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SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 10-203

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Operations

DUTY LIMITING CONDITIONS

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This instruction is new and supplements profiling and duty restriction guidance contained in Air Force Instruction (AFI) 48-123V2, Medical Examinations and Standards Volume 2, Chapter 4, Profiles & Duty Limitations. It also supplements Medical Evaluation Board (MEB) requirements contained in AFI 41-210, Patient Administration Functions. This instruction describes how to communicate to commanders individual member restrictions due to medical reasons. The application of restrictions is a commander's program with medical recommendations. It also describes the disposition and management of members who have duty limitations and reporting requirements. It also introduces AF Form 422, Notification of Air Force Member's Qualification Status and Air Force Form 469, Duty Limiting Condition Report. This instruction carries out, in part the requirements of Title 10 United States Code (USC), Chapter 61, the Department of Defense Directive (DODD) 1332.18, Separations or Retirement for Physical Disability, Department of Defense Instruction (DODI) 1332.38, Physical Disability Evaluation, and DODI 6130.4, Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces. It implements Air Force Policy Directive (AFPD) 10-2 Readiness. It interfaces with AFPD 44-1, Medical Operations, AFPD 48-1, Aerospace Medical Program, AFI 41-210 and AFI 48-123. This instruction applies to all applicants for military service, scholarship programs, Air National Guard and the Air Force Reserve. Active duty flight medicine offices will use the Air Force Reserve Command (AFRC) supplement to this instruction when managing units assigned Reserve Members, and will maintain a copy of the AFRC Supplement when Reserve units are located on the same base.

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 instruction are outlined in Title 10, United States Code, Section 8013 and Executive Order, 9397. Privacy Act System Notice F044 AFSG G, Aeromedical Information Management and Waiver Tracking System (AIMWTS), applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123 (will convert to AFMAN 33-363), Management of Records and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at **https://afrims.amc.af.mil/**. The reporting requirements in this volume are exempt from licensing according to AFI 33-324, paragraph 2.11.10, The Information

Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF IMT 847, Recommendation for Change of Publication; route AF IMT 847s from the field through the appropriate functional's chain of command. **Attachment 1** is a list of references and supporting information.

Chapter 1

GENERAL PROVISIONS

1.1. Purpose. This AFI establishes procedures for the documentation and administrative management of members with duty limitations and occupational restrictions. These procedures have been developed to ensure maximum utilization and readiness of personnel, while preserving their health and preventing further injury or illness. When individuals have medical conditions affecting their continued qualification for retention in the Air Force, as outlined by the standards in AFI 48-123V2, Attachment 2, this AFI describes appropriate courses of action for medical board disposition.

1.1.1. The goal is that appropriate medical recommendations are communicated to commanders so they are able to determine the optimum utilization of members in their charge within the guidelines of the medically imposed restrictions.

1.1.2. Commanders and supervisors should consult with healthcare providers to maximize use of personnel with duty limiting conditions (DLC)s. An assessment based on operational risk of personnel assigned to a squadron/unit is key to maintaining unit readiness to the highest degree possible.

1.1.3. Purpose of AF Form 469, Duty Limiting Condition Report. The AF Form 469 is used to convey to the commander when a member's health, safety and well being, mission safety or abilities to effectively accomplish the mission are at risk.

1.2. Physical Profile System. The physical profile system classifies individuals according to physical functional abilities and availability for mobility duties. It applies to the following categories of personnel:

1.2.1. Applicants for appointment, enlistment, and induction into military service.

1.2.2. Active and ARC military personnel, cadets, and scholarship participants.

1.3. Profiles. Profiles are descriptions of physical capabilities which are used for establishing suitability for career fields or Air Force Specialty Code (AFSC). A profile can be entered on a SF 88, Medical Record-Report of Medical Examination, DD 2808 Report of Medical Examination, or an AF Form 422, Notification of Air Force Member's Qualification Status. They are valid for a minimum of five years unless the member has undergone a Medical Evaluation Board (MEB), world wide duty (WWD) evaluation, or have a current duty or mobility restriction. If a member wishes to retrain and the baseline is greater than five years, Force Health Management (FHM) will revalidate the member's physical capabilities.

1.4. Duty limitations. Duty limitations are occupational or mobility restrictions entered on the AF Form 469. The maximum duration of the AF Form 469 is one year. It must be renewed annually at each Preventive Health Assessment (PHA) or Reserve Component Periodic Health Assessment (RCPHA) as appropriate.

1.5. Special Considerations.

1.5.1. ARC Unique Issues. For ARC members, refer to AFI 48-123V2 Chapter 5 and AFI 36-3209, Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members.

1.5.2. AF Form 422, Notification of Air Force Member's Qualification Status. This form WILL NO LONGER be used for documenting deployment or duty limitations/restrictions. This form will continue to be used for initial qualifications, qualification for retirement or separation, military retraining, permanent change of station (PCS), school clearance, etc. For further instruction please refer to AFI 48-123V2, Chapter 4.

1.5.3. Refusal to obtain medical evaluation or treatment. After evaluation by medical consultants, members who refuse to obtain medical evaluations or treatment as required or recommended will be processed via MEB or WWD evaluation as appropriate. The MEB or WWD evaluation will evaluate the member's retainability in the service with the medical condition in its current state and will consider the probability of progression of disease or worsening of medical condition without the recommended medical treatment. The member may not be eligible for military disability payments.

1.5.3.1. Members will be provided, if desired, with a second opinion from a Primary Care Manager (PCM) selected consultant to explore treatment options. If both opinions agree, the MEB or WWD will progress, if they disagree, the member may choose his/her treatment course. Further opinions will only be considered through the administrative appeal process.

Chapter 2

RESPONSIBILITIES

2.1. USAF Chief of Staff. Establishes USAF personnel readiness goals, policies, and standards.

2.1.1. CSAF is responsible for Force Readiness, including medical readiness to ensure the USAF can meet national requirements.

2.2. HQ USAF/SG. Establishes medical standards, policies, and procedures for recommending physical duty limitations.

2.3. MAJCOM/SGP.

2.3.1. Acts as liaison between medical units, medical squadrons, or medical groups and Air Force Medical Operations Agency (AFMOA).

2.3.2. Performs MAJCOM fitness for duty (FFD) and restrictions trend analysis and reports to MAJCOM/CC.

2.4. Medical Treatment Facility (MTF), Medical Squadron (MDS), Medical Group (MDG), or Reserve Medical Unit (RMU) Commander.

2.4.1. Ensures timely scheduling and appropriate completion of required examinations and consultations. Unless delays are adequately explained and documented, examinations shall be completed not more than 30 days after they have begun. (90 days for ARC).

2.4.2. Authorized to use 72 hour consultations as a means to expedite duty limitation determinations if a patient is in a mobility position and this condition may result in a Code 31 (Medical Deferment) or 37 (Medical and/or Physical Evaluation Board (MEB/PEB).

2.4.2.1. ARC members with a non-duty related issue (Existing Prior to Service (EPTS) – Line of Duty (LOD) N/A) will be referred to their civilian providers. The Medical Unit Commander will then track timely provision of civilian medical records by the member, reporting delays to the member's commander IAW AFI 10-250, Individual Medical Readiness.

2.5. Senior Aerospace Medicine Physician (SGP).

2.5.1. The MTF/CC, RMU/CC, MDG/CC or Wing/CC IAW AFI 48-101, Aerospace Medical Operations, appoints the SGP in writing. This individual will be a credentialed flight surgeon and must have active privileges in flight medicine. Unless otherwise required by paragraphs 2.6.1.1 or 2.6.1.2 the SGP will serve as the Senior Profile Officer (SPO).

2.5.1.1. The standards experts in the Air Force Medical Service (AFMS) are graduates of the Residency in Aerospace Medicine (RAM). Where a RAM is assigned, he/she will serve as the senior profiling officer when more than one profile officer is appointed by the MTF Commander.

2.5.1.2. At MTFs where a RAM is not assigned, or the sole RAM is a squadron or group commander, the MTF/CC may appoint the profile officer most knowledgeable in physical standards as the senior profile officer.

2.5.2. SGP will consult with MAJCOM/SGP to liaison with the Combatant Commander (COCOM)/SG when conflicts between patient interest and commander interest with regard to deployment suitability cannot be resolved locally. If there is a risk to the patient that the SGP believes may not be fully realized by the unit commander, the next higher commander, who is at least a Group/CC, will have the final authority to resolve the issue(s) of both parties. See paragraphs 3.2.4.1 and 3.2.4.2 for additional guidance.

2.5.3. Serves as chairman of the Deployment Availability Working Group (DAWG).

2.5.4. Reports profile, duty limiting conditions, and deployment availability statistics to MAJCOM and as directed.

2.5.5. Responsible for ensuring profiling and duty limitation standards are met.

2.5.6. Responsible for training all providers with the Chief of Medical Staff (SGH) on the appropriate completion of profiles and duty limitations.

2.6. Chief of the Medical Staff (SGH).

2.6.1. Responsible for training all providers with the SGP on the clinical aspects of appropriate completion of profiles and duty limitations.

2.6.2. Responsible for the clinical review and quality control of all MEB narrative summaries, and ensure the timely completion of all MEBs.

2.6.2.1. ARC note: Includes WWD narrative summaries. The AD MTF maintains quality control and completion of ARC MEBs.

2.6.2.2. Air National Guard (ANG) note: National Guard Bureau (NGB)/SG maintains quality control and completion of WWD evaluations and ANG MEB's accomplished at the ANG MDG. AD MTF maintains quality control and completion of ANG MEB's accomplished at AD MTFs.

2.6.3. Ensure all clinical standards of care are met.

2.6.4. Should monitor clinical duty limiting actions through the facility peer review program in conjunction with the SGP.

2.7. Primary Care Elements (to include Flight Medicine) and Reserve Physical Examination Sections.

2.7.1. All providers must determine if the reason for the current encounter or another identified condition will affect the member's ability to perform his/her job functions or world wide deployability. The provider will then utilize the duty limitation system via the AF Form 469, to describe any limitations.

2.7.2. The patient's assigned provider will complete or coordinate additional clinical follow-ups or consultations needed to finalize physicals and/or assessments for clearance. ARC medical units will coordinate with the AD MTFs or TRICARE to obtain follow-up and/or consultations for service connected issues. ARC members with non-duty connected issues will be referred to their civilian providers for additional evaluation with explicit instructions to provide clinical information to the medical unit.

2.7.3. Deploying or TDY physicians who will be unable to complete MEB narrative summaries and case coordination within the 30 days allowable are required through the flight commander to transfer responsibility for their duties to another provider.

2.7.4. Providers derelict in their duty to complete narrative summaries and case coordination may be subject to review and disciplinary action IAW AFI 44-119, Clinical Performance Improvement, and the Uniform Code of Military Justice, as appropriate.

2.7.5. Providers must convey to commanders the necessary information to make informed decisions on the management of people in their charge. Because the member's commander is ultimately responsible for determining how best to utilize their member's capabilities, the DLC report is limited to stating functional limitations. The limitations need to be timely, accurate, and unambiguous to help commanders make the best decisions for their personnel and mission. The AF Form 469 will contain no positive affirmations as this is the responsibility of the commander/supervisor to determine where a member can work and the type of work they can do. Duty limitations will describe functional impairments. (EXAMPLE: SSgt who works in a shop that uses a pressure hose to clean items. He hurts his shoulder and has a functional limitation of "no lifting shoulder above 90 degrees." The AF Form 469 WOULD NOT say "Member is able to use pressure hose" (a positive affirmation). This form is used solely to describe limitations-"No raising shoulder above 90 degrees.)"

2.7.5.1. AF Form 469 functional limitations which impact unit fitness will be processed IAW AFI 10-248, Fitness Program. AF Form 469 will not be used to remove a member from unit fitness training or testing. Members with a functional limitation which impacts unit fitness greater than 30 days or members with an impending fitness test in less than 30 days will report to the Fitness Program Manager (FPM) at the Health and Wellness Center (HAWC) for testing exemption and exercise prescription evaluation. AF Form 422A will be used to document exercise program evaluations performed at the HAWC by the FPM.

2.7.6. Providers and PCM team personnel, or the Reserve Physical Examination Section will review existing duty limitations during all standard and special purpose medical examinations, PHAs, or RCPHAs.

2.7.7. Providers will also assist Force Health Management (FHM) by making assignment or deployment recommendations for their patients with duty limiting conditions, and for retraining profiles. Conditions that may render a member at risk must be fully explored with the concurrence of the Profile Officer (EXAMPLE: direct communication with a patient's commander may reveal specific duty limitations not previously documented).

2.7.8. Providers will ensure that patient visits are appropriately documented in the medical record and that duty limitation data is entered into the PHA and Preventive Individual Medical Readiness (PIMR)/RCPHA software program or equivalent program.

2.7.9. Mental Health providers communicate with commanders IAW AFI 44-109, Mental Health and Military Law.

2.7.10. Flight Medicine Responsibilities: Complete all clinical components of flying, special operational duty and occupational health exams and/or assessments. Non-special duty occupational health exams and/or assessments may be delegated to the Occupational Health Clinic when present. PCMs will perform initial physical profiling for special duty applicants.

2.8. Clinical Consultants. Will provide timely, complete, and concise narrative summaries regarding the member's clinical status with specific functional limitations. Narrative summaries will be accomplished within 14 days of patient encounter. This may be delayed if significant studies are pending, but will never exceed 14 days following definitive diagnosis.

2.8.1. Civilian clinical consultants. Civilian clinical consultants should limit recommendations to functional limitations. Military providers retain final deployment recommendation authority.

2.8.2. ARC members who are seen by their civilian providers may take up to 90 days to receive a narrative summary.

2.9. Profile Officers.

2.9.1. Profile officers are appointed in writing by the medical unit Commander.

2.9.2. Profile officers will be Flight Surgeons credentialed in Flight Medicine (unless no Flight Surgeons are assigned). They will be familiar with this AFI as well as AFI 48-123. Profile Officers will also be graduates of the Specialized Profile Officer Training (SPOT) program (when available).

2.9.3. Profile officers will ensure squadron interests (mission) and the patient's interests (health or restoration of health) are considered to maximize the benefit to both.

2.9.4. Profile Officer performs final review and signs all Duty Limiting Conditions AF Forms 469 which include mobility restrictions.

2.9.5. Profile officers may supersede the recommendations of a healthcare provider and should communicate the reason for superseding the provider's recommendation to the provider or the SGH. In cases where there is disagreement on profiling or duty limitation issues, the senior profile officer will make the final determination after review of the records and, when necessary consulting with the unit commander.

2.10. Public Health Function (Force Health Management) Note: These functions are performed by a 4N in the physical examination section for AFRC and the Full Time Health Technician for the ANG, as they do not have a FHM function (see ARC supplements for further clarification). (Flight Medicine for the ARC; Health Technician for the ANG).

2.10.1. Performs administrative quality reviews of DLCs, physical examinations, profiles, and appropriate clearances before these documents are forwarded/leave the facility (except routine PHAs, MEBs, and WWDs).

2.10.2. Manages the profiling/duty limitation system in accordance with this instruction. Serves as the communications link between squadron/unit commanders, supervisors, and the health care providers.

2.10.3. Keeps Primary Care Elements, medical facility executive leadership, unit health monitors, unit deployment managers, and unit as well as installation leadership informed of current status for all duty limitations over 30 cumulative days, and mobility availability decisions.

2.10.4. Attends DAWG, produces agenda, metrics, minutes and any required reports.

2.10.5. Sends pregnancy duty limitations to the clinic providing primary care to the patient for review. Any changes in restrictions must be referred to Public Health.

2.10.6. FHM notifies the health care provider to initiate MEB action FFD or WWD action for ARC members (with non-duty related medical conditions) as soon as the provider determines that the member will not be expected to return to duty within 1 year of the non-mobility start date (or within 1 year of the date a non-mobility profile should have been initiated) unless directed earlier by any volume of AFI 48-123.

2.10.7. Approval Authority for exception to policy of Assignment Limitation Code C (ALC-C) on active duty members depends on stratification. For ARC personnel, the appropriate ARC/SGP is the approval authority for ALC-C. For ANG personnel, ANG/DP is the approval authority for Deployment Availability Code 42 (DAC-42). Refer to AFI 41-210.

2.10.8. Ensure AF Form 469 is appropriately accomplished by a medical provider. A minimum quality review must be accomplished utilizing MTF acceptable and approved practices. Public Health is responsible for timely execution, and follow-up. Questions on applicability of standards versus restrictions may be addressed with either the provider, the Profile Officer or the SGP.

2.10.9. FHM will review and sign the following duty limitation actions:

2.10.9.1. MEB action/disposition on AF Form 469 when a member is returned to duty and in accordance with HQ AFPC/DPAMM or ARC/SGP recommendations.

2.10.9.2. WWD packages when a member is returned to duty.

2.10.9.3. Non-mobility actions and removal thereof.

2.10.9.4. Pregnancy duty limitations.

2.10.9.5. Duty limitations reporting serious medical conditions (i.e., restrictions that prevent mobility for 60 days or more) that may ultimately lead to MEB action.

2.10.9.6. PCS or other assignment deferral.

2.10.9.7. Other limitations actions as directed by the SGP or senior profile officer.

2.10.10. Through Armed Forces Health Longitudinal Technology Application (AHLTA)/PIMR, FHM will distribute AF Form 469 as directed in this instruction to the member's commander. Care should be taken to ensure that distribution of a patient's protected health information (PHI) is limited to the minimum necessary and these disclosures must be tracked using local medical unit procedures.

2.10.11. FHM will accomplish an initial medical record and PIMR review for incoming base personnel to ensure any limitations to duty performance, TDY, deployment/mobility and PHA data are appropriately captured. FHM will refer duty limitations suspected to be inappropriate, no longer necessary, or otherwise in need of correction or amendment to the PCM to ensure mission effectiveness and patient safety are maintained. Questionable limitations may also be made available to the Profile Officer to determine in consultation with the individual's commander and senior profile officer or SGP acceptable duty restrictions.

2.10.12. FHM will review retraining applications to ensure members are qualified for entry into the AFSC(s) for which the member is applying. Review of each AFSC's physical requirements is found in the Air Force Enlisted Classification Directory (AFECD) and the Air Force Officer Classification Directory located on the Air Force Personnel Center (AFPC) website. The AF Form 422 will indicate each of the selected AFSCs the member is, and is not qualified to enter. When flying or special operational duty AFSCs are selected, AFI 48-123V3 Attachments 3, 4 and 5 will be reviewed for disqual-

ifying defects. If defects are found, the member will be informed and a determination of potential waiver action will be determined by a flight surgeon.

2.11. Member's Commander.

2.11.1. Ensures the unit attains and maintains maximal medical readiness.

2.11.2. Ensures the member is available for and completes examinations including required follow-up studies and final disposition.

2.11.3. Reviews and concurs/non-concurs with mobility recommendations. The commander should coordinate all non-concur determinations with the Senior Profile Officer.

2.11.4. Issues AF Form 469 to member. Counsels and issues written instructions on duties and responsibilities of member when required.

2.11.5. Commanders must know the FFD status of the people in their charge. The HIPAA Privacy Rule allows for disclosures of PHI to commanders without the patient's authorization, but currently these disclosures must be tracked. Refer to AFI 41-210 for more information on commander access to medical information.

2.11.6. Commanders must determine how a member is used based on the functional limitations and their knowledge of the job. The commander and supervisor know best how to utilize their people.

2.12. Member.

2.12.1. Member must report potential deployment limiting conditions as well as any significant change in those conditions at the time they become present to the appropriate medical provider.

2.12.2. Meets scheduled medical appointments as directed. Informs unit supervisor of required follow-up evaluations and appointments. Reports all medical/dental treatment obtained through civilian sources or any medical condition that hinders duty performance to the appropriate military medical authority. See AFI 48-123, V2, Chapter 5 for additional guidance regarding ARC members.

2.12.3. Member must make all attempts to resolve medical condition in timely manner. This includes but is not limited to attendance at all appointments, active participation in rehabilitation, and using medications as prescribed by their physician. Failure to meet this requirement as determined by medical authority and commander may result in MEB and resultant administrative separation from the USAF, without medical disability compensation. See AFI 48-123V2, Chapter 5 for additional guidance regarding ARC members.

2.12.4. Defer the following actions when a member's failure to comply with medical assessment requirements renders the Air Force Medical Service unable to determine a member's current medical status: clearance actions for deployment, PCS, retraining or attendance at service academies or Professional Military Education (PME). Defer such actions until the member's physical status can be determined.

2.12.4.1. When a member declines an invasive procedure recommended for a return to functional status, they will be offered a second opinion. If the second opinion concurs with the first recommendation and the member still declines, they will be processed for MEB or WWD as appropriate with possible separation without disability compensation.

2.13. Military Personnel Flight (MPF).

2.13.1. Provides a monthly listing of personnel with Assignment Availability Codes of 31, 37, and 81 (pregnancy deferment) from Military Personnel Data System (MilPDS) to FHM if electronic system fails.

2.13.2. Refers members recommended for retraining with available AFSCs and job descriptions to FHM for determination of physical suitability. Processes retraining requests.

2.13.3. Ensures FHM is part of the process in clearing applicants for special duty assignments, PME, formal schools clearance, medical retraining requests, overseas PCS clearances, or security clearances. See AFMAN 10-3902, Nuclear Weapons Personnel Reliability Program (PRP), for specific procedures.

2.13.4. Attends the DAWG.

2.14. HQ AFPC/DPAMM.

2.14.1. If member is qualified for continued active duty following an MEB or PEB, HQ AFPC/DPAMM returns medical evaluation report to the medical facility with instructions for disposition of the examinee. ARC/SGP assists DPAMM with this function for ARC members.

Chapter 3

ESTABLISHING AND DISSEMINATING DUTY RESTRICTIONS

3.1. Duty Limitations and Mobility Restrictions.

3.1.1. Members will be evaluated for potential duty limitations at every medical encounter. If a member is determined to require a duty limitation or mobility restriction, the AF Form 469 will be used.

3.1.2. The healthcare provider or his designee will enter the demographic data; specify duty limitations or mobility restrictions enter the physical limitations and/or restrictions and a release date into PIMR. Only specific limitations will be entered. Diagnoses will not be recorded on the comment or limitation section of this form. The provider will then electronically sign the form.

3.1.2.1. AF Form 469 functional limitations which impact unit fitness will be dispositioned IAW AFI 10-248, Fitness Program. AF Form 469 will not be used to remove a member from unit fitness training or testing. Members with a functional limitation which impacts unit fitness greater than 30 days or for those with an impending fitness test in less than 30 days will report to the Fitness Program Manager (FPM) at the HAWC for testing exemption and exercise prescription evaluation. AF Form 422 will be used to document exercise program evaluations performed at the HAWC by the FPM.

3.2. Duty Limitations Only.

3.2.1. For duty limitations with no mobility or retraining implications, copies will be sent electronically to the member's unit and FHM.

3.2.2. Duty limitations that could permanently affect a member's ability to perform their specific AFSC duties should be handled via retraining administratively.

3.3. Mobility Restrictions.

3.3.1. When a medical condition with or without duty limitations also prevents the member from deploying, the PCM will check the Mobility Restriction box on the AF Form 469. After electronic signature, the form will be automatically forwarded to FHM which will assess the form, determine if the condition will require a code 31, 37, or 81 (illness expected to last between 31 and 365 days, MEB or WWD, or pregnancy respectively), annotate it appropriately, and forward it to the Profile Officer. The Profile Officer will validate by electronic signature, and the form will be automatically returned to FHM. It is then forwarded electronically to the member's unit commander for concurrence/non-concurrence. The commander or designated representative will issue the form to the member.

3.3.1.1. Commander concurrence (member's squadron commander or higher):

3.3.1.1.1. When the commander agrees with the mobility restriction, they sign the AF Form 469 and issue the form personally to the member or distribute via designated representative.

3.3.1.1.2. If a commander chooses to non-concur, they contact FHM via reply email. FHM will collect pertinent medical data and provide it to the SPO. The SPO will contact the PCM and review the medical data. The SPO can override the PCM's recommendation and revise the mobility restriction in order to resubmit to the member's commander. If the SPO agrees with the PCM, the SPO will meet with the member's commander to review the case. If the SPO and

unit commander disagree, the member can be placed on mobility status with the concurrence of the commander's next reporting official (normally the member's group commander). The final commander acting on the Form 469 serves a completed copy on the member.

3.3.1.1.3. A specified deployment may have medical requirements determined by the COCOM. Thus, while a commander can place an individual on mobility regardless of medical recommendations, the gaining force commander may not accept the individual for deployment. For a defined deployment, the SPO will coordinate through their MAJCOM to the gaining command regarding waiver of defined medical requirements.

3.3.2. Permanent mobility restrictions (Assignment Limitation Code C) may only be determined by AFPC/DPAMM (ARC/SGPs for ARC members). These limitations will be displayed on the AF Form 469 permanently at the bottom of the physical limitations/restrictions portion and cannot be overridden by any local AF Form 469 action.

3.3.3. Pregnancy Duty Limitations. In addition to duty and mobility restriction, the member's worksite will be evaluated for any physical or chemical hazards that could affect the mother or fetus. This may require temporary removal from certain AFSC duties. This will not require retraining. An OB/GYN provider should validate any standard duty limitation on AF Form 469 annually.

3.3.4. External duty limitations (civilian or sister service). Members must report changes in physical status to their military medical unit. Duty limitations specified by any non-USAF provider must be entered onto an AF Form 469 to be considered valid. Military providers retain final deployment recommendation authority.

3.4. Assignment Limitation Code C (ALC-C).

3.4.1. Further detailed guidance is available in AFI 41-210, Medical Operations, AFI 41-210, USCENTAF Supplement, and AFI 48-123V2. When AFI 41-210, directs a profiling action, the annotation will be on an AF Form 469 as a mobility limitation.

3.4.2. Authority. HQ AFPC/DPAMM is the authority to assign or remove the ALC-C on active duty members and the appropriate ARC/SGP is the authority to assign or remove the ALC-C for ARC members.

3.4.3. AFPC/DPAMM or ARC/SGP may assign stratified ALC-C codes based on risk and medical requirement. The code may be valid indefinitely but must be reviewed and renewed as mandated by Review in Lieu Of (RILO) requirements.

3.4.4. The authority to deploy a member with an ALC-C is based on stratification levels, or as specified in the reporting instructions for a defined deployment.

Chapter 4

QUALITY ASSURANCE

4.1. Deployment Availability Working Group (DAWG).

4.1.1. Purpose. The DAWG will meet monthly to review all personnel identified as having a deployment-limiting medical condition. The working group will identify all non-deployment eligible personnel and track progress from identification of medical condition through resolution or removal from mobility status. They will further identify cases exceeding the prescribed time limits, review a representative sample of DLCs and provide feedback to PCM teams, including providers, via the SGH and generate statistics that can be used for comparison with other like-sized MTFs and the Air Force as a whole.

NOTE: The DAWG will meet quarterly for ARC.

4.1.2. Membership will consist of the SGP, SGH, FHM function, Physical Evaluation Board Liaison Officer (PEBLO), a PCM representative, an OB/GYN representative, a referral management specialist and an MPF representative. Other members may be assigned as required.

4.1.3. The DAWG will review and provide oversight of the following processes:

4.1.3.1. For members on Code 31: The FHM function will maintain a spreadsheet of current code 31 members. The list will be reviewed for progress as well as impediments in order to facilitate the rapid resolution of all cases. All AF Form 469 duty restrictions that have recently exceeded 30 days and have converted to code 31 will be reviewed. Providers will be notified when a code 31 case reaches 10 months cumulative time in preparation for code 37 MEB processing. When it becomes obvious the member will not be returned to full duty prior to one year on a code 31, an MEB should be initiated even if the year has not elapsed.

4.1.3.2. For members on Code 37: The PEBLO will maintain a spreadsheet of all code 37 cases currently open at the MTF. Cases exceeding 90 days from initiation of the MEB will be reviewed for progress and impediments to completion.

4.1.3.3. Code 81, pregnancy. The FHM function will maintain a spreadsheet of all code 81 cases. This list will be confirmed by the OB/GYN representative.

4.1.3.4. ALC-C RILO due dates. The FHM function will maintain a spreadsheet of all ALC-C RILO due dates.

4.1.4. Peer review. The SGH will present monthly peer review statistics for clinical practice standards for DLCs. The SGP will present administrative peer review statistics for DLCs.

4.1.5. MPF representative will bring list of code 31, 37, and 81s for reconciliation with medical data.

4.2. Metrics

4.2.1. The FHM function will develop a report from PIMR data reflecting the current status of their wing and supported units, reporting through the DAWG to the medical unit executive function and wing commander:

4.2.1.1. Medically Mobility Ready (MMR) percentage. These members show all status green in PIMR and are capable of deploying with no medical actions required.

4.2.1.2. Medically Mobility Capable (MMC) percentage. These members have no assignment availability code (AAC) 31, 37 or 81 and no ALC –C codes. They do have unmet PIMR requirements that could be resolved within 30 days.

4.2.1.3. Medically Mobility Limited (MML) percentage. Members who would require greater than 30 days to become MMR, are Codes 31, 37, or 81, or are on a stratified ALC-C.

4.2.2. Diagnosis and Medication Surveillance. FHM will present the findings to the DAWG of selected monthly diagnostic or medication utilization queries to ensure military members with certain medical conditions do not remain unidentified to the mobility reporting system. A population risk assessment should be performed to determine which diagnoses or medications will be queried monthly. A Composite Health Care System (CHCS)/AHLTA query will be compared to existing code 31, 37 and 81 lists to provide increased visibility on conditions which may impact deployment availability. Personnel identified using this surveillance should be referred to their PCM for initiation of DLC action if indicated. Overall statistics and findings will be presented to the professional staff at least every six months for education purposes.

4.2.3. The DAWG will produce the following minimum data and report to the MTF Executive committee via the Aerospace Medicine Council monthly (Quarterly for ANG):

TOTAL CODED #CODED

TOTAL CODED RATE #CODED/#MOBILITY

CODE 31 # CODE 31

CODE 31 RATE # CODE 31/#MOBILITY

CODE 37 # CODE 37

CODE 37 RATE # CODE 37/#MOBILITY

CODE 81 # CODE 81

CODE 81 RATE # CODE 81/#MOBILITY

CODED RATE VS AF CODED RATE (from AFCHIPS website)

AVG CODE 31 DURATION

AVG CODE 37 DURATION

AVG CODE 37 COMPLETION TIME

RILO DUE DATE

SUBMISSION TO AFPC/DPAMM DATE

Peer review and surveillance significant findings

Chapter 5

MEDICAL EVALUATION BOARD AND WORLD WIDE DUTY

5.1. Medical Evaluation Board (MEB). Whenever a member has physical limitations or diagnoses that may affect their retainability for continued military service, the member will have an MEB for his/her service connected conditions. ARC members with non-service connected issues will have a WWD determination. The respective ARC/SGP will specify criteria and processes for WWD determinations. Active duty units supporting ARC members should obtain and maintain a copy of applicable guidance.

5.2. The purpose of the MEB. In order to maintain a fit and vital force, the Secretary of the Air Force relies on disability laws to remove active duty and ARC members who can no longer perform their military duties because of a service connected or aggravated mental or physical defect. The MEB is the first step in the Air Force disability evaluation process. The primary purpose of the MEB is to determine whether or not a member's medical condition warrants consideration for continued military service (including mobility potential). AFI 48-123V2, Attachment 2, outlines those medical conditions that require a medical board. ARC members must be entitled to disability processing to undergo MEB processing by active duty MTFs. ARC/SGP will provide ARC specific guidance. For FFD purposes, commanders and their designees, to include personnel offices, must receive medical information. Only the minimum necessary will be provided. If disclosures of this information have not been specifically authorized by the armed forces member, the MTF will account for the disclosures in accordance with DODD 6025.18-R.

NOTE: The MEB guidance in AFI 41-210 should be reviewed in addition to this chapter.

5.2.1. Presumption of Fitness. The existence of a physical defect or condition does not of itself necessarily provide justification for or entitlement to an MEB. The law that provides for military disability, Title 10 USC., Chapter 61, is not used to bestow additional benefits upon those approaching retirement. A presumption of fitness is established if a member has performed his or her duty satisfactorily prior to scheduled retirement date. This presumption of fitness can be overcome only if clear and convincing evidence to the contrary is established by a preponderance of evidence that an acute, grave illness or injury occurs that would prevent the member from performing duty if they were not retiring, or a serious deterioration of a previously diagnosed condition occurs that would prevent the member from performing duty.

5.2.2. Establishing the MEB.

5.2.2.1. The medical unit commander appoints in writing members of MEBs. The number of appointees should be large enough to convene a three-member board without delay. A PEBLO will also be designated.

5.2.2.2. The PCM provider will accomplish a narrative summary and obtain physician countersignature if not a physician and supporting documentation from applicable medical consultants if available. As an exception, mental health cases will always have a military psychiatry review and concurrence.

5.2.2.3. The PEBLO or MEB clerk will coordinate a commander's Member Utilization Questionnaire with endorsements, ensuring the commander has meaningfully assessed the member's deployability, mobility, and ability to perform normal duties.

5.2.3. MEB Process.

5.2.3.1. The Senior Profile Officer will serve as the senior board member with detailed knowledge of standards relating to medical fitness, disposition of patients and disability separation processing. The SGH will serve as the second board member. The third member of the board will be any physician privileged and appointed to participate in the MEB process as outlined above. If the MEB includes a mental health diagnosis, one of the board members must be a psychiatrist.

5.2.3.2. The SGH will perform a clinical quality and appropriateness assessment as part of the medical evaluation board process.

5.2.3.3. The Senior Profile Officer will conduct a fitness for continued military duty assessment with attention to mission and operational needs as part of the medical evaluation board.

5.2.3.4. The three-member board will then conduct the medical evaluation board according to AFI 41-210.

5.2.3.5. The completed MEB will be forwarded with all supporting documentation to AFPC or to ARC/SGP for ARC members by the PEBLO or MEB clerk.

5.2.3.6. For further guidance on the MEB process, refer to AFI 41-210.

Chapter 6

PRESCRIBED AND ADOPTED FORMS

6.1. Prescribed Forms

AF Form 422, Notification of Air Force Member's Qualification Status

AF Form 469, Duty Limiting Condition Report

6.2. Adopted Forms

AF IMT 847, Recommendation for Change of Publication

DD Form 2808, Report of Medical Examination

SF Form 88, Medical Record-Report of Medical Examination

JAMES R. ROUDEBUSH, Lt Gen, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

Executive Order 9397

Title 10 United States Code, Section 8013

Title 10 United States Code, Chapter 61

DODD 1332.18 Separations or Retirement for Physical Disability

DODD 6025.18-R DOD Health Information Privacy Regulation

DODI 1332.38 Physical Disability Evaluation

DODI 6130.4 Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces

DODR5210.42_AFMAN 10-3902 Nuclear Weapon Personnel Reliability Program (PRP)

AFI 10-248 Fitness Program

AFI 10-250 Individual Medical Readiness

AFI 33-324 The Information Collections and Reports Management Program: Controlling Internal, Public, and Interagency Air Force Information Collections

AFI 36-3209 Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members

AFI 41-210 Patient Administration Functions

AFI 44-109 Mental Health and Military Law

AFI 44-119 Clinical Performance Improvement

AFI 48-101 Aerospace Medicine Operations

AFI 48-123 V2 Medical Examinations and Standards

AFMAN 37-123 Management of Records

AFPD 44-1 Medical Operations

AFPD 48-1 Aerospace Medicine Program

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule

Abbreviations and Acronyms

AAC—Assignment Availability Code

AD—active duty

AETC—Air Education and Training Command

AFECD—Air Force Enlisted Classification Directory

AFI—Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFOCD—Air Force Officer Classification Directory

AFPC—Air Force Personnel Center

AFPD—Air Force Policy Directive

AFSC—Air Force Specialty Code

AHLTA—Armed Forces Health Longitudinal Technology Application

ALC-C—Assignment Limitation Code-C

ANG—Air National Guard

ARC—Air Reserve Component

CHCS—Composite Health Care System

COCOM—Combatant Commander

DAWG—Deployment Availability Working Group

DLC—Duty Limiting Condition

DODD—Department of Defense Directive

DODI—Department of Defense Instruction

e-Publishing—the e-Publishing website (**www.e-publishing.af.mil**)

EPTS—Existing Prior to Service

FFD—fitness for duty

FHM—Force Health Management

FPM—Fitness Program Manager

HAWC—health and Wellness Center

HIPAA—Health Insurance Portability and Accountability Act

HQ USAF/SG—Air Force Surgeon General

IPEB—Informal Physical Evaluation Board

LOD—Line of Duty

MAJCOM—Major Command

MDG—Medical Group

MDS—Medical Squadron

MEB—Medical Evaluation Board

MilPDS—Military Personnel Data System

MMC—Medically Mobility Capable

MML—Medically Mobility Limited

MMR—Medically Mobility Ready

MNMC—Medically Non-Mission Capable

MPF—Military Personnel Flight

MTF—medical treatment facility

PCM—Primary Care Manager

PCS—permanent change of station

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PHA—Preventive Health Assessment

PHI—Protected Health Information

PIMR—Preventive Individual Medical Readiness

PME—Professional Military Education

RAM—Residency in Aerospace Medicine

RCPHA—Reserve Component Periodic Health Assessment

RDS—Records Disposition Schedule

RILO—Review In Lieu Of

RMU—Reserve Medical Unit

RTD—Return to Duty

SG3PF—Aerospace Medicine Division

SGH—Chief of the Medical Staff

SGP—Senior Aerospace Medicine Physician

SPO—Senior Profile Officer

SPOT—Specialized Profile Officer Training

RMU—Reserve Medical Unit

USC—United States Code

WWD—World Wide Duty