order to determine the exact copy number of cells per μl of cell lysate. Serially diluted ACH-2 DNA was also subjected to the above PCR to obtain standard curves. Finally, real-time PCR specific for HIV DNA was carried out as described above and the copy number of HIV DNA per 1×10^6 $CD4^+$ T cells was calculated based on the results obtained from the PCR experiments.

High-input quantitative coculture assays

In order to determine the frequency of $CD4^+$ T cells carrying replication-competent HIV, high-input quantitative coculture assays were carried out in which multiple wells containing 1×10^7 $CD4^+$ T cells were subjected to activation in 12-well tissue culture plates as described previously [11]. Briefly, highly enriched $CD4^+$ T cells were enumerated using an automated cell counter (Guava PCA, Guava Technologies) and precisely 10×10^6 $CD4^+$ T cells were seeded to each well in 12-well plates. Subsequently, 8×10^6 irradiated PBMCs from HIV-negative healthy donors were added to each well along with anti-CD3 antibody and incubated overnight in the presence of culture medium including recombinant IL-2 (20 units/ml). 1×10^6 CD8-depleted and anti-CD3 stimulated PBMC blasts from HIV-negative donors were added to each well the following day and again on day 7. The cultures were subjected to removal of 33% of the cell suspension every three days and replenished with fresh media. The culture supernatants were subjected to HIV p24 ELISA between days 14 and 21. The viability of cultures was periodically measured using dyes that stain cell membrane and DNA (Guava PCA, Guava Technologies). The infectious units per million cells (IUPM) values from the high-input coculture (HIC) assays were determined as described [2] except that the Newton-Raphson algorithm with a convergence criteria of relative change of the estimated IUPM value less than 1×10^{-6} was used. When high-HICs

were negative, the IUPM value was estimated to be lower than a number that assumes that one well containing 10 million cells was indeed culture-positive.

Determination of plasma viremia following discontinuation of antiretroviral therapy

Plasma viral loads were monitored longitudinally using a branched DNA assay (the limit of detection of 50 copies of HIV RNA per ml) after one study participant voluntarily discontinued all antiretroviral drugs.

Results

In order to determine the frequency of $CD4^+$ T cells carrying HIV DNA from the study participants, genomic DNA was prepared from highly purified $CD4^+$ T cells and subjected to real-time PCR specific for HIV proviral DNA (limit of detection 2.6 copies of HIV DNA per μg of genomic DNA or 150 000 cell equivalent) [10]. The median copy number of HIV proviral DNA for all study participants examined was 417.1 (range <2.6–8804.4) per 10^6 $CD4^+$ T cells (Fig. 1a). The median copy number of HIV proviral DNA in the study participants who had initiated ART within 6 months of infection was significantly lower (4.6 copies per 10^6 $CD4^+$ T cells) compared to those who had initiated ART during the chronic phase of infection (949.4 copies per 10^6 $CD4^+$ T cells) ($P = 0.003$). Of note, no measurable HIV proviral DNA was detected in four of nine early treated (44.4%) and four of 35 chronic treated (11.4%) individuals.

In order to examine the frequency of $CD4^+$ T cells carrying infectious virus, a HIC assay [11], which allows examination of large numbers of cells, was conducted using highly enriched $CD4^+$ T cells from the eight infected individuals in whose cells no measurable HIV proviral DNA had been detected. As shown in Fig. 1b, infectious virus was recovered in all infected individuals using the HIC assay on $CD4^+$ T cells. In one particular individual, the first HIC assay involving 3×10^8 purified $CD4^+$ T cells failed to produce replication-competent virus (7.6 years after initiation of ART). The infectious viral burden was estimated to be below 0.0012 per 10^6 $CD4^+$ T cells, using the assumption that one additional well would have resulted in HIV p24-positive outcome. However, a subsequent HIC assay conducted 10.5 years after initiation of ART using 1.56×10^9 $CD4^+$ T cells resulted in one out of 156 wells being positive for infectious virus. This translated into an infectious viral burden of 0.00064 per 10^6 $CD4^+$ T cells or one infected cell per 1.7×10^9 $CD4^+$ T cells. This is the lowest infectious HIV burden recorded to date in our laboratory and is considerably lower than the previously reported average frequency of 0.059 infectious units per 10^6 $CD4^+$ T cells in HIV-infected individuals having received ART for more than 7.6 years [10]. When the coculture data were stratified by time of initiation of ART, the frequency of cells carrying infectious virus in infected individuals who initiated therapy within 6 months of infection was significantly lower (median: 0.0074 infectious units per 10^6 $CD4^+$ T cells, range 0.00064–0.0173) than that of infected individuals who initiated therapy during the chronic phase of infection (median 0.0666 infectious units per 10^6 $CD4^+$ T cells, range 0.0345–0.0847) ($P = 0.03$).

Colonoscopy was performed on two infected individuals in order to measure levels of HIV in GALT. As shown in Table 1, real-time PCR conducted on CD8-depleted cells from sigmoid colon biopsies from one infected individual (who initiated ART during the chronic phase of infection) in whom HIV proviral DNA was undetectable in peripheral blood $CD4^+$ T cells, but in whom infectious virus was recovered, revealed readily detectable HIV DNA (89 copies of DNA per million cells). However, HIV DNA was undetectable in CD8-depleted cells isolated from the sigmoid colon biopsies of the infected individual (who initiated ART during the early phase of infection) in whom HIV proviral DNA was undetectable and the level of infectious virus was extraordinarily low (one infected cell per

1.7×10^9 $CD4^+$ T cells) in peripheral blood $CD4^+$ T cells (Table 1), suggesting that a profound reduction in the size of viral reservoir was achieved in this study participant.

In order to investigate whether discontinuation of ART in the individual who was started on ART early in the course of infection and who had an extraordinarily low HIV reservoir would result in rebound of plasma viremia, and what the kinetics of such a rebound would be if it occurred, we discontinued ART in the patient upon his consent and monitored plasma viremia. As shown in Fig. 2, plasma viremia was not detected for the first 50 days following discontinuation of therapy. Subsequently, plasma viremia rebounded to 1593 copies of HIV RNA per ml followed by spontaneous suppression to an undetectable level. However, plasma viremia then rebounded again to 8684 copies of HIV RNA per ml on day 143 at which point ART was re-initiated.

Discussion

The persistence of HIV proviral DNA and/or infectious virus in $CD4^+$ T cells of infected individuals receiving ART and in whom plasma viremia was suppressed below the level of detection for prolonged periods of time has thus far made the prospect of eradicating virus extremely problematic [2–4,10]. In the present study, we demonstrated undetectable levels of HIV DNA in the blood of eight infected individuals on long-term ART, including one individual in whom HIV proviral DNA could not be detected in the GALT and infectious HIV burden was extraordinarily low. Among the eight individuals whose peripheral blood $CD4^+$ T cells had undetectable HIV DNA, the frequency of cells carrying infectious virus was significantly lower in those in whom ART was initiated during the acute/early phase of infection compared to those who began therapy during the chronic phase of infection. It is not clear whether differential decay rates of virus in subsets of memory $CD4^+$ T cells [12] and/or efficacy of different drug regimens contributed to rapid clearance of HIV in some infected individuals receiving ART. Although we cannot rule out the existence of low levels of HIV replication [13,14] or the persistence of virus in other lymphoid tissue [5,8], our data clearly suggest that, at least in a subset of infected individuals, the profound suppression of viral replication by long-term effective ART that had been initiated early in the course of infection may lead to substantially greater reduction of residual HIV compared to those in whom ART was initiated after HIV infection had already been established as a chronic process. Of note, it is likely that a standard quantitative coculture assay would not have detected any replication competent virus in one study participant, given the unusually large number of cells (over one billion $CD4^+$ T cells) used to detect one well containing infectious HIV in the $CD4^+$ T cells. Nonetheless, the present study clearly demonstrated that the combination of early initiation of ART, an extended duration of therapy, and a profoundly low HIV burden in $CD4^+$ T cells did not eradicate HIV, nor did it indefinitely suppress the re-emergence of plasma viremia; however, it did lead to a longer period (50 days) of aviremia compared to previous studies (average 9 days) after cessation of antiretroviral drugs [7]. It is possible that profoundly low HIV burden and/or HIV-specific immune responses may have contributed to the long delay of plasma viral rebound in this infected individual [15]. The secondary plasma viral rebound may have been due to emergence of escape mutants [16]. Our data also suggest that the vast majority of, if not all, infected individuals receiving ART will experience plasma viral rebound regardless of the level of HIV in their $CD4^+$ T cell compartment at the time of discontinuation of ART.

Several attempts have been made in the past to ‘flush’ out HIV from $CD4^+$ T cells in infected individuals receiving ART without providing definitive evidence for eradication of virus [6,17,18]. Of note, we have previously demonstrated that co-administration of IL-2 and ART could lead to a dramatic diminution in the size of the $CD4^+$ T-cell viral reservoir [11]. Yet, despite the diminution in the size of the viral reservoir, HIV proviral DNA was

still readily detectable in their $CD4^+$ T cells prior to cessation of antiviral drugs. Given the presence of detectable proviral DNA, it should not have been surprising that these patients experienced rebound of plasma viremia upon discontinuation of therapy [6]. However, the present study demonstrates that despite the fact that prolonged treatment with ART initiated early in the course of HIV infection resulted in undetectable levels of proviral DNA and profoundly low levels of infectious HIV in peripheral blood $CD4^+$ T cells, virus still rebounded upon discontinuation of therapy. It appears that currently available antiretroviral drugs, even when initiated early in the course of infection and continued for prolonged periods of time resulting in 'undetectable' HIV DNA, do not eradicate HIV [19]. In order to achieve a condition under which HIV does not rebound for extended periods of time in the absence of ART, novel therapeutic strategies aimed at more specifically targeting these extremely rare infected cells may be necessary with or without the use of therapeutic vaccination to boost immune system control of viral rebound. In addition, prior to interrupting antiretroviral therapy in HIV-infected individuals, exhaustive laboratory assays, especially HIC assays that allow detection of infectious virus in large numbers of $CD4^+$ T cells, should be conducted given rebound of plasma viremia following cessation of therapy is all but certain as long as infectious viral reservoirs are present.

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References

1. Walensky RP, Paltiel AD, Losina E, Mercincavage LM, Schackman BR, Sax PE, et al. The survival benefits of AIDS treatment in the United States. J Infect Dis. 2006; 194:11–19. [PubMed: 16741877]
2. Chun TW, Stuyver L, Mizell SB, Ehler LA, Mican JA, Baseler M, et al. Presence of an inducible HIV-1 latent reservoir during highly active antiretroviral therapy. Proc Natl Acad Sci U S A. 1997; 94:13193–13197. [PubMed: 9371822]
3. Finzi D, Hermankova M, Pierson T, Carruth LM, Buck C, Chaisson RE, et al. Identification of a reservoir for HIV-1 in patients on highly active antiretroviral therapy. Science. 1997; 278:1295–1300. [PubMed: 9360927]
4. Wong JK, Hezareh M, Gunthard HF, Havlir DV, Ignacio CC, Spina CA, et al. Recovery of replication-competent HIV despite prolonged suppression of plasma viremia. Science. 1997; 278:1291–1295. [PubMed: 9360926]
5. Chun TW, Nickle DC, Justement JS, Meyers JH, Roby G, Hallahan CW, et al. Persistence of HIV in gut-associated lymphoid tissue despite long-term antiretroviral therapy. J Infect Dis. 2008; 197:714–720. [PubMed: 18260759]
6. Chun TW, Davey RT Jr, Engel D, Lane HC, Fauci AS. Reemergence of HIV after stopping therapy. Nature. 1999; 401:874–875. [PubMed: 10553903]
7. Davey RT Jr, Bhat N, Yoder C, Chun TW, Metcalf JA, Dewar R, et al. HIV-1 and T cell dynamics after interruption of highly active antiretroviral therapy (HAART) in patients with a history of sustained viral suppression. Proc Natl Acad Sci U S A. 1999; 96:15109–15114. [PubMed: 10611346]
8. Zhang L, Ramratnam B, Tenner-Racz K, He Y, Vesanen M, Lewin S, et al. Quantifying residual HIV-1 replication in patients receiving combination antiretroviral therapy. N Engl J Med. 1999; 340:1605–1613. [PubMed: 10341272]

9. Chun TW, Justement JS, Moir S, Hallahan CW, Maenza J, Mullins JI, et al. Decay of the HIV reservoir in patients receiving antiretroviral therapy for extended periods: implications for eradication of virus. J Infect Dis. 2007; 195:1762–1764. [PubMed: 17492591]
10. Chun TW, Nickle DC, Justement JS, Large D, Semerjian A, Curlin ME, et al. HIV-infected individuals receiving effective antiviral therapy for extended periods of time continually replenish their viral reservoir. J Clin Invest. 2005; 115:3250–3255. [PubMed: 16276421]
11. Chun TW, Engel D, Mizell SB, Hallahan CW, Fischette M, Park S, et al. Effect of interleukin-2 on the pool of latently infected, resting CD4+ T cells in HIV-1-infected patients receiving highly active antiretroviral therapy. Nat Med. 1999; 5:651–655. [PubMed: 10371503]
12. Chomont N, El-Far M, Ancuta P, Trautmann L, Procopio FA, Yassine-Diab B, et al. HIV reservoir size and persistence are driven by T cell survival and homeostatic proliferation. Nat Med. 2009; 15:893–900. [PubMed: 19543283]
13. Sharkey ME, Teo I, Greenough T, Sharova N, Luzuriaga K, Sullivan JL, et al. Persistence of episomal HIV-1 infection intermediates in patients on highly active antiretroviral therapy. Nat Med. 2000; 6:76–81. [PubMed: 10613828]
14. Strain MC, Gunthard HF, Havlir DV, Ignacio CC, Smith DM, Leigh-Brown AJ, et al. Heterogeneous clearance rates of longlived lymphocytes infected with HIV: intrinsic stability predicts lifelong persistence. Proc Natl Acad Sci U S A. 2003; 100:4819–4824. [PubMed: 12684537]
15. Rosenberg ES, Altfeld M, Poon SH, Phillips MN, Wilkes BM, Eldridge RL, et al. Immune control of HIV-1 after early treatment of acute infection. Nature. 2000; 407:523–526. [PubMed: 11029005]
16. McMichael AJ, Borrow P, Tomaras GD, Goonetilleke N, Haynes BF. The immune response during acute HIV-1 infection: clues for vaccine development. Nat Rev Immunol. 2010; 10:11–23. [PubMed: 20010788]
17. Kulkosky J, Nunnari G, Otero M, Calarota S, Dornadula G, Zhang H, et al. Intensification and stimulation therapy for human immunodeficiency virus type 1 reservoirs in infected persons receiving virally suppressive highly active antiretroviral therapy. J Infect Dis. 2002; 186:1403–1411. [PubMed: 12404155]
18. Lehrman G, Hogue IB, Palmer S, Jennings C, Spina CA, Wiegand A, et al. Depletion of latent HIV-1 infection in vivo: a proof-of-concept study. Lancet. 2005; 366:549–555. [PubMed: 16099290]
19. Richman DD, Margolis DM, Delaney M, Greene WC, Hazuda D, Pomerantz RJ. The challenge of finding a cure for HIV infection. Science. 2009; 323:1304–1307. [PubMed: 19265012]

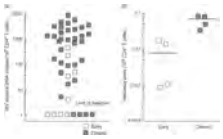

Fig. 1. Frequencies of HIV proviral DNA (a) and infectious virus (b) in CD4$^+$ T cells of HIV-infected individuals receiving effective ART for prolonged periods of time

(a) Levels of HIV proviral DNA in highly enriched CD4$^+$ T cells was determined by real-time PCR as previously described [10]. The open and closed squares represent data obtained from the 'early treated' and 'chronic treated' individuals, respectively. (b) Levels of replication-competent HIV in CD4$^+$ T cells from infected individuals were determined by high input coculture assay as previously described [11]. The median is shown as gray bars.

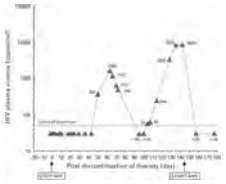

Fig. 2. Levels of plasma viremia following discontinuation and re-initiation of ART

Plasma viremia was determined by a branched DNA assay with the detection limit of 50 copies of HIV RNA per ml of plasma. ARV, antiretroviral.

Table 1

Immunologic and virologic profiles of selected HIV-infected individuals in whom sigmoid colon biopsies were preformed.

Participant	Sex	Age	Time of initiation of antiretroviral therapy	Duration of antiretroviral therapy at time of study (year)	Antiretroviral therapy at time of study[a]	CD4 cell count at time of study (cells/μl)	CD8 cell count at time of study (cells/μl)	CD4/CD8 ratio	Plasma HIV RNA at time of study (copies/ml)[b]	Level of HIV DNA in blood (copies/10^6 cells)	Level of infectious HIV in blood (/10^6 cells)	Level of HIV DNA in sigmoid colon (copies/10^6 cells)
1	Male	44	Chronic	8.6	ABC/3TC/EFV	410	580	0.7	<50	<2.56	0.05750	89.0
2	Male	46	Early	10.5	ABC/3TC/EFV	1060	840	1.3	<50	<2.56[c]	0.00064	<2 56

[a] 3TC, lamivudine; ABC, abacavir; EFV, efavirenz.

[b] Measured by a branched DNA assay with a detection limit of 50 copies per ml of plasma.

[c] 80 wells containing 1 μg of genomic DNA per well resulted in undetectable levels of HIV proviral DNA.

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Transfusion-transmitted human T-lymphotropic virus Type I infection in a United States military emergency whole blood transfusion recipient in Afghanistan, 2010

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BACKGROUND: The United States introduced human T-lymphotropic virus Type I (HTLV-I) screening of blood donors in 1988. The US military uses freshly collected blood products for life-threatening injuries when available stored blood components in theater have been exhausted or when these components are unsuccessful for resuscitation. These donors are screened after donation by the Department of Defense (DoD) retrospective testing program. All recipients of blood collected in combat are tested according to policy soon after and at 3, 6, and 12 months after transfusion.

CASE REPORT: A 31-year-old US Army soldier tested positive for HTLV-I 44 days after receipt of emergency blood transfusions for severe improvised explosive device blast injuries. One donor's unit tested HTLV-I positive on the DoD-mandated retrospective testing. Both the donor and the recipient tested reactive with enzyme immunoassay and supplemental confirmation by HTLV-I Western blot. The donor and recipient reported no major risk factors for HTLV-I. Phylogenetic analysis of HTLV-I sequences indicated Cosmopolitan subtype, Subgroup B infections. Comparison of long terminal repeat and *env* sequences revealed molecular genetic linkage of the viruses from the donor and recipient.

CONCLUSION: This case is the first report of transfusion transmission of HTLV-I in the US military during combat operations. The emergency fresh whole blood policy enabled both the donor and the recipient to be notified of their HTLV-I infection. While difficult in combat, predonation screening of potential emergency blood donors with Food and Drug Administration–mandated infectious disease testing as stated by the DoD Health Affairs policy should be the goal of every facility engaged with emergency blood collection in theater.

Human T-lymphotropic virus Type I (HTLV-I) is an intracellular human RNA retrovirus that is associated primarily with adult T-cell leukemia in 2% to 5% and HTLV-I–associated myelopathy or tropical spastic paraparesis in 1% to 2% of infected carriers.[1-3] Six subtypes have been identified: a (Cosmopolitan)—Japan; b to f—Central Africa; c—Melanesia; and e—South and Central Africa.[4-9] Isolates from West African countries are almost identical to those from the French West Indies, Haiti, French Guyana, and Peru.[8] While the genetic variability of the HTLV-I proviral sequence is relatively low when compared to other viruses such as human immunodeficiency virus (HIV) and hepatitis C virus (HCV), epidemiologically linked infections

ABBREVIATIONS: ASBPO = Armed Services Blood Program Office; DoD = Department of Defense; FOB = forward operating base; IED = improvised explosive device; LTR = long terminal repeat; MTF(s) = military treatment facility(-ies).

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TABLE 1. Countermeasures employed to reduce the risk of transfusion-transmitted viral infection from freshly collected blood products in the combat theater of operations

Countermeasure	HIV	HCV	HBV	HTLV-I/II
Periodic screening of the force	Every 2 years*			
Theater entrance screening	Within 120 days†			
Vaccination	NA*	NA*	Required‡	NA
Volunteer donor screening questionnaire	Yes	Yes	Yes	No§
Volunteer donor pools‖	Yes	Yes	Yes	Yes
Rapid test	Yes	Yes	Yes	NA

* Force screen policy 2001—current by service and component for active component; every 5 years for reserve component.
† Central Command (CENTCOM) theater entrance requirement for predeployment HIV testing within 120 days of deployment, as of December 2011 (MOD 11).
‡ Universal vaccination during initial entry training since 2001. Required to initiate vaccination prior to entry in to the CENTCOM combat theater of operations.
§ Not currently utilized; recommendation has been made to consider modification of the DoD donor screening questionnaire (DD572) and include questions pertaining to risk for HTLV-I/II infection.
‖ Volunteers at facilities with blood donation capacity are screened for HIV, HBV, HCV, HTLV-I/II, West Nile virus, and syphilis. Donors are admitted to the donor pool upon receipt of negative test results and rescreened every 90 days after readmission. At the time of donation, donated units are tested for HIV, HBV, and HCV with rapid diagnostic tests.

have been identified.[10-12] In HTLV-I–endemic areas such as southwestern Japan, the Caribbean, sub-Saharan Africa, South America, and parts of Iran, seroprevalence rates range from less than 5% to 10%.[13]Infection is lifelong with transmission of the virus primarily through breast milk, sexual contact, blood transfusion, or from sharing needles in intravenous drug use.

Reports of transfusion-transmitted HTLV-I in the United States have been infrequent with the last such report in 1989.[14] The United States initiated HTLV-I screening of blood donors in 1988[15] to prevent transmission of the virus from transfusion of blood products.[14,16] As a lifesaving measure when stored blood products have failed and when existing US Food and Drug Administration (FDA)-approved blood products have been exhausted or are unavailable, the US military uses freshly collected blood products during conflicts for combat casualty resuscitation.[17,18] Health Affairs policy guidelines for non–FDA-compliant emergency blood collection include, in order of preference, 1) blood donors screened for FDA-mandated transfusion-transmitted pathogens within 90 days by a Clinical Laboratory Improvement Amendments–certified laboratory; military treatment facilities (MTFs) and US Naval vessels conducting predonation screening are required to maintain up-to-date rosters of eligible blood donors; 2) donors who self-report to have been nondeferred repeat donors; and 3) donors who neither have been screened for FDA-mandated transfusion transmitted pathogens nor have a history of donation.[19] The US military utilizes several countermeasures to reduce the risk of transfusion-transmitted viral infections from battlefield transfusion of emergency blood products collected in the deployed setting. Any MTF in the combat theater of operations with blood donation capability may initiate a walking donor program, which includes screening volunteers for HIV, hepatitis B virus (HBV), HCV, HTLV, West Nile virus, and syphilis. MTFs send samples collected from volunteers to a commercial laboratory in the continental United States for testing. After being tested, volunteers who screened negative are eligible to donate for a period of 90 days and are retested at 90-day intervals and at each donation event. Other countermeasures include universal HBV immunization and, in accordance with Health Affairs policy, screening of blood products for HIV, HBV, and HCV with rapid diagnostic test devices at the time of collection from donors in emergency situations who have not been screened in the combat theater of operations (Table 1). We report here the results of an investigation conducted as a result of the Department of Defense (DoD) retrospective testing program of non–FDA-compliant fresh whole blood.

CASE REPORT

The recipient, a 31-year-old US Army soldier, received 13 units of fresh whole blood in Jalalabad, Afghanistan, on the day of his injury after an improvised explosive device (IED) blast (Table 2). The soldier had sustained multiple injuries to the head, chest, midsection, groin, and lower extremities requiring chest tubes, fasciotomies, and washouts. Before arrival at the forward operating base (FOB) he had received basic care in the field on the day of the blast (Day 0, Table 2). He was transferred to Bagram Airfield from the FOB for a laparoscopic splenectomy and follow-up care, which included more washouts, external fixation placements, and splinting for his groin and fracture injuries. He received 4 units of platelets (PLTs). He was evacuated subsequently to a military hospital in Germany on Day 3 where he remained for 2 days for stabilization due to his traumatic brain injury, which required bolts for subarachnoid injuries.

On Day 5 he was transferred by a Critical Care Air Transport Team to a tertiary care military hospital in Texas where he remained for approximately 3 months before

TABLE 2. Timeline of events and testing for a lookback investigation of a donated unit which tested positive for HTLV-I, Afghanistan, 2010

Donor	Day	Recipient
1 unit donated in theater	0	IED blast; field medical care; 13 units fresh whole blood transfused, FOB Fenty, Jalalabad, Afghanistan
	2	4 units PLTs, BAF, Bagram, Afghanistan
	3	Medical evacuation to Germany
	4	Germany
	5	Transfer to a military hospital in United States for definitive care
Donated unit tested HTLV+	12	
	15	Lookback Test 1 = HTLV-I indeterminate
Notified in theater of HTLV diagnosis	31	
	44	Lookback Test 2 = HTLV-I ; notification and counseling
	180	Lookback Test 3 = HTLV-I+
	234	Reposed sample collected 142 days before transfusion = HTLV–
Reposed sample collected 265 days before donation = HTLV+	279	
	293	Epidemiologic interview; sample collection for HTLV sequencing
Epidemiologic interview; sample collection for HTLV sequencing	309	

BAF = Bagram Airfield.

being released to the Veterans Administration health system for follow-up care. While in care at the military hospital in 2012, recurring fever and increasing white blood cell counts in the soldier 29 days into his admission led to an infectious disease work-up for malaria, brucellosis, cytomegalovirus, Epstein Barr virus, *Clostridium difficile,* and Q fever. These tests, along with routine evaluation for nosocomial and other trauma-related wound infections, were unrevealing. In the midst of his infectious disease work-up, his providers received notification that the soldier's posttransfusion surveillance sample, drawn 19 days after the IED blast as part of the DoD retrospective testing program, had tested HTLV-I indeterminate: rg46-1 and -2 reactive, p19 and GD21 nonreactive (Day 19, Table 3). The sample had tested negative for HIV, HBV, HCV, and other pathogens. Retrospective testing performed 44 days after transfusion (Quest Laboratories, Irving, TX) indicated that the recipient had seroconverted and was HTLV-I infected: rgp 46-1, p19, GD21 reactive (Day 44, Table 3).

The Armed Services Blood Program Office (ASBPO) initiated a lookback investigation for the donors of the recipient. Mandatory testing of donation aliquots shipped to the United States after fresh whole blood combat theater donations had revealed a blood unit, donated 12 days prior in Afghanistan (Day 0, Table 2), that was positive for HTLV but negative for HIV, HBV, HCV, and syphilis.[19,20] The other 12 of 13 fresh whole blood units the recipient had received at the FOB had tested negative for HTLV and other blood-borne pathogens.

The ASBPO initiated another investigation to determine the HTLV-I infection status of the recipient and donor before transfusion and donation, respectively. The method has been previously described.[21] Briefly, the recipient's pretransfusion and donor's predonation reposed sera, residual sample from mandatory HIV force

TABLE 3. Results for donor and recipient samples tested in the lookback investigation of an HTLV-I–positive donated unit in Afghanistan, 2010

	Days in relation to donation/transfusion					
	Donor		Recipient			
Assay	–265*	128	–142*	19	44	180
HTLV-I/II EIA	R	R	NR			R
Western blot†						
Band interpretation				Ind	P	
P19				NR	R	
P24				NR	R	
GP46				NR	NR	
P26				NR	R	
GD21				NR	R	
P28				NR	R	
P32				NR	R	
RG46-1				R	R	
RG46-2				R	NR	
P53				NR	NR	
P36				NR	R	
Line immunoassay						
Interpretation	P	P				P
Streptavidin	NR	NR				NR
P19 I/II	R	R				R
P24	R	R				R
GP46	R	R				R
GP21	R	R				R
P19	R	R				R
GP46 I	R	R				R
GP46 II	NR	NR				NR

* Predonation and pretransfusion testing for donor and recipient, respectively.

† Positive for HTLV-I if P19, GD21, and RG46-I are reactive; positive for HTLV-II if P24, GD21, and RG46-II are reactive; indeterminate if criteria for positivity are not met; negative if HTLV bands are not present.

Ind = indeterminate; NR = nonreactive; P = positive; R = reactive.

testing, were retrieved from the DoD Serum Repository and sent to Quest Laboratories for HTLV testing (Days –142 and –265, respectively; Table 3).[22] For the donor, both a predonation sample, drawn 265 days before donation, and a postdonation sample, drawn 128 days after donation, were HTLV enzyme immunoassay (EIA) reactive and HTLV line immunoassay positive. The recipient's pretransfusion sample, drawn 142 days previously, was HTLV EIA nonreactive (Table 3). Since all evidence pointed to a case of transfusion-transmitted HTLV-I infection, an epidemiologic investigation was launched.

An infectious disease clinician interviewed both the donor and the recipient for HTLV risk factors using a standardized case report form for transfusion-transmitted viral infections. The interview indicated that the recipient was white and US-born and had served 13 years in the US military at the time of his transfusion. At the time of the interview, he had no signs or symptoms of HTLV-I/II: skin lesions; numbness, stiffness, or weakness of the legs; difficulty walking; acute bronchitis; asthma; pneumonia; leukemia; arthritis; abscess; lymphadenopathy; bladder or kidney infection; and *Staphylococcus* or *Strongyloides* infections. There was no evidence of HTLV infection–related neurologic disease on physical examination. The only risk factors reported were blood transfusions received in theater reported here, ear piercings, and corrective surgeries as described above for injuries sustained in combat. The recipient revealed no history of: sexually transmitted diseases, sex with a commercial sex worker, or injection drug user; incarceration; residence in a group or halfway home; tattoos; rape; needlestick; blood splash to mucous membranes; organ, tissue, or marrow transplant; and sex or household contact with a person with hepatitis, HIV, or HTLV-I/II or a person who had received clotting factors. He recounted that he had traveled to Australia, France, and Germany.

The donor was a US-born 32-year-old white male from the Pacific Northwest region whose parents were white and not of mixed race. He was an Army Reservist who had been in service for 3 years at the time of his donation. He reported having no awareness of HTLV infection until he was informed of his donated unit's screening results (Table 2). At the time of his interview, he reported no signs or symptoms of his HTLV-I infection and revealed no risk factors other than acquiring a couple of tattoos at reputable facilities and having had surgery as a child. He indicated no history of blood transfusions and denied having sex or household contact with a person known to have HTLV-I/II infection and did not report having sex partners from HTLV-endemic regions of the world. His travel history included trips to Germany, Prague, Poland, Spain, and Amsterdam.

Molecular characterization of HTLV-I from both the donor and the recipient was initiated to determine whether HTLV-I infection in the recipient was transfusion transmitted. Blood samples provided at the time of interviews were sent to the US Military HIV Research Program for sequencing. DNA extracted from peripheral blood mononuclear cells was used for partial genome sequencing: 433 nucleotides of the long terminal repeat (LTR) region (ATK1 reference positions, 8269 to 8700) and 1353 nucleotides from the envelope (*env*) region (ATK1, 5217-6569). Phylogenetic analysis was performed using computer software (MEGA 5.05, http://www.megasoftware.net/). Due to the very low evolutionary rate of HTLV-1, a maximum likelihood approach with the number of nucleotide substitutions per site estimated by general time reversible model and number of bootstrap replications at 1000 was chosen for the analysis.

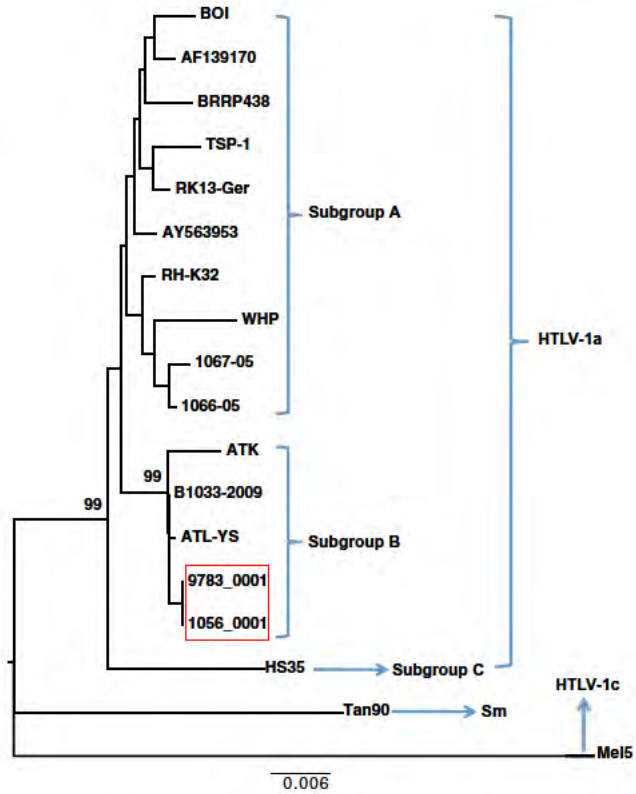

Fig. 1. A phylogenetic tree of HTLV-1 sequences from the donor (9783) and recipient (1056), as highlighted by the red box, and 16 HTLV-I subtype reference sequences was constructed by the maximum likelihood method using MEGA 5.05 software. The sequences were concatenated from 1353 nucleotides in envelope gene corresponding to ATK1 numbering Positions 5217 to 6569 and 433 nucleotides in LTR region corresponding to ATK1 numbering positions 8269 to 8700. The scale bar indicates the number of nucleotide substitutions per site estimated by general time reversible model with number of bootstrap replications at 1000.

Maximum likelihood trees generated from LTR and *env* concatenated sequences (Fig. 1) showed that the virus sequences from the pair, 1056_001 (recipient) and

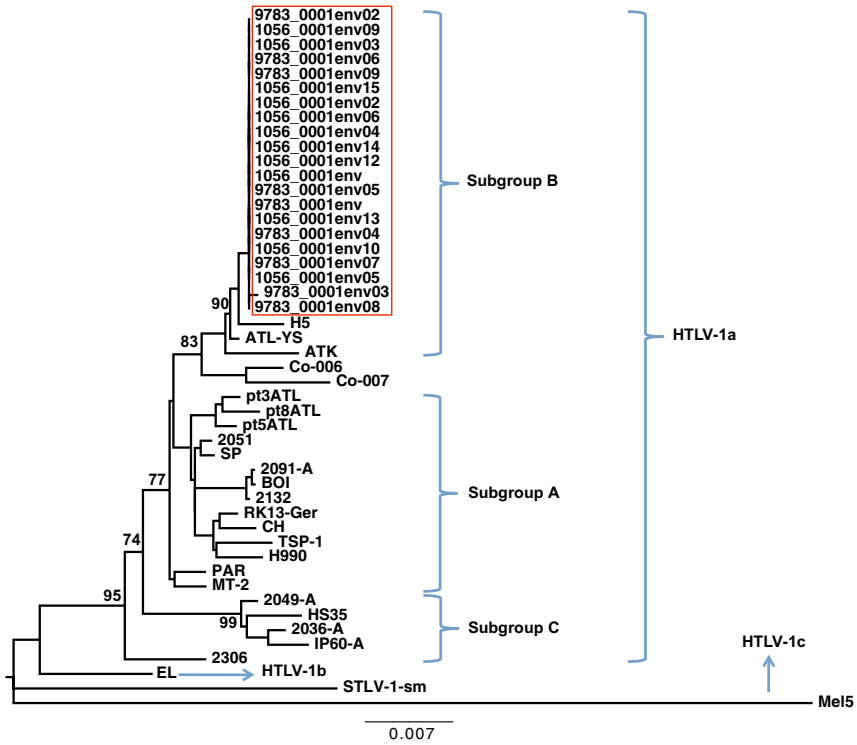

Fig. 2. A phylogenetic tree of HTLV-1 envelope genes corresponding to ATK Positions 5217 to 6569 was constructed by the maximum likelihood method using MEGA 5.05 software. There are 27 HTLV-1 subtype references and 21 envelope sequences from the donor (9783) and recipient (1056), as highlighted by the red box. The scale bar indicates the number of nucleotide substitutions per site estimated by general time reversible model with number of bootstrap replications at 1000.

9783_0001 (donor) clustered together with HTLV-I reference strains: Cosmopolitan subtype or Subtype a, Subgroup B (Japanese). To further confirm molecular genetic linkages between HTLV-I viruses from the donor and recipient, an independent polymerase chain reaction amplification reaction strategy was utilized. A DNA template at near endpoint dilution was used to generate an additional eight and 11 *env* gene sequences from the donor (9783) and recipient (1056), respectively. Comparison of these *env* sequences revealed nearly 100% sequence identity, except for a single-base pair (9783-0001*env*03) G-to-A transition. A maximum likelihood tree of the *env* sequences provided further evidence of a molecular genetic linkage between the viruses from these two individuals (Fig. 2).

DISCUSSION

We present a case report wherein evidence indicates that a service member was infected with HTLV-I after transfusion of non–FDA-licensed fresh whole blood. This transfusion-transmitted HTLV case is the first such report in the US military and a rarely reported occurrence in the United States; the last documented transmission in the United States occurred more than a decade ago but not since universal donor screening.[14,23] Transfusion-transmitted HTLV is strongly suggested for several reasons: 1) The recipient's pretransfusion reposed sample indicated no evidence of HTLV-I, whereas the donor's predonation reposed sample demonstrated HTLV-I infection; 2) the timing of the recipient's anti-HTLV status was consistent with a new infection: EIA positivity and indeterminate Western blot profile on Day 19 after transfusion, but full complement of HTLV-I bands by Day 44; 3) both the donor and the recipient were infected with HTLV-I Subtype a, Subgroup B; 4) viral sequences from the donor and recipient were nearly 100% homologous, indicating molecular genetic linkage; 5) the recipient had no major risk factors for HTLV-I; 6) clinical presentation of the recipient 29 days after transfusion fits the 30- to 90-day incubation period reported for HTLV before seroconversion.[24] The lookback investigation identified the donor who was unaware of his HTLV-I infection until notification of his test results in theater.

Prevention of transfusion transmission of HTLV in combat settings is challenging. While a voluntary HTLV screened donor pool is available near combat support hospitals and MTFs, in mass casualty scenarios, where prepositioned FDA-approved blood component supplies have been exhausted, or at smaller outposts, limited screening of emergency blood donors is possible. In the 2010 incident described herein, although 13 screened blood donors of

groups O and A were standing by at the FOB, the IED blast injuries necessitated additional donors since 54 fresh whole blood units were required for the ensuing mass casualties. Emergency donors are called from among volunteers who might be members of the receiving in-theater MTF, the recipient's military unit, or other civilian workers on the base and are referred to as the "walking blood bank." Theater infrastructure precludes donor screening with a FDA-approved screening assay and a Western blot investigational assay. Furthermore, a HTLV rapid kit has not been licensed for point-of-care use and questionnaires used in theater to screen emergency blood donors do not inquire about HTLV-I/II infection.

Since the issuance of the FDA guidance in November 1988 to screen blood donors for HTLV antibodies, transmission of HTLV-I/II has decreased in the United States.[25] A prevalence of 0.11 per 10,000 donations was found among first-time and repeat male US donors at the American Red Cross in 2009.[25] HTLV-I seroprevalence among US blood donors has been associated with older age, female sex, black race, birthplace outside the United States, and positive HCV serology.[26] US military blood donation centers in the continental United States, Hawaii, Germany, and Japan have routinely screened donors for HTLV-I/II since universal donor screening began in the United States (ASBPO). In 2011, of 91,656 donated units, 81 were repeat reactive by EIA of which 1 unit was confirmed positive by Western blot for a seroprevalence rate of 0.001% (0.11 per 10,000 units), which is consistent with that seen in US first-time donors (ASBPO). Donor screening and deferral in the US military for HTLV are based on FDA's 1997 guidance.[27] Donors repeatedly reactive for licensed HTLV screening tests are deferred from donation and placed under surveillance; in the combat theater, any donor testing HLTV positive on an initial screen is deferred indefinitely from theater donations. These donors are indefinitely deferred if repeatedly reactive a second time using screening assays. Although military health care providers may at their discretion request supplemental Western blot confirmatory testing for repeat-reactive donors, this information is not relayed systematically to the deployed environment. Screened donor pools at FOBs would be the best course of action to prevent future cases of transfusion-transmitted HTLV.

While the HTLV seroprevalence among blood donors in the US military and the general US population is low, and HTLV survival in stored red blood cells is limited,[16] the threat of transfusion transmission of HTLV-I/II among fresh whole blood recipients in the combat theater remains. Additionally, the seroprevalence of HTLV-I among US military personnel is unknown. Whereas modification of the predonation screening questionnaire administered to emergency blood donors to include questions regarding HTLV-I/II infection may be helpful, this would not have deferred donation in this instance. However, the utility of modifying the DoD donor screening questionnaire (DD572) to include questions pertaining to risk for HTLV-I/II infection should be considered. Since no licensed confirmatory assay is currently available for blood establishments, the use of HTLV Western blot assays should be employed to confirm any EIA HTLV reactive or repeat-reactive donor samples. Rapid detection of HTLV-I/II for emergency blood donations would be beneficial to prevent transfusion transmissions.

SEQUENCE DATA

Sequences described here were submitted to GenBank and are available under Accession Numbers JX984801-JX984802 and JX885208-JX885228.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest relevant to the manuscript submitted to **TRANSFUSION**.

REFERENCES

1. Murphy EL, Hanchard B, Figueroa JP, Gibbs WN, Lofters WS, Campbell M, Goedert JJ, Blattner WA. Modelling the risk of adult T-cell leukemia/lymphoma in persons infected with human T-lymphotropic virus type I. Int J Cancer 1989; 43:250-3.
2. Manns A, Hisada M, La Grenade L. Human T-lymphotropic virus type I infection. Lancet 1999;353:1951-8.
3. Ratner L. Human T cell lymphotropic virus-associated leukemia/lymphoma. Curr Opin Oncol 2005;17:469-73.
4. Komurian-Pradel F, Pelloquin F, Sonoda S, Osame M, de The G. Geographical subtypes demonstrated by RFLP following PCR in the LTR region of HTLV-I. AIDS Res Hum Retroviruses 1992;8:429-34.
5. Ratner L, Philpott T, Trowbridge DB. Nucleotide-sequence analysis of isolates of human T-lymphotropic virus type-1 of diverse geographical origins. AIDS Res Hum Retroviruses 1991;7:923-41.
6. Salemi M, Van Dooren S, Audenaert E, Delaporte E, Goubau P, Desmyter J, Vandamme AM. Two new human T-lymphotropic virus type I phylogenetic subtypes in seroindeterminates, a Mbuti pygmy and a Gabonese, have closest relatives among African STLV-I strains. Virology 1998;246:277-87.

7. Gessain A, Yanagihara R, Franchini G, Garruto RM, Jenkins CL, Ajdukiewicz AB, Gallo RC, Gajdusek DC. Highly divergent molecular variants of human T-lymphotropic virus type-I from isolated populations in Papua New Guinea and the Solomon Islands. Proc Natl Acad Sci U S A 1991;88: 7694-8.
8. Gessain A, Gallo RC, Franchini G. Low degree of human T-cell leukemia/lymphoma virus type I genetic drift in vivo as a means of monitoring viral transmission and movement of ancient human populations. J Virol 1992;66:2288-95.
9. Vidal AU, Gessain A, Yoshida M, Tekaia F, Garin B, Guillemain B, Schulz T, Farid R, Dethe G. Phylogenetic classification of human T-cell leukaemia/lymphoma virus type-I genotypes in 5 major molecular and geographical subtypes. J Gen Virol 1994;75:3655-66.
10. van Tienen C, McConkey SJ, de Silva TI, Cotten M, Kaye S, Sarge-Njie R, da Costa C, Goncalves N, Parker J, Vincent T, Jaye A, Aaby P, Whittle H. Schim van der Loeff M. Maternal proviral load and vertical transmission of human T cell lymphotropic virus type 1 in Guinea-Bissau. AIDS Res Hum Retroviruses 2012;28:584-90.
11. Toro C, Rodes B, Poveda E, Soriano V. Rapid development of subacute myelopathy in three organ transplant recipients after transmission of human T-cell lymphotropic virus type I from a single donor. Transplantation 2003;75:102-4.
12. Zarranz Imirizaldu JJ, Gomez Esteban JC, Rouco Axpe I, Perez Concha T, Velasco Juanes F, Allue Susaeta I, Corral Carranceja JM. Post-transplantation HTLV-1 myelopathy in three recipients from a single donor. J Neurol Neurosurg Psychiatry 2003;74:1080-4.
13. Proietti FA, Carneiro-Proietti AB, Catalan-Soares BC, Murphy EL. Global epidemiology of HTLV-I infection and associated diseases. Oncogene 2005;24:6058-68.
14. Kleinman S, Swanson P, Allain JP, Lee H. Transfusion transmission of human T-lymphotropic virus types I and II: serologic and polymerase chain reaction results in recipients identified through look-back investigations. Transfusion 1993;33:14-8.
15. Food and Drug Administration. Memorandum dated 11/29/88. Subject: HTLV-I antibody testing. 1988. [cited 2013 JN 2013]. Available from: URL: http://www.fda.gov/downloads/biologicsbloodvaccines/guidancecomplianceregulatoryinformation/otherrecommendationsformanufacturers/memorandumtobloodestablishments/ucm063001.pdf
16. Sullivan MT, Williams AE, Fang CT, Grandinetti T, Poiesz BJ, Ehrlich GD. Transmission of human T-lymphotropic virus types I and II by blood transfusion. A retrospective study of recipients of blood components (1983 through 1988). The American Red Cross HTLV-I/II Collaborative Study Group. Arch Intern Med 1991;151:2043-8.
17. Spinella PC. Warm fresh whole blood transfusion for severe hemorrhage: U.S. military and potential civilian applications. Crit Care Med 2008;36:S340-5.
18. United States Army Institute of Surgical Research. Joint Theater Trauma System clinical practice guidelines: fresh whole blood (FWB) transfusion, 2008. 2011. [cited 2012 Jun 13]. Available from: URL: http://www.usaisr.amedd.army.mil/assets/cpgs/Fresh_Whole_Blood_Transfusion_30_Mar_2011.pdf
19. Department of Defense, Office of the Assistant Secretary of Defense. Memorandum for Secretary of the Army, Secretary of the Navy, Secretary of the Air Force, Commanders of the Combatant Commands, Director, Joint Staff. Subject: Policy on the use of non-U.S. Food and Drug Administration compliant blood products. Dated March 19, 2010. Washington, D.C.: Department of Defense, Health Affairs, 2010.
20. Rentas FJ, Lincoln DA, Jenkins CR, O'Connell RJ, Gates RG. Walking blood banks: screening blood in the battlefield. MLO Med Lab Obs 2010;42:13; quiz 18-9.
21. Hakre S, Peel SA, O'Connell RJ, Sanders-Buell EE, Jagodzinski LL, Eggleston JC, Myles O, Waterman PE, McBride RH, Eader SA, Davis KW, Rentas FJ, Sateren WB, Naito NA, Tobler SK, Tovanabutra S, Petruccelli BP, McCutchan FE, Michael NL, Cersovsky SB, Scott PT. Transfusion-transmissible viral infections among US military recipients of whole blood and platelets during Operation Enduring Freedom and Operation Iraqi Freedom. Transfusion 2011; 51:473-85.
22. Rubertone MV, Brundage JF. The Defense Medical Surveillance System and the Department of Defense serum repository: glimpses of the future of public health surveillance. Am J Public Health 2002;92:1900-4.
23. Donegan E, Busch MP, Galleshaw JA, Shaw GM, Mosley JW. Transfusion of blood components from a donor with human T-lymphotropic virus type II (HTLV-II) infection. The Transfusion Safety Study Group. Ann Intern Med 1990; 113:555-6.
24. Martin-Davila P, Fortun J, Lopez-Velez R, Norman F, Montes de Oca M, Zamarron P, Gonzalez MI, Moreno A, Pumarola T, Garrido G, Candela A, Moreno S. Transmission of tropical and geographically restricted infections during solid-organ transplantation. Clin Microbiol Rev 2008;21:60-96.
25. Stramer SL, Notari EP, Zou S, Krysztof DE, Brodsky JP, Tegtmeier GE, Dodd RY. Human T-lymphotropic virus antibody screening of blood donors: rates of false-positive results and evaluation of a potential donor reentry algorithm. Transfusion 2011;51:692-701.
26. Murphy EL, Watanabe K, Nass CC, Ownby H, Williams A, Nemo G. Evidence among blood donors for a 30-year-old epidemic of human T lymphotropic virus type II infection in the United States. J Infect Dis 1999;180:1777-83.
27. Food and Drug Administration. Donor screening for antibodies to HTLV-II. FDA guidance for industry, August 1997.

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FRESH WHOLE BLOOD (FWB) TRANSFUSION

Original Release/Approval		Oct 2006	Note: This CPG requires an annual review.
Reviewed:	Oct 2012	Approved:	24 Oct 2012
Supersedes:	Fresh Whole Blood (FWB) Transfusion, updated 17 Jul 2012		
☐ Minor Changes (or)		☒ ***Changes are substantial and require a thorough reading of this CPG (or)***	
☐ Significant Changes			

1. **Goal.** Provide the rationale and guidelines for FWB transfusion, including but not limited to indications, collection, testing, transfusion, and documentation.

2. **Background.** Whole blood has been used extensively to resuscitate casualties in military conflicts since World War I. Its use in civilian settings is limited due to the wide availability of fractionated components derived from whole blood and provided for specific deficits (e.g., packed red blood cells (RBCs) for anemia, fresh frozen plasma (FFP) to replace lost/consumed clotting factors, apheresis platelets (PLTs) for thrombocytopenia, cryoprecipitate (Cryo) for hypofibrinoginemia.) However, in austere conditions, fractionated blood products may be in limited supply or unavailable. In these settings, FWB may be the only source of blood components available for the management of hemorrhagic shock and its associated coagulopathy in casualties. (Appendix A, Blood Donor Pre-Screening SOP).

   Massively transfused casualties (≥ 10 units RBCs in 24 hours) have a high mortality rate (33%) and have the greatest potential to benefit from appropriate transfusion strategies.[1] Large retrospective cohort studies of casualties requiring massive transfusions during Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF) demonstrate a significant survival benefit for the massively transfused casualty when RBCs, fresh frozen plasma, and platelets are transfused at a 1:1:1 ratio. Two retrospective analyses in combat casualties comparing FWB to component therapy (which included platelets) have been published. One study showed a potential survival benefit to the use of FWB during resuscitation of severe combat injuries, and the other showed FWB to be equivalent to component therapy.[2, 3]

   Advantages to FWB: FWB provides FFP:RBC:PLTs in a 1:1:1 ratio. For US casualties presenting in hemorrhagic shock, a transfusion strategy that included FWB with RBCs and plasma has an improved survival compared to the use of stored components only (FFP, RBCs, and PLTs). Additionally, FWB is available in austere conditions, has no loss of clotting factor or platelet activity that is often associated with cold storage, and has no red blood cell "storage lesion".

   Disadvantages to FWB: Since FWB has both RBCs and plasma, it must be ABO type-specific. There are risks associated with the use of FWB, including but not limited to increased risk of transfusion-transmitted infections (e.g., HIV, hepatitis B/C, syphilis), a period of decreased exercise tolerance in donors (who are often members in the casualty's unit), and an increased risk of clerical errors (e.g., ABO typing) due to the potentially chaotic activity during which FWB is requested. Additionally, field conditions are inherently unsanitary and are presumed to increase the risk of bacterial contamination of the blood. Recent history with approximately 10,000 FWB transfusions to U.S. personnel during

OIF/OEF have resulted in one Hepatitis C (HCV), one Human T-Lymphocyte Virus (HTLV) seroconversion, and one fatal case of transfusion-associated graft-versus host disease.[4]. Fresh WB is not FDA-approved and is not intended or indicated for routine use. **It is NOT appropriate, as a matter of convenience, to use FWB as an alternative to more stringently controlled blood products for patients who do not have severe, immediately life-threatening injuries. FWB is to be used only when other blood products are unable to be delivered at an acceptable rate to sustain the resuscitation of an actively bleeding patient, when specific stored components are not available (e.g., pRBCs, PLTs, Cryo, FFP), or when stored components are not adequately resuscitating a patient with an immediately life-threatening injury.**

3. **Recommendations**. The use of FWB should be reserved for casualties who are anticipated to require massive transfusion (10 or more units pRBCs in 24 hours), for those with ***clinically significant shock or coagulopathy (e.g. bleeding with associated metabolic acidosis, thrombocytopenia or INR>1.5) when optimal component therapy (e.g. apheresis platelets and FFP) are unavailable or stored component therapy is not adequately resuscitating a patient with immediately life-threatening injuries.***

   a. *Facilities where full component therapy is available:* Due to infectious concerns, the risk:benefit ratio does not justify the routine use of FWB over banked blood products in non life-threatening severe trauma. Conversely, when platelets and FFP inventories are depleted, or in contingencies such as mass casualty (MASCAL) situation where the blood inventory may be exhausted, the use of FWB remains an appropriate life-saving option.

   b. Surgical Facilities where component therapy is limited (e.g. no availability of apheresis platelets): Due to risks inherent with the use of FWB it should only be used for patients *with immediate life-threatening injuries.*

   c. *Facilities where full component therapy is not available:* FWB should only be used when there is a threat to loss of life, limb or eye-sight.

4. **Guidelines**. The decision to use FWB is a medical decision that must be made by a physician who has full knowledge of both the clinical situation and the availability of compatible blood components. A Walking Blood Bank (WBB) Program will be established based on a risk assessment and the potential for casualties. Coordination with the Area Joint Blood Program Officer (AJBPO) is required to establish a WBB Program. (Appendix A, Blood Donor Pre-screening SOP). FWB should be collection for transfusion as outlined in Appendix B, Emergency Whole Blood Drive SOP.

   a. In general, the use of FWB should be limited to casualties who are anticipated to require a massive transfusion when the physician determines that optimal component therapy is unavailable or in limited supply, or in patients that are not responding to stored component therapy.

   b. The decision to initiate a FWB drive should be made in consultation with the appropriate MTF medical authority (e.g., DCCS, Trauma Director) and Laboratory/Blood Bank OIC.

   c. Pre-screened donors registered into the WBB Program are preferably composed of active duty, active reserve, active National Guard, and other DoD beneficiaries. Coalition Forces will not be utilized routinely as donors, only by exception. Foreign Nationals should be used as a last resort.

d. Donor FWB must be an ABO type-specific match to the casualty. If not matched, a fatal hemolytic reaction may occur. **TYPE O whole blood is NOT universal.**

e. **The decision to use FWB that has not been completely screened for infectious agents is a medical decision that must be made after thorough consideration of risks and benefits. Decision-making should be adequately documented in the casualty record**.

f. Prior to issuing FWB for transfusion, the ABO and Rh type should be verified and approved rapid infection disease tests (e.g., HIV, HCV, and HBV) should be performed as outlined in Appendix B, Emergency Whole Blood Drive SOP to the greatest extent possible.

g. Theater Medical Data Stores (TMDS), Blood Portal, shall be utilized to record FWB donations and infectious disease testing results.

5. Precautions. Transfusion of FWB in the field may be dangerous for several reasons:

a. There is no universally compatible FWB type. Transfusions of FWB must be an ABO match. For female casualties of child-bearing potential, there must also be an Rh match. Service members' blood types are not always known with certainty. The blood type on identification tags is occasionally incorrect (last correlated data equated to about 4%) and must not be relied upon routinely to determine blood type for either donors or recipients. **Identification tags for ABO/Rh verification should be utilized as a last resort only.**

b. Because it is not subject to the same infectious disease testing and strict quality controls as banked blood, FWB does not meet FDA standards and has an increased risk of transfusion-transmitted infections (e.g., HIV, hepatitis B/C, syphilis).

c. In MASCAL situations, particularly when more than one blood type is being collected, there is an increased risk of a clerical error leading to a life-threatening transfusion reaction.

d. Field conditions are inherently unsanitary and increase the risk of bacterial contamination of the blood.

e. Use of non-standard blood donation material and equipment may lead to coagulation during the collection process potentially causing an adversely transfusion reaction; therefore, only authorized equipment will be utilized (Appendix B enclosure 6, WBB Supply List (with NSNs)).

6. Planning. Since the need for FWB cannot be predicted, a robust contingency operational plan should be developed by the MTF staff to include the Laboratory/Blood Bank and surgical and anesthesia providers in coordination with the Area Joint Blood Program Officer. The plan should be reviewed and rehearsed regularly.

The key elements for planning and readiness to administer FWB are knowledge and rehearsal of two SOPs: Appendix A, Blood Donor Pre-Screening SOP and Appendix B, Emergency Whole Blood Drive SOP.

a. A contingency plan should be developed for collecting, storing, and transfusing FWB in MASCAL situations or when it may be deemed the current blood inventory will be exhausted prior to re-supply (e.g., when multiple type-O trauma casualties are exhausting the type-O RBC inventory).

b. The physical donation site should be organized in such a way as to maintain the integrity of the screening and donation process, and to minimize the possibility of clerical errors. This is especially important in emergency situations involving more than one casualty.

c. Every effort should be made to adhere to the same screening, drawing, labeling, and issuing standards required for U.S. FDA-approved blood products.

d. Pre-screened donors in the WBB Program determined to be suitable should be utilized before using personnel who: (1) are not fully suitable; (2) do not have a current screening and infectious disease testing history; (3) have no donation history, to the greatest extent possible.

e. Upon determining the ABO/Rh status of the casualty, activate the WBB Program re-calling pre-screened donors with the exact same ABO/Rh using the TMDS>Manage Donor>View Donor List, if available, or other communication networks.

f. Before any FWB is transfused, rapid infectious disease testing (i.e., HIV, HBV, HCV) of donor specimens shall be performed, to the greatest extent possible.

g. Retrospective samples must be sent to a state-side laboratory for FDA-approved testing, regardless whether the rapid infectious disease testing is performed pre- or post-transfusion, as these tests are not licensed for donor testing.

h. Upon the notification of confirmed positive infectious disease results, a medical provider or preventive medicine personnel should be notified to ensure the donor is notified and counseled.

i. If a patient receives a confirmed positive infectious disease unit, the AJBPO will notify the Armed Services Blood Program immediately to initiate patient notification and a respective evaluation of both the donor and patient.

j. In accordance with HA Policy 10-002, *Policy on the Use of Non-U.S. Food and Drug Administration*, recipients of FWB shall receive follow-up infectious disease testing as soon as possible, 3-, 6-, and 12-months post-transfusion.

k. A contingency plan should be developed for collecting, storing, and transfusing FWB in MASCAL situations or when it may be deemed the current blood inventory will be exhausted prior to re-supply (e.g., when multiple type-O trauma casualties are exhausting the type-O RBC inventory).

l. **Procedure**. See Appendix B for DD Form 572–Emergency Whole Blood Donation Record.

7. Performance Improvement (PI) Monitoring.

a. Intent (Expected Outcomes).

FWB is reserved for casualties who are anticipated to require massive transfusion (10 or more units of RBCs in 24 hours), for those with clinically significant shock or coagulopathy (e.g., bleeding with associated metabolic acidosis, thrombocytopenia or INR >1.5) when optimal component therapy (e.g., PLTs and FFP) are unavailable or stored component therapy is not adequately resuscitating a patient with immediately life-threatening injuries.

b. Performance/Adherence Measures.

1) FWB was used for casualties who were anticipated to require massive transfusion (10 or more units of RBCs in 24 hours), for those with clinically significant shock or coagulopathy (e.g., bleeding with associated metabolic acidosis, thrombocytopenia or INR >1.5) when optimal component therapy (e.g., PLTs and FFP) was unavailable or stored component therapy was not adequately resuscitating the patient with immediately life-threatening injuries.

c. Data Source

1) Patient Record

2) Joint Theater Trauma Registry (JTTR)

3) Blood transfusion databases

d. System Reporting & Frequency.

The above constitutes the minimum criteria for PI monitoring of this CPG. System reporting will be performed annually; additional PI monitoring and system reporting may be performed as needed.

The system review and data analysis will be performed by the Joint Theater Trauma System (JTTS) Director, JTTS Program Manager, and the Joint Trauma System (JTS) Performance Improvement Branch.

8. Responsibilities. It is the trauma team leader's responsibility to ensure familiarity, appropriate compliance and PI monitoring at the local level with this CPG.

9. References:

[1] Repine TB, Perkins JG, Kauvar DS, Blackborne L. The use of fresh whole blood in massive transfusion. *J Trauma.* 2006;60:S59-S69.

[2] Spinella PC, Perkins JG, Grathwohl JG, Beekley AC, Holcomb JG. Warm fresh whole blood is independently associated with improved survival for patients with combat-related traumatic injuries. *J Trauma.* 2009;66:S69-S76.

[3] Perkins JG, Cap AP, Spinella PC, Shorr AF, Beekley AC, Grathwohl KW, Rentas FJ, Wade CE, Holcomb JB; 31st Combat Support Hospital Research Group. Comparison of platelet transfusion as fresh whole blood versus apheresis platelets for massively transfused combat trauma patients (CME). *Transfusion*. 2011 Feb;51(2):242-52.

[4] Gilstad C, Roschewski M, Wells J, Delmas A, Lackey J, Uribe P, Popa C, Jardeleza T, Roop S. Fatal transfusion-associated graft-versus-host disease with concomitant immune hemolysis in a group A combat trauma patient resuscitated with group O fresh whole blood. *Transfusion*. 2012 May;52(5):930-5.

[5] CENTCOM FRAGO 09-1222: *Joint Theater Blood Program Update*: 4 May 2007.

[6] *Emergency War Surgery*, 2004, Third US Revision, Chap 7: Shock and Resuscitation.

[7] Theater MTF-specific Standard Operating Procedures (SOPs).

[8] *Technical Manual*, AABB, Bethesda Maryland, 16th Edition, 2008.

[9] *Standards for Blood Banks & Transfusion Services*, AABB, 25th Ed, February 2008.

[10] Theater Medical Data Stores (TMDS), Blood Portal, Standard Operating Procedures (http://militaryblood.dod.mil/Staff/eMOAS.aspx).

Approved by CENTCOM JTTS Director, JTS Director and CENTCOM SG

Opinions, interpretations, conclusions, and recommendations are those of the authors and are not necessarily endorsed by the Services or DoD.

APPENDIX A

Blood Donor Pre-Screening SOP

Materials and Equipment	Use the following materials and equipment as applicable. • Modified DD Form 572s • Clip Boards • Gloves • Testing Collection Set: premade bags with 2x2 gauze, 2 gold tops (SST), 2 pearl tops (PPT), 1 purple top tube (more tubes may be required if using short draw or small volume tubes) • Blood Collection Needles • BD Vacutainer Hubs • Coban • Assigned Pre Screen ISBT Labels (500 number series) • Sharps Containers • ABO/Rh Testing Card (e.g., Eldon Military Kit or other FDA-approved device) • Centrifuge • Disposable Pipettes • Plastic Aliquot tubes/lids 13X100mm (or 12X75mm) • Para-Film • Biohazard Bags • Trash Bags • Leak Resistant Chucks • Disposable Lab Coats • Cold Packs • Test Tube Racks
Records/Forms	• Modified **DD FORM 572**, Form 147, Form 148 (See Enclosures—Blood Donor Pre-Screening SOP.) • Theater Medial Data Store (TMDS), Blood Portal
Quality Control	Perform QC on ABO/Rh Testing Card (See instrument package inserts for procedures). Medical personnel should be trained by BSD or other qualified personnel.
Procedure	**Pre-screening of a prospective emergency whole blood donor pool is mandatory. Development of a pre-screened donor pool should be considered a commander's priority when a level II or III facility is established or replaced. It is imperative that a donor pool once established is maintained because of the frequent redeployment of units out of theatre. Due diligence in establishing a pre-screened whole blood donor pool will decrease the risk of transmitting infectious disease while simultaneously increasing the efficiency of the whole blood collection process.** Perform the following steps when Pre-screening Donors:
	Prepare for Donor Pre-Screening Event
	1. Coordinate with appropriate units/contacts for times and location of event. May need to conduct a site survey to ensure appropriate site, i.e., space, lighting, privacy for interview, etc. Samples need to be sent to the blood support detachment as soon as possible after collection, so prior coordination with transport assets is a must.

Blood Donor Pre-Screening SOP

	Conducting the Pre-Screening Event		
	1.	**Medical History**-Provide prospective donor a Modified DD Form 572 – ensure demographic info is legible and as complete as possible.	
	2.	**Interview**-Trained medical personnel will need to determine if the donor is eligible to donate based on the information collected –Donor eligibility requirements. can found on the Blood Portal at: http://rceast.afghan.swa.army.mil/sites/tfmeda/	
		If	**Then**
		There are all '**N**'o responses except for questions 22-24	Proceed to Step 3.
		There are any '**Y**'es responses except for questions 22-24	Document the reason for the 'Y'es response. Refer donor to a qualified provider (i.e., MD, DO, NP or PA) to determine the donor's eligibility. Defer the donor as required, if necessary document "Ineligible" status on **DD FORM 572** and in TMDS.
		NOTE: For Q: 39, use State Tattoo and Permanent Make-up Reference List. See Tattoo and Make-up Reference List to screen for acceptability.	
	3.	Using the Direct Oral Questions, ask the donor Group A, B, and C questions. Record name of interviewer on DD Form 572. See Enclosures—Blood Donor Pre-Screening SOP.	
		If	**Then**
		The donor answers '**N**'o to each group	Proceed to Step 4.
		The donor answers '**Y**'es to any group	Defer donor for designated period of time and stop the donation process. Document donor as "Ineligible".
	4	**Phlebotomy**- Collect 1 Purple Top, 2 Pearl Top (PPT), 2 Gold Top (SST) and label with small **Pre-Screen** (500 number series) ISBT labels (***without*** barcodes). Apply the same ISBT label number to the DD Form 572.	
	Register Donor in TMDS per Manage Donations/Donors SOP . See steps below.		
	Rapid Infectious Disease Testing. If performed, see Emergency Whole Blood Collection SOP for instructions**.**		
	Perform ABO/Rh Testing		
	1.	Utilizing blood from purple top tube, perform ABO/Rh confirmation using Eldon Card or other FDA-approved method to verify ABO listed on **DD FORM 572**. (Refer to package inserts and approved SOPs for further instructions).	
	2.	Record Lot # of reagents, EXP Date and Results on Form 147.	
	3.	Record blood type in TMDS.	
	See Enclosures—Blood Donor Pre-Screening SOP.		

Blood Donor Pre-Screening SOP

	Processing Samples for Shipment & Testing	
	1.	Centrifuge Gold Top and Pearl Top Tubes for 5 minutes at 4000 RPM.
	2.	Label aliquot (pour off) tubes with corresponding ISBT Labels ***with small*** **barcodes**. Position the ISBT label vertically toward top of tube as shown at left. **If ISBT labels are not available utilize the Donor SSN as the unit number.** 
	3.	Pour 1 Pearl Top into 1 aliquot tube and mark as **Plasma**. Repeat for each Pearl Top tube. ***3ml sample requirement per aliquot.**
	4.	Pour contents of 2 Gold Top tubes into 1 aliquot tube and mark as **Serum**. * Do not fill over ¾ full to allow for expansion from freezing
	5.	The seal of capped aliquot tubes should be reinforced with para-film wrap and placed into a biohazard shipping bag or rack. If a rack is not used, rubber-band tubes from the same donor together. Repeat for each series.
	6.	Record sample and donor demographic data on Form 148 (Shipping Manifest). Include a printed copy of manifest with shipment and e-mail to BSD or designated facility, if possible.
	7.	Maintain the (pre-screening) **DD FORM 572**s at your site until the potential donor redeploys. As soon as possible ship samples, and Form 148 in a blood box (Collins Blood Box) with ice bag(s) to your respective blood detachment. E-mail a copy of manifest to BSD or designated facility, if possible, or call to alert incoming shipment. **For Afghanistan**: Blood Support Detachment TF MED/Bagram Airfield APO AE 09354 (BAF) 431-5446/5536 Blood Support Detachment Kandahar Air Field APO AE 09355 (KAF) 421-6171 **For other deployed units**. Freeze samples until they can be shipped to a designated laboratory to perform FDA-approved testing.
	8.	The BSD or unit will send all samples for FDA-approved testing to designated laboratory for FDA-approved testing. Enter results in TMDS and forward to submitting Level II or Level III upon completion. **NOTE: The prospective donor is NOT considered pre-screened and fully qualified for FWB donation until negative or non-reactive testing results are received from a testing facility.**
	9.	Any positive testing that is received by BSD or unit will be forwarded to Preventive Medicine Consultant to ensure proper donor care and follow-up is initiated. At no time will laboratory staff notify donors directly regarding positive testing results.

Blood Donor Pre-Screening SOP

	Maintain Database (TMDS)	
	1.	Transfer demographic information from the **DD FORM 572** and Form 147 to Donor Management Database in TMDS. This will act as a deferral list or an eligible donor list when a whole blood drive is necessary. It is recommended that a hard copy of Donor Database and deferral list be printed monthly (or at some regular interval) for use during Emergency Whole Blood Collection when computer assets are unavailable. **Information in database should be kept confidential.**
	2.	To enter demographic data into TMDS, go to the **Manage Donation** tab and select **Donate Product**. Enter the Donor SSN, first name, last name in appropriate fields and click **NEXT**.
	3.	In product code field, enter **E9999V00** (pre-screen). In the expiration date field, enter date 90 days from today and click **Add Product**.
	4.	Verify donation ID, product code, ABO/Rh and expiration date are correct, then click **NEXT**.
	5.	Carefully Re-verify all demographic data that populates on the screen, then click **Confirm Donation**. Prospective donor is now entered in TMDS.
	6.	From **Manage Donation** tab, select **Update Donation.** Enter donation ID number and click **NEXT.**
	7.	Enter ABO/Rh test result and date tested from Form 147 under Rapid Testing Results. In "Samples sent to" field, select BSD or unit from pull down menu and enter date samples were sent out from your facility. Now click **Update Tests**.
	8.	To Register another donor, select **Donate Product** under **Manage Donation** tab and repeat process above.
	9.	Once pre-screen donations have been created utilizing the process above, a re-deployment date must be entered to ensure the active donor list will auto-update upon donor's exodus from theater. To accomplish this, select Manage Donor from beneath Manage Donor tab. Enter donor SSN and click Next. Select re-deployment date from the calendar tool in the "Update Re-deployment Date" field and click Update Donor. Once the displayed entry is confirmed to be correct, click Confirm Update. TMDS will now remove donor from active donor list on the re-deployment date that was entered.
	10.	BSD will populate FDA results and forward to submitting facility. Donor alerts will also be activated by BSD or unit, as necessary. This data once populated, will be the basis by which potential donors will be deemed fully qualified for Fresh Whole Blood (FWB) donations, should the need for a Walking Blood Bank (WBB) arise at your facility.
	NOTES: Investing time and care into building a donor pool will make performing whole blood drives easier and safer when the time comes. Your donor pool does not need to be enormous. 50 people covering most of the blood types (O, A, B) is ideal for most locations. **!!!REMEMBER WHOLE BLOOD MUST BE TRANSFUSED TYPE SPECIFIC!!!**	
References	[1] AABB *Technical Manual*, current edition [2] AABB *Standards for Blood Banks and Transfusion Services* [3] JTTS Clinical Practice Guideline: Fresh Whole Blood (FWB) Transfusion [4] Theater Medical Data Store (TMDS) Version 2.7.0.0 System User's Manual	

Blood Donor Pre-Screening SOP

Enclosures	DD Form 572-Emergency Whole Blood Donation Record Approved State Tattoo and Permanent and Make-up Reference List Direct Oral Questions Form 147–Eldon Card ABO/Rh Typing Record Form 148–Pre-Screen/Whole Blood Sample Shipping Manifest

DD FORM 572—EMERGENCY WHOLE BLOOD DONATION RECORD

Please circle as appropriate:
WHOLE BLOOD DONATION
PRE-SCREEN

EMERGENCY WHOLE BLOOD DONATION RECORD
(Modified Version of the DD Form 572)

Blood Unit Number

Use Donor SSN if ISBT # Not Available

MTF/Location: _____ Donation Date: _____

Donor's Full Name: _____ Rank: _____ Branch: USA USAF USN USMC CIV

SSN: _____ Date of Birth (DDMMMYYYY): _____ Sex: M / F Ht/Wt: _____ (> 110 lbs) ABO/Rh (Blood Type) :_____

Deployed Unit/Location: _____ Local DSN Phone: _____ Local Cell/ Evening Phone_____

Redeployment Date: _____

Current Residence: Bldg/Tent # _____ RM # _____

Home Address (Stateside) _____

Home Phone Number: (____) _____ Email: _____

Y 21. N	Female Donors: Are you pregnant now, or have you been Pregnant in the last 6 weeks?	Y 36. N	Have you ever had Chagas' disease, babesiosis, or Leishmaniasis?
Y 22. N	Are you feeling well and healthy today?	Y 37. N	In the past 12 months, have you been given a rabies shot?
Y 23. N	Have you read and do you understand all the donor information presented to you, and have all your questions been answered?	Y 38. N	In the past 12 months, have you had an accidental needle stick or come in contact with someone else's blood?
Y 24. N	Do you understand that if you are in a high risk group, you may have the AIDS virus and you can give it to someone else even though you may feel well and have a negative AIDS test?	Y 39. N	In the past 12 months, have you had a tattoo, ear or skin piercing, or acupuncture?
Y 25. N	Have you ever given blood under another name or Social Security Number?	Y 40. N	In the past 12 months, have you had close contact with a person with yellow jaundice or hepatitis or been given Hepatitis B Immune Globulin (HBIG)?
Y 26. N	In the past 8 weeks have you given blood, plasma or platelets?	Y 41. N	Have you ever had yellow jaundice, liver disease, hepatitis, or a positive test for hepatitis?
Y 27. N	Have you ever been refused as a blood donor or told not to donate blood?	Y 42. N	In the past 4 weeks, have you had any shots or vaccinations?
Y 28. N	In the past 12 months have you been under a doctor's care, had an illness, or surgery?	Y 43. N	In the past 8 weeks, have you received a smallpox vaccination or had close contact with the vaccination site of anyone else?
Y 29. N	In the past 12 months, have you received blood, blood products, or a tissue transplant including any you may have donated for yourself (autologous)?	Y 44. N	In the past month, have you taken Finasteride (Proscar, Propecia) or Isotretinoin (Accutane, Amnesteem, Claravis, Sotret) or in the past 6 months, have you taken Dutasteride (Avodart)
Y 30. N	In the past 3 years, have you had malaria?		
Y 31. N	In the past month, have you taken any pills or medications?		
Y 32. N	Have you ever been given growth hormone or received a dura mater (or brain covering) graft?		
Y 33. N	Have you ever taken Etretinate (Tegison) or Acitretin (Soriatane)?		
Y 34. N	Have you ever had cancer, a blood disease, or a bleeding problem?		
Y 35. N	Have you ever had chest pain, heart disease, or lung disease?		

(Use this section and reverse side of form to explain "Yes" answers above. With the exception of questions 22-24)

High Risk Oral Questions (10 Jan 2010) Asked By: _____ Donor: Temp: _____°F/°C (< 99.6°F/37.5°C) BP: _____/_____ (≤ 180/100) Pulse: _____ (< 100 bpm) HCT/Hgb: _____ (> 38% or 12.5 g/dL)

31. Medications: _____

Malaria Prophylaxis: Daily_____(Doxycycline) Weekly_____(Mefloquin) N/A _____

Your blood will **NOT** be tested for viral diseases prior to transfusion due to the emergency, if you any reason you feel your blood may not be safe or you could answer yes to the high risk questions, please do not donate today. I have read/ had explained to me the high risk questions and am not in a high risk category, and feel my blood is safe to donate at this time.

I verify that I have answered the questions honestly, and feel my blood is safe to be transfused. _____
Donor's Signature

Phlebotomist:_____ Start Time:_____ Stop Time:_____ (Should be < 15 minutes)

Bag Manufacturer _____Lot #:_____ Expiration date: _____ Segment Number: _____

The Modified DD Form 572 has been reviewed for completeness. If there are any risk factors that place the recipient at harm notify the ordering physician immediately for appropriate follow-up.

DD 572 (WB)
Version: 13 May 2010

APPROVED STATE TATTOO AND PERMANENT AND MAKE-UP REFERENCE LIST

Armed Services Blood Program
State Tattoo and Permanent Make-Up Reference List

NOTICE: The Department of Defense (DOD) assumes no risk for the use of this information by non-DoD personnel, blood programs, or individual medical institutions. The use of this information by DoD personnel is strictly for blood donor operations and must adhere to the current Service (Army, Navy and Air Force) specific Standard Operating Procedure dealing with the screening of blood donors.

NOTE: The following criteria provided by AABB Reference Standard 5.4.1A, Requirements for Allogeneic Donor Qualification, were used to determine acceptability of each state: (a) application by a state-regulated entity, (b) mandated use of sterile needles, (c) one-time use ink required.

If the state is acceptable, defer the donor for one week to ensure the site has properly healed. Although the state of application may be acceptable, prospective donors should be asked if the procedure was performed using sterile needles and single-use dye. If the donor answers no, or does not know, he/she should be deferred for 12 months. Prospective donors who had a procedure performed in a state listed as "No" must be deferred for 12 months from the time of application.

Armed Services Blood Program

State	Acceptable	Note
Alabama	YES	
Alaska	YES	
Arizona	YES	
Arkansas	YES	
California	NO	
Colorado	YES	
Connecticut	NO	
Delaware	YES	
District of Columbia	NO	
Florida	NO	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 1 of 3

Armed Services Blood Program

State	Acceptable	Note
Georgia	NO	
Hawaii	YES	
Idaho	NO	
Illinois	YES	
Indiana	YES	
Iowa	YES	
Kansas	YES	
Kentucky	YES	
Louisiana	YES	
Maine	YES	
Maryland	NO	
Massachusetts	NO	
Michigan	NO	
Minnesota	NO	
Mississippi	YES	
Missouri	YES	
Montana	YES	
Nebraska	YES	
Nevada	NO	
New Hampshire	NO	
New Jersey	YES	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 2 of 3

Armed Services Blood Program

State	Acceptable	Note
New Mexico	NO	
New York	NO	
North Carolina	YES	
North Dakota	NO	
Ohio	YES	
Oklahoma	NO	
Oregon	YES	
Pennsylvania	NO	
Rhode Island	YES	
South Carolina	YES	
South Dakota	YES	
Tennessee	YES	
Texas	YES	
Utah	NO	
Vermont	YES	
Virginia	YES	
Washington	YES	
West Virginia	YES	
Wisconsin	YES	
Wyoming	NO	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 3 of 3

DIRECT ORAL QUESTIONS

<table>
<tr><td>Preamble</td><td colspan="2">I am required to ask you some questions. If you do not understand a question, please ask me to explain it before answering. The reason for asking these questions is to determine your suitability as a volunteer blood donor. Your answers to these questions will be kept strictly confidential, but may result in you being asked not to donate blood, either temporarily or permanently. Do not respond until I have asked you the entire group of questions, which at that time only give me one answer – Yes or No.</td></tr>
<tr><td>Group A</td><td colspan="2">1. Do you have AIDS or have you ever had a positive test for the AIDS virus (HIV)?
2. Have you ever taken illegal drugs with a needle, even one time (including steroids)?
3. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia?
4. At any time since 1977, have you taken money or drugs in exchange for sex?
5. Male donors only: Have you had sex with another male, even one time since 1977?
A “Yes” answer to Group A is a PERMANENT DEFERRAL</td></tr>
<tr><td rowspan="11">Group B</td><td colspan="2">1. Were you born in, have you lived in, or traveled to any African country since 1977?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group B, Question 3</td></tr>
<tr><td>Yes</td><td>Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?</td></tr>
<tr><td>If No</td><td>Go to Group B, Question 3</td></tr>
<tr><td>If Yes – Travel Only</td><td>Proceed to Group B Question 2</td></tr>
<tr><td>If Yes – Born or Lived in</td><td>Document when, DEFER INDEFINITELY</td></tr>
<tr><td colspan="2">2. When you traveled to (name of country) did you receive a blood transfusion, or any other medical treatment with a product made from blood?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group B, Question 3</td></tr>
<tr><td>Yes</td><td>DEFER INDEFINITELY</td></tr>
<tr><td colspan="2">3. Have you had sex with anyone who was born in, or has lived in any African Country since 1977?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group C</td></tr>
<tr><td>Yes</td><td>Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?</td></tr>
<tr><td>If No to listed countries</td><td>Proceed to Group C</td></tr>
<tr><td>Yes to listed countries</td><td>Document when, DEFER INDEFINITELY</td></tr>
</table>

Group C	1. Have you had sex in the last 12 months, even once, with anyone who has AIDS or has had a positive test for the AIDS virus? 2. Have you had sex in the last 12 months, even once, with anyone who has ever taken illegal drugs with a needle (including steroids)? 3. Have you had sex in the last 12 months, even once, with anyone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? 4. At any time in the last 12 months have you given money or drugs to someone to have sex with you? 5. At any time in the last 12 months, have you had sex with someone who has taken money or drugs in exchange for sex? 6. In the past 12 months, have you had a positive test for syphilis? 7. In the last 12 months have you had syphilis or gonorrhea or have you been treated for syphilis or gonorrhea? 8. In the last 12 months, have you received blood or blood products? 9. In the last 12 months, have you been incarcerated in a correctional institution (including jail or prison) for more than 72 consecutive hours? 10. In the last 12 months, have you taken (snorted) cocaine through your nose? 11. Female donors only: In the past 12 months, have you had sex with a man who had sex with another man, even one time since 1977? **A "Yes" answer to Group C is a TEMPORARY DEFERRAL for 12 months following the event**
Group D	1. Have you at any time since 1980 injected Bovine (Beef) Insulin? **A "Yes" answer to Group D is an INDEFINITE DEFERRAL**

FORM 147–ELDON CARD ABO/RH TYPING RECORD

Eldon Card ABO/Rh Typing

Date of Testing:__________.

	Eldon Card ABO/Rh Typing					
	Lot #					
	Exp:					Tech
Assigned Unit #	Anti-A	Anti-B	Anti-D	Rh Control	Interpretation	Initials
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
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	+ =	+ =	+ =	+ =		
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	+ =	+ =	+ =	+ =		

Form 147
V: 28 June 2010

Technical Review: __________ Date: __________
QA/QC Review: __________ Date: __________

FORM 148–PRE-SCREEN/WHOLE BLOOD SAMPLE SHIPPING MANIFEST

Prescreen/Whole Blood Sample Shipping Manifest

Blood Unit Number				Donation Date	Donor Name		Branch of Service	Nationality	SSN or ID #	DOB	FOB/Base	Unit	Donation Type (PS or FWB)
Facility ID (W0138)	YR	Unit Id #	ABO RH		Last	First							

rm 148

APPENDIX B
EMERGENCY WHOLE BLOOD COLLECTION SOP

Materials and Equipment	Use the following materials and equipment as applicable: • Vitals Machine • Blood Collection Beds • Stethoscope • Blood Pressure cuff • Digital Thermometer and/or Tempadots • Lancets • STAT Site M* (*or other POCT Hemaglobinometer) • STAT Site M test cards* • STAT Site M controls* • Coban • Alcohol Pads • Electronic table top scale (optional) • Blood Bags (Terumo- Single Blood Bags, preferred) **NOTE: If an additive solution (AS) bag is present with a multiple bag set-up, the AS SHALL NOT be added to the whole blood.** • Blood Trip Scale with 585±2g trip counter-weight and QC weights or HemoFlow. • Testing Collection Set: premade bags with sterile 4x4 gauze, Frepp Sepp, 2 gold tops (SST), 2 pearl tops (PPT), 1 purple top tubes, and tube collection device. • ChloraPrep, Iodine alternative • Adapter MS DIR 100S Luer 100S • ABO/Rh Testing Card (e.g., Eldon Military Kit or other FDA-approved device) • Rapid HIV, Malaria, HBsAg, and HCV test kits • Serological RPR kit • Clinical Rotator • Centrifuge • Disposable Pipettes • Adhesive Tape • Hemostats • Scissors • Strippers • Metal Clips • Gloves • Tourniquet • Biohazard Container/ Sharps Container • Whole Blood ISBT Labels (100 number series)
Records/Forms	Forms required: modified **DD FORM 572**, Form 145A, Form 147, Form 148, Form 150A, Form 150B, Form 151 and SF 518 (as applicable.) See Enclosures-Emergency Whole Blood Collection SOP. Theater Medical Data Store (TMDS), Blood Portal.

EMERGENCY WHOLE BLOOD COLLECTION SOP

Quality Control	Perform QC on STAT Site M (or equivalent POCT Hemaglobinometer) Perform QC on ABO/Rh Testing Card, RPR, HCV, HBsAg, HIV, and Malaria Kits (See instrument package inserts and local SOPs for procedures.) Medical personnel should be trained by BSD or other qualified personnel.	
Procedure	Perform the following steps when the physician request whole blood units:	
	Permission to conduct the blood drive	
	1.	Notify Level II/III Commander, DCCS and Laboratory OIC/NCOIC that a physician is requesting whole blood for transfusion.
	2.	Once the Commander/DCCS grants permission, initiate the emergency whole blood collection. Trained medical personnel should oversee the process.
	Donor Recruitment	
	1.	!!!REMEMBER WHOLE BLOOD MUST BE TRANSFUSED TYPE SPECIFIC!!! Announce the whole blood drive. -First, donors should be recruited from the pre-screened donor pool, who's infectious disease testing results are negative or non-reactive. -If insufficient pre-screened donors are available, determine acceptability based on prospective donors: (1) are not fully suitable; (2) do not have a current screening and infectious disease testing history; (3) have no donation history.
	2.	Pull a pre screened donor list from TMDS: **Manage Donor**>**View Donor List**.
	3.	Select filters for ABO/Rh of the potential whole blood recipient, Screened (select **ALL**), Alert (select **ALL),** Cocom (select **CENTCOM**). Highlight your facility in the Available Facilities tab and click **Add**. Once your facility appears in the Search Facility box, click **Display Donor List**. The potential donor list for the blood type required will now appear on the screen.
	Donor and Testing Area Preparation	
	1.	Set up blood donor beds.
	2.	Perform QC on weighing device, (i.e., HemoFlow or Trip Scale). **NOTE:** If no trip scale is available, see section below Whole Blood Collection, Step 6.
	3.	Ensure counterweight is set at **585**g One milliliter of blood equals 1.053g 450 mL of Whole Blood equals 474g The final container must weigh 425g to 520g (405 to 495 ml) plus the weight of the primary blood bag with its anticoagulant. The target weight for a 450mL bag is 585g. • Under fill is less than 555g total weight • Over fill is greater than 650g total weight
	4.	Perform QC on the STAT Site M*, ABO/Rh Cards, HIV, HCV, HBsAg, Malaria, and RPR Kits.
	5.	Ensure the necessary equipment to perform donor screening, testing and collection are available. (See WBB Supply List (with NSNs)).

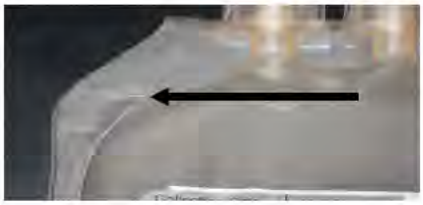
EMERGENCY WHOLE BLOOD COLLECTION SOP

	Perform Donor Screening		
	1.	**To the greatest extent possible, potential whole blood donors should be selected from among the pre-tested and qualified population documented in TMDS. This is the best practice to mitigate the risk of Transfusion Transmitted Disease (TTD) to the recipient.**	
	2.	Give donor Emergency Donation Record (Modified DD Form 572) and instruct donor to complete demographic information and to answer questionnaire by circling '**Y**'es or '**N**'o. If donor already has a pre-completed DD Form 572 on file, have them review the form and verify information is correct and update as necessary. While donor is completing **DD FORM 572**, screen for donor alerts and completed FDA test results in TMDS (deferrals).	
	3.	Locate donor's name on the Donor List displayed in TMDS. To the left of their name, click **View**. If all TTD results are Negative (within last 90 days) and there are no Donor Alerts, then the Donor is deemed fully **Pre- Screened/Tested.** To minimize risk to the recipient, it is recommended that pre-tested population be exhausted prior to resorting to collections from the untested population.	
	4.	A qualified interviewer will review Modified DD Form 572 for completeness and Donor Suitability Criteria following Steps 5-11 below (See attached Enclosures).using standards available for reference and download through Blood Portal at http://rceast.afghan.swa.army.mil/sites/tfmeda/ or at http://www militaryblood.dod mil/.	
	5.	**If**	**Then**
		There are all '**N**'o responses except for questions 22-24	Proceed to Step 6.
		There are any '**Y**'es responses except for questions 22-24	Document the reason for the 'Y'es response. Refer donor to a qualified provider to determine the donor's eligibility. Defer the donor as required, if necessary document "Ineligible" status on **DD FORM 572** and in TMDS.
		NOTE: For Q: 39, use State Tattoo and Permanent Make-up. Reference List (See Enclosure.) to screen for acceptability.	
	6.	Using the Direct Oral Questions (See Enclosure), ask the donor Group A, B, and C questions. Record name of interviewer on Modified DD Form 572.	
		If	**Then**
		The donor answers '**N**'o to each group.	Proceed to Step 7.
		The donor answers '**Y**'es to any group.	Defer donor for designated period of time and stop the donation process. Document donor as "Ineligible".

EMERGENCY WHOLE BLOOD COLLECTION SOP

	7.	Perform and record temperature on Modified DD Form 572. (See DD Form 572– Emergency Whole Blood Donation Record.)	
		If	**Then**
		≤99.5 ºF or 37.5 ºC	Proceed to Step 8.
		>99.5 ºF or 37.5 ºC	Stop the donation process. The donor is "Ineligible" at this time.
	8.	Perform and record measurements of donor pulse and blood pressure.	
		If	**Then**
		BP ≤ 180/100 and Pulse is ≤ 100 bpm	Proceed to Step 9.
		BP >180/100 and Pulse is > 100 bpm	Stop the donation process. The donor is "Ineligible" at this time.
	9.	For female donors, perform and record hematocrit/hemoglobin results on Modified DD Form 572, if possible. Male donors do not require hematocrit/hemoglobin testing.	
		If	**Then**
		≥38% or 12.5 g/dL	Proceed to Step 10.
		<38% or 12.5 g/dL	Defer donor and stop the donation process. The donor is "Ineligible" at this time.
	10.	Donor is physiologically acceptable to donate, have the donor sign the Modified DD Form 572 and proceed to Step 11.	
	11.	A competent medical authority should review the Modified DD Form 572 to determine the eligibility of the donor.	
		If	**Then**
		Acceptable	Donor is "Eligible". Proceed to Step 12.
		Unacceptable	Donor is "Ineligible". Stop donation process and document deferral as appropriate in TMDS.
	12.	Issue blood bag and test collection set to donor. Label bag and **DD FORM 572** with Whole Blood ISBT labels. Blood collection tubes (2 gold tops (SST), 2 pearl tops (PPT), 1 purple top tube) should be labeled with the corresponding small ISBT labels (without barcode). See Illustration to the left. If no labels are available, bags and all samples should be labeled with donor's full name and SSN or Blood Bag Segment Number.	

EMERGENCY WHOLE BLOOD COLLECTION SOP

	Whole Blood Collection	
	1.	Seat donor in blood donor table or reclining chair. Ask the donor their name and verify donor demographic information is correct on the Modified DD Form 572. Verify also that the labels the blood bag, sample tubes, and Modified DD Form 572 correctly correspond to each other and the donor. **NOTE:** If a discrepancy is noted, STOP and correct before proceeding further.
	2.	Ask donor if they are allergic to iodine or shellfish.
		If / **Then**
		Yes / Skip Step 3 and proceed to Step 4.
		No / Proceed to Step 3.
	3.	Utilizing Frepp-Sepp, apply Povidone Iodine (Frepp), 2% Aqueous Solution. Scrub vigorously for at least 30 seconds. Within a 3" diameter area around venipuncture site. Then Apply 10% Iodine (Sepp) to venipuncture site starting at the center and moving outward in concentric circles at least 1½ inches in all directions
	4.	For donors allergic to iodine follow the same procedure outlined above, but substitute a chlorohexidene scrub (ChloraPrep). **NOTE:** If a disinfectant is not available, clean the site with alcohol or other solution, if possible.
	5.	Allow area to dry.
	6.	Set-up trip scale (Manual or Electronic). Perform quality control, if possible, to obtain a counter-weight of 585 grams. **NOTE:** If no trip scale is available, the Terumo Single Blood Bag can be filled with whole blood to the mark pictured below. It is however recommended that weight then be checked with table top scale (if available)  The target weight for 450 mL is 585 grams. **Do not use if overfilled as blood clots may develop from an incorrect ratio of whole blood to anti-coagulant causing potential harm to the patient.**
	7.	Using a hemostat, clamp tubing between the needle and the main bag. This will prevent air contamination of blood after the needle cover is removed. Place tape within reach for anchoring the needle during phlebotomy. **NOTE:** Place a loose knot in the tubing approximately 6 inches from the needle **prior** to uncapping needle, if metal seal clips and hand crimpers are not available.
	8.	Apply tourniquet with enough pressure. If using a blood pressure cuff adjust to approximately 40-60 mm Hg.
	9.	Twist off the needle cover and inspect the needle for barbs or other defects.
	10.	Pull the skin taut below the venipuncture site.
	11.	With the bevel up, hold the needle at the hub, at approximately a 30-45 degree angle and pierce the skin with a smooth, quick thrust at the selected point of entry.

EMERGENCY WHOLE BLOOD COLLECTION SOP

	12.	When the bevel is completely under the skin, lower the angle of the needle to approximately 10º or less and, with a steady push, advance needle to penetrate the vein wall. Thread needle approximately ½ inch inside the vein to maintain a secure position and to lessen the chance of a clot forming.
	13.	Release the hemostat clamp on the collection bag tubing and observe the blood flow through the tubing and into the collection bag.
		If blood flow / **Then**
		Is impeded / Try adjusting the needle with least discomfort without hurting the donor.
		Is still impeded / Seek assistance from another phlebotomist before discontinuing the phlebotomy.
	14.	Fill sample tubes using the tube adaptor. After filling sample tubes, gently rock tubes to mix contents and verify once again that donation identification number on tubes corresponds to donation identification number on the collection bag and the **DD FORM 572**.
	15.	Instruct donor to relax their grip and to rhythmically squeeze every 5 to 10 seconds, relaxing between squeezes.
	16.	Secure the needle to the donor's arm with tape, across the hub or on the tubing near the hub of the needle. This will optimize the positioning of the needle to prevent rotation of the needle or drag on the tubing, which may impede blood flow. An additional piece of tape may be placed across the tubing lower on the arm.
	17.	Partially reduce the pressure by loosening the tourniquet or blood pressure cuff to approximately 20-40 mm Hg. **Mix blood bag several times during the collection to prevent clotting.**
	18.	Cover the phlebotomy site with sterile gauze dressing, to keep the site clean and needle out of view. Lift the gauze occasionally to monitor for a hematoma.
	19.	If a hematoma is evident, remove tourniquet and needle from donor's arm and place sterile gauze square over the hematoma and apply firm digital pressure while donor's arm is held above the heart level.
	20.	Record the following in the appropriate blocks on the DD Form 572: • Time phlebotomy was started • Initials of the phlebotomist
	21.	Watch for the signal of a filled unit by monitoring for the completion indicator of the weighing device or visual reference point (see step 6), if not using a weighing device. Record stop time on the **DD FORM 572**.
	22.	Seal the tubing 1 to 2 inches below the "Y" segment of the tubing using a metal seal slip and a hand crimper (or pulling tight the loose knot in the tubing).
	23.	Grasp the tubing on the donor side of the seal and press to remove a portion of blood in the tubing. Crimp the tubing at this spot. Cut the tubing between the two seals.
	24.	Remove tourniquet or blood pressure cuff and tape strips from donor's arm.
	25.	Place the fingers of one hand gently over the sterile gauze. DO NOT APPLY PRESSURE OVER THE NEEDLE. With the other hand, smoothly and quickly withdraw the needle. Apply firm pressure to the phlebotomy site.

EMERGENCY WHOLE BLOOD COLLECTION SOP

	26.	Instruct donor to apply firm pressure over the gauze. Encourage donor to maintain a relaxed elevated position, rather than tensing the muscle. This precaution will minimize the bleeding into the venipuncture area.
	27.	Discard the needle assembly into a sharps container.
	28.	Using a hand stripper/crimper, strip all blood from the tubing into the primary collection bag. This should be done ASAP after collection. (Stripping is pushing the blood in the tubing into the blood filled bag with the rollers on the stripper/crimper device)
	29.	Mix contents in the primary collection bag. DO NOT strip the tubing and allow tubing to refill without mixing. Release the stripper and allow the anti-coagulated blood to reenter the tubing. Perform this procedure three times.
	Processing Donor Units	
	1.	Take donor unit and donor sample tubes (2 gold tops (SST), 2 pearl tops (PPT), and 1 purple top tubes) to processing area.
	2.	Strip donor units segment tubing three times and mix, so as to avoid the development of clots.
	3.	Perform ABO, Rh type utilizing ABO/Rh Testing Card and purple top tube. Record results on Form 147.
	4.	Write the donor blood type **on the bag** (ABO/Rh Testing Card) along with date, time and phlebotomist initials of collection.
	5.	Write the expiration of the unit, which is 24 hours from collection if stored in a refrigerator (1 to 6 degrees Celsius) or 8 hours from collection if stored at room temperature (20 to 24 degrees Celsius).
	6.	Create product in TMDS while Rapid Testing is being performed. **NOTE: Rapid tests should be performed and found to be negative prior to transfusion, to the greatest extent possible. In situations requiring whole blood, available blood component inventory should continue to be transfused in lieu of whole blood until rapid testing has been performed and found to be negative.**
	Creating Whole Blood Units in TMDS	
	1.	From Manage Donation tab, select **Donate Product**.
	2.	Enter SSN of donor and click **Next**.
	3.	Verify demographic information for donor is correct, enter donation date and Donation ID number (from bar code label) and click **Add Products**.
	4.	Enter product code **E0009V00** for whole blood.
	5.	Enter expiration date (24 hours from collection if stored in a refrigerator (1 to 6 degrees Celsius) or 8 hours from collection if stored at room temperature (20 to 24 degrees Celsius).
	6.	Click **Add Product.**
	7.	Verify Donation ID/ ABO/Rh and expiration date then click **Next**.
	8.	Re-verify all demographic and unit data then click **Confirm Donation.**
	9.	Repeat steps 1-8 for each product collected.

EMERGENCY WHOLE BLOOD COLLECTION SOP

	Pre-Transfusion Rapid Testing	
	1.	**Rapid tests should be performed and found to be negative prior to transfusion, to the greatest extent possible. In situations requiring whole blood, available blood component inventory should continue to be transfused in lieu of whole blood until rapid testing has been performed and found to be negative.**
	2.	Spin down gold and pearl top tubes.
	3.	Perform rapid HBsAg, HCV, RPR using Serum/Plasma, and HIV, Malaria using whole blood. Testing should be performed IAW Test Kit package inserts and local SOP. Record reagent Name, Lot #, Exp Date, and Results on Form 145a.
	4.	Upon completion of rapid tests with negative results, whole blood unit may be issued for transfusion.
	5.	When time allows, rapid test results need to be entered into TMDS. To do this click on **Update Donation** under the Manage Donation tab.
	Issuing &Managing Whole Blood Inventory	
	1.	It is recommended that some sort of blood product issue document (ex., SF 518) be utilized to account for the issue of Whole Blood from the laboratory. WBB operations are at times chaotic and do not often allow for real-time updates of TMDS.
	2.	Provider requesting Fresh Whole Blood should sign Emergency Release Letter of understanding Form 150a or 150b as appropriate. Forms should be maintained in patient transfusion records.
	3.	Accurate dispositions of all Whole Blood units collected **MUST** be properly dispositioned in TMDS**.** Every unit must be created, transfused, expired or destroyed as appropriate.
	4.	**Fresh Whole Blood should be destroyed 24-hours post collection**. FWB can be stored at room temperature for 8-hours, and refrigerated thereafter.
	Processing Samples for Shipment & Testing	
	1.	Label aliquot (pour off) tubes with corresponding ISBT Labels ***with small*** **barcodes**. Position the ISBT label vertically toward top of tube as shown at left. **If ISBT labels are not available utilize the Donor SSN as the unit number.**
	2.	Pour 1 Pearl Top into 1 aliquot tube and mark as **Plasma**. Repeat for each Pearl Top tube. *3ml sample requirement per aliquot.
	3.	Pour contents of 2 Gold Top tubes into 1 aliquot tube and mark as **Serum**. * Do not fill over ¾ full to allow for expansion from freezing.
	4.	The seal of capped aliquot tubes should be reinforced with para-film wrap and placed into a biohazard shipping bag or rack. Repeat for each series.
	5.	Record sample and donor demographic data on Form 148 (Shipping Manifest). Include a printed copy of manifest with shipment and e-mail to BSD or designated facility, if possible.
	6.	Form 151- Whole Blood Transfusion Checklist must be submitted with shipment for **every unit of whole blood transfused.**
	7.	Copies of **DD FORM 572** and for all units of whole blood collected **MUST** be forwarded to BSD or designated facility with specimens and Form 145a.

EMERGENCY WHOLE BLOOD COLLECTION SOP

	8.	As soon as possible ship samples, Form 145a, Form 148, Form 151 and all **DD FORM 572**s in a blood box (Collins Blood Box) with ice bag(s) to your respective blood detachment. E-mail a copy of manifest to BSD or designated facility, if possible, or call to alert of incoming shipment. For Afghanistan: Blood Support Detachment TF MED/Bagram Airfield APO AE 09354 (BAF) 431-5446/5536 Blood Support Detachment Kandahar Air Field APO AE 09355 (KAF) 421-6171 Or **For other deployed units**, freeze samples until they can be shipped to a designated laboratory to perform FDA-approved testing.
	9.	The BSD or unit will send all samples for FDA approved testing in the rear enter results in TMDS and forward to submitting Role II or Role III upon completion. **NOTE: This results of this testing will be viewed as pre-screen for donors next donation.**
	10.	Any positive testing that is received will be forwarded to Preventive Medicine Consultant to ensure proper donor care and follow-up is initiated. At no time will laboratory staff notify donors directly regarding positive testing results.
References	AABB *Technical Manual*, current edition AABB *Standards for Blood Banks and Transfusion Services* JTTS Clinical Practice Guideline: Fresh Whole Blood (FWB) Transfusion Theater Medical Data Store (TMDS) Version 2.7.0.0 System User's Manual	
Enclosures	DD Form 572–Emergency Whole Blood Donation Record Direct Oral Questions Approved State Tattoo and Permanent Make-up List Acceptable Donor Worksheet Form 145A–Rapid Testing Worksheet Form 147–Eldon Card ABO/Rh Typing Record Form 148–Pre-Screen/Whole Blood Sample Shipping Manifest Form 150A–Emergency Release Letter of Understanding (tested) Form 150B–Emergency Release Letter of Understanding (un-tested) Form 151–Whole Blood Transfusion Checklist WBB Supply List (with NSNs)	

DD FORM 572–EMERGENCY WHOLE BLOOD DONATION RECORD

Please circle as appropriate:
WHOLE BLOOD DONATION
PRE-SCREEN

EMERGENCY WHOLE BLOOD DONATION RECORD
(Modified Version of the DD Form 572)

Blood Unit Number
Use Donor SSN if ISBT # Not Available

MTF/Location: _____ Donation Date: _____

Donor's Full Name: _____ Rank: _____ Branch: USA USAF USN USMC CIV

SSN: _____ Date of Birth (DDMMMYYYY): _____ Sex: M / F Ht/Wt: _____ (> 110 lbs) ABO/Rh (Blood Type) :_____

Deployed Unit/Location: _____ Local DSN Phone: _____ Local Cell/ Evening Phone_____

Redeployment Date: _____

Current Residence: Bldg/Tent # _____ RM # _____

Home Address (Stateside) _____

Home Phone Number: (_____) _____ Email: _____

Y	21. N	Female Donors: Are you pregnant now, or have you been Pregnant in the last 6 weeks?	Y	36. N	Have you ever had Chagas' disease, babesiosis, or Leishmaniasis?
Y	22. N	Are you feeling well and healthy today?	Y	37. N	In the past 12 months, have you been given a rabies shot?
Y	23. N	Have you read and do you understand all the donor information presented to you, and have all your questions been answered?	Y	38. N	In the past 12 months, have you had an accidental needle stick or come in contact with someone else's blood?
Y	24. N	Do you understand that if you are in a high risk group, you may have the AIDS virus and you can give it to someone else even though you may feel well and have a negative AIDS test?	Y	39. N	In the past 12 months, have you had a tattoo, ear or skin piercing, or acupuncture?
Y	25. N	Have you ever given blood under another name or Social Security Number?	Y	40. N	In the past 12 months, have you had close contact with a person with yellow jaundice or hepatitis or been given Hepatitis B Immune Globulin (HBIG)?
Y	26. N	In the past 8 weeks have you given blood, plasma or platelets?	Y	41. N	Have you ever had yellow jaundice, liver disease, hepatitis, or a positive test for hepatitis?
Y	27. N	Have you ever been refused as a blood donor or told not to donate blood?	Y	42. N	In the past 4 weeks, have you had any shots or vaccinations?
Y	28. N	In the past 12 months have you been under a doctor's care, had an illness, or surgery?	Y	43. N	In the past 8 weeks, have you received a smallpox vaccination or had close contact with the vaccination site of anyone else?
Y	29. N	In the past 12 months, have you received blood, blood products, or a tissue transplant including any you may have donated for yourself (autologous)?	Y	44. N	In the past month, have you taken Finasteride (Proscar, Propecia) or Isotretinoin (Accutane, Amnesteem, Claravis, Sotret) or in the past 6 months, have you taken Dutasteride (Avodart)
Y	30. N	In the past 3 years, have you had malaria?			
Y	31. N	In the past month, have you taken any pills or medications?			
Y	32. N	Have you ever been given growth hormone or received a dura mater (or brain covering) graft?			
Y	33. N	Have you ever taken Etretinate (Tegison) or Acitretin (Soriatane)?			
Y	34. N	Have you ever had cancer, a blood disease, or a bleeding problem?			
Y	35. N	Have you ever had chest pain, heart disease, or lung disease?			

(Use this section and reverse side of form to explain "Yes" answers above. With the exception of questions 22-24)

High Risk Oral Questions (10 Jan 2010) Asked By: _____ Donor: Temp: _____°F/°C (< 99.6°F/37.5°C) BP: _____/_____ (≤ 180/100) Pulse: _____ (< 100 bpm) HCT/Hgb: _____ (> 38% or 12.5 g/dL)

31. Medications: _____

Malaria Prophylaxis: Daily_____(Doxycycline) Weekly_____(Mefloquin) N/A _____

Your blood **will NOT be tested** for viral diseases prior to transfusion due to the emergency, if you any reason you feel your blood may not be safe or you could answer yes to the high risk questions, please do not donate today. I have read/ had explained to me the high risk questions and am not in a high risk category, and feel my blood is safe to donate at this time.

I verify that I have answered the questions honestly, and feel my blood is safe to be transfused. _____
Donor's Signature

Phlebotomist:_____ Start Time:_____ Stop Time:_____ (Should be < 15 minutes)

Bag Manufacturer _____Lot #:_____ Expiration date: _____ Segment Number: _____

The Modified DD Form 572 has been reviewed for completeness. If there are any risk factors that place the recipient at harm notify the ordering physician immediately for appropriate follow-up.

DD 572 (WB)
Version: 13 May 2010

DIRECT ORAL QUESTIONS

<table>
<tr><td>Preamble</td><td colspan="2">I am required to ask you some questions. If you do not understand a question, please ask me to explain it before answering. The reason for asking these questions is to determine your suitability as a volunteer blood donor. Your answers to these questions will be kept strictly confidential, but may result in you being asked not to donate blood, either temporarily or permanently. Do not respond until I have asked you the entire group of questions, which at that time only give me one answer – Yes or No.</td></tr>
<tr><td>Group A</td><td colspan="2">1. Do you have AIDS or have you ever had a positive test for the AIDS virus (HIV)?
2. Have you ever taken illegal drugs with a needle, even one time (including steroids)?
3. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia?
4. At any time since 1977, have you taken money or drugs in exchange for sex?
5. Male donors only: Have you had sex with another male, even one time since 1977?
A “Yes” answer to Group A is a PERMANENT DEFERRAL</td></tr>
<tr><td rowspan="11">Group B</td><td colspan="2">1. Were you born in, have you lived in, or traveled to any African country since 1977?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group B, Question 3</td></tr>
<tr><td>Yes</td><td>Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?</td></tr>
<tr><td>If No</td><td>Go to Group B, Question 3</td></tr>
<tr><td>If Yes – Travel Only</td><td>Proceed to Group B Question 2</td></tr>
<tr><td>If Yes – Born or Lived in</td><td>Document when, DEFER INDEFINITELY</td></tr>
<tr><td colspan="2">2. When you traveled to (name of country) did you receive a blood transfusion, or any other medical treatment with a product made from blood?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group B, Question 3</td></tr>
<tr><td>Yes</td><td>DEFER INDEFINITELY</td></tr>
<tr><td colspan="2">3. Have you had sex with anyone who was born in, or has lived in any African Country since 1977?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group C</td></tr>
<tr><td>Yes</td><td>Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?</td></tr>
<tr><td>If No to listed countries</td><td>Proceed to Group C</td></tr>
<tr><td>Yes to listed countries</td><td>Document when, DEFER INDEFINITELY</td></tr>
</table>

Group C	1. Have you had sex in the last 12 months, even once, with anyone who has AIDS or has had a positive test for the AIDS virus? 2. Have you had sex in the last 12 months, even once, with anyone who has ever taken illegal drugs with a needle (including steroids)? 3. Have you had sex in the last 12 months, even once, with anyone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? 4. At any time in the last 12 months have you given money or drugs to someone to have sex with you? 5. At any time in the last 12 months, have you had sex with someone who has taken money or drugs in exchange for sex? 6. In the past 12 months, have you had a positive test for syphilis? 7. In the last 12 months have you had syphilis or gonorrhea or have you been treated for syphilis or gonorrhea? 8. In the last 12 months, have you received blood or blood products? 9. In the last 12 months, have you been incarcerated in a correctional institution (including jail or prison) for more than 72 consecutive hours? 10. In the last 12 months, have you taken (snorted) cocaine through your nose? 11. Female donors only: In the past 12 months, have you had sex with a man who had sex with another man, even one time since 1977? **A "Yes" answer to Group C is a TEMPORARY DEFERRAL for 12 months following the event**
Group D	1. Have you at any time since 1980 injected Bovine (Beef) Insulin? **A "Yes" answer to Group D is an INDEFINITE DEFERRAL**

APPROVED STATE TATTOO AND PERMANENT MAKE-UP LIST

Armed Services Blood Program
State Tattoo and Permanent Make-Up Reference List

NOTICE: The Department of Defense (DOD) assumes no risk for the use of this information by non-DoD personnel, blood programs, or individual medical institutions. The use of this information by DoD personnel is strictly for blood donor operations and must adhere to the current Service (Army, Navy and Air Force) specific Standard Operating Procedure dealing with the screening of blood donors.

NOTE: The following criteria provided by AABB Reference Standard 5.4.1A, Requirements for Allogeneic Donor Qualification, were used to determine acceptability of each state: (a) application by a state-regulated entity, (b) mandated use of sterile needles, (c) one-time use ink required.

If the state is acceptable, defer the donor for one week to ensure the site has properly healed. Although the state of application may be acceptable, prospective donors should be asked if the procedure was performed using sterile needles and single-use dye. If the donor answers no, or does not know, he/she should be deferred for 12 months. Prospective donors who had a procedure performed in a state listed as "No" must be deferred for 12 months from the time of application.

Armed Services Blood Program

State	Acceptable	Note
Alabama	YES	
Alaska	YES	
Arizona	YES	
Arkansas	YES	
California	NO	
Colorado	YES	
Connecticut	NO	
Delaware	YES	
District of Columbia	NO	
Florida	NO	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 1 of 3

Armed Services Blood Program

State	Acceptable	Note
Georgia	NO	
Hawaii	YES	
Idaho	NO	
Illinois	YES	
Indiana	YES	
Iowa	YES	
Kansas	YES	
Kentucky	YES	
Louisiana	YES	
Maine	YES	
Maryland	NO	
Massachusetts	NO	
Michigan	NO	
Minnesota	NO	
Mississippi	YES	
Missouri	YES	
Montana	YES	
Nebraska	YES	
Nevada	NO	
New Hampshire	NO	
New Jersey	YES	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 2 of 3

Armed Services Blood Program

State	Acceptable	Note
New Mexico	NO	
New York	NO	
North Carolina	YES	
North Dakota	NO	
Ohio	YES	
Oklahoma	NO	
Oregon	YES	
Pennsylvania	NO	
Rhode Island	YES	
South Carolina	YES	
South Dakota	YES	
Tennessee	YES	
Texas	YES	
Utah	NO	
Vermont	YES	
Virginia	YES	
Washington	YES	
West Virginia	YES	
Wisconsin	YES	
Wyoming	NO	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 3 of 3

ACCEPTABLE DONOR WORKSHEET

Document all results on **DD FORM 572**

Donor Weight	≥ 110 lbs
Donor Weight	≥ 110 lbs
Blood Pressure	≤ 180/100
Pulse	50-100 bpm (may be < 50 if donor is athletic)
Temperature	≤ 99.6°F
Hemoglobin	≥ 12.5 g/dL
Hematocrit	≥ 38 %
Medications	Do not collect from donors currently on antibiotics, to exclude anti-malarial prophylaxis. Donors taking medications that the competent medical authority deems may cause harm to the recipient must be deferred from donating. Be advised: If the purpose of the whole blood drive is derive a source of platelets for a patient then donors who have taken aspirin in the last 72 hours should be deferred.
Medical Conditions	Any donors with an underlying medical condition that could put them at risk if they were to donate should be deferred from donating i.e., heart and/or lung conditions.

FORM 145A–RAPID TESTING WORKSHEET

Rapid Testing Worksheet

Date of Testing:__________

Tech:________

	Rapid Tests												RPR (ASI/Cardinal)		
													Rotator (100 +/- 5 rpm):		
	Malaria Now			HIV (Oraquick)			HCV (Oraquick)			HBsAg (CTK)			Needle Calibrated (0.5ml= 30 +/- 1 drop):		
	Lot #:			Lot #:			Lot #:			Lot #:			Lot #:		
	Exp:			Exp:			Exp:			Exp:			Exp:		
Assigned Unit #	Sample results		IQC OK?	Sample results		IQC OK?	Sample results		IQC OK?	Sample results		IQC OK?	"SR" Strong Reactive	"WR" Weak Reactive	"NR" Non-Reactive
POS EQC	R	NR		R	NR		R	NR		R	NR				■
NEG EQC	R	NR		R	NR		R	NR		R	NR		■	■	
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
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	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
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	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR

√=Acceptable

R= Reactive

NR= Non-Reactive

Form 145a
V: 24 Nov 2010

Technical Review: __________ Date: __________

QA/QC Review: __________ Date: __________

FORM 147–ELDON CARD ABO/RH TYPING RECORD

Eldon Card ABO/Rh Typing

Date of Testing:__________

	Eldon Card ABO/Rh Typing					
	Lot #					
	Exp:					
Assigned Unit #	Anti-A	Anti-B	Anti-D	Rh Control	Interpretation	Tech Initials
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		

Form 147
V: 28 June 2010

Technical Review: __________ Date: __________
QA/QC Review: __________ Date: __________

FORM 148–PRE-SCREEN/WHOLE BLOOD SAMPLE SHIPPING MANIFEST

Prescreen/Whole Blood Sample Shipping Manifest

Blood Unit Number					Donor Name								
Facility ID (W0138)	YR	Unit Id #	ABO RH	Donation Date	Last	First	Branch of Service	Nationality	SSN or ID #	DOB	FOB/Base	Unit	Donation Type (PS or FWB)

rm 148

FORM 150A–EMERGENCY RELEASE LETTER OF UNDERSTANDING (TESTED)

Provider Letter of Understanding for Emergency (Non-FDA) Whole Blood Units

I understand that Emergency Whole Blood Units are NOT FDA approved and transfusion of these units may result in unintended disease and/or transfusion reactions. I accept full responsibility for the units and the consequences that may follow transfusion.

Print Sign Date

_____ _____ _____

Provider

Form 150a

FORM 150B–EMERGENCY RELEASE LETTER OF UNDERSTANDING (UN-TESTED)

Provider Letter of Understanding for Untested Emergency Whole Blood Units

I understand that these Emergency Whole Blood Units have not had complete Rapid Testing prior to transfusion and transfusion of these units may result in an increased risk of unintended disease and/or transfusion reactions. I accept full responsibility for the units and the consequences that may follow transfusion.

Print Sign Date

_____ _____ _____

Provider

Form 150b

STANDARD FORM 518–BLOOD OR BLOOD COMPONENT RELEASE

518–123 NSN 7540-00-634-4158

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- ☐ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- ☐ TYPE AND SCREEN
- ☐ CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH
DONOR	RECIPIENT		
ABO	ABO		
Rh	Rh		

PREVIOUS RECORD CHECK: ☐ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA	POST-TRANSFUSION DATA
INSPECTED AND ISSUED BY *(Signature)*	AMOUNT GIVEN ML; TIME/DATE COMPLETED/INTERRUPTED
AT *(Hour)* / ON *(Date)*	REACTION ☐ NONE ☐ SUSPECTED; TEMPERATURE; PULSE; BLOOD PRESSURE
IDENTIFICATION: I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.	If reaction is suspected—IMMEDIATELY: 1. Discontinue transfusion, treat shock if present, keep intravenous line open. 2. Notify Physician and Transfusion Service. 3. Follow Transfusion Reaction Procedures. 4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.
1st VERIFIER *(Signature)*	DESCRIPTION OF REACTION ☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN ☐ OTHER *(Specify)*
2nd VERIFIER *(Signature)*	OTHER DIFFICULTIES *(Equipment, clots, etc.)* ☐ NO ☐ YES *(Specify)*
PRE-TRANSFUSION TEMP. / PULSE / BP	SIGNATURE OF PERSON NOTING ABOVE
DATE OF TRANSFUSION / TIME STARTED	

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility) | SEX | WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

FORM 151–WHOLE BLOOD TRANSFUSION CHECKLIST

WHOLE BLOOD TRANSFUSION CHECKLIST

COMPLETE THIS CHECKLIST FOR EACH UNIT TRANSFUSED POST EVENT

LOCATION OF TRANSFUSION:	DATE:
WHOLE BLOOD UNIT #	

1. DONOR PRESCREENED FOR TRANSFUSION TRANSMITTED DISEASE (TTD) MARKERS WITH FDA APPROVED TESTS WITHIN LAST 90 DAYS?

YES_____ NO_____

2. DONORS SCREENED AT TIME OF COLLECTION USING RAPID TESTS FOR:

MALARIA YES_____ NO_____
HIV YES_____ NO_____
HBV YES_____ NO_____
HCV YES_____ NO_____
RPR YES_____ NO_____

3. RAPID TEST RESULTS AVAILABLE PRIOR TO PRODUCT RELEASE?

YES_____ NO_____

4. DONORS SCREENED USING **DD572** & CURRENT SOP ? YES_____ NO_____

5. BLOOD TUBES COLLECTED AT THE TIME OF COLLECTION FOR FOLLOW UP WITH FDA TTD TESTING YES_____ NO_____

6. INTERNATIONAL SOCIETY FOR BLOOD TRANSFUSION (ISBT) LABELS USED YES_____ NO_____

7. TUBES AND A COPY OF **DD572** FORWARDED TO BSD? YES_____ NO_____

8. UNIT ACCOUNTED FOR IN TMDS? YES_____ NO_____

9. WAS COMPONENT THERAPY AVAILABLE WHEN FWB WAS GIVEN YES_____NO_____

10. PLEASE PROVIDE ANY INFLUENCING FACTORS THAT PREVENTED YOU FROM FOLLOWING THE SOP FOR THIS TRANSFUSION EVENT (IF APPLICABLE):

_____

_____

_____

_____

INDIVIDUAL COMPLETING CHECKLIST

Print Name	**Signature**

This checklist is to be kept on file for a minimum of one (1) year. Forward a copy to BSD with corresponding samples for Every unit of Whole Blood transfused.

Form 151

WBB SUPPLY LIST (WITH NSNS)

Item Description	Stock# / NSN #
SHARPS Container	6515014922824
Biohazard Bags	0707A950012
Leak Resistant Chucks	3583001093
Gloves-SM	4352MG6001
-MED	4352484802
-LRG	4352MG6003
Surgical Tape	6510009268882
Sphygmomanometer	3596994215
Stethoscope	3596994510
Tempa Dots	4509005122
Lancet	F50924058510
Alcohol Pads	4725APP104
2x2 Gauze	3583001806
STAT SiteM	1750SB900900
STAT SiteM Test Cards	6550015096101
Blood Bag Scales-Hemo Flow	6515015137010
Blood Bag Stand	6515004114375
Terumo Single Blood Bags	6515014802307
Frepp/Sepp Kit	4335260288
4x4 Gauze	3583002634
Hand Stripper/Sealer/Cutter	6515011405267
Hand Sealer Clips	06814R4418
Scissors	6515003650640
Hemostats	5867097442
Adapter MS DIR 100S Luer 100S	723364902
Purple Top (EDTA Plasma)	0723367861
Pearl Top (PPT)	0723362788
Gold Top (SST)	723364902
Coban 5x1	4509001583
Eldon Card (Rapid ABO/Rh)	65500 8T003314
HIV 1/2 RA OraQuick	6550015267424
ORAQUIK HCV	6550015899845
ONSITE (CTK) HBSAG (Hep B)	6550008T000102
Malarial Rapid Test	6550081332341
RPR Test Kit	6550015110291

APPENDIX C

ADDITIONAL INFORMATION REGARDING OFF-LABEL USES IN CPGs

Purpose. The purpose of this Appendix is to ensure an understanding of DoD policy and practice regarding inclusion in CPGs of "off-label" uses of U.S. Food and Drug Administration (FDA)–approved products. This applies to off-label uses with patients who are armed forces members.

Background. Unapproved (i.e., "off-label") uses of FDA-approved products are extremely common in American medicine and are usually not subject to any special regulations. However, under Federal law, in some circumstances, unapproved uses of approved drugs are subject to FDA regulations governing "investigational new drugs." These circumstances include such uses as part of clinical trials, and in the military context, command required, unapproved uses. Some command requested unapproved uses may also be subject to special regulations.

Additional Information Regarding Off-Label Uses in CPGs. The inclusion in CPGs of off-label uses is not a clinical trial, nor is it a command request or requirement. Further, it does not imply that the Military Health System requires that use by DoD health care practitioners or considers it to be the "standard of care." Rather, the inclusion in CPGs of off-label uses is to inform the clinical judgment of the responsible health care practitioner by providing information regarding potential risks and benefits of treatment alternatives. The decision is for the clinical judgment of the responsible health care practitioner within the practitioner-patient relationship.

Additional Procedures.

1. Balanced Discussion. Consistent with this purpose, CPG discussions of off-label uses specifically state that they are uses not approved by the FDA. Further, such discussions are balanced in the presentation of appropriate clinical study data, including any such data that suggest caution in the use of the product and specifically including any FDA-issued warnings.
2. Quality Assurance Monitoring. With respect to such off-label uses, DoD procedure is to maintain a regular system of quality assurance monitoring of outcomes and known potential adverse events. For this reason, the importance of accurate clinical records is underscored.
3. Information to Patients. Good clinical practice includes the provision of appropriate information to patients. Each CPG discussing an unusual off-label use will address the issue of information to patients. When practicable, consideration will be given to including in an appendix an appropriate information sheet for distribution to patients, whether before or after use of the product. Information to patients should address in plain language: a) that the use is not approved by the FDA; b) the reasons why a DoD health care practitioner would decide to use the product for this purpose; and c) the potential risks associated with such use.