Summary of Changes

USMEPCOM Regulation 40-1
Medical Qualification Program

Immediate revisions have been made to this regulation and are formatted in red text; information that is obsolete and will be deleted is formatted in red text with strikethrough. It is highly recommended that this regulation be reviewed in its entirety to have a clear understanding of all revisions.

Incorporating changes effective July 24, 2017

- Paragraph 2-3e(1): Redefines “Processing Authorized (PA)” to include MEPS profilers authorizing medical examinations for applicants disqualified during the medical prescreening process because there is the possibility for a Service medical waiver after the medical examination is complete.
- Paragraph 2-3e(2): Clarifies the definition of “Processing Requested by SMWRA (PRW)” for those instances when the SMWRAs request an applicant disqualified during the medical prescreening process be allowed to come to the MEPS for a medical examination.
- Paragraph 11-1d(59): clarifies that either a T or O in the profile signifies that the PULHES is not complete and therefore should not be signed (bottom-lined) by the profiling provider.
Executive Summary. This regulation prescribes policy and procedures for administration of the United States Military Entrance Processing Command (HQUSMEPCOM) Medical Qualification Program.

Applicability. This regulation applies to all elements of USMEPCOM and to the recruiting and liaison personnel of all military components insofar as their duties relate to all aspects of applicant medical processing required under this and related regulations.

Supplementation. Supplementation of this regulation is prohibited without prior approval from Headquarters, United States Military Entrance Processing Command (HQ USMEPCOM), ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Suggested Improvements. The proponent agency of this regulation is HQ USMEPCOM, [J-7/MEMD]. Users are invited to send comments and suggested improvements on Department of the Army (DA) Form 2028, Recommended Changes to Publications and Blank Forms, or memorandum, to HQ USMEPCOM, ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Internal Control Process. This regulation contains internal control provisions and provides an internal control evaluation checklist, in Appendix B, for use in conducting internal controls.
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Chapter 1
General

1-1. Purpose
The purpose of this regulation is to establish policies and procedural guidance for the USMEPCOM Medical Qualification Program of the USMEPCOM Medical Program. The Medical Qualification Program is executed at USMEPCOM locations such as Military Entrance Processing Stations (MEPS) and remote processing sites and is applicable to all applicants medically processing for accession into the Military Services and other federal organizations as approved by higher authority. The Medical Qualification Program consists of performing medical services including performing medical prescreening; performing medical examinations which consist of medical history interviews, physical screening examinations, medical tests, specimen collections, determining whether medical processing is warranted, determining additional medical information and consultative services required; and determining medical qualification. Medical qualification decisions include determining if an applicant does or does not meet Department of Defense (DoD) accession medical standards and when requested by the Services and approved by USMEPCOM, Service specific medical standards. USMEPCOM designated physicians are the DoD medical authority for applicants processing with USMEPCOM for determining if an applicant medically meets the requirements of Title 10 to be qualified, effective, and able-bodied prior to enlistment. USMEPCOM provides medical services support to other federal organizations approved by Accession Policy; services provided are determined through a memorandum of agreement arrangement with the organization requesting medical services.

1-2. References
References are listed in Appendix A.

1-3. Abbreviations and Terms
Abbreviations and terms used in this regulation are explained in Appendix C, Glossary.

1-4. Responsibilities

a. J-7/Medical Plans and Policy, (J-7/MEMD) Director will:
   
   (1) Exercise primary staff responsibility and develop policies and procedures for applicant medical processing and related matters for the USMEPCOM Medical Qualification Program.

   (2) Ensure the execution and quality of the USMEPCOM Medical Qualification Program in accordance with (IAW) DoD and Commander, USMEPCOM policies.

   (3) Provide a single point of contact for all applicant daily medical processing issues to facilitate standardized applicant medical processing, services and decisions.

b. J-7/MEMD, Deputy Director will:

   (1) Formulate and manage policy concerning the USMEPCOM Medical Qualification Program.

   (2) Ensure policies set forth in this regulation are complied with across the Command.

   (3) Be responsible for daily applicant medical processing mission support.
(4) Manage systematic feedback and support to Sector and Battalion Commanders on the USMEPCOM Medical Qualification Program.

(5) Provide supervision of personnel assigned to J-7/MEMD divisions including the Clinical Operations Division (J-7/MEMP-COD) consisting of a division chief, HIV/DAT Program Office (J-7/MEMD-COD-HPO), Battalion Support Accession Medicine Branches (J-7/MEMD-COD-BD, J-7/MEMD-COD-BL, and J-7/MEMD-COD-BR); and the Clinical Quality Division (J-7/MEMD-QD) consisting of the division Chief, Medical Informatics Officer, and Medical Program Business Manager; Quality and Requirements Branch (J-7/MEMD-QD-QDO); Clinical Management Branch (J-7/MEMD-QD-QDM) and Programs Branch (J-7/MEMD-QD-QDP).

c. J-7/MEMD, Clinical Operations Division Chief will:

(1) Ensure the MEPS comply with the policies and guidance set forth in this regulation.

(2) Manage the applicant Human Immunodeficiency Virus (HIV) testing program, the drug and alcohol testing (DAT) programs.

(3) Manage J-7/MEMD applicant daily medical support for MEPS medical processing issues through the Operations Center (MOC) ticket system.

(4) Formulate medical policies and procedures for applicant HIV testing program, DAT testing program, and medical operational aspects of the USMEPCOM Medical Qualification Program.

(5) Develop and provide training for Command personnel on medical policies and procedures for HIV testing program, DAT testing program, and medical operational aspects of the USMEPCOM Medical Qualification Program.

(6) Ensure collaboration by Clinical Operations Division personnel with Clinical Quality Division personnel. Participate in Quality Medical Assessment Teams, when assigned.

(7) Provide oversight of Clinical Operations Division continuous performance improvement efforts for the USMEPCOM Medical Program balanced scorecard, trend analysis, and metrics planning and execution.

(8) Provide supervision of the HIV/DAT Program Office and Battalion Support Accession Medicine Branches.

(9) Develop the curriculum for the annual medical training seminar for MEPS medical leadership including Chief Medical Officers (CMOs), Assistant CMOs (ACMOs), Assistant Medical Officers (AMOs) and MEPS medical department paraprofessional staff.

d. J-7/MEMD, HIV/DAT Program Officer will:

(1) Manage the USMEPCOM Applicant Drug and Alcohol and Human Immunodeficiency Virus (HIV) Programs in accordance with (IAW) USMEPCOM Regulation (UMR) 40-8 (Department of Defense (DoD) Drug and Alcohol Testing (DAT) Program and Human Immunodeficiency Virus (HIV) Testing Program.
(2) Respond to HIV/DAT MOC tickets in support of daily applicant medical processing.

(3) Collaborate with the USMEPCOM Contracting Officer Representative (COR) for the HIV contract to ensure USMEPCOM compliance with contract requirements.

d. **J-7/MEMD, Battalion Support Accession Medicine Branch (BSB) Chiefs will:**

(1) Formulate medical policies and procedures for medical operational aspects of the USMEPCOM Medical Qualification Program as a fully qualified accessions medical officers.

(2) Execute the J-7/MEMD clinical operational aspects of the USMEPCOM Medical Qualification Program ensuring collaboration for quality aspects of the program with the Clinical Quality Division for adherence to DoD medical standards and USMEPCOM policies and guidelines.

(3) Ensure the MEPS comply with the policies and guidance set forth in this regulation.

(4) Respond to MOC tickets and other inquiries (congressional, inspector general, special action, etc.) requiring physician input in support of applicant medical processing.

(5) Engage Service Medical Waiver Review Authorities (SMWRAs) as appropriate to facilitate applicant medical processing while authorizing use of medical funds effectively.

(6) Provide medical provider evaluation visits and quality medical assessment team support and visits to the MEPS including evaluation and assessment of USMEPCOM regulatory medical policy in USMEPCOM Regulations (UMRs) 40-1, 40-2, 40-8, and 40-9.

(7) Provide clinical support for business process reengineering efforts, assigned medical projects and continuous performance improvement efforts for the USMEPCOM Medical Program balanced scorecard, trend analysis, and metrics planning and execution.

(8) Develop and provide training/training guides for MEPS medical providers on current and pending medical processes to facilitate consistent implementation of medical policies and procedures.

(9) Perform applicant medical examinations at MEPS when required.

(10) Provide feedback to MEPS CMOs on Existed Prior to Service (EPTS) cases received from the training bases.

(11) Provide supervision of the Medical Management Analysts (MMAs).

e. **J-7/MEMD, BSB Accession Medicine Branch MMAs will:**

(1) Be responsible for the medical paraprofessional staff aspects of the USMEPCOM Medical Qualification Program as fully qualified accessions medical specialists.

(2) Provide staff assistance visits (SAVs), individual training visits (ITVs), and medical reassessment visits (MRVs) to MEPS including evaluation and assessment of USMEPCOM regulatory medical policy in USMEPCOM regulations and policies.
(3) Ensure completion of MOC tickets applicable to the USMEPCOM Medical Qualification Program.

(4) Review and recommend updates to USMEPCOM regulations and policies.

(5) Provide medical technical support for business process reengineering efforts, assigned medical projects and continuous performance improvement efforts for the USMEPCOM Medical Program balanced scorecard, trend analysis, and metrics planning and execution.

(6) Provide medical technical coding support for the EPTS program.

(7) Manage the Command-wide participation in the College of American Pathology/Clinical Laboratory Improvement Program (CAP/CLIP).

(8) Provide management analyst support to the HIV/DAT programs.

g. **J-7/MEMD, Clinical Quality Division (QD) Chief will:**

(1) Formulate medical policies and procedures for medical quality/performance improvement and contract management aspects of the USMEPCOM Medical Qualification Program.

(2) Manage the business needs of the USMEPCOM Medical Qualification Program.

(3) Manage USMEPCOM medical contracts associated with the USMEPCOM Medical Qualification Program. Provide contracting officer representative (COR) and alternate COR (ACOR) personnel for managing completion of workload associated with medical contracts.

(4) Manage the medical aspects of USMEPCOM special programs as assigned.

(5) Coordinate with the J-7/MEMD staff on the medical aspects of future initiatives including requirements definition and studies.

(6) Manage United States Military Entrance Processing Command Integrated Resource System (USMIRS) medical changes and manage user acceptance of these changes. Provide technical expertise in support of future technical initiatives impacting the Medical Qualification Program.

(7) Provide supervision for the medical informatics officer, medical program business manager, Quality and Requirements Branch, Quality Management Branch, and Programs Branch.

h. **MEPS Commanders will:**

(1) Ensure MEPS personnel comply with this regulation.

(2) Hire the chief medical officer (CMO), assistant CMO (ACMO), and assistant medical officer (AMO) including physician assistants (PAs) and Certified Nurse Practitioners (CNPs) through the local servicing civilian personnel activity IAW USMEPCOM (UMR) Regulation 40-2.
3. Ensure Fee Basis Provider (FBP) training and administrative requirements are met IAW UMR 40-2 before allowing an FBP to conduct aspects of the USMEPCOM Medical Program.

4. Ensure any deviation from USMEPCOM policy in this regulation has an approved exception to policy (ETP) signed by the J-7/MEMD Director (or designated representative) prior to implementation.

i. **MEPS Operations Officers (OPSOs) will:**

   1. Responsible for monitoring applicant flow through the MEPS and the Medical Department.
   
   2. Keep the MEPS Commander abreast of applicant flow and current processing concerns.
   
   3. Ensure medical processing is complete and an applicant is medically qualified to "ship" per the MEPS CMO (or CMO designated medical lead) during Quality Review Program (QRP).
   
   4. Ensure USMIRS is updated with medical data in a timely and accurate manner.
   
   5. Ensure reconciliation between the medical process results and medical processing departments USMEPCOM Form (UMF) 727-E is accomplished.

j. **MEPS CMOs will:**

   1. Supervise and manage the MEPS Medical Department and the execution of the Medical Qualification Program at the local MEPS level to ensure program quality.
   
   2. Supervise and provide written evaluations on ACMOs and MEPS Medical NCOICs/ SUP MTs.
   
   3. Serve as the principal MEPS medical officer and local authority in all accession medicine decisions, including but not limited to, requesting laboratory studies, radiographic procedures, ancillary services, and specialty consultations; requesting and reviewing applicants’ medical documents; counseling applicants with regard to medical problems discovered during their MEPS evaluation, qualification/disqualification decisions, and recommendations for medical waivers. MEPS Commanders and other non-medical personnel cannot reverse the professional accession medicine decisions of CMOs/ACMOs and contract physicians working as Fee Basis-CMOs (FB-CMOs).
   
   4. Establish a professional working relationship with the Medical Non-Commissioned Officers in Charge (Medical NCOIC)/Supervisory Medical Technician (SUP MT) and provide them the support to execute CMO decisions and medical policies.
   
   5. Ensure medical staff (government and contract medical providers and paraprofessional staff) is fully trained in conducting all aspects of the USMEPCOM Medical Qualification Program.
   
   6. Ensure assigned requirements associated with USMEPCOM medical contracts are executed at the local MEPS level including documentation of issues where contract providers are not providing quality medical services.
(7) Ensure applicant’s medical documents are appropriately reviewed for completeness and accuracy.

(8) Prepare and conduct quarterly training and inspection of the entire medical department.

(9) Ensure Occupational Safety and Health Administration (OSHA) requirements are met for all medical personnel.


(11) Ensure MEPS medical personnel training requirements are met.

(12) Act as the appointed Lab Director.

k. **MEPS Medical Non-Commissioned Officers in Charge/Supervisory Medical Technicians will:**

   (1) Establish a professional working relationship with the CMO as well as the rest of the medical department.

   (2) Support and follow through with CMO-directed medical decisions and policies.

   (3) Supervise and provide written evaluations on all medical technicians to ensure the quality of the USMEPCOM Medical Qualification Program.

   (4) Ensure each medical station is properly staffed for an efficient applicant flow through the medical department processes.

   (5) Serve as the government point of contact for USMEPCOM medical contracts and ensure compliance with COR assigned responsibilities.

   (6) Ensure quality control of medical packets with complete and legible entries.

   (7) Act as the primary trainer for the medical department and ensure technicians are thoroughly trained and capable in all phases of the Medical Qualification Program.

   (8) Responsible for the daily checks, calibration, periodic maintenance, and timely repairs of medical equipment to optimize functionality.

   (9) Coordinate scheduling of annual biomedical equipment maintenance.

   (10) Ensure daily organization, professional appearance, and cleanliness of the MEPS medical department.

   (11) Coordinate with the other MEPS departments and Service Liaisons on medical matters impacting applicant flow.

   (12) Ensure disruptive applicants are managed appropriately.
(13) Aid the Commander and the CMO in the requirements of UMR 40-1, 40-2, 40-8, and 40-9 to include ensuring contract providers only provide medical services appropriate to their Designated Provider Category (DPC).

(14) Ensure quality review process (QRP) of projected applicants’ medical packets is accomplished at least two working days before the applicant processes at the MEPS.

(15) Ensure weekly and quarterly departmental and CMO-directed training is accomplished.

(16) Ensure OSHA requirements are met for all medical personnel.

(17) Establish verification and validation procedures for invoice reconciliation to ensure data accuracy for all medical contracts.

(18) Complete all required taskings within the established time period.

(19) Ensure accuracy of USMIRS data entry.

l. MEPS Lead Medical Technicians will:

(1) Establish a professional working relationship with the CMO and Medical NCOIC/SUP MT as well as the rest of the medical department.

(2) Support and follow through with CMO and Medical NCOIC/SUP MT-directed medical decisions and policies.

(3) Lead all medical technicians to ensure the quality of the USMEPCOM Medical Qualification Program in the absence of a Medical NCOIC/SUP MT.

(4) Assist the Medical NCOIC/SUP MT with the duties outlined in the preceding section.

(5) Ensure accuracy of USMIRS data entry.

m. MEPS Medical Technicians will:

(1) Establish a professional working relationship with the CMO and NCOIC/SUP MT.

(2) Support and follow through with CMO and NCOIC/SUP MT/Lead Medical Technician-directed medical decisions and policies.

(3) Perform quality checks accurately and daily.

(4) Accurately execute applicant vision and hearing testing, specimen collections, and other assigned medical services.

(5) Perform accurate and daily USMIRS, FBP, and Invoice Reconciliation Program (IRP) application entries.
(6) Complete the technician portion of the USMIRS and Training Standardization Job Task Sheets (TSJTS) within 90 working days after arrival.

(7) Ensure that documents and Department of Defense (DD) Form 2807-2 are completed accurately and timely and are tracked accordingly.

(8) Ensure QRP of projected applicants’ medical packets is accomplished at least two working days before the applicant processes at the MEPS.

(9) Comply with all training requirements for all phases of the Medical Qualification Program as well as additional USMEPCOM training as established by NCOIC/SUP MT.

(10) Ensure accuracy of USMIRS data entry.

n. FBP responsibilities. FBPs will conduct accession medical services at the MEPS according to established guidance and the individual Service directives.

o. J-4/Facilities and Acquisition Directorate will:

(1) Provide medical logistics support to the USMEPCOM Medical Qualification Program.

(2) Provide acquisition support for medical contracts associated with the USMEPCOM Medical Qualification Program.

1-5. General Policy

a. Medical Services Execution. All personnel performing medical services for USMEPCOM will adhere to current version of DoD Instruction (DoDI) 6130.03 (Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces), this regulation, UMR 40-2, UMR 40-8, and UMR 40-9.

b. Applicant Medical Qualification Decisions. Profiling is a critical part of applicant processing. Profiling duties are done by USMEPCOM medical providers with a DPC Level of 3 or higher. The accuracy of the final applicant profile is the responsibility of the CMO. When profiling proficiency has been demonstrated by an FBP to the satisfaction of the CMO, a modification of DPC level to allow profiling can be requested (DPC Level 3). An FBP will not profile unless specifically assigned by the J-7/MEMD Director (or designated J-7/MEMD representative). An FBP will not be designated as FB-CMO if not assigned to DPC Level 4 which includes the ability to profile.

c. Designation of FB-CMO. If the CMO is absent from the MEPS or if the MEPS has a CMO vacancy, MEPS with ACMOs will have the ACMO be administratively in charge of the medical department and perform any required CMO duties as designated by the MEPS Commander. If there is no ACMO, then a FB-CMO can be requested from the contractor. Only FBPs assigned to DPC Level 4 will be designated as the FB-CMO. FB-CMOS will conduct applicant accession medical services including medical prescreening and examinations and are clinically responsible for the MEPS medical department and will respond to requests from the MEPS Commander to attend meetings and provide technical advice and medical guidance to the medical department. Medical processing questions that cannot be resolved at the local level will be referred to J-7/MEMD via MOC ticket.
1-6. Use of Reserve Component and National Guard Practitioners
MEPS Commanders will contact J-7/MEMD for guidance when there are requests for Armed Forces Reserve and National Guard (NG) practitioners in drill status or on active duty for training (ADT) for duty at the MEPS. When working in a MEPS as FBPs, reserve component providers cannot be paid through the contract if they are in a duty status. Providers must meet the requirements in UMR 40-2 to have their initial credentials reviewed by J-7/MEMD, before performing medical examinations or associated MEPS duties.

1-7. MEPS Communication with J-7/ MEMD

a. The USMEPCOM MOC ticket system will be used for applicant medical processing issues. If immediate help is needed after submitting a MOC ticket, contact the appropriate J-7/MEMD personnel using the contact list provided on the USMEPCOM intranet, Sharing, Policy, Experience and Resources (SPEAR), on the J-7/MEMD home page.

b. Use the following address for mailing information to J-7/MEMD

HQ USMEPCOM
ATTN: J-7/MEMD (position or person who should receive the mail)
2834 Green Bay Road
North Chicago, IL 60064-3091

c. Use the following facsimile number for faxing information to J-7/MEMD. If faxing personal or medical information, call J-7/MEMD first and verify someone is available to immediately retrieve the fax from the machine.

FAX: (847) 688-2453

d. J-7/MEMD has group email addresses for a number of areas. These addresses are in the USMEPCOM global address list and are listed on the J-7/MEMD SPEAR page. Emails containing personal and medical information must always be sent encrypted.
Chapter 2
Pre-Processing

2-1. Dial-A-Doc/Email-A-Doc Program

a. This program provides recruiters with access to the MEPS medical department, enabling them to obtain answers to questions concerning an applicant’s medical condition(s) or problem(s) prior to submission of a prescreen and scheduling a MEPS medical examination. This communication will allow the recruiter to understand the type of supporting medical information/documents required to expedite the medical processing. The Email-A-Doc program statement must comply with Privacy Act and encryption requirements of USMEPCOM.

b. Each MEPS will have a Standard Operating Procedure (SOP) governing the program. The MEPS can have one or both programs.

c. Any inquiry that cannot be answered by the technician, CMO or FBP will be referred to J-7/MEMD via MOC ticket for resolution.

d. An example of both the Dial-a-Doc and Email-A-Doc SOPs can be found on SPEAR in the general information section.

2-2. Submission of Applicant Prescreen

a. All MEPS medical departments must conduct a medical prescreen program as established by the CMO with support from MEPS Commanders and Interservice Recruitment Committee (IRC) (reference UMR 601-23). MEPS medical departments must effectively manage medical prescreens so recruiting partners know the status of their applicants. If there are workload issues, the MEPS Commander and CMO need to work with the service liaison and IRC if needed, so that the quality of medical prescreening is not compromised but medical prescreens are completed in a timely manner.

b. The applicant completes sections I through V of the DD Form 2807-2. Sections II and III will be completed by the applicant before coming to the MEPS. All “yes” answers in Section II are required to be explained in Section III. If the form is completed manually, it will be filled in with black ink. A DD Form 2807-2 is valid for 90 days from the date applicant signed in Section V. For overseas processors, the prescreen is valid for 120 calendar days from the date applicant signed in Section V. A new prescreen will be required after the validity period has passed or the applicant changes the Service Processed For (SPF) during the prescreen process.

c. The Recruiting Services must submit the following completed documentation to be considered for a medical examination at the MEPS:

(1) UMF 680-3A-E (Request for Examination)

(2) DD Form 2807-2 with substantiating and supporting medical documents as specified in the USMEPCOM Medical Prescreen Documents List and all other documentation requested by the MEPS provider.

(3) Optional: DD Form 1966/5 (Parental/Guardian Consent for Enlistment), if applicable)
(4) Optional: Over-40 Documentation (UMF 40-1-10 Over-40 Applicant Questionnaire, if applicable)

(5) Optional: Refractive Eye Surgery Worksheet (LASIK Surgery) (UMF 40-1-4, if applicable)

(6) Prior Service Documentation (if applicable)

   (a) Prescreen of prior service applicants is the same as it is for all applicants. Confirm that the prior service applicant has answered “yes” to question 161 (and possibly question 163) on the DD Form 2807-2.

   (b) Those that have been discharged for medical reasons must supply the following items at the time of prescreen submission:

      1. A signed Memorandum for Record (MFR) on Service letterhead stating that the Service understands they are assuming responsibility for processing an applicant with a pre-existing disqualifying condition and for authorizing medical processing. This MFR will become a permanent document in the applicant’s medical record. A copy of this MFR will be kept in a medical department office file for two years.

      2. All medical documentation from a military treatment facility (MTF) related to the reason for discharge (to include discharge physical, if obtainable).

      3. Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) documentation (if applicable).

d. If incomplete prescreens or prescreens without proper medical records are submitted, then the MEPS medical department will notify the Service Liaison. The MEPS medical department is not required to complete a medical prescreen review until all the proper and completed documentation is provided.

e. Prescreens that have no "yes" responses noted in any item numbers other than 9, 11, 20, and 138 on the DD Form 2807-2 will be reviewed the same day. All other prescreen reviews will be done as shows in the tables below:

f. Prescreens that have no “yes” responses noted in any item numbers other than 9, 11, 20, and 138 and 5 or less single-sided pages of supporting medical documents will have 2 processing days for review. See Figure 2-1 for example.
g. Prescreens that have no “yes” responses noted in any item numbers other than 9, 11, 20, and 138 and more than 5 single-sided pages of supporting medical documents will have 3 processing days for review. See Figure 2-2 for example.

h. In the instances of exceptionally complex cases a longer review may be required as determined by the CMO. In these cases, the medical department will notify the Service Liaison within the initial time period with an estimate of how much additional time may be required to complete review.

i. A walk-in is defined as an applicant not projected for processing at or before the established MEPS projection cut-off time. A walk-in prescreen must have no "yes" responses noted in any item numbers other than 9, 11, 20, and 138 (except if the arrest or law enforcement encounter indicates a behavioral health issue requiring a prescreen review by a MEPS medical provider) on the DD Form 2807-2.

j. MEPS medical department personnel will enter in USMIRS only prescreens that reflect a disqualification status (B030J or B030R) or incomplete paperwork (B030L) as indicated by the CMO/ACMO/FBP on DD Form 2807-2. If a prescreen disqualification is determined, the Service Liaison will be notified. The date the CMO reviewing provider signs the form is the date used to enter the transaction in USMIRS. If the prescreen reveals no disqualifying condition(s), USMIRS will not be updated.
2-3. Review of Applicant Prescreen

a. The CMO, ACMO or profiling FBP (collectively referred to here as profiler) reviews all submitted prescreen documentation. Non profiling providers (PAs, CNPs etc.) are allowed to review prescreens for the CMO at his/her discretion. Prescreens with no “yes” responses or “yes” responses only to item numbers 9, 11, 20, and 138 (except if the arrest or law enforcement encounter indicates a behavioral health issue requiring a prescreen review by a MEPS medical provider) on the DD Form 2807-2 are authorized to be reviewed by medical technicians at the discretion of the CMO and must be signed by the provider no later than the applicant medical history interview. The MEPS medical department can develop a local SOP to have the profiler acknowledge the prescreens that have been reviewed by the medical technician and/or non-profiling providers.

Note: Non-profiling reviewers will consult with the CMO before making prescreen disqualification decisions.

b. List all identified conditions in Section VI from Sections II and III that might impact the decision to medically qualify the applicant. Make additional entries to summarize the results of record review until a determination is made. Attach a Standard Form (SF) 507 if more space is required.

c. For each entry, include:

(1) Date of entry.

(2) Body system item number (#17-43 from DD Form 2808), if applicable. This body system item number is needed in order to enter the appropriate workload in USMIRS.

(3) Concise summary of the essential points for each condition and the dates they occurred.

(4) What medical records/documents are needed to determine if the condition is qualifying or not.

(5) If condition is disqualifying, write “CD” (considered disqualified) along with the ICD code, if applicable.

(6) If the condition is qualifying, write “NCD” (not considered disqualified).

(7) Provider signature.

d. Use only the original DD Form 2807-2 (the version submitted by the Service Liaison is considered the original). If additional prescreens are generated, then in Section VI of the extra prescreen write “SEE ORIGINAL” and add the new information, as outlined above, to the original DD Form 2807-2. The extra prescreen(s) will be stored in the applicant’s medical record.

e. The reviewing provider then comes to a decision, to be recorded in section VII, block 1 (on DD Form 2807-2) as follows:
Figure 2-3. DD Form 2807-2 Section VII Block 1

(1) Processing Authorized (PA): No disqualifying issues noted upon reviewing the prescreen per current DoDI 6130.03. Gives authorization to physical. Reviewing provider will check the “PA” box and date and initial the appropriate row in Section VII, items 1a and 1d. Also, when there are disqualifying conditions identified per the current version of DoDI 6130.03 and there is the potential for a medical waiver based on clinical judgment/“common sense” decision of the MEPS reviewing provider, the “PA” box will also be used. Reviewing provider will check “PA”, document the disqualifiers appropriately in Section VII, item 1c (complete 1c with ICD code, condition (diagnosis), and PUHLES), and date and initial the appropriate row in Section VII, items 1a and 1d. In Section VI – MEDICAL PROVIDER’S SUMMARY AND DESCRIPTION OF PERTINENT INFORMATION, the reviewing provider should have already documented their comments concerning the disqualifying conditions. Draw a line across the block under the last line of comments and initial and date the line so future reviewing providers will know where the last provider left off. For box 2, see Chapter 10-1. Complete box 3a, b, and c with printed or stamped name of provider, signature, and date of signing (if not already signed).

(2) Processing Requested by SMWRA (PRW):

(a) Evaluating provider has determined there are disqualifying conditions per the current version of DoDI 6130.03 and either there isn’t the potential for a medical waiver (based on “common sense”/clinical judgment) and the MEPS receives a written request from a SMWRA physician to perform the medical examination; or

(b) the reviewing provider is not sure the examination is warranted and decides to process the case as a “courtesy prescreen review” either by verbally discussing with a SMWRA physician or a copy of the case is sent to the SMWRA and a verbal discussion happens between a reviewing provider/SMWRA physician; or

(c) the MEPS receives, in writing, a request from a SMWRA physician to have a medical examination occur which is an outcome of the Service providing the SMWRA the applicant case and a SMWRA review occurs.

For these cases, the reviewing provider will check the “PRW” box in 1b and date, identify the disqualifying condition(s) and initial the appropriate row in Section VII, items 1a, 1c (complete 1c with ICD code, condition (diagnosis), and PUHLES), and 1d. If the MEPS receives a request for a medical examination from the SMWRA (either written or verbally directed) indicate the person who authorized the examination in the SMWRA Input box.

Note: If the SMWRA requests in writing that an applicant has the potential for medical waiver and thus is requesting the applicant physical, the written request must stay with the applicant’s medical packet.

Note 2: For item 2, see Chapter 10-1. Complete items 3a, b, and c with printed or stamped name of provider, signature, and date of signing (if not already signed)
the applicant is Processing Not Justified (PNJ); however, the SMWRA has authorized the MEPS Medical Department to physical the applicant. This also includes disqualifying conditions that are routinely waived by SMWRA. Reviewing provider will check the “PRW” box and date and initial the appropriate row in Section VII, items 1a and 1d. Complete 3a, b, and c with printed or stamped name of provider, signature, and date of signing (if not already signed). In some cases, a written waiver may be received from the SMWRA that authorizes the applicant to physical. Indicate the person who authorized the physical in the SMWRA Input box. This waiver must stay with the applicant’s medical packet.

(3) Processing Hold (PH): Other circumstances that would prevent an applicant from being authorized to physical. Reviewing provider will check the “PH” box and date and initial the appropriate row in Section VII, items 1a and 1d.

(4) Return Justified (RJ): Evaluating provider has determined the applicant has a temporary disqualifying condition that will eventually resolve and allow medical processing at a later date as determined by the provider per the current version of DoDI 6130.03. Reviewing provider will annotate the RJ date in the “RJ” box and date and initial the appropriate row in Section VII, items 1a and 1d. Complete item 1c with ICD code, condition (diagnosis), and PULHES. If there are multiple disqualifying conditions requiring RJ, give detailed explanations in Section VI for each disqualification.

(5) Medical Evaluation and/or Treatment Records (METR): Evaluating provider has determined that additional medical documents and/or treatments are required prior to making a decision. This includes any condition that requires additional medical evaluation by the Primary Care Provider (PCP) per the current version of DoDI 6130.03. Reviewing provider will check the “METR” box and date and initial the appropriate row in Section VII, items 1a and 1d and return to the submitting Service. When the additional requested documentation and original prescreen are received by the MEPS medical department, the prescreen review process starts over.

**Note:** A new row is not required for each conditions requiring medical record review. One row is sufficient until all medical records for all conditions requiring records are received and reviewed.

(6) Processing Not Justified (PNJ): Disqualifying conditions identified per the current version of DoDI 6130.03. Not authorized to physical. Reviewing provider will check the “PNJ” box and date and initial the appropriate row in Section VII, items 1a and 1d. Complete item 1c with ICD code, condition (diagnosis), and PULHES. Complete 3a, b, and c with printed or stamped name of examiner, signature, and date of signing. If there are multiple disqualifying conditions requiring PNJ, give detailed explanations in Section VI for each disqualification.

**Note:** Every time this prescreen returns for review, an additional row will be added in Section VII, item 1 (if change is required). If all rows in Section VII on the DD Form 2807-2 are used, annotate additional information in Section VI or on an SF 507, if needed.

f. Block 2, Section VII on the DD Form 2807-2 is completed at the time of medical history interview.

g. All documentation submitted with the DD Form 2807-2 up until the time of the physical will be annotated in Block 4, Section VII on the DD Form 2807-2. Any duplicate pages or billing/insurance information can be eliminated. Each page of additional documentation must be numbered. The first and last page of additional documents must be stamped/printed with “reviewed and considered”.
h. No specialty consultations/ancillary services will be ordered for applicants who are at the prescreen stage of their medical processing.

i. Copies (not original medical documents) will be accepted from the Service Liaisons for the applicant’s medical prescreen. All reviewed medical documents will be accounted for and kept (in their entirety) in the applicant’s medical record; do not destroy medical documents. If original medical documents are submitted, they will be returned to the Service Liaisons.

j. The reviewed, completed, and signed DD Form 2807-2 is an “original” document and is maintained in the applicant’s medical packet. If a packet does not exist for the applicant, one must be created. The DD Form 2807-2 will be returned to the files room with the applicant’s packet and the MEPS medical department will notify the Service Liaison of the applicant’s prescreen status. Only prescreens that have not been signed by a provider may be destroyed after the validity period has passed.

k. The MEPS medical department is not obligated to review prescreen DD Form 2807-2 with incomplete administrative information. In these instances, the MEPS medical department will notify the Service Liaison per local SOP.

2-4. VA and Other Disability Compensation
The applicant will submit all relevant medical documentation related to the disability as part of the prescreen. When the profiler has determined that supporting documents related to the disability are sufficient to make a medical qualification decision, the applicant will be processed IAW 2-2 Submission of Applicant Prescreen.

2-5. Entry-Level Medical Separation (ELS)
An entry-level medical separation (ELS) is defined as a medical condition that developed during training (in the first 180 days) that did not exist prior to service (e.g., a broken arm from the obstacle course). The applicant will submit all relevant medical documentation related to the medical separation as part of the prescreen. When the profiler has determined that supporting documents related to the medical separation are sufficient to make a medical qualification decision, the applicant will be processed IAW 2-2 Submission of Applicant Prescreen.

2-6. Temporary Disability Retirement List (TDRL)

a. Military members are sometimes found medically unfit for duty and discharged to the temporary disability retirement list (TDRL). Within a 5-year period, TDRL military members are periodically reexamined to determine fitness. Within 5 years, a medical board makes a final evaluation and removes the member from TDRL status, determining if the member is fit or unfit for duty. TDRL personnel who have been found “fit for duty” by a medical board are authorized a MEPS physical only into the service that he/she left.

b. The applicant will submit all medical evaluations during the TDRL status and all medical board documents as part of the prescreen. The medical department may process TDRL applicants if, upon review by the profiler of the supplied documentation, the applicant meets accession medical standards. During medical processing, the MEPS provider cannot disqualify an applicant for the problem that originally put him/her on TDRL status if the condition has been found “fit for duty” by a board; interval medical history that changes the condition(s) can be considered and an applicant medically disqualified if the interval
history causes the condition to now not meet medical accession standards. For all other conditions, the TDRL applicant is evaluated by accession standards and referred to waiver authority when applicable.

Note: Permanent disability retirement list (PDRL) members will not be processed.

2-7.  No Medical Required (B0M0)

   a. The B0M0 process allows the MEPS USMIRS user to project an applicant as ‘no medical required’. The MEPS staff submits a MOC request for guidance from J-7/MEMD when a Service Liaison requests to project an applicant as a B0M0 when any medical data (including prescreen data) exists in the applicant’s USMIRS record. The MOC request must include why the B0M0 is being requested. Instructions will be given via MOC ticket response on how to process the applicant if approval for the B0M0 is granted.

   b. Service Liaisons are prohibited from entering "No Medical Required" ("B0M0P") when any medical data (including prescreen data) exists in the applicant’s record.
Chapter 3
Medical Processing Admin

3-1. General

a. All forms will be completed in black ink. If corrections need to be made, correct entries by lining through once and entering the corrected entry above, below, or adjacent to the original entry. Corrections and changes must be initialed and dated by the person making the correction. Use of white out or correction tape on any applicant medical documents is not authorized.

b. The MEPS are not authorized to perform any medical services or medical processing during “night” testing without approval from J-7/MEMD. “Night” testing is for aptitude testing and not medical testing.

c. In the case of MEPS-to-MEPS packet transfers, the original medical documentation must be received by the gaining MEPS before applicant can be medically processed. Medical processing on copies is not authorized. These packets are considered mission critical and can be shipped overnight IAW UMR 25-50.

d. Engaging in the medical treatment of applicants, except as authorized in emergency situations, is prohibited.

3-2. Military Entrance Medical Examinations

a. Military entrance medical examinations are conducted according to the principles of accession medicine as outlined in the current version of DoDI 6130.03 and are used for the purpose of enlistment, accession, and induction into the Armed Services. The MEPS will perform other examinations as listed in Chapter 16. Additional federal applicant medical examinations may be done when authorized by DoD, that conducting them does not materially impact MEPS operations (i.e., space and resources available), and that prior approval is given by USMEPCOM J-7/MEMD, approved by the Deputy Assistant Secretary of Defense, Military Personnel Policy and communicated to the MEPS staff from J-7/MEMD. MEPS medical department will never perform medical services for USMEPCOM employees or recruiting personnel other than MEPS medical providers performing medical services as required due to an emergency situation at the MEPS.

b. A physical examination for accession is valid for 2 years or until the applicant has reported to initial entry training. If the physical is going to expire before the applicant reports for initial entry training the intent of the original physical can be accomplished, the CMO, Medical NCOIC/SUP MT, or MEPS Commander is authorized to approve a new, full medical examination. The former examination is attached as supporting medical records to the new examination. A new prescreen is not required under these circumstances.

c. If the original physical examination is lost, the applicant will receive a new physical examination to include a new drug and HIV test.

d. If an individual who has already reported to initial entry training and was separated and returns to the MEPS within two years to again attempt accession into a military service, s/he will require a new prescreen. The physical examination (to include new drug and HIV tests) will be repeated. The former examination is attached as supporting medical records to the new examination, if available. Separation
documentation and related medical records will be provided to the MEPS in accordance with Section 2-5 in this regulation.

3-3. Use of Non-Medical Personnel

a. Use of MEPS-assigned non-medical personnel is authorized to perform medical functions at the discretion of the CMO. Non-medical personnel can be used with proper training and documentation in their training folder to:

(1) Chaperone applicants
(2) Measure height, weight, and body fat
(3) Demonstrate ortho-neuro maneuver
(4) Observe urine collection
(5) Verify drug results
(6) Verify HIV results
(7) Check applicants into the medical department
(8) Present medical briefing
(9) Enter medical data into USMIRS

b. All other medical tests and examinations may not be performed by non-medical personnel unless a medical ETP has been submitted to and approved by J-7/MEMD Director or his/her designated representative.

Note: Additional administrative functions as determined by the medical department (making copies, etc.) may also be performed.

c. Any personnel not assigned to the MEPS (Reservists, students, externs, interns, recruiters, Service Liaisons, etc.) are not authorized to work in the medical department.

3-4. Special Category Processor

Special-category applicant processing is intended to recognize applicants deserving of special treatment commensurate with their expected position in military service. Processing for these applicants should be done IAW UMR 601-23. When in doubt as to the eligibility of an applicant for special-category processing, either accept as a special category or seek guidance from HQ USMEPCOM, J-3/MEOP through the MOC.

3-5. Same-Day Processor

The MEPS medical department is authorized to conduct the medical brief before the ASVAB for same-day processors. If the applicant does not return from ASVAB testing and has front-loaded, then the medical data must be entered into USMIRS and the PULHES will be annotated as an open profile. The reason for the open PULHES (did not return from testing) must be documented on the DD Form 2808.
3-6. The 6-hour Applicant Processing Window

During normal MEPS operations, the goal is to allot the Recruiting Services a 6-hour applicant processing window to work new contracts. For each Service, the 6-hour window begins when the first scheduled full-physical applicant completes their physical and is released from the MEPS medical department to the appropriate Recruiting Services Liaison/Guidance Counselor Service(s) office. The first group of applicants through the medical department should be a mix of all services. The quality of the medical examination/inspection will not be sacrificed to meet compliance with the 6-hour window goal. Refer to UMR 601-23 for additional guidance.

Note: If processing a limited number of applicants per service, then it may not be possible for the first group to be a mix of all services.

3-7. Physical Examination Consent and Chaperone Policy

a. Commanders may appoint any MEPS employee (on the recommendation of the CMO/Medical NCOIC/SUP MT) to serve as a chaperone, as long as that person has successfully completed the chaperone training as verified by the CMO/Medical NCOIC/SUP MT. Appointment orders (see Confirmed Training Order) remain in effect throughout the period of employment at the MEPS unless otherwise revoked by the MEPS Commander. When the MEPS Commander is replaced, the Chaperone appointment remains in effect. Re-training is not required when a change of command occurs. Once appointed by the MEPS Commander, the chaperone policy will be reviewed annually and documented in the employee’s training folder.

b. All applicants will read the MEPS Physical Examination Information Sheet prior to the physical examination. After reading, applicants will date, print, and sign his/her name on the top three lines of the Consent Stamp in block 73 of DD Form 2808. The Consent Stamp will be signed once by the applicant to cover the full physical and any subsequent medical inspections.

c. The chaperone will be the same gender as the applicant. When the examiner is of the opposite gender of the applicant a chaperone must be provided while the applicant is in a state of undress. When the examiner is of the same gender as the applicant a chaperone will be provided on request of either the applicant or the medical provider. The applicant or medical provider may request a chaperone at any time and one will be provided.

d. The examining provider must confirm that the applicant does or does not want a chaperone before beginning the medical examination (where the applicant will be in a state of undress).

(1) If no chaperone is required/requested, then the last two lines of the Consent Stamp will be left blank.

(2) During the initial physical, if a chaperone is required/requested, then the last two lines of the Consent Stamp will be completed.
Figure 3-1. MEPS Examination Consent Stamp

Note: The MEPS are authorized to use mailing labels in lieu of a stamp.

(3) When an applicant returns for a medical or physical inspection and a chaperone is required/requested, the chaperone will print their name followed by the word “chaperone” and “inspect” the chaperone’s initials and date the entry in block 73 of DD Form 2808.

e. If the chaperone observes impropriety issues during the applicant’s physical examination, the examination must be immediately stopped. Refer to Training Standardization Job Task Sheet for additional guidance. A detailed explanation of observed issues that surface during a chaperoned examination will be postponed until after the examination has been stopped and the applicant is fully clothed.

f. Chaperones are not required during interviews conducted while the applicant is fully dressed.

Note: Chaperones are required for all medical providers who interact with applicants until satisfactory completion of security clearances.

3-8. Uncooperative or Disruptive Applicants

If an applicant is uncooperative or disruptive, the Medical NCOIC/SUP MT or CMO will counsel the applicant on their inappropriate behavior and a decision made as to whether or not the applicant will continue processing. If the applicant’s processing is discontinued, the applicant will be placed in an ‘N’ status and escorted to the MEPS Operations Officer. The Medical NCOIC/SUP MT or CMO will ensure the PULHES reflects an open profile and the incident is documented on the DD Form 2808 item 78 (e.g. uncooperative or disruptive) and then further explanation/information in item 88. Refer to UMR 601-23 for additional guidance. Note: Discontinuation of processing these applicants are not considered BAT/DAT/HIV refusals.

3-9. Deferring of the Medical Examination Prior to Completion

a. The MEPS medical examination begins once the applicant has been properly checked into the medical department. The MEPS medical examination, once started, should be followed through to completion unless the applicant wishes to discontinue processing of their own accord. The CMO, ACMO, or FB-CMO is authorized to defer an applicant’s processing if:

(1) The applicant appears to be ill with a communicable disease.

(2) There is a significant discrepancy between prescreen (DD Form 2807-2) and medical history (DD Form 2807-1).

(3) The applicant appears to be under the influence of drugs or alcohol.
(4) The applicant has had a physical examination at another MEPS and original records are not present.

(5) The applicant does not comprehend English well enough to complete processing requirements.

(6) The applicant is attempting to process under false pretenses (e.g. special contact lenses to pass color vision testing, etc.).

(7) Medical records must be submitted in order to determine whether an applicant can safely continue medical processing.

(8) The applicant has a positive HCG test result.

(9) The MEPS medical provider contacts J-7/MEMD concerning a unique situation and approval is provided by the J-7/MEMD Director or his/her designated representative.

**Note:** In all instances of an applicant being deferred the applicant will be placed in USMIRS with an “N” status code of “P2” along with an explanation of medical discrepancy. The applicant’s profile will be in an “open” status. Any medical tests that have been completed by the applicant will have the results entered into USMIRS and any required fields that have not been completed must be filled in with “9”s (999 for weight, 99.00 for height, 90 for hearing, etc.). Medical documents will be kept in the medical packet and maintained in the files room.

b. Once the exam is deferred, the CMO/ACMO/FB-CMO will determine which parts of the exam can still be completed.

c. Any discontinuation of processing needs to be documented on the DD Form 2808 item 88 and the MEPS Commanding Officer informed.

### 3-10. Access to the MEPS Medical Department

a. Under no circumstances will recruiters be allowed in the medical department when applicants are being processed.

b. Each MEPS local SOP will determine when Service Liaisons and other non-medical personnel may enter the medical department when no applicants are present (i.e., to submit medical prescreens, medical reviews, applicant waiver issues, address MEPS administrative issues, etc.). Consideration must be given to allow the medical department to complete medical processing uninterrupted.

c. Non-medical personnel serving in MEPS leadership positions are expected to visit and observe operations within the medical department, to include examination areas where both open activities (e.g., hearing, vision, laboratory, etc.) and private aspects of examination are conducted. In order to maintain appropriate consideration for applicant privacy and consent, the following provisions are provided as specific guidance:
(1) For the purposes of this policy, MEPS leadership is defined as the MEPS Commander and other respective members of higher command (Battalion, Sector, HQ USMEPCOM) and their deputies.

(2) Consent of all applicants is required for any non-medical personnel serving in MEPS leadership positions to enter and observe activities in any area within the medical department where medical information is discussed and/or elements of an examination are performed (whether in a state of undress or not).

(3) Non-medical personnel serving in MEPS leadership positions will be allowed to observe applicants of any sex during private aspects of the medical examination when applicants are fully dressed, specifically the medical history interview.

(4) Non-medical personnel serving in MEPS leadership positions will be allowed to observe applicants of the same sex when applicants are partially undressed, specifically the ortho-neuro examination and can observe opposite sex applicants only with the explicit approval, in writing (email for example), from the applicable Sector Commander each time observation of opposite sex applicants occurs. MEPS leadership granted approval must report back to the Sector Commander in writing after each observation of opposite sex applicants occurs.

(5) Non-medical personnel serving in MEPS leadership positions will not be allowed to observe applicants of the opposite sex during private aspects of the medical examination when applicants are in a state of undress, specifically the general physical examination and male/female genitourinary (GU) exams. Same sex is allowed.

(6) Training requirements for non-medical personnel serving in MEPS leadership positions to be able to observe private aspects of medical processing include the following:

(a) Chaperone Training. Non-medical personnel serving in MEPS leadership positions must complete the Chaperone Training module and maintain current training competencies prior to being permitted to observe private aspects of the physical examination. The purpose of this is to ensure a minimum basic understanding of the roles and responsibilities of personnel serving as chaperones in this environment. Completion of this training also enables the individual to serve the capacity of a chaperone, if called upon to do so, in accordance with the USMEPCOM chaperone policy. However, completion of training does not imply agreement to serve in the capacity of a chaperone.

(b) Health Insurance Portability and Accountability Act (HIPAA) Training. For non-medical staff, the HIPAA and Privacy Act Training (DHA—US001) available through Joint Knowledge Online (JKO) is sufficient to meet this requirement.

(7) Observation of sensitive aspects of the physical exam is permissible by same-sex non-medical personnel serving in MEPS leadership positions when all of the following conditions are met:

(a) The applicant has provided his or her consent to allow nonmedical personnel to be present in the exam area to observe that aspect of the examination being conducted. Verbal consent is permissible; however, written documentation of this consent is encouraged (Enter "Applicant consents to Non-Medical MEPS Leadership observing history and/or examination" in Block 88 of DD Form 2808. For the purposes of this regulation, consent will include the following, as a minimum:
1. Identification, by name, rank, and position, of the non-medical personnel serving in a MEPS leadership position who desire to observe the medical activity;

2. Acknowledgement of the main purpose for this observation, that it is intended to serve as a quality control tool for management to improve medical processing at the MEPS, and that this observer will not be participating or assisting in any manner with their medical examination (except if as a chaperone);

3. Understanding of the potential benefits to the applicant as a result of their agreeing to a non-medical observer during their private examination, such as helping to improve the quality and consistency of medical processing during their exam and for all applicants;

4. Disclosure that the non-medical personnel observing the medical activity has completed, and maintains currency of, required training regarding the protection of sensitive and personal health information;

5. Explanation of what aspects of the examination are to be observed, such as observing the conduct of the ortho-neuro exam, or observing the physician take the applicant’s medical history;

6. Understanding of the requirement for non-disclosure regarding anything that may be seen or heard during the observation period by the non-medical observer except for mission-required reasons as part of their official duties;

7. Agreement that consenting to or not consenting to a non-medical member of the MEPS leadership being allowed to observe their examination will have absolutely no bearing on whether or not they will be found qualified for service;

8. Agreement that the applicant can withdraw their consent at any time during the conduct of their examination without any repercussion, by simply indicating to their attending provider that they no longer agree to their examination being observed;

(b) Non-medical personnel serving in MEPS leadership positions observing private aspects of physical examination may not ask questions or engage with the applicant in a state of undress, except when also serving in the capacity of a chaperone, and then only in conjunction with that which is required of this duty. Observers may move freely within the exam areas, as space and circumstances allow, with care to not interfere with the conduct of the examinations.

Note: Talking to the applicants and asking questions afterwards is permissible within the medical department, but must be done outside the exam areas and only when the applicant is dressed, preferably in the common waiting area. Care should be taken to ensure that any discussions are not overheard by other applicants.

(8) If the attending medical provider (e.g., CMO, ACMO, FBP) has specific concerns regarding the inappropriateness of observation of sensitive examinations by non-medical personnel not involved with a specific applicant's case, he or she may raise these concerns to the chain of command. While it is understood that MEPS leadership does not need the CMO's permission to observe activities as described in this regulation, careful consideration of the risks and benefits with respect to a specific applicant’s situation should be made before proceeding.
(9) The above guidance promotes collaboration between the medical departments and MEPS leadership and improves situational awareness of medical operations among the entire team. While this policy covers the most likely situations encountered, not all scenarios have been specifically addressed (e.g., VIP visits, visiting providers, medical students, etc.). Thus, any request for deviation from this guidance must be submitted through the MOC ticket and J-7/MEMD for review and approval by the USMEPCOM Commander.

Note: USMEPCOM Inspector General Medical Inspectors and J-7/MEMD physicians, nurse practitioners, and medical management analysts are all considered medical personnel who can access the MEPS Medical Departments. Although there is a general intent to allow the medical department to complete medical processing uninterrupted, the above policies are not intended to preclude reasonable access to the MEPS medical department by MEPS nonmedical personnel such as the MEPS Operations Officer collaborating with the medical department to ensure effective applicant processing flow between the Operations Group and medical department, MEPS Operations Officer working e-Security program areas, MEPS information technology (IT) specialist working an IT issue, etc.

3-11. Medical Exception to Policy (ETP)
Any medical processing and procedures that fall outside of USMEPCOM regulatory guidance require submission of an ETP. Obtaining a medical ETP requires the MEPS Commander to submit a request to J-7/MEMD through the appropriate Chain of Command. All Medical ETPs will be reviewed by J-7/MEMD and must be signed by the USMEPCOM Director or his/her designated representative. Approved medical ETPs will be maintained at the MEPS and a copy will be maintained at USMEPCOM J-7/MEMD. A template for requesting medical ETPs can be found on SPEAR.

3-12. Undergarments/Body Piercing

a. Applicants undergoing any medical services associated with the USMEPCOM Medical Qualification Program (e.g. medical examination, medical inspection, etc.) will be required to wear undergarments (brief or boxers for males and brassieres/sports bras and underpants for females).

b. The applicant’s Service is responsible for informing the applicant of proper undergarments to be worn. Males/females are not authorized to wear compression shorts, thongs, bathing suits, etc. The applicants are required to have all piercings and gauges of any type removed prior to processing through the MEPS medical department. If the applicant has a piercing that cannot be removed, the Service Liaison will be informed by the MEPS medical department that processing of this applicant is on hold until the removal of piercing.

c. If the applicant does not have the appropriate undergarments, the Service Liaison will be informed by the MEPS medical department of the situation. The MEPS medical department may complete all portions of the physical examination with the exception of the height/weight and Ortho/Neuro portions. The provider will annotate the applicant's PULHES accordingly, and the applicant’s medical data will be entered into USMIRS.

3-13. Photographing Medical Conditions
No photographing of medical conditions is permitted. If the applicant’s medical condition is sufficiently documented and legible, then photographic documentation is not necessary.
3-14. X-rays and Radiology Reports
Radiology reports are kept inside the applicant’s medical packet until the applicant ships or the packet is destroyed IAW UMR 601-23. Radiology reports are included in the applicant’s shipping packet and sent with the applicant to the basic training site. Actual film X-rays and/or CD will be returned to the applicant. If this cannot be accomplished keep x-rays/CD’s in the Medical Department under RN 40-66z/500C, “Entrance and Separation X-Ray Films” (see Appendix A, Section III), for 2 years, then destroy.

3-15. Medical Packet Assembly

Applicant packet will be assembled IAW Figure 3-2. There is a Medical Record Quality Check Training Standardization Job Task Sheet that accompanies this packet assembly that can be found on the SPEAR J-7/MEMD.

Figure 3-2. Applicant Packet Assembly
3-16. Freedom of Information Act (FOIA)

a. MEPS personnel are reminded of the requirement to reasonably safeguard PII to prevent inadvertent, unauthorized, or malicious disclosure of packet content in either paper or electronic format during processing, storage, transmission, and disposal. If an applicant requests a copy of his/her packet, he or she will be directed to the designated MEPS FOIA Officer.

Release requests of applicant information collected during MEPS processing, including applicant medical records, is governed by the Freedom of Information Act (FOIA) and the Privacy Act (PA). Generally, an applicant is entitled upon written request to obtain a copy of his own MEPS processing file. However, because these information requests involve protected information, the MEPS should not immediately release the information to the requestor without first coordinating the request through the appropriate official(s). Records containing sensitive medical data may only be released by the USMEPCOM PA/FOIA Program Manager after consultation with J-7/MEMD. Sensitive medical data for this purpose is defined as psychiatric consults, positive/indeterminate HIV test results, or other data which, if released directly to the applicant, might have an adverse effect on that person’s mental or physical health.

b. If an applicant appears personally at a MEPS and requests a copy of his/her record, the designated MEPS FOIA Officer should ask the applicant to put his request in writing. The request should contain the applicant’s name, SSN, a contact address and telephone number, and the applicant’s signature. The MEPS FOIA officer will review the applicant’s record. If the record does not contain sensitive medical data, the MEPS FOIA officer may provide the applicant a photocopy of his/her record. If the applicant’s record does contain sensitive medical data, the MEPS FOIA Officer will then send the applicant’s request and a copy of the record to the USMEPCOM PA/FOIA Program Manager for a release determination.

c. All requests for applicant records made by third parties, including the parent or spouse of an applicant, must be submitted in writing. The MEPS should forward any written requests for records, along with a copy of the requested record (or a note that the record no longer exists) to the USMEPCOM PA/FOIA Program Manager for a release determination.

Note: Under no circumstances will the MEPS medical department ever give the original medical packet to the applicant under a FOIA request.

3-17. Medical Data Retention

All medical data pertaining to an applicant shall be retained in the applicant’s USMIRS record IAW UMR 601-23.
Chapter 4
Medical Check-in

4-1. Applicant Medical Check-in

    a. The medical staff is required to biometrically check applicants in and out of the MEPS medical
department using USMIRS and e-Security IAW UMR 601-23. In the event that e-Security is not available,
the MEPS medical department will still be required to check applicants in and out by verifying that a signed
UMF 680-3A-E is present. All applicants must have name tags.

    b. Applicant packet will be reviewed for the following documentation upon check-in:

       (1) UMF 680-3A-E

       (2) Completed and reviewed DD Form 2807-2 (with applicable medical documentation). The
parental consent in Section V must be signed if the applicant is a minor.

       (3) DD Form 1966/5 (if applicable). The parental consent in Section VIII must be signed if the
applicant is a minor.

       (4) Prior Service Documentation (when applicable).

    c. In USMIRS, validate applicant social security number and ensure all “N” statuses are cleared.

    d. To ensure the efficiency of the medical check-in process, the applicant must be sent to the
Operations control desk for evaluation and resolution of any issues.

Note: Applicants with “N” statuses in USMIRS caused by e-Security partial enrollments are acceptable for
processing.

4-2. Front Loading
Front loading refers to medical tests that are authorized to be performed before the Medical Brief but are
not authorized during “night” aptitude testing timeframes.

The following tests may be done before the Medical Brief:

    a. Blood Pressure/Pulse
    b. Vision
    c. Hearing
    d. Preliminary check for cerumen (ear wax)
Chapter 5
Medical Brief

5-1. Medical Brief

a. The medical brief is used to inform and instruct the applicant and to assist them in the completion of required medical documentation (DD Form 2005, DD Form 2807-1, DD Form 2808, UMF 40-8-1-E, USMEPCOM Form (UMF) 40-1-15-1-E and Standard Form (SF) 507 Medical Record. A copy of the most current standardized medical brief is available on SPEAR in the medical brief section.

b. A provider, medical technician, or non-medical personnel who has documented training will give the brief in English only. If a non-medical staff member gives the medical brief, a medical department staff member must be available to answer applicant questions. The briefer must follow the standardized medical brief verbatim and can use the medical brief script document on SPEAR in the medical brief section to assist in this. The MEPS Medical Department will print the medical brief slides and the audio script document and have on hand in a binder for use in case the MEPS have to brief the applicants manually.

c. The medical briefer will be responsible for conducting the brief and ensuring that the applicants have a clear understanding of the content of the forms they are reviewing and filling out. The briefer can also have other medical personnel present to circulate and assist. The MEPS medical briefers are authorized to verbally add to the slides as long as the mandatory information is read and/or played. Applicants must remain in the medical briefing room until all forms are completed.

d. The following forms, provided by the MEPS medical department, may be completed by the applicant while waiting for the medical brief to begin. The medical staff is responsible for identifying the forms, instructing the applicants how to complete each form, explaining to read/fill out/sign/date each form, as applicable, and ensuring all applicant questions have been answered.

(1) DD Form 2005 Privacy Act Statement: Each applicant must read this form must be read in its entirety and then sign and date by each applicant.

(2) Male/Female Physical Exam Information Sheet: This information sheet must be read in its entirety by each applicant. The medical staff will be responsible for explaining to the applicant that he/she will date, print, and sign his/her name on the top three lines of the Consent Stamp in block 73 of DD Form 2808 after reading.

(3) UMF 40-1-15-1-E Medical History Provider Interview (MHPI): The applicant must fill out Sections 1-7 (front side of the form) and is authorized to fill out the proper MEPS code on the back side of the form. The medical staff is responsible for explaining to the applicant how to properly fill out the form in pencil and give instructions on how to transcribe “yes” answers to the DD Form 2807-1.

(4) UMF 40-8-1-E Drug/Alcohol and HIV Acknowledgement: This form must be read in its entirety and then signed and dated by each applicant before the conduction of the Breath Alcohol Test (BAT).

(5) UMF 40-1-18 Tattoos/Brands/Piercing/Ear Gauging/Scars/Birthmarks: This form may be filled out in its entirety by the applicant if approved by the CMO. The form will be signed and dated by the examining provider during the medical history interview. see Paragraph 11-1(14)d for use of UMF 40-1-18 in conjunction with the DD Form 2808.
e. The Breath Alcohol Test is performed immediately after the medical briefing. The breath alcohol test will be accomplished using the prescribed procedures in UMR 40-8.

f. MEPS personnel will not discuss an applicant’s medical history in the public medical briefing setting. If an applicant has questions that are not of a general nature for all applicants, MEPS personnel will discuss the applicant’s personal medical history in a private setting where other applicants will not overhear the discussion.

g. The front side of UMF 40-1-15-1-E must be reviewed for completeness by a medical technician before the applicant continues medical processing.
Chapter 6
Hearing and Cerumen Removal

6-1. Hearing Testing Procedures

a. Hearing tests will be conducted in an environment that is as quiet as possible. The environment will be readily accessible and away from outside walls, elevators, heating and plumbing noises, waiting rooms, and noisy hallways. Procedures on how to accomplish the audiogram program can be found in the Training Standardization Job Task Sheets on SPEAR (J-1/MEHR Training Development Division under Training Standardization Job Task Sheets).

b. The information that will be entered into the audiometer will include:

(1) Applicant name (last then first)

(2) Last four digits of applicant SSN

c. Eyeglasses, piercings, and hearing aids will be removed before testing. Ensure the applicant understands the test and required responses. Advise applicants that job selection may be dependent on the results of this test. Only MEPS audiograms are acceptable for enlistment.

d. Trained technicians must review audiograms to ensure their validity and proper recordkeeping requirements are met.

e. The results at 500, 1000, 2000, 3000, 4000, and 6000 cycles per second will be recorded on DD Form 2808, item 71a (and 71b, if failed first hearing test). The 1khz test is the same as the 1000 Hz test. Record the lesser number of the 1khz/1kt result for all tests (baseline weekly calibrations and applicant tests) for all MEPS using the HT Wizard audiometers. The entire unit serial number and date the unit was calibrated must also be recorded in item 71a (and 71b, if failed first hearing test).

f. A repeat audiogram test, if indicated, will be performed on a different audiometer. Repeat hearing tests for additional job opportunities are not authorized.

g. The hearing testing at the MEPS adheres to strict military accession standards and, once complete, is the hearing screening of record. Applicant-provided hearing testing conducted outside the MEPS, after initial MEPS hearing testing, may not be used to refute any MEPS hearing testing results.

Note: A medical technician will observe the applicant during repeat audiogram tests to ensure applicant with unilateral hearing loss does not switch the audiometer headphones or the left and right headphone jacks.

6-2. Repeat Audiograms – Ears Normal on Examination

a. If the initial audiogram is H3, the MEPS audiogram may be repeated the same day and once more after at least 48 hours. The applicant must be advised to avoid exposure to loud noise during the 48 hour rest period. Document this advice on the DD Form 2808.

b. After the audiogram has been repeated, use the best audiogram result to profile the applicant’s hearing.
c. If the applicant is returning on a different date from the initial MEPS exam for audiometry retest, enter a 3T in the H section of the “PULHES” for USMIRS and enter an RJ date corresponding to the advised rest period and/or ear trauma. If DD Form 2808 items 71a and 71b are full, any subsequent audiometry results will be recorded in item 73 or on SF 507.

6-3. Repeat Audiograms – Post Cerumen Removal

a. If the audiometer code is not H1, the audiogram may be repeated the same day after the ear cleaning. If the second audiogram is H1, profile the applicant as H1.

b. If the second audiogram is H3, the MEPS audiogram will be repeated once more after at least 48 hours. The applicant must be advised to avoid exposure to loud noise during the 48 hour rest period. Document this advice on the DD Form 2808.

c. After the audiogram has been repeated, use the best audiogram result to profile the applicant’s hearing.

d. If the applicant is returning on a different date from the initial MEPS exam for audiometry retest, enter a 3T in the H section of the “PULHES” for USMIRS and enter an RJ date corresponding to the advised rest period and/or ear trauma. If DD Form 2808 items 71a and 71b are full, any subsequent audiometry results will be recorded in item 73 or on SF 507.

6-4. Profiling Hearing

When properly calibrated, the audiometer used at the MEPS automatically determines and prints out a hearing profile.

For applicants who come under accession standards:

a. The hearing profile is H1 if:

The average hearing loss for each ear is not more than 30 db on the average at 500, 1000, and 2000 Hz; there is not a hearing loss in either ear more than 35 db at 500, 1000, and 2000 Hz; the hearing loss is not greater than 45 db at 3000 Hz in either ear; and the hearing loss is not greater than 55 db at 4000 Hz in either ear.

b. Profile as H3 as defined in the DoDI 6130.03. An H3 profile is considered disqualifying.

6-5. Cerumen Removal

a. Each MEPS shall develop and maintain a protocol for cerumen removal from applicants whose ear wax prevents adequate examination of the external ear canal and at least 2/3 of the tympanic membrane in accordance with the current version of DoDI 6130.03. The need for cerumen removal is left to the discretion of the examining provider. Before cerumen removal is attempted, the provider shall ensure that the MEPCOM SF 600 Ear Wax Removal Consent Form is completed for each applicant. The original SF 600 is to be kept with the DD Form 2808. A copy is to be maintained in a medical administrative file for two years.
b. Cerumen removal protocol will include these authorized four methods either alone or in combination, at the discretion of the CMO:

(1) Manual lavage with bulb syringe (or similar technique) (provider or technician)

(2) Direct external canal curettage (provider only)

(3) Debrox or hydrogen peroxide/water solution (50/50) (provider or technician)

(4) Welch-Allyn Ear Wash System (WEWS) (provider or technician)

c. MEPS medical staff can only perform ear cleaning when a certified (trained in cerumen removal) medical provider is present at the MEPS location. The CMO and Medical NCOIC/SUP MT shall be responsible for the cerumen removal program and for ensuring that all personnel involved in executing the MEPS cerumen removal protocol comply with all training, operation, and maintenance (UMF 40-1-16-E, WEWS Cleaning and Maintenance Log) guidance found on SPEAR in the cerumen removal section. If attempted techniques for cerumen removal are unsuccessful, the examining provider may refer applicants for cerumen removal.

d. If the applicant does not tolerate the procedure, or a medical complication results, or a contraindication is recognized that precludes continuation of the procedure, the applicant may then be referred outside the MEPS for cerumen removal. If procedure is discontinued due to a medical complication, refer applicant to a MEPS provider immediately who will decide if applicant needs to be referred to local emergency care IAW with MEPS Post-procedure Evaluation Plan.

e. In the event that a MEPS wishes to use medical equipment other than the equipment listed above for cerumen removal, the CMO (or MEPS Commander, for MEPS without a CMO) shall submit cost and safety data for the specified equipment to the appropriate J-7/MEMD Battalion Support Accession Medicine Branch Chief for study and approval prior to any purchase or use, and shall specify alternative means of cerumen removal to be used until and unless the specified durable or powered alternative is approved.
Chapter 7
Vision

7-1. Vision Screening

All applicants that are taking an accession medical examination will have a vision screening done at the MEPS performed by trained MEPS medical department personnel. The vision screening consists of several mandatory, service specific, and job specific vision tests. MEPS medical departments must be familiar with all vision tests and how they apply to the applicants based on the service for which they are processing. The medical staff must be familiar with all equipment associated with vision screening, and the proper preventive maintenance and cleaning procedures per the guidelines in this regulation and the manufacturer’s instructions. All vision screenings will be performed with the room lights on.

a. **Prescreen** - Applicants that wear corrective lenses (glasses or contacts) must indicate this on the DD Form 2807-2. If available, copies of most recent optometry/ophthalmology records may be submitted with the prescreen.

b. **Initial Physical** - Applicants that wear corrective lenses must bring them in for their examination (glasses are preferred due to ease of taking on/off during the vision screening). If the applicant wears corrective lenses, he/she will indicate this in item 11f and 29 of the DD Form 2807-1 during the medical brief. The medical staff will indicate the applicant’s eye color in item 60b and if they wear corrective lenses (glasses or contact lenses) in item 73. Medical staff will also indicate if the applicant wears corrective lenses but did not bring them in block 73 with any follow on instructions if applicable (e.g., applicant could not complete heterophoria testing due to not having corrective lenses). The provider will address the reason for any corrective lenses worn by the applicant in item 88.

**Note:** The vision testing at the MEPS adheres to strict military accession standards and, once complete, is the vision screening of record. Applicant-provided vision testing conducted outside the MEPS, after initial MEPS vision testing, may not be used to refute any MEPS vision testing results.

7-2. Screening for Undisclosed Contact Lenses and Color Correcting Contact Lenses

Color corrective contact lens/glasses are marketed (trade names Color Max, Color View, Chroma Gen, Color lite) to color blind people as an aid to “passing” military and civilian color vision tests. The lenses filter colors so that the applicant can see the Pseudoisochromatic Plates (PiP) dot patterns. These lenses are only developed to allow an individual to “pass” a color vision test but they do not give the wearer the ability to discriminate normal colors and do not correct the underlying colorblindness. There is no treatment or cure for colorblindness.

a. Before medical technicians conduct any vision testing, they must ask each applicant if he/she wears corrective lenses.

b. The medical technician will then screen all applicants for the presence of contact lenses by shining a pen light into the applicant’s eyes. **If the edge of a lens is seen overlying the sclera, then the applicant must remove it before vision testing.**

c. In all cases, observe the removed contact lenses for tint.

(1) Designer tinted contacts give the wearer the eye color of their choosing, and has a colored outer area that aligns with the iris and a central colorless area to align with the pupil. These types of contact lenses will not alter color vision testing results. Processing may continue with these designer lenses in
place but medical technicians will ensure the eye color recorded for the applicant matches the actual color of the iris and not the designer color of the lens.

(2) Color correcting lenses are different from designer lenses in that they have a central area of tint to align with the pupil. An example of these lenses can be found on SPEAR.

d. If a medical technician identifies an applicant attempting to “pass” vision tests by not disclosing contact lenses or by using color corrective lenses, medical processing will be stopped, the physical will be discontinued by the CMO (Open Profile), and the applicant will be placed in an “N” status with a no MEPS processing status of six months.

e. The MEPS Commander or his/her designee will submit a STARNet report for medical irregularity.

7-3. Color Vision Testing
Color vision testing the at the MEPS consists of administration of the Pseudoisochromatic Plates (PiP) test, with additional administration of the Farnsworth Lantern color perception test (FALANT) on the OPTEC 900 and the Army Red/Green test if necessary. All applicants testing for color vision are given the PiP color vision test first. All applicants (except all Air Force components) who FAIL the PiP test are given the Farnsworth Lantern Test (FALANT) on the OPTEC 900. All Army applicants from ALL components, who FAIL the FALANT are then given the Army Red/Green test. If the applicant passes one color vision test, then the subsequent tests will not be conducted (for example, if an Army applicant passes the FALANT, do not test them with the Army Red/Green test).

a. When conducting the PiP color vision test, the applicant will be tested 30 inches from the PiP book with the room lights on and the book placed on a Richmond Light Color Perception stand. Applicant will be tested with corrective lenses if applicable.

b. Instruct the applicant to read the number aloud. The applicant is not allowed to touch the test plates. Each of the 14 plates will be displayed for a maximum of THREE seconds before the plate is turned. The applicant will be shown the demonstration plate number “16” first. The demonstration plate does not count towards the actual test. If an incorrect response is given DO NOT provide the correct answer. Continue the PiP test by showing the remaining 14 plates. If the applicant answers with a number, whether incorrect or correct the plate can be turned. If the applicant does not answer before three seconds has expired, the plate will be turned. Hesitation or not answering is an indication of a color vision deficiency.

c. All applicants must correctly identify 12 of the 14 PiP plates to pass. Three or more incorrect responses in reading the test plates is considered a failure. This includes failure to respond to the displayed plate within 3 seconds.

d. The results will be recorded as “PASS” or “FAIL” followed by the number missed over the total number of test plates in block 66 of the DD Form 2808 (EXAMPLE: “PASS 2/14” or “FAIL 3/14”). Also, P or F must be entered in USMIRS.

Note: If the applicant wears corrective lenses and does not have them, attempt to give him/her the PiP test. If he/she cannot identify the PiP plates, do not fail the applicant. Annotate in item 73 that applicant did not have corrective lenses and must bring them in to complete PiP test. Discontinue ALL color vision testing until the applicant returns with corrective lenses.
e. DO NOT use any type of writing instrument to turn the plates in order to eliminate stray marks that may draw attention to the number that needs to be read by the applicant. DO NOT touch the white space or color dots. This will eliminate oil smudges on the book. Due to the tendency of fading and to extend the life of the PiP book(s), they must remain closed unless an applicant is being tested. When plates/books become unserviceable, they must be replaced.

f. Upon completion of daily color vision testing, the MEPS will reshuffle the PiP test plates at least once, with the exception of the demonstration template "16". The plates can be shuffled any time after color vision processing has ended, but before the start of color vision testing the next day. If the MEPS suspect memorization of the plate order by applicant(s), the plates can be reshuffled at any time during color vision testing.

g. All applicants who fail the PiP test, must be given the FALANT using the OPTEC 900 (except all Air Force components).

   (1) Applicants will be tested one time, with corrective lenses on (if applicable). Applicants will be positioned 8 feet from the OPTEC 900 and may be either standing or seated. The room lights will be on.

   (2) Read the FALANT test instructions found on the side panel of the OPTEC 900 to the applicant. (Example: The lights you will see are red, green, or white. They look like traffic signal lights at a distance. Two lights are shown at a time in any combination of colors. Call out the colors you see, naming first the color at the top and then the color at the bottom. Remember, there are only three colors: red, green, and white and name the top one first.)

   (3) Press the black rocker switch at the top of the instrument to change test targets: FWD moves the target to the next higher number; REV moves the target to the next lower number. Press the BLUE button to expose the target lights to the test subject. Pressing this button momentarily will expose the target for the required TWO seconds. If a longer exposure time is desired for demonstration purposes, for instance, this button may be held down to expose the target for any length of time.

   (4) Expose the targets in random order, but you must start with target numbers 1 or 5 (Red/Green or Green/Red combination). Continue exposing targets until all nine combinations have been exposed.

   (5) If no errors are made on the first run of the nine targets, the test is passed. If any errors are made on the first run, the test results will not be counted and two more complete runs will be administered.

   (6) Average the errors of these two additional runs. If the subject has an average of more than one error per run, the test is failed. If the subject has an average of one error or less, the test is passed.

   (7) An error is considered the miscalling of one or both of the test light pairs. If a response is changed by the subject before the next target is presented, record the second response only. If a test subject responds with "yellow", etc., remind the applicant once that there are only three colors (red, green, and white). If a test subject takes a long time to respond, remind the applicant once to call the light colors as soon as s/he sees them.

   (8) The FALANT results will be recorded in item 73 on the DD Form 2808 and in USMIRS.
(a) In item 73, record the test using the standard FALANT scoring template. A standard stamp will be utilized based on Figure 7-1 below.

(b) Write a plus mark (+) in the appropriate box when the response is correct; write a minus mark (-) in the appropriate box when it is incorrect. At the end of the trial(s), indicate how many total errors in the appropriate ERRORS box by annotating a minus sign with number missed (e.g. -2). If the applicant made no errors you will still annotate -0 in the appropriate ERRORS box.

(c) Take the average number of errors missed in trials 2 and 3 by annotating a minus sign with the overall average on the AVERAGE FOR TRIALS 2 & 3 line (e.g. -3). If the applicant passed trial 1, lines 2 and 3 will be left blank.

**Note:** To calculate the proper average take the two ERRORS number(s) from trials 2 and 3 and add them together and then divide by 2 (the number of trials).

**EXAMPLE.** Applicant has -2 in the trial 2 ERRORS box and has -1 in the trial 3 ERRORS box. 2 + 1 = 3. 3/2 = 1.5. Annotate -1.5 on the AVERAGE FOR TRIALS 2 & 3 line.

(d) In all cases of FALANT testing, indicate the results of the test by annotating a checkmark on the PASS or FAIL line.

![FALANT:](image)

**Figure 7-1. FALANT Scoring Template (Stamp)**

h. All Army, Army Reserve and Army Guard, who fail the PiP test AND the FALANT will then be given further color vision testing using the Army RED/GREEN test. The Army RED/GREEN test consists of twelve plates that are broken down as 6 black plates, 3 red plates and 3 green plates. The Army Red/Green plates will be placed in the same book as the PiP plates.

(1) The applicant will be tested 30 inches from the Army Red/Green plates with the room lights on and the book placed on a Richmond Light Color Perception stand. Applicant will be tested with glasses on or contacts in.

(2) Each of the twelve plates will be shown for a maximum of THREE seconds. Instruct the applicant to “Please read the colors aloud.” The applicant is not allowed to touch the test plates.

(a) First show the applicant two demonstration plates, one black and one colored. The first plate must be a black plate. The next plate must be a colored plate (either red or green). These two plates do not count towards the actual test. If an incorrect response is given by the applicant, DO NOT provide the correct answer and start the actual test.
(b) After completion of the demonstration plates, begin the actual Red/Green test. The applicant must be shown the remaining 10 plates (5 black and 5 colored). The applicant must respond with the color shown (black, red, or green) within the THREE second time limit.

(c) The applicant must respond correctly to all five of the red and green plates to pass the test. One miss equals failure.

(d) The MEPS staff member may change the order of the six color plates when the PiP plates are shuffled. There must always be a black plate between each of the red or green plates.

(3) The Army Red/Green Test results will be recorded as “PASS” or “FAIL” in item 59 on the DD Form 2808 and in USMIRS.

i. The MEPS are not authorized to request consults for further color vision testing.

7-4. Depth Perception Testing
Depth Perception testing will be conducted for job classification. The MEPS Medical Department will administer the Depth Perception test on the OPTEC 2300 for all Navy and Air Force applicants (from all components) during the conduction of the initial physical vision processing. Army, Marine Corps, and Coast Guard applicants will be tested for depth perception after determination of job classification (MOS/NEC) which requires depth perception capability. The Depth Perception test will only be performed once.

a. The Depth Perception test utilized at the MEPS with the OPTEC 2300 is a difficult test to give and interpret correctly even in cases where the applicant has normal vision and has interpreted other Depth Perception tests correctly. Even complete failure on this test is not necessarily indicative of poor depth perception. In order to reduce to a minimum the number of “false failures,” the examiner should not hurry through the demonstration and practice period which precede the actual test.

b. To explain the test, the applicant will first be told that the test is difficult but there is no time limit to complete the test, so the applicant should not hurry. To help explain the test, the applicant will be shown a demonstration device consisting of a plastic plate with five circles. As in the depth perception test itself, one circle appears nearer than the other four. After the plastic demonstration model of the test has been shown, the applicant is told to look into the OPTEC 2300 and focus on group A, the three rows of circles in the upper left corner of the square.

(1) Group A will be used to further explain the test and allow adequate time for the perception of depth to develop. The top row of five circles in group A demonstrates a relatively large difference in depth, the middle row a moderate difference, and the bottom row a small difference. Some applicants may not see any depth for the first minute or so. In such cases, do not hurry through the practice test.

(2) You may tell the correct answers to the three rows of group A and instruct the applicant to look at each circle in turn until the applicant can see that one of the five circles in each row is nearer than the others.

(3) The examiner may demonstrate the difference between monocular (one-eyed) vision and binocular (two-eyed) vision by using an occlude or have the applicant close or cover one eye or showing the demonstration Group A row with one Eye Test indicator button pressed in the OFF position and the other Eye Test indicator button pressed in the ON position. This demonstration will show that with one-
eyed vision, all the circles appear in the same plane, while with two-eyed vision, one may appear nearer than the other four. This demonstration may help the applicant better understand the depth perception test. When you are satisfied that the applicant actually sees depth in AT LEAST the top row of group A, proceed to the actual test. This will be given without any help or hints used in the practice period. The applicant will take the test with both eyes open and corrective lenses on if applicable. The testing procedures are as follows:

(a) The applicant will be asked to indicate by number, counting from left to right, which circle is nearer in the top, the middle, and the bottom rows of group B. If all three answers are correct, the same questions will be asked for group C, group D, etc.

(b) The test will be discontinued when the applicant gives one incorrect answer in any one line beyond group A, with one exception: If one incorrect answer is given in group B, repeat the practice session with group A, then have the applicant try group B again. If correct answers are now given in B, the test will continue. If the applicant cannot get past group B a second time, the test will be discontinued and graded as “Failed B”.

(4) Test score and recording: Medical technicians will annotate the results of the last correct completed group with all correct responses as: Passed B, Passed C, Passed D, Passed E, or Passed F. If applicant is unable to complete group B after a repeat practice session then annotate block 67 as Failed B. The results are entered on DD Form 2808. If glasses or contact lenses are not worn, enter the score on DD Form 2808, item 67, in the block titled “Uncorrected”. If glasses or contact lenses are worn, enter the score in item section titled “Corrected”.

Note: If the applicant wears corrective lenses and does not have them, attempt to give him/her the depth perception test. If he/she cannot successfully pass Group B, do not fail the applicant. Annotate in item 73 that applicant did not have corrective lenses and must bring them in to complete depth perception test.

7-5. Visual Acuity Testing
All applicants will have their uncorrected distant and near visual acuities tested using the OPTEC 2300 in a room with the lights on. If needed, their specific refraction will be determined by the use of the auto-refractor. The auto-refractor will be connected to an Uninterrupted Power Supply with surge protection.

a. Uncorrected visual acuities will be determined with the OPTEC 2300 and with the applicant’s corrective lenses removed.

(1) For both distant and near visual acuities, the applicant must be able to read the largest letters in the OPTEC 2300 (20/400 line). An applicant may miss no more than one on the first line of the OPTEC 2300 (20/400) and no more than three per line for all other lines in order to pass that line. If the applicant cannot pass the first line of the OPTEC 2300, test the applicant for finger count by holding up fingers 1 meter from the applicant’s eyes. If the applicant can correctly answer the number of fingers held up, record the vision as 20/FC (finger count). If the applicant fails the finger count but perceives light, the result will be recorded as 20/LP (light perception).

(2) Express vision testing results in terms of English Snellen Linear System (20/20, 20/40 etc.). Use only full numbers for vision testing results. Do not use (+) or (-) signs in connection with visual acuity.

(3) If uncorrected vision is 20/50 or greater in either eye and/or the applicant wears glasses or contact lenses, then the applicant must be tested using the auto-refractor to determine corrected vision.
Note: If the applicant wears glasses, s/he WILL NOT be tested with his/her glasses to determine corrected vision. The applicant must be tested by the MEPS auto-refractor in order to determine the most current corrected vision.

(4) When using the auto refractor, applicants cannot miss more than one of the letters/numbers displayed on the lines indicating visual acuities of 20/40 or better. The smallest line of letters/numbers that the applicant can read with not more than one error will be recorded as the best visual acuity. If the visual acuities are worse than 20/40, no errors are permitted.

b. Corrected visual acuities will be determined using the auto-refractor or the pinhole method without the applicant wearing his/her corrective lenses.

(1) The auto-refractor is used when the applicant wears corrective lenses and/or is 20/50 or greater in the worse eye:

(a) Use objective refractions for entries on DD Form 2808, item 62, circle “AUTOREFRACTION”. Subjective confirmatory refractions are not necessary but may be used in problem cases at the discretion of the examiner. The "confidence index" or “reliability number” is the number to the right of the print out from the auto-refractor. The higher the value, the more accurate the reading with a max value being 9. For Confidence Index <8, repeat auto-refraction; the MEPS provider may instruct the applicant to put artificial teardrops in eyes before repeating. This has shown to bring the Confidence Index up in most cases. Two tests with a Confidence Index <8 could indicate some type of pathology (keratoconus, cataracts, extreme dry eye, corneal scarring, etc.) and referred to an ophthalmologist/optometrist for a complete exam including manifest refraction, topography, IOPs and dilated fundus exam. If you see an "E" that means error and a very low Confidence Index.

(b) The auto-refractor printout slip will be attached to the SF 507 and kept in the applicant’s medical packet.

(c) When a spherical equivalent of the refractive error needs to be manually calculated, add the sphere algebraically to one-half of the cylinder, as in the following example:

Refraction: +7.00 -2.50 x 90
Spherical equivalent = (+7.00) + 1/2(-2.50) = +5.75

(2) The Pinhole method (or the auto-refractor) may be used when the applicant is over 20/20 and under 20/50 in either eye for uncorrected distant and near visual acuity. If 20/50 or over, the auto-refractor will be used to obtain corrected visual acuities. The medical technician conducting the visual acuity test can choose to go straight to the auto-refractor instead of using the pinhole method (for example, if the applicant wears reading glasses and must be put on the auto-refractor anyway).

(a) The pinhole method is administered by having the applicant hold the black pinhole device up to the eye that is being tested.

(b) Instruct the applicant to focus through a particular hole on the smallest line that can be read.

(c) Allow the applicant time to get used to the pinhole device and adjust it as necessary.
(d) Record the results by annotating “PINHOLE” in item 61 (Distant Vision) and item 63 (Near Vision).

(e) When pinhole method is the same or worse than the unaided vision, results will be entered 20/NC (NC=no correction) in items 61 and 63.

7-6. Non-Contact Tonometer
Abnormally high intraocular pressure can be indicative of glaucoma, a disqualifying condition. This test is done during medical processing for all over-40 and NOAA physical applicants, or any applicant that needs the test as indicated during prescreen and/or medical history review or upon medical examination. Intraocular pressure testing is conducted at the MEPS using the MEPS Non-Contact Tonometer and will be performed on each eye. See Training Standardization Job Task Sheet for vision on how to use the Non-Contact Tonometer.

7-7. Profiling Vision

a. Profile as E1 when the following [(1) or (2)] as well as (3), (4), and (5) inclusive below conditions are met:

   (1) Uncorrected visual acuity is 20/20 or better in both eyes.

   (2) Uncorrected distant visual acuity of any degree that corrects to at least one of the following:

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

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

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

   (3) Uncorrected near visual acuity of any degree that corrects to 20/40 in the better eye.

   (4) Cylinder (CX) is not in excess of -3.00 or +3.00 diopters.

   (5) Spherical Equivalent (SE) is not in excess of -8.00 or +8.00 diopters.

Note: When corrected vision is obtained by the pinhole method you will not have a CX or SE result. See Paragraph 7-5b(2) above for standards of obtaining corrected visual acuity by conduction of the pinhole method.

b. Profile as E3 as defined in the current version of DoDI 6130.03. An E3 profile is considered disqualifying.

c. Corneal Refractive Surgery (LASIK, LASEK, and PRK) is any eye surgery used to improve the refractive state of the eye and decrease or eliminate dependency on glasses and contact lenses. Because of the specific medical information needed to make a qualification decision, follow these guidelines:
(1) Prescreen must include: all pre-op, operative report, and post-op records. The applicant must have at least 2 post-op visits that are at least one month apart. The first visit must be at least 90 days post-op.

(2) Review all corneal refractive surgery medical documents for possible disqualifying conditions as outlined in the current DoDI 6130.03, vision chapter.

(3) The UMF 40-1-4 Refractive Eye Surgery Work Sheet can be utilized to assist the MEPS provider in ensuring s/he has all the information needed to make a qualification decision.

**Note:** Lamellar and/or penetrating keratoplasty, radial keratotomy (RK), astigmatism keratotomy (AK) are incisional and not laser. In these cases, the applicant must be PDQ.

### 7-8. Optometry/Ophthalmology Consults

a. In applicants with cylinder readings in excess of 3.00 diopters, keratoconus must be ruled out. If a consult reveals no keratoconus and no other pathology, then a waiver is likely and the profile is E=3P.

b. Refractive errors in excess of -7.50 or +7.50 Spherical Equivalent (SE) will require a manifest refraction. If the refractive error is in excess of -10.50 or +10.50 SE, then no consult is needed and the applicant is profiled as E=3P.

c. When there is a difference of 50 or more in the denominator of the corrected distant visual acuities, and the MEPS provider cannot determine the cause for the unilateral loss, an ophthalmology or optometry consultation will be obtained to rule out retinal, vascular, lenticular disease, keratoconus, or other eye pathology.

d. MEPS provider should consider requesting an optometry/ophthalmology consult if any of 3 below are present:

   (1) The retinal vessels cannot be clearly visualized (rule out keratoconus).

   (2) Clinical concern for an underlying condition requiring dilated exam to adequately investigate.

   (3) The applicant’s visual acuity does not correct to 20/40 or better in one or both eyes (both distant or near vision). For example, the provider should consider a consult for 20/50 or worse.
Chapter 8
Height/Weight/Body Fat/BMI/Vital Signs

If the applicant has a height, weight, or body fat done by the medical staff, it is considered official and will be documented on the DD Form 2808. If a MEPS medical staff member conducts a height, weight, or body fat measurement on a qualified applicant and that applicant is found to be disqualified at any point during their DEP time, he/she is now disqualified and will have proper actions taken on his/her medical exam paperwork.

8-1. Height/Weight Procedures

a. Record applicant’s height (rounding up to the nearest quarter-inch) without shoes or socks and notate in item 53 on the DD Form 2808 in decimal format. The applicant will stand erect with heels together on a flat surface with the head held horizontally, looking directly forward with the line of vision horizontal and the chin parallel to the floor.

Note: Anything that interferes with height measurement will be addressed before coming to the MEPS for examination so that the applicant’s height and scalp can be accurately evaluated.

b. Record the weight in pounds of the applicant in his/her underwear only and notate in item 54 on the DD Form 2808. Weight will be measured and recorded to the nearest pound within the following guidelines: if the weight fraction is less than 1/2 pound, round down to the nearest pound; if the weight fraction is 1/2 pound or greater, round up to the next highest pound (.0-.4 round down, .5-.9 round up).

c. Service-specific height and weight charts are on the SPEAR J-7/MEMD homepage in the Service Medical Height and Weight Standards.

d. J-7/MEMD physicians reserve the right to adjust an height/weight RJ date. Any adjustments requested by the Services will be directed to J-7/MEMD via a MOC ticket.

e. Once the applicant leaves the medical department, the applicant cannot return until the RJ period had been met or a waiver is granted by the Service. Note: Upon SPF change, RJ date will be lifted and applicant will be re-evaluated using new Service-specific height and weight standards.

8-2. Over Maximum Allowable Weight/Body Fat Standards

a. Overweight – RJ Date - Calculate an RJ date based on the amount of weight to be lost and number of calendar days that must pass prior to the applicant returning to the MEPS. The RJ date will reflect a waiting period of 4 calendar days for every 1-pound to be lost. Note: The RJ date starts the day of measurement.

b. Body Fat - MEPS medical technicians will measure all overweight applicants (except Marine Corps, unless requested) for body fat using the Gulick II tape measure. Training Standardization Job Task Sheets have specific guidance.

(1) All MEPS have access to WINFAT program to assist in calculating body fat. A body fat calculation spreadsheet can also be found on SPEAR.
(2) The MEPS are to use the male/female body fat percentage charts from the DoDI 1308.3 regulation for all Services. The charts can be found on SPEAR J-7/MEMD homepage in the Service Medical Height and Weight Standards.

(3) Calculate a RJ date based on the number of percentage points over the maximum allowable body fat percentage and number of calendar days that must pass prior to the applicant returning to the MEPS. The RJ date will reflect a waiting period of 16 calendar days for every 1-percentage point to be lost.

Note: The body fat measurement may be completed by one trained MEPS person.

c. **Assignment of RJ Date and Profiling for Overweight Applicants**

   (1) Applicant will be assigned the lesser of the two RJ date (weight and body fat) calculations. If the body fat measurements are not required, then MEPS will use the RJ date for overweight. There is an RJ date calculator (Microsoft Excel File) on SPEAR to determine the calendar date the applicant can return to the MEPS.

   (2) MEPS profiling provider will indicate “P-3T” in item 74b on the DD Form 2808. In item 76, the profiling provider will notate the following in the appropriate blocks: item 54 and/or 55b: medical condition (overweight or over body fat); proper ICD code; P-3T; RJ date; disqualified; and examiner initials.

8-3. **Requested Courtesy Measurements**

There is no courtesy height, weight or body fat measurement to be done by the MEPS medical personnel, even on applicants that are currently qualified.

8-4. **Underweight applicants/Body Mass Index/Assignment of RJ Date**

   a. Applicants who are underweight according to their Service-specific standards will have their Body Mass Index (BMI) calculated. A BMI calculator can be obtained using http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm.

   b. The minimum body mass index (BMI) for applicants to be qualified for the military is 19.0. If the applicant’s BMI is between 17.5 and 19, the provider will determine if there is any underlying medical condition/cause for applicant being underweight and at a low BMI and document any medical findings and profile accordingly. A chart is available on SPEAR that provides the weight that corresponds to the 17.5 and 19.0 BMI measurements.

   c. Applicants with a BMI less than 17.5 will be temporarily disqualified and an RJ date calculated (to get the applicant to a minimum BMI of 17.5) if there is no permanently disqualifying medical condition present. The RJ date will reflect a waiting period of 4 days for every 1-pound increment to gain body mass. If a permanent disqualification is requested by a Service in order to apply for waiver, this can be granted by the profiling provider.

   d. If a Non-Prior Service Marine Corps applicant’s BMI is less than 19.0, their BMI is recorded on the DD Form 2808 item 73 or 88 (depending on who documents the BMI) and receive a 3P for being
underweight and no RJ date. The Marine Corps will provide the appropriate level waiver to continue processing their applicants (see Marine Corps Information Sheet on SPEAR).

8-5. Height Waivers
Heights not listed on Service-specific height/weight charts are permanently disqualified and profiled accordingly. For all Services, determination of over- and under-height applicants can be obtained through the medical waiver authority. MEPS personnel will annotate the applicant’s height, weight, and body fat measurements in the medical packet. The body fat calculator for these circumstances can be found on SPEAR.

8-6. Blood Pressure

a. Applicant will be seated with feet flat on the floor and legs uncrossed for a minimum of one minute prior to initial blood pressure check. Instruct applicant not to talk while taking BP. For BP determinations, ensure that the BP cuff is at heart level and that the BP cuff is placed properly over the brachial artery on bare skin.

b. Abnormal readings are either one of the following:

   (1) Systolic measurements greater than 140mmHg.

   (2) Diastolic measurements greater than 90mmHg.

c. If the initial BP obtained by the automatic blood pressure machine is abnormal, one manual blood pressure reading will be performed by the provider after the applicant has been seated for a minimum of five minutes. The results will be annotated in item 73. A manual BP of 140/90 or lower will be qualifying. The manual blood pressure is the result entered into USMIRS.

d. If an applicant’s manual BP exceeds the maximum permissible limits, he/she will be assigned an open profile (P=O) and instructed to see a private healthcare practitioner for blood pressure evaluation of manual blood pressure on two separate days. The applicant must provide all medical documentation with regards to his/her evaluation from the private healthcare practitioner, and it will be submitted as a ‘med read’ for further review.

e. Medical department will call 911 for immediate transport to ER for applicants exhibiting signs/symptoms of hypertensive emergency. If no signs of organ damage and systolic >180 and/or diastolic >120, stop processing and send applicant to their PCP for evaluation of hypertensive crisis. Hypertensive crisis is not an emergency.

8-7. Pulse

a. An elevated pulse is commonly seen during MEPS examination. If the applicant’s pulse is 99 or below while at the MEPS, then the applicant meets the standard.

b. For an applicant with a pulse rate between 100 and 120, a MEPS medical technician is authorized to do up to three automated heart rate readings and a fourth (manual) reading by a MEPS provider, if necessary. The heart rate readings must be obtained at least 15 minutes apart. The first result is recorded in item 57. If first result is abnormal, all subsequent results will be recorded in item 73. The last pulse taken is the result entered into USMIRS.
c. Pulses above 120 beats or above per minute will be evaluated with an EKG. The EKG must be interpreted by a board-certified cardiologist or internist if the MEPS provider is not comfortable performing his/her interpretation. If the pulse does not decrease below 100 beats per minute, he/she will be assigned an open profile (P=O) and urged to seek follow-up evaluation (pulse check) with a private healthcare practitioner. The applicant must provide all medical documentation with regards to his/her evaluation for elevated pulse from the private healthcare practitioner, and it will be submitted as a ‘med read’ for further review.

d. For applicants with bradycardia (less than 60 bpm), provider will individually evaluate each applicant on a case-by-case basis. An EKG should be considered for those applicants with pulses below 50 beats per minute.

e. Applicants with symptomatic tachycardia will be sent to the ER for evaluation.

8-8. Temperature

a. Temperatures will be taken on all shippers and recorded in item 56 on DD Form 2808. Those that are above 100.5 degrees will be referred back to the CMO. The MEPS will temporarily medically disqualify the shipper for 72 hours. The profile will be changed to “3T” and the shipper given an RJ date in USMIRS 72 hours out.

b. Temperatures may be taken on any applicants that appear to be ill at the discretion of the CMO.
Chapter 9
Clinical Laboratory Improvement Program

9-1. Clinical Laboratory Improvement Program (CLIP)
The CLIP is a quality improvement program directed at all MEPS medical departments. All laboratories Recertification of CLIP occurs in odd years. Standards for CLIP are DoDM 6440.02. The program includes inspection of laboratories and implementation of various quality control, and improvement procedures (normally conducted twice a year (CAP Testing)). This program also requires semiannual training of all personnel conducting tests.

a. **Renewing CLIP Certificates** - A tasking message is sent to the MEPS to complete this requirement on odd years. There are several items that need to be complete in order to receive CLIP Re-Certification.

b. **CAP Testing** - MEPS laboratories must maintain CLIP certification. In order to comply with CLIP requirements, MEPS are required to review and update Lab SOP annually and complete proficiency testing two times per year (February and September). This proficiency testing is a part of the quality control procedures required to maintain certification and is funded for the MEPS by the Department of the Army. Proficiency testing is administered by the College of American Pathology (CAP) and monitored for USMEPCOM by the US Army Program Manager Center for Clinical Laboratory Medicine.

c. **Mailing of CAP Kits**

   (1) HQ-J-7/MEMD-Battalion Support Accession Medicine Branch will release messages twice a year on this subject with required timelines. The CAP kits must be refrigerated. MEPS mailroom will ensure the kit is delivered ASAP to the Medical NCOIC/ SUP MT. Once received, the kit must be stored at 2-8 degrees Celsius (35.6-46.4 degrees Fahrenheit) until testing can be performed, except for occult blood, which can be stored upright at room temperature; however, the specimen will not be contaminated if it is stored in the refrigerator.

   (2) Failure to accomplish CAP proficiency testing may result in an order to cease testing at the MEPS by the CLIP regulatory officer. This will cause a work stoppage for the MEPS as applicants will not process without laboratory results.

d. **Acting Lab Director Appointment** - DoD Center for Clinical Laboratory Medicine OASD (HA)/TMA requires that the Laboratory Director be a government physician who oversees the laboratory locally (CMO/ACMO). When vacancies prevent this appointment, a J-7/MEMD Battalion Support Accession Medicine Physicians is appointed for the interim. Government non-physicians and any non-government personnel (physicians and non-physicians) are not acceptable alternatives. J-7/MEMD Battalion Support Accession Medicine Physicians will be assigned as Acting Laboratory Director for all MEPS who do not have a CMO/ACMO on staff. For all MEPS requiring a J-7/MEMD Physician being assigned as Acting Laboratory Director, the following will be gathered and submitted to Battalion Support Accession Medicine Branch at osd.north-chicago.usmepcom.list.hq-j7-memd-battalion-support@mail.mil for review: 1) Copy of logs for the last two years for Over 50 Guaiac, Protein/Glucose, and HCG; 2) Copy of the last two CAP results; and 3) Complete a Clinical Laboratory Improvement Program Change Request Form, CLMS Form 2 (rev 1.0) (available on SPEAR).
(1) If information found during the review is incorrect, the MEPS will be notified to correct and resubmit. Once the documentation is reviewed and accurate, the change of directorate memorandum is forwarded by J-7/MEMD to US Army Program Manager Center for Clinical Laboratory for processing.

(2) The MEPS Medical Department will coordinate with J-7/MEMD Battalion Support Accession Medicine Branch Physicians quarterly by emailing the Over 50 Guaiac, Protein/Glucose, and HCG logs and CAP results (if applicable) for review. The MEPS will continue to follow the above guidance until a CMO/ACMO has been hired and assumes responsibility for the lab.

e. **MEPS Change of address** - The change of address must be completed using, Clinical Laboratory Improvement Program - Change Request Form, CLMS Form 2 (rev 1.0) and forwarded to J-7/MEMD Battalion Support Accession Medicine once a MEPS moves to reflect the change of address. The attachment is then forwarded to US Army Program Manager Center for Clinical Laboratory Medicine to be processed and updated with the change.

f. **Request CAP Web Access Procedures:**

(1) Each MEPS laboratory must have at least two site administrators (Medical NCOIC/SUP MT and LMT).

(2) The Medical Director of the laboratory must submit a letter to CAP requesting the current site administrator be revoked (such as when the previous site administrators are no longer assigned to the MEPS). The letter will include the MEPS CAP number, name of the old site administrator and name of the new site administrator. Send the letter via email to contactcenter@cap.org.

(3) The new site administrator will create an account by going to http://www.cap.org/, then in the upper right hand corner click log in, my profile, then register with the CAP and request access to the laboratory.

(4) An email will be sent to the new site administrator confirming their status as site administrator.

g. **Annual CAP Survey Renewal Forms** - All MEPS medical departments will be tasked to provide J-7/MEMD and the Center for Clinical Laboratory Medicine a completed College of American Pathologists (CAP) renewal forms. This renewal packet is mailed annually in November to each MEPS. The packet will contain the CAP survey reorder form and Excel booklet. The required Excel booklet must be downloaded from the CAP website by November 1 each year. The MEPS medical department is required to review the order forms for the correct information. If changes are required, there are boxes directly below the data for those changes. The renewal form is required to maintain laboratory certification. Without the completion of the order form, the MEPS will not receive CLIP test kits.
Chapter 10
Applicant Interviews

10-1. Medical History Interview

a. The medical history interview will be conducted in a professional manner with appropriate introductions to establish rapport. The medical history will be reviewed in private with each applicant. All forms will be completed in black ink. The provider will verify the applicant’s identity and review the applicant’s medical packet to:

1. Determine if the applicant is a minor and if so, make sure the DD Form 1966/5 is present.
2. Transfer the relevant information from the DD Form 2807-2 to the DD Form 2807-1.
3. Review the DD Form 2807-1 for completeness.
4. Complete Block 2, Section VII on the DD Form 2807-2 as follows:

   ![Figure 10-1. DD Form 2807-2, Section VII, Block 2](image)

   (a) Item a: PSN COMP (Prescreen Complete) will be checked if there is no significant discrepancy between the prescreen (DD Form 2807-2) and medical history (DD Form 2807-1).

   (b) Item b: PSN INCOMP (Prescreen Incomplete) will be checked if there is a significant discrepancy between prescreen (DD Form 2807-2) and medical history (DD Form 2807-1).

   (c) Item c: NPS (Not Prescreened) will be checked for all walk-in applicants.

   (d) Items d through g are optional and are available for trend tracking purposes.

   (e) Item h and i: The provider will date and initial the appropriate boxes.

5. Apply the principles of Accession Medicine as established in the current version of DoDI 6130.03 to determine if a medical condition is considered disqualifying (CD) or not considered disqualifying (NCD).

b. The interview must be completed prior to the physical examination and the ortho-neuro screening of applicants.

Note: An exception is the examination of the ears of all applicants to identify applicants who need ear cleaning as early as possible during the processing day. Providers may conduct ear examinations on applicants after first taking a history of ear problems or problems with syncope.
(1) DD Form 2807-1, items 30a and 31 are for the provider’s summary and elaboration of the applicant’s medical history as revealed through the interview and in items 8 through 29. For every item discussed, the provider will include the corresponding number from DD Form 2807-1, items 8-29. The provider will ask the applicant for information as required and document with sufficient detail to demonstrate whether the condition is CD or NCD according to the principles of Accession Medicine.

(2) For any item that the applicant did not answer or needs to revise as a result of additional information that is revealed during the interview, the provider will discuss the item with the applicant, and the applicant will mark the appropriate response by changing the item number (#8-29) to yes, line out no, initial and date and add new info to #29 on DD Form 2807-1.

(3) If the applicant affirms the absence of any significant medical history (all “no” answers), an entry will be made in item 30a documenting that the applicant has no significant medical history.

(4) The provider will complete the Alcohol & Other Drug/Substance Abuse History in item 30a1 on the DD Form 2807-1 and supply any medically relevant details.

<table>
<thead>
<tr>
<th>DRUG OR SUBSTANCE</th>
<th>EVER USED</th>
<th>USE DISORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) ALCOHOL</td>
<td>Yes</td>
<td>Deferred</td>
</tr>
<tr>
<td>(2) MARIJUANA (Any form)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>(3) OTHER ILLEGAL DRUGS</td>
<td>Yes</td>
<td>Deferred</td>
</tr>
<tr>
<td>(4) OTHER SUBSTANCES*</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*E.g., Chemical Inhalants, Synthetic Cathinones (“Bath Salts”)

Figure 10-2. DD Form 2807-1 Alcohol & Other Drug/Substance Abuse Block

c. This item of the DD Form 2807-1 has been provided specifically to assist the provider in the determination of an applicant’s current condition or history of alcohol dependence, drug dependence, alcohol abuse, or other drug abuse. The provider can refer to the DSM V for assistance in this determination.

d. The provider will complete item 30a1 by asking the applicant if he/she has ever used alcohol, marijuana, other illegal drugs, or other substances (such as inhalants). The applicant will answer yes or no to these questions.

(1) A no answer requires the provider to checkmark “no” for the appropriate substance in the “Ever Used” box and no other annotation needs to be made.
(2) A yes answer requires the provider to checkmark “yes” for the appropriate substance and then move to the “Use Disorder” block. The provider will then complete the “Use Disorder” box for any "yes" answer to the “Ever Used” block. The provider must determine if the use of a substance is a disorder.

(a) The provider will checkmark "no" if s/he feels the use is not considered a disorder

(b) The provider will checkmark "yes" if s/he feels the use is considered a disorder and profile accordingly.

(c) The provider will checkmark "deferred" if s/he feels more information is needed to make a decision on a disorder. This applicant will be profiled in an Open status until the provider has the information needed (consult, counseling records, etc.) to make a yes or no decision.

e. The provider will annotate in the Details section of item 30a1 of the Drug or Substance block: total use, legal or social issues, tolerance or withdrawal issues, evaluation and treatment for the substance, any remission status, and any other pertinent information the provider may deem necessary in regards to alcohol, drug or substance use. The provider will use item 31a if additional space is needed.

Note: The provider can also look at items 8 and 17 of the DD Form 2807-1 as well as items 145, 146, and 147 of the DD Form 2807-2 to assist in the completion of item 30a1.

f. The applicant will sign and date in the Examinee Signature block. The interviewing medical provider’s full name and the date of examination will be typed, printed, or stamped in the appropriate space on DD Form 2807-1, items 30b and d. The provider will sign his/her name in the signature block (item 30c) in black ink.
g. The Closing Review overprint checklist in Item 31a is to be completed by the Examining Provider when completing the medical history review with the Applicant; if the medical history review is interrupted and not completed, the Closing Review will be completed upon return to the MEPS. The Closing Review is designed to provide additional one-on-one review of significant medical subject areas that are sometimes non-disclosed and/or can be linked to attrition or duty limitation. If an 'Admits' box is checked for any area, the appropriate condition(s) must be circled in the ‘Conditions’ box and ensure details are provided in Item 30a or Item 31a on the DD Form 2807-1. The “Other” row is provided for management of areas of local concern that the MEPS CMO may want to emphasize for review and/or for other Command-wide initiatives. After the Closing Review is completed, the provider must print, sign, and date Items 31 b-d.

**Note:** If an applicant discloses additional significant medical information at any time after medical processing has been completed, a [UMF 601-23-E](https://example.com) must be completed with the applicant present. See [UMR 601-23](https://example.com) for guidance.

### 10-2. Behavioral Health Provider Interview

All USMEPCOM medical providers will assess applicant behavioral health during the physical screening examination process to determine if an applicant meets accession medical standards for behavioral health. The interview also consists of reviewing applicant responses to the Medical History Provider Interview (MHPI - the front page of the [UMF 40-1-15-1-E](https://example.com)) and the Applicant Behavioral Health Interview (the back page of the [UMF 40-1-15-1-E](https://example.com)). The MHPI and the Applicant Behavioral Health Interview will be completed for all applicants receiving a medical examination.
Establishing rapport with the applicant is key to facilitate disclosures.

a. **Medical History Provider Interview (MHPI) (front side of UMF 40-1-15-1-E)**

   (1) **Items 1-5.** These demographic items are completed by the applicant (in pencil) before/during the Medical Brief.

   (2) **Item 6.** The applicant will answer all parts of item 6 (letters a through l) in pencil before/during the Medical Brief. Any “yes” answer in item 6 must have an explanation transcribed by the applicant (in black ink) to the DD Form 2807-1 item 29 (or SF 507) during the Medical Brief.

   (3) **Item 7.** The applicant will answer all parts of item (letters a through c) in pencil before/during the Medical Brief.

   The provider will review the applicant-completed item 6 (Screening Questions Part 1) of the UMF 40-1-15-1-E and explore each “yes” answer with additional questioning. The provider will review the applicant-completed number 7 (Screening Questions Part 2) of the UMF 40-1-15-1-E to determine if the applicant meets the diagnostic criteria of substance use disorder as outlined in the most current DSM as specified by J-7/MEMD.

   The provider must ensure that the form has been completed appropriately by the applicant.

b. **Applicant Behavioral Health Interview (back side of UMF 40-1-15-1-E)**

   The Applicant Behavioral Health Interview (formerly known as the Omaha 5) questions are a framework for behavioral health discussion areas. Each MEPS medical provider must use their clinical judgment to ask questions in these areas which will elicit applicant medical history information not previously disclosed on the DD Form 2807-2, DD Form 2807-1, and in the MHPI. The Applicant Behavioral Health Interview questions can be found on SPEAR.

   (1) **MEPS Provider Interview.** The provider will use the questions found on page 1 of the Applicant Behavioral Health Interview (found on SPEAR) as a framework for these discussion areas; however, each provider can use his/her clinical judgment to ask questions in these areas to elicit applicant medical history information for each area. The provider will fill in the corresponding “Y” or “N” bubble in this section based upon the applicant’s answers. Only items 1 through 5 are used in this section.

   (2) **MEPS Provider Interview Results.** The provider will record the results of the interview in this section, filling in the corresponding bubbles for the questions on page 2 of the Applicant Behavioral Health Interview, found on SPEAR. Only items 1 through 3 are used in this section.

   (3) **MEPS Codes.** The provider or the applicant will bubble in the correct MEPS. If it is found upon QC that this bubble was not filled in, the MEPS medical personnel may fill in the correct bubble.

   (4) **Provider 3 Initials.** The provider must bubble in his/her role (CMO, ACMO, FBP) and enter his/her initials. If it is found upon QC that the role was not filled in, the MEPS medical personnel may fill in the correct bubble. An FBP performing the role of FB-CMO must fill in the bubbles for FBP.
c. Behavioral Health Provider Assessment (on DD Form 2807-1)

(1) All significant responses to any of the areas in the behavioral health screening will be explored in detail and annotated in block 30a or 31 of DD Form 2807-1 under the heading “BH Screen”, along with the dates of occurrences. Minor legal issues do not need to be recorded unless there is a pattern of behavior that is deemed significant to the behavioral health screen. Providers do not need to document medically innocuous traffic tickets, etc. The tickets only become medically significant if there is a pattern of impulsive behavior that clinically would result in a conclusion that the applicant is not fit for service based on a behavioral health issue. MEPS medical providers will document arrest information only to the extent that there is medical applicability in determining whether or not an applicant does or does not meet accession standards and thus is or is not medically qualified to serve. It is up to the clinical judgment of the provider to determine if the “yes” answer is deemed important enough to warrant additional explanation on the DD Form 2807-1. The provider will make a decision for further evaluation (e.g., medical record requests, psychiatric consultation, etc), based upon the behavioral health interview and the applicant provided responses to the UMF 40-1-15-1-E.

(2) The provider will make an entry to indicate that the behavioral health screen was negative in block 30a (or if necessary block 31) of DD Form 2807-1 if the results of the behavioral health screening do not reveal any behavioral health diagnoses.

Note: see Section 14-5 for the QC and disposition of the UMF 40-1-15-1-E forms.

10-3. Guidance on Allergy Standards

In addition to accession medicine standards as outlined in the current version of DoDI 6130.03, providers will assess the applicant for the following allergic reactions:

a. Anaphylaxis

Anaphylaxis is a systemic allergic reaction that may consist of one or more of the following:

(1) Skin reactions, including hives along with itching and flushed or pale skin (Note: Hives and/or itching alone without other symptoms of anaphylaxis is not sufficient to make the diagnosis of anaphylaxis).

(2) Nasal congestion, wheezing, cough, stridor, or slurred speech

(3) Difficulty swallowing or breathing

(4) Syncope, pre-syncope, or dizziness

(5) Abdominal pain, cramping, nausea/vomiting, or diarrhea

(6) Anxiety, confusion, or palpitations

b. Oral Allergy Syndrome

(1) Uncomplicated Oral Allergy Syndrome manifesting as self-limiting itching or burning sensation in the lips, mouth, ear canal, or pharynx within minutes of eating a trigger food in the absence of
any other symptoms listed in the Supplemental Guidance (SMPG) for Anaphylaxis IS NOT considered disqualifying.

(2) Oral Allergy Syndrome that manifests as swelling of the tongue and/or oral mucosa or demonstrates any of the other symptoms listed in the SMPG for Anaphylaxis IS disqualifying.
Chapter 11  
Physical Examination

The physical examination is a head-to-toe evaluation of the applicant that will be recorded on the DD Form 2808. The DD Form 2807-1 must be reviewed to determine if any focused exams are needed for each applicant.

11-1. Recording the Medical Examination on DD Form 2808

a. The applicant will complete items 1 through 16 during the medical briefing. The applicant demographic information is reviewed during the medical briefing.

b. Items 17 through 43 are the specific areas of clinical evaluation performed by the provider. The provider annotates each item with a check mark as normal, abnormal, or NE (not examined). Each item must have one box checked.

c. All consultations, test results, civilian treatment, and hospitalization records pertaining to the applicant’s health are part of the medical examination and will be filed in the applicant’s packet.

d. Gloves will be worn by the provider any time they will come in contact with bodily fluids or mucous membranes while examining applicants. A new pair of gloves will be used with each applicant. The examiner will adhere to current Standard Precautions and Chaperone Policies during examinations. After annotating each finding, mark the entry as “CD” or “NCD”. Consultations will not be used in lieu of MEPS Examination. Provider documentation on the DD Form 2808 will be in items 44 or 88 and medical technician documentation will be in item 73.

(1) Item 17: Head, face, neck, and scalp. The skull will be observed for defects and deformities that will interfere with the use of head gear. The skull must be palpated in applicants with a history of serious head injury or neurosurgery. Facial and scalp lesions, and cervical lymphadenopathy will be noted.

(2) Item 18-20: Nose, sinuses, mouth and throat. Observe for diseases and disorders of the nasal and oral cavities. For dental screening, see item 43 below.


(a) The external auditory canal and tympanic membrane will be examined. Adequate visualization consists of visualizing the reflective cone or triangle of the TM, the pars flaccida of the TM, and the handle of the malleolus behind the TM. If all three are visualized, then adequate visualization of the TM has occurred. If one or more of these structures cannot be seen because of cerumen, then ear cleaning is required.

(b) Cerumen removal will be provided to applicants whose eardrum(s) cannot be properly visualized, if determined necessary by the provider (see Section 6-5). Findings in this category will be noted. Refer to and follow current cerumen removal policy.

(c) Check behind the ear for mastoidectomy scar.

(4) Items 23-26: Eyes. General, Ophthalmoscopic, Pupils, Ocular motility
(a) Routine examination will include a survey of the globe (pterygium), lids, and pupils; testing of ocular motility in the six cardinal directions; and observation for nystagmus. An examination with a halogen light ophthalmoscope will be performed to evaluate the pupils, refracting media, and the optic fundus. Inability to visualize the retinal vessels must be evaluated with ophthalmology consultation if not explained on examination.

(b) Significant unilateral loss of vision. When there is a difference of 50 or more in the denominator of the corrected distant visual acuities, and the MEPS provider cannot determine the cause for the unilateral loss, an ophthalmology or optometry consultation will be obtained to rule out retinal, vascular, lenticular disease, keratoconus, or other eye pathology.

(c) Applicants with a cylinder reading in excess of 3.00 diopters are at an increased risk for keratoconus, a disqualifying condition. Applicant medical documentation must be provided or a consultation obtained to rule out keratoconus.

(5) Item 27: Heart. Auscultation for heart sounds will include auscultation at the mitral, tricuspid, aortic and pulmonic valve areas. Heart murmurs suspicious for disease require echocardiogram and cardiology referral.

(6) Item 28: Lungs and chest. Lungs will be anteriorally and posteriorally auscultated. Chest wall will be observed for deformity. Female breasts will be examined visually and by palpation. Palpation will include the axillary tail of the breasts.

(7) Item 29: Vascular system. Look for varicosities, peripheral vascular impairment, and other vascular pathology.

(8) Item 30: Anus and rectum. Observe for hemorrhoids, pilonidal cysts/sinuses, anal fissures, anal fistulas, and warts. Note: Digital rectal examination and stool occult blood test are performed on applicants when clinically indicated or age 50 and over.

(9) Item 31: Abdomen and viscera. Abdomen will be palpated for organomegaly in supine position and hernias in standing position. Examine for direct and indirect inguinal hernia.

(10) Item 32: External genitalia.

(a) Male examination. The testicles, penis, and scrotum will be examined both by visual inspection and palpation for developmental or acquired abnormality. All skin of the penis must be checked with the foreskin retracted (if possible). Palpate for groin lymphadenopathy.

(b) Female examination. Applicant will be examined in the dorsal lithotomy position. External examination (introitus only) of the vulva and perineum will be examined by both visual inspection and manual examination for developmental or acquired abnormality. Examine the mucous membranes of the labia for abnormalities, excoriations, open wounds, or other findings. Palpate for groin lymphadenopathy.

(11) Items 33 and 34: Upper and lower extremities. (see Chapter 12) The upper and lower extremities will be assessed during the ortho-neuro examination. A focused examination may be indicated based upon history interview and/or review of medical documentation. Any history of dislocation of a shoulder, hip, or other joint will have a thorough examination of that joint documented by the provider.
(12) **Item 35: Feet.** Note that there are two blocks that must be addressed for item 35. Examination of the foot includes careful evaluation for hammer and claw toes, pes planus, pes cavus, clubfoot, hallux valgus, significant scars, and for calluses, corns, and plantar warts. Circle the appropriate categories, including arch-type, severity, and presence or absence of symptoms. If symptomatic, comment on whether pes planus is flexible or rigid. Ability to wear combat boots and stand for prolonged periods and history of symptoms related to feet are major considerations for qualification. Abnormal findings even when not disqualifying must be noted.

(13) **Item 36: Spine, other musculoskeletal.**

   (a) The orthopedic/neurologic screening examination is in Chapter 12.

   (b) Any history of an orthopedic problem requires an examination of the involved area. Annotate positive findings and pertinent negative findings (e.g., “non tender” or “normal range of motion”).

   (c) If a joint is unstable or symptomatic after surgery, the applicant must be medically disqualified. If the applicant is asymptomatic but has a history of orthopedic surgery of a major joint, or surgical scars are discovered, an orthopedic consultation may be warranted.

   (d) All old fractures require examination by the provider. Give special attention to fractures involving joints, misalignment of bone at the site of a healed fracture and/or compound fractures. X-rays may be taken to determine if retained hardware is present and to determine adequacy of healing and alignment. Document whether known retained hardware is palpable and/or symptomatic, and if a risk when wearing military gear or equipment.

   (e) Complaints of lower spine discomfort are particularly difficult to evaluate. Special emphasis must be placed on the history. Percuss the spine, check range of motion, and straight leg raising for radiculopathy. Qualify, disqualify or obtain consultation as appropriate.

   (f) Examination of the spine will include an evaluation for lumbar scoliosis (> 30 degrees), thoracic scoliosis (> 30 degrees), and kyphosis (> 50 degrees). If further evaluation is warranted, specify the condition for which the radiologist must evaluate that the radiologist must measure for excessive lumbar curvature on a lateral lumbar spine film using the Cobb Angle as measured from the superior endplate of L1 to the inferior endplate of L5.

   (g) During the examination, note body symmetry of the pectoralis muscles, scapulas, etc. as clues to presence of scoliosis.

**NOTE:** For female applicants wearing sports bras, the MEPS provider will evaluate the spinal area not visible during the ortho-neuro exam during the applicant’s physical exam.

(14) **Item 37: Identifying body marks, scars, tattoos, ear gauges.**

   (a) The provider will assess for medically significant body markings, scars, tattoos, and ear gauges as well as anybody markings or scars that appear to interfere with the proper wearing of military attire and/or protective gear.
(b) Medically significant findings will be notated on the DD Form 2808, item 37 (as applicable) with an explanation in item 88.

(c) In the absence of associated medical conditions, questionable body altering marks and/or possibly offensive tattoos must be documented and explained in item 88 on the DD Form 2808. These applicants will be assessed to determine if they should be referred for a psychiatric consult in the opinion of the medical provider. Clinical judgment is key to this assessment in determining if applicants do or do not meet DoDI 6130.03 medical standards. All other medically insignificant findings are service specific administrative issues.

(d) The UMF 40-1-18-E, Tattoos/Brands/Piercing/Ear Gauging/Scars/Birthmarks can be utilized by the provider to notate any medically significant conditions and save space on the DD Form 2808. The filling out of this form is not mandatory, but if utilized, follow these guidelines:

1. The form can be filled out by the provider or the applicant during the medical history interview. If only one side is filled out, the provider will sign and date the bottom of that page. If both sides of the form are needed, the provider will sign the bottom of the second page.

2. In item 44 (NOTES) make a notation “37 see additional sheet”. This form will now be a part of the physical and be filed in the medical record as “other medical documents”.

3. The CMO can authorize the filling out of this form by applicants during the medical brief. This can be done at the before the medical brief begins or during the brief any time prior to the conduction of the breathalyzer. If the applicant fills out the form during the brief, it will be reviewed and signed by the provider during the medical history interview.

4. The provider will still have to explain any questionable body altering marks and/or possibly offensive tattoos in item 88 on the DD Form 2808. The UMF 40-1-18-E is for documenting purposes in order to save space on DD Form 2808 only.

Note: This form is not intended to replace service specific tattoo forms. It is strictly for clear and concise documentation of the applicant’s medically significant tattoos, brands, piercings, ear gauging, scars, and birthmarks.

(15) Item 38: Skin, lymphatics. Describe skin eruptions and abnormalities, including acne if extensive. Examine the applicant so that all skin surfaces are evaluated by the completion of the examination. The skin of the arms, abdomen and thighs must be carefully examined using a light to detect any scars which may indicate a history of self-mutilation.

(16) Item 39: Neurologic. If indicated by history or performance on the orthopedic/neurologic screening examination (e.g., severe balance or coordination deficiencies), a systematic neurological evaluation must be performed and documented to determine whether the applicant meets the standard.

(17) Item 40: Psychiatric. Specific psychiatric/psychologic evaluation is necessary whenever there is reason to question the applicant’s emotional, social, or intellectual adequacy for military service. The examining provider will determine if an evaluation by a consultant is required.

(18) Item 41: Pelvic. Not conducted at MEPS. Check “NE”.
(19) **Item 42: Endocrine.** Palpate the thyroid. Give general consideration to any physical finding indicative of thyroid, pituitary, adrenal, pancreatic, or gonadal dysfunction.

(20) **Item 43: DENTAL DEFECTS AND DISEASE.**

(a) Observe for diseases of the gingiva, presence of any orthodontic appliances, condition and number of teeth (caries), malocclusion, and other abnormalities. Record “acceptable” or “not acceptable” in item 43. Significant dental abnormalities and defects will be annotated in item 44, even if not disqualifying.

(b) An applicant with orthodontic appliances will be allowed to DEP if he/she provides a signed letter from his/her orthodontist stating the date on which braces will be removed and that no further treatment is contemplated after that. If the applicant terminates orthodontic treatment on their own or before treatment is complete, the MEPS medical personnel may contact J-7/MEMD if guidance is needed.

At time of inspection prior to shipping, the provider will ensure that the appliance has been removed according to requirements in the current version of DoDI 6130.03 (with the exception of hometown or direct shippers).

(c) Permanent or removable retainers are permissible if the applicant is in the retention phase of treatment.

(21) **Item 44: NOTES.** Use item 44 to describe pertinent positive and negative findings on physical examination. Enter the appropriate item number before each comment. Utilize block 88 for detailed discussion of pertinent medical and physical findings.

(SECTION - LABORATORY FINDINGS)

(22) **Item 45: URINALYSIS.** If an applicant is found to have used diuretics applicant will be temporarily disqualified for two weeks.

(a) **Item 45a: Albumin.** Enter the value for urine samples that show proteinuria on initial testing; enter results as “NEG,” “Trace,” “+1,” “+2,” “+3,” or “+4” as indicated on Uristix bottle. For negative results, enter “NEG.”

(b) **Item 45b: Sugar.** Enter the value for urine samples that show glycosuria on initial testing; enter results as “NEG,” “100,” “250,” “500,” “1000,” or “>2000” as indicated on Uristix bottle. For negative results, enter “NEG.”

Note: See Appendix D for Positive Result Guidance for Albumin and Sugar.

(23) **Item 46: URINE HCG.**

(a) Enter the test result.

(b) If positive, the test will be repeated with the same urine sample. If the second test is positive, the applicant will be escorted to the provider and informed by the provider that the test indicates that she might be pregnant. The physical examination will be discontinued and the provider will advise the applicant to see her private physician for further evaluation.
Item 47: H/H. Hemoglobin/hematocrit is not conducted at MEPS.

Item 48: BLOOD TYPE. Not conducted at MEPS.

Item 49: HIV RESULTS. Perform according to UMR 40-8.

Items 50 and 51: DRUGS RESULTS and ALCOHOL RESULTS. Perform according to UMR 40-8.

Item 52: OTHER. Clearly annotate the test name and result of any additional testing required.

SECTION - MEASUREMENTS AND OTHER FINDINGS

Item 53: HEIGHT. Record height (rounding up to the nearest quarter inch) in decimal format (ex. 65.50).

Item 54: WEIGHT. Record weight of the applicant to the nearest pound (e.g., 150).

Item 55:
   (a) 55a MIN WGT – MAX WGT. Enter minimum and maximum weight standard per Service-specific standards. (see Service Height and Weight Standards on SPEAR)
   (b) 55b MAX BF%. Maximum body-fat percentage allowed (use if the screening weight is not within the Service-specific standards).

Item 56: TEMPERATURE. Temperature will be recorded in Fahrenheit degrees on shippers only. See Section 8-8 for more guidance.

Item 57: PULSE. The resting (seated) pulse rate is taken on the automatic blood pressure/pulse rate machine and recorded in item 57 for all examinations. The number recorded is the number on the machine’s display screen.

Item 58: BLOOD PRESSURE. Sitting blood pressure (BP) will be taken on the automatic blood pressure/pulse rate machine and recorded in item 58 for all examinations. The number recorded is the number on the machine’s display screen. Manual blood pressure, if taken, is to be recorded in Item 73.

Item 59: RED/GREEN (Army Only). Record as Pass/Fail.

Item 60: OTHER VISION TESTS. Leave blank.
   (a) Item 60a: Color Hair. Will be verified and recorded by MEPS personnel only. Record as black, blond, brown, gray, or red. If completely bald, record as none. If the hair is dyed, annotate the natural hair color.
(b) **Item 60b: Color Eyes.** Will be verified and recorded by MEPS personnel only. Record as blue, brown, gray, or green. If the color is nondescript (hazel), record as “other.” If each eye is a different color, record separately. If the applicant is wearing colored contacts, annotate the natural eye color.

37. Items 61 and 62: DISTANT VISION TESTING and REFRACTION BY AUTOREFRACTION OR MANIFEST. (Section 7-5)

38. **Item 63: NEAR VISION.** (Section 7-5)

39. **Item 64: HETEROPHORIA.** Performed only on selected applicants based upon Service requirements or clinical indication. (For instructions on how to conduct these tests refer to the Training Standardization Job Task Sheet for vision).

40. **Item 65: ACCOMMODATION.** Record documentation of observed accommodative defects.

41. **Item 66: COLOR VISION.** Applicants wearing corrective lenses will be tested for color perception with lenses. Record result as Pass/Fail. (Section 7-3)

42. **Item 67: DEPTH PERCEPTION.** Selected applicants will be tested for depth perception and results recorded. (Section 7-4)

43. **Items 68 and 69: FIELD OF VISION and NIGHT VISION.** Not tested at the MEPS.

44. **Item 70: INTRAOCULAR TENSION (IOT).** All applicants 40 years of age or older will have intraocular pressure tested. Reports of privately obtained IOTs are acceptable if the IOT was done within the previous 365 days. A value will be recorded for each eye.

45. **Items 71a and b: AUDIOMETER.** Obtain an audiogram by a microprocessor audiometer as part of each MEPS examination. Enter the serial number of the audiometer used for the examination in the box Unit Serial Number and the electro-acoustic calibration date in the Date Calibrated box. Record results from the audiometer slip into the blocks provided.

46. **Item 72a: READING ALOUD TEST.** The cause for medical unfitness for flying class examinations is failure to clearly communicate in the English language in a manner compatible with safe and effective aviation operations. The reading aloud test (RAT) will be performed when required (only on selected applicants). The RAT may be administered by a trained medical department technician (see Training Standardization Job Task Sheet for administering the RAT). If the medical technician determines that the applicant has issues with the RAT, he/she will refer the applicant to the provider to repeat the test and the provider will make the determination of “SAT” or “UNSAT” in item 72a and record his/her observations in item 88. A copy of the reading aloud Paragraph can also be found on SPEAR.

47. **Item 72b: VALSALVA.** The Valsalva maneuver will be performed and annotated, when required, to check movement of eardrums. Check “SAT” box if movement is observed in both tympanic membranes; if not, check “UNSAT”.

62
Item 73: NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY. The medical technicians will use this box to record medical information as specified in USMEPCOM medical regulations.

Item 74a: QUALIFICATION/DISQUALIFICATION FOR SERVICE. Check the appropriate box “IS QUALIFIED FOR SERVICE” or “IS NOT QUALIFIED FOR SERVICE”. If the applicant is not qualified for service, have the applicant sign and date items 75a and b. If an applicant has an open profile (O), then neither box is checked. Any 3T/O or 3P/O in the profile will be checked “IS NOT QUALIFIED FOR SERVICE”.

Item 74b: PHYSICAL PROFILE. Section 11-2 on Profiling.

Item 75. I have been advised of my disqualifying condition, items 75a, SIGNATURE OF APPLICANT, and item 75b: DATE. This section will be signed and dated by the applicant on the date of the examination when the applicant has been informed of a temporary/permanent disqualifying condition. If an applicant becomes disqualified on medical documentation review or when the applicant is not present, a letter stating that the applicant is disqualified and the medical condition that they are disqualified for must be sent to the applicant. The phrase “applicant notified by letter” will be noted in the applicant signature block (item 75a). The letter must be dated the date the applicant was disqualified. A copy of the letter will be placed in the applicant’s medical packet and maintained in a medical office file under Record Number 40/500A, “General Medical Services Files” (see Appendix A, Section III) for 2 years, then destroy.

Item 76: SIGNIFICANT OR DISQUALIFYING DEFECTS. DD Form 2808 item 76 is used only for disqualifying conditions. List all permanent and temporary disqualifications. List item number from the DD Form 2808, the common medical terminology for the condition, the corresponding ICD code, and the profile series (e.g., L3P, P3T) for each disqualifying condition. Annotate the RJ date for all temporary disqualifications. Place a check mark in the disqualified box. The profiler will then record his or her initials.

If an initially disqualifying condition no longer exists, check the qualified box for the condition and line out/initial the disqualified check mark. The medical condition is worded in this item as succinctly as possible given the limited line space. For instance, “Acne” is written in item 76 and “Extensive cystic acne on back, shoulders, and chest” is written in item 77. The use of a “w” in the disqualified block is acceptable but not required.

If a waiver is received for a disqualifying condition, note the Service issuing the waiver and the date that the MEPS received it. If waiver is denied, complete item 86 but leave waiver block in item 76 blank.

Item 77: SUMMARY OF DEFECTS AND DIAGNOSES. Other diagnoses thought by the medical provider to be significant (but not disqualifying) are recorded in item 77. Precede statements with corresponding item numbers, if applicable. If a condition that is under evaluation (identified as O for “open” PULHES) becomes a disqualifying condition (CD), it will then be annotated by completing an additional row in item 76.

Item 78: RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED. This block is used to identify a brief plan of action for each condition requiring further work-up. Precede each entry with a corresponding item number, if applicable. When the plan of action for
a particular item has been completed, write the word “done” and initial for each item. Provide all important additional details (results of lab tests or consults, dates, etc.), explanation, and/or discussion with a dated and signed entry for each in item 88 or SF 507 and indicate in this box to “see item 88” or “see SF 507”.

(55) Item 79: MEPS WORKLOAD. Enter the work identification code (WKID), status (ST), and date. The MEPS Medical NCOIC/SUP MT or trained medical technician will complete item 79 and date and initial each entry. If there are more than six WKID and ST entries, then record additional entries in item 73 or on the SF 507.

(56) Item 80: MEDICAL INSPECTION DATE. Enter the date of the medical inspection followed by the applicant’s height (HT); weight (WT); percent body fat (%BF), if required; and maximum weight authorized (MAX WT) in the appropriate columns. For HCG results (female applicants only), enter “POS” for a positive HCG test result and enter “NEG” for a negative HCG test result. After the inspection is conducted and any new information is annotated, the provider will check qualified or disqualified if indicated, print/stamp and sign his/her name. When conducting a medical inspection, and there is a “3” in the PULHES, block 80 is checked as “disqualified.” Applicants with approved waivers remain disqualified. The use of a “w” in the disqualified block is acceptable but not required.

(57) Items 81a and b: TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER AND SIGNATURE. These items will be completed by the interviewing provider and signed on the date of the interview.

(58) Item 82a and b or Item 83a and b: If a different provider conducted the physical examination, then this provider will print/stamp and sign items 82a and b. If more than one provider participates in the physical examination of the applicant, the second provider prints/stamps and signs items 83a and b. If the physical examination was done by a non-profiling provider, then a profiler will review the record for completeness and prints/stamps and signs items 83 a & b.

(59) Items 84a and b: The profiling provider reviews the medical packet to ensure errors are corrected appropriately. The profiling provider will sign (bottom-line) these items when the PULHES is complete. If there is a T or a T or an O in the profile, then the PULHES is not complete. Note: The reviewing profiler may be the same person as items 81 and/or 83.

Note: Any provider participating in the history interview or physical examination must provide a signature as outlined above in numbers 57-59.

(60) Item 85a, b, c: The medical staff member that performs the review of the medical packet on the date of the initial physical examination will complete these items after reviewing the forms to ensure that any identified deficiencies or errors are corrected appropriately.

(61) Item 86: WAIVER GRANTED. The profiler will checkmark yes or no if a waiver was approved/disapproved and will record the name of the individual issuing the waiver and the date of the waiver. Complete the waiver received column in item 76. If additional space is required (for example, multiple waivers), use item 88 or an SF 507. If waiver is denied, complete item 86 but leave waiver block in item 76 blank.

(62) Item 87: NUMBER OF ATTACHED SHEETS. All medical documentation submitted day of and after the physical will be annotated in Item 87. Any duplicate pages or billing/insurance information can be eliminated. The DD Form 2807-2 and supplemental prescreen documentation does not need to be
counted in this block. Each page of additional documentation must be numbered. The first and last page of additional documents must be stamped/printed with “reviewed and considered”.

(63) **Item 88**: Additional Remarks (extension of blocks 44, 76, 77, or 78).

(a) The provider will use this space to:

1. Document additional information or supply details to provide clarification of the medical decision-making process.

2. Summarize the results of a test or consultation.

3. Document significant interval history including new findings on inspect.

4. Any other relevant medical information the provider deems significant in order to determine or support accession standards.

(b) Date, stamp/print name, and sign every entry. When appropriate, supply corresponding item number. An [SF 507](#) can be used if additional space is required.

**11-2. Profiling**

a. The physical profile (PULHES) is a system for classifying individuals according to functional abilities as defined by Accession Medicine standards. The letter designators are to be considered for the following factors:

1. **P**—Physical capacity or stamina. Includes conditions of the heart, respiratory system, gastrointestinal system, genitourinary system, nervous system, allergic, endocrine, metabolic and nutritional diseases, diseases of the blood and blood forming tissues, dental conditions, diseases of the breast, and all other organic defects and diseases that do not fall under other specific factors of the system (e.g., underweight/overweight).

2. **U**—Upper extremities. Includes the hands, arms, shoulder girdle, and upper spine (thoracic and cervical) with regard to strength, range of motion and general efficiency.

3. **L**—Lower extremities. Includes the feet, legs, pelvic girdle, lower back and lower spine (lumbar and sacral) with regard to strength, range of motion and general efficiency.

4. **H**—Hearing and ears. Includes auditory acuity and diseases and defects of the ear.

5. **E**—Eyes. Includes visual acuity and diseases and defects of the eye.

6. **S**—Psychiatric. Includes personality, emotional stability, psychiatric diseases, and any substance abuse disorders.

7. **X**—Air Force Incremental Lifting Device. This is not used by the medical department.
b. For applicants who are processing under the DoD initial entry medical standards (DoDI 6130.03), each letter designator must be assigned a numerical designator 0, 1, 3T or 3P.

   (1) O—Open status. Further information, such as medical treatment records or consultation is needed. UMF 40-1-2, Record of Medical Examination/Treatment, may be given to the applicant to assist in procuring additional medical information and/or documents required to complete the med read and/or medical examination.

   (2) I—Qualified. Meets the medical fitness standards of the current version of DoDI 6130.03.

   (3) 3T—Disqualified for a temporary medical condition. Must be given an RJ date based on knowledge of medical condition natural history and/or regulatory guidance. J-7/MEMD physicians reserve the right to adjust any RJ date.

   (4) 3P—Disqualified for a permanent medical condition (or one for which the profiler wishes to forward to the medical waiver authority for consideration).

Note: To ensure the right profile designator is entered into USMIRS, a hierarchy will be established: 3P supersedes a 3T, which supersedes an O. Recording the profile in this hierarchical order will ensure the correct profile is entered into USMIRS by the medical technician.

c. Multiple numeric designators can be used under a letter designator. When multiple conditions exist under a letter designator, the profiling provider will use the appropriate number designators for each condition.

   (1) For example, an applicant who has a history of anaphylaxis to penicillin, is overweight, and has a history of asthma that was not disclosed on prescreen would have the following profile:

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<tr>
<th></th>
<th>U</th>
<th>L</th>
<th>H</th>
<th>E</th>
<th>S</th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3P/3T/O</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>CMO</td>
<td>YYYYMMDD</td>
</tr>
</tbody>
</table>

   Figure 11-1. Example of Applicant Profile

   (2) In Figure 11-1, the applicant is 3P for anaphylaxis, 3T for overweight, and O for medical records concerning his asthma. The profiling provider will ensure that the disqualifying conditions are documented in block 76, with an RJ date calculated for the 3T condition. In addition, the profiler needs to ensure that the recommendations/requirements to clear the open or DQ conditions are clearly outlined in block 78. In this example, block 78 would read:

   (a) Item 28: Submit all medical records regarding treatment for asthma, and all records from past 5 years

   (b) Item 54: RJ 16 days to lose 4 pounds (YYYYMMDD)

   (c) Forward for waiver consideration after items 28 and 54 are completed
Note: The applicant should not return for repeat weight measurement until he has submitted the medical records regarding asthma for review. This will cut down on unnecessary visits to the MEPS.

(3) This ensures that any other provider can pick up the chart and know what the profiler was thinking, what is required to close out the profile, and ensures that medical conditions are not overlooked.

(4) In Figure 11-1 above, once the applicant submitted the medical records, the profile would be changed to P=3T/3P (Figure 11-2, line 2); once the applicant returns and is within weight/body fat standards (Figure 11-2, line 3), the physician will complete the final profile and make a waiver recommendation.

<table>
<thead>
<tr>
<th>P</th>
<th>U</th>
<th>L</th>
<th>H</th>
<th>E</th>
<th>S</th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3P/3T/O</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>CMO</td>
<td>YYYYMMDD</td>
</tr>
<tr>
<td>3P/3T</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>CMO</td>
<td>YYYYMMDD</td>
</tr>
<tr>
<td>3P</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>CMO</td>
<td>YYYYMMDD</td>
</tr>
</tbody>
</table>

Figure 11-2. Example of Applicant Profile Continued

(5) In Figure 11-2 above, as the steps are completed, item 78 will look like this:

(a) Item 28: Submit all medical records regarding treatment for asthma, and all records from past 5 years **DONE, INITIALS**

(b) Item 54: RJ 16 days to lose 4 pounds (and give the date) **DONE, INITIALS**

(c) Forward for waiver consideration after items 28 and 54 are completed

d. Applicants whose records must be referred to a SMWRA for consideration must have a final closed profile (no 0 or 3T conditions, and blocks 84a and 84b completed). Services should not send medical records for waiver consideration if the profiling provider has requested further documentation or consultation. If the profile contains 0/3T as well as a 3P, the MEPS provider should contact the SMWRA to discuss the 3P before spending consult funds to close the profile so a waiver could be granted.

(1) MEPS providers are the eyes/ears of the SMWRAs; the only information they have is what the MEPS providers put on the record. Once the profiler has completed a profile with a permanently disqualifying condition, it is important to clearly make a recommendation, based on knowledge of the natural history/progression of the condition, as well as knowledge of the rigors of military training, to either recommend or not recommend a waiver.

(2) In Figure 11-2 above, penicillin is an easily avoidable substance; block 78 would read:

(a) Item 28: Submit all medical records regarding treatment for asthma, and all records from past 5 years **DONE, INITIALS**

(b) Item 54: RJ 16 days to lose 4 pounds (and give the date) **DONE, INITIALS**

(c) Forward for waiver consideration after items 28 and 54 are completed. **WAIVER RECOMMENDED BY CMO**
e. Applicants discharged from the military by a medical or physical evaluation board (MEB, PEB) may not be found qualified by MEPS providers. Forward these records to the appropriate SMWRA for waiver consideration, along with your recommendation for waiver based on history and exam findings.

f. Temporary profiles given at one MEPS may be terminated at another MEPS if the reason for the temporary profile no longer exists.

g. Permanent profiles given at one MEPS may be changed at another MEPS for one of the following:

   (1) The permanent profile was originally given for a condition that has corrected itself or has been corrected by appropriate treatment (e.g., termination of a pregnancy or successful surgical correction of a hernia).

   (2) A J-7/MEMD Battalion Support Accession Medicine Branch physician concurs that the original profile was issued in error.

   (3) The regulatory guidance has changed, making the condition no longer disqualifying.

h. When changing a physical profile (e.g., from a disqualified or open status to a qualified status) or correcting an error in the profile, the entire profile will be annotated in the next row and the profiling provider will record his or her initials and the date of the transaction in the designated items.

i. If more than the five rows are needed to annotate changes to an applicant’s profile, indicate in box 74b after the words “Physical Profile” that additional profiles can be found in item 88. If space is not available in item 88, use an SF 507.

11-3. Medical Waivers

a. A current list of the SMWRA members and contact information is located on SPEAR for consultation as needed.

b. Medical Waiver Recommendations

   (1) Factors to consider in making a medical waiver recommendation:

      (a) Is the condition progressive?

      (b) Is the condition subject to aggravation by military service?

      (c) Will the condition preclude satisfactory completion of training and subsequent military duty?

      (d) Will the condition constitute an undue hazard to the applicant or to others?

   (2) If the MEPS physical is expired, all medical waivers are also expired.

   (3) Medical waivers granted by one Service are not valid for another Service.
(4) MEPS providers do not have medical waiver authority for any condition.

Note: Do not make recommendations for Marine weight waivers.

c. SMWRA Consultation/Ancillary Services Requests

(1) At times, the SMWRA will request additional documentation and/or consultations/ancillary services in order to make a medical waiver decision. SMWRA requests for consultations/ancillary services will be analyzed by the CMO for appropriateness and need. The CMO will determine if the consultation/ancillary service request makes clinical sense. If not, the consultation/ancillary service request should not be approved. If needed, coordinate with J-7/MEMD when disapproving a request.

(2) When a detailed and legibly documented history and physical has been performed, and the provider feels that a consult is not necessary, the SMWRA will be contacted directly by the provider.

(3) If issues arise at any point during this process, contact J-7/MEMD or submit a MOC ticket.

11-4. Medical Read

A “med read” is any applicant medical documentation that has been requested and/or supplied following the initial physical examination, to include medical waivers from SMWRA. Waiver reviews will be done as soon as possible but are required to be completed no later than the next working day. Reviews of additional medical documentation will be done as soon as possible but are required to be completed no later than 4 working days after submission for review. In the instances of exceptionally complex cases a longer review may be required as determined by the CMO. In these cases, the medical department will notify the Service Liaison within the initial 4 working day period with an estimate of how much additional time may be required to complete the med read.

After the review, the MEPS provider will summarize the pertinent medical information on DD Form 2808 item 88 (or SF 507). Additionally supplied medical documents that were reviewed by the MEPS provider are now a permanent part of the medical packet along with the DD Form 2808.

Note: UMF 40-1-2, Report of Medical Examination/Treatment, may be given to the applicant to assist in procuring additional medical information and/or documents required to complete the med read and/or medical examination.

11-5. Disqualified Applicant Notification

a. If notified in person, the MEPS provider will explain to the applicant the nature of the disqualification. The applicant must be informed of any significant medical condition and whether or not this condition needs immediate medical attention. The applicant will be referred to his or her physician if any medical condition is found that requires further evaluation and/or treatment. The applicant must be advised that his/her medical issue can be reconsidered following evaluation and/or treatment but no guarantee of medical qualification should be indicated. Additionally, the applicant must be advised that the government will not cover any costs of evaluation and/or treatment of his/her medical issue. The applicant must sign item 75a and enter the date in item 75b. The applicant’s signature is to verify notification of the disqualification and of the instructions given by the provider.
b. If the applicant is not present, the CMO/ACMO/FB-CMO will send a letter advising of the disqualification and suggesting medical treatment (if needed), annotate in item 75a on the DD Form 2808 “Applicant notified by letter”, and enter the date of the notification in item 75b. If the applicant is a minor, a letter will also be sent to the applicant’s parent/guardian.

c. Those disqualified with dangerous and/or life-threatening medical conditions must be sent a certified letter by the CMO/ACMO/FB-CMO and when the signed acknowledged receipt is returned, it must be included in the medical administration file. The fact that the applicant may have been notified personally does not negate the requirement for a certified letter.

d. Copies of all letters sent to applicants will be placed in the applicant’s medical packet and in a medical administration file for two years. Templates for both letters can be found on SPEAR and in Appendix E. Letter templates should also be saved to several medical department local share drives in the event of connectivity issues.

e. When an applicant reveals a medical condition without supporting medical documentation (for example, allergy, counseling, etc.), attempts to obtain additional medical documentation or treatment records must be made and the profile will be adjusted accordingly.

11-6. Air Force X-Factor Testing

a. All Air Force applicants must have an X-Factor code for Air Force Specialty Code (AFSC) processing. The X-Factor weight levels start at 40 pounds and reach a max weight of 110 pounds and the Air Force does this testing using an incremental lifting device (ILD). The applicant starts with knees slightly bent and lifts the handles of the machine up into a standing overhead press.

b. For applicants who have a TDQ or PDQ in the Hearing (H), Vision (E), and/or Psychiatric (S) categories of the PULHES, MEPS providers are authorized to annotate on item 88 of the DD Form 2808: "DQ condition does not preclude X-Factor testing." For applicants who have a TDQ or PDQ in the Physical Condition (P), Upper (U), and Lower (L) categories of the PULHES, MEPS providers are authorized to annotate on item 88 of the DD Form 2808: “Medical Waiver permission needed for X-Factor”. At no time will the MEPS medical providers and/or medical staff be used for conducting or medical coverage during the X-Factor test.
Chapter 12
Orthopedic/Neurologic

12-1. Orthopedic/Neurologic Screening Examination
The orthopedic/neurological examination may be performed individually or in groups to afford accurate and detailed observation of applicants. This screening is an important part of the applicant’s medical examination, and, when combined with the physical examination and medical history interview, the provider will have a complete overall assessment of the applicant. Trained MEPS personnel will verbally describe and/or physically demonstrate each maneuver, allowing the provider the freedom of observation. This can also be accomplished by using the ortho-neuro DVD. Demonstrator must be the same sex as the applicants being tested. The demonstrator will inform the provider of any suspected abnormality detected. The provider has the option to lead the session. The provider must be in the room while the orthopedic/neurologic maneuvers are being completed by the applicants.

Note: Blood pressure, pulse, a negative HCG result, and medical history interview must be obtained prior to the ortho-neuro examination.

a. The purpose of this examination is to observe for and discover the following:

(1) Abnormalities in constitution, posture, habitus, and gait
(2) Deformities, particularly of extremities
(3) Reduced Range of Motion (ROM) of joints
(4) Muscle absence, decreased muscle bulk, or muscle atrophy
(5) Reduced muscle strength
(6) Reduced coordination
(7) Missing digits, incomplete digits, extra digits, or digit deformities
(8) Skin eruptions and other skin abnormalities
(9) Apprehension, reluctance, or inability to perform a prescribed maneuver because of fear that it will produce pain or dislocate a joint
(10) Clinically significant scars, including skin grafts
(11) Other abnormalities

b. The orthopedic/neurologic examination is a series of provocative maneuvers intended to identify orthopedic or neurological abnormalities that must be further investigated by the examining provider (or by an appropriate medical consultant). It is not an exercise or strength test. Difficulty or inability to perform a maneuver is not disqualifying, but the underlying condition or defect may be disqualifying.
c. The orthopedic/neurologic examination (O.N.E.) begins with the provider, trained MEPS personnel, or the ortho-neuro DVD asking all applicants, as a group, if they have had any of the following:

1. Current or recent injuries
2. Cardiovascular/heart problems
3. Recent surgery

d. If the additional history requires detailed questioning, it must be done in private. Instruct applicants to immediately report any pain, numbness, or other problems that develop during the examination.

e. Trained MEPS personnel and experienced medical technicians must verbally describe and/or physically demonstrate each movement, as described below. The provider must be able to closely observe each applicant during every prescribed maneuver. The number of applicants is determined by the physical layout and size of the room in which the examination is conducted. The number of providers required is limited by the provider’s ability to view all maneuvers of the applicants they are overseeing and the ability of the applicants to complete all maneuvers. It is highly recommended that there be no more than 8 applicants performing the O.N.E. per monitoring provider.

f. While providers and/or trained MEPS personnel medical technician may choose to exercise their discretion by varying the order of O.N.E. movements, all maneuvers must be accomplished with all applicants.

g. The recommended sequence for the orthopedic/neurologic examination maneuvers as follows:

1. Arch and feet examination

   **(a) APPLICANTS:** Stand relaxed with arms to the side, heels together, feet spread at least 90 degrees for inner arch evaluation, thereby simultaneously evaluating the required minimal 60 degree individual hip abduction requirement.

   **(b) PROVIDERS:** Observes each applicant for:

   1. General body habitus
   2. Clinically significant scars and skin abnormalities
   3. Pes planus, Pes cavus, hallux valgus, hammertoes, and other foot deformities

2. Arm circles

   **(a) APPLICANTS:** Make full arm circles by extending arms forward, rotating above the head, back, and down to complete full circles. Repeatedly mimic swimming backstrokes by simultaneously rotating both fully extended arms backward from each shoulder (liked paired windmills) by circularly rotating both shoulders backwards while maintaining fully extended and locked elbows above the head, back, and down to complete full circles. Repeat until instructed to stop.
(b) PROVIDERS: This is a provocative test intended to aggravate or induce shoulder subluxation and shoulder pain in those applicants with shoulder problems or concealed history thereof. Observe each applicant for:

1. Symmetry and coordination of shoulders, clavicles, and arms
2. Subluxation of shoulders
3. General coordination and balance
4. Facial grimacing / Facial Apprehension Sign
5. Impaired shoulder abduction to less than 90 degrees
6. Impaired shoulder forward elevation to less than 90 degrees.

(3) Arms out and Flex elbow/touch shoulder

(a) APPLICANTS: Fully extend arms out laterally at right angles to body, make fists with thumbs pointing up and elbows locked. Flex elbows and touch thumbs to shoulder. Repeat rapidly until told to stop.

(b) PROVIDERS: This is a provocative test intended to aggravate or induce elbow subluxation and elbow pain in those applicants with elbow problems or concealed history thereof. Observe each applicant for:

1. Impaired elbow extension failing to fall within the 0 – 15 degree range
2. Impaired elbow flexion failing to meet or exceed 135 degrees
3. Elbow subluxation
4. Uncoordinated movement
5. Deltoid weakness

(4) Arm flap

(a) APPLICANTS: Extend arms to the ceiling and lower sharply to side of the body without slapping the sides. Repeat until told to stop (applicants need to face away from the examiner in order to have scapulae observed).

(b) PROVIDERS: Observes each applicant for:

1. Winging of the scapula
2. Full range of shoulder excursion to no less than 180 degrees
3. Position and movement of the scapula

4. Muscular Atrophy of the paraspinal musculature

5. Muscular Atrophy of the shoulder girdle

6. Subluxation of the shoulders

(5) Swan dive or cheerleader Y

(a) APPLICANTS: Begin by extending both arms in front at shoulder level, with both palms together and with both thumbs pointing upward. Then, perform a forceful sweeping shoulder hyperabduction posteriorly throwing both shoulders to the rear, both beyond and slightly above shoulder level, while simultaneously standing on tip toes, thereby raising the applicant’s body as the arms hyperabduct, and then returning the feet to a standing foot level position as the hands return in front of the nose with the extended and locked elbow position maintained. Repeat until instructed to stop.

(b) PROVIDERS: This is a provocative test intended to aggravate or induce shoulder subluxation and shoulder pain in those applicants with shoulder problems or concealed history thereof. Observe each applicant for:

1. Symmetry and coordination of shoulders, clavicles, and arms

2. Subluxation of shoulders

3. General coordination and balance

4. Facial grimacing / Facial Apprehension Sign

5. Impaired individual shoulder abduction to less than 90 degrees (R.O.M. for both shoulders together less than 180 degrees)

6. Impaired individual shoulder forward elevation to less than 90 degrees (R.O.M. for both shoulders together less than 180 degrees)

(6) Bend over for spine exam

(a) APPLICANTS: Stand relaxed, extend arms above head, locking thumbs together; bend over forward and touch floor with fingertips, if able, keeping the knees straight. Bend forward at the waist touching the floor with both hands, so that the spine may be palpated.

(b) PROVIDERS: Observe each applicant for:

1. Scoliosis Angle exceeding 30 degrees in the frontal (coronal) plane

2. Thoracic Kyphosis Angle exceeding 50 degrees in the lateral (sagittal) plane

3. Lumbar Lordosis Angle exceeding 50 degrees in the lateral (sagittal) plane
3. Possible Pelvic Tilt

4. Possible Leg Length Discrepancies exceeding 2 inches or causing limping

(7) Toe crunch and ankle rotation

(a) APPLICANTS: Stand up straight, extend one leg forward, lifting foot from the floor, toes down, then up; then relax toes and rotate foot at the ankle. Repeat until told to stop (repeat for other leg when instructed).

(b) PROVIDERS: Observes each applicant for:

1. Inability to dorsiflex the ankle to at least 10 degrees upward
2. Inability to plantarflex the ankle to at least 30 degrees downward
3. Inability to circularly rotate the ankle at least 5 degrees
4. Uncoordinated movements and/or imbalance
5. Open or unhealed wounds

(8) Kicks forward and backward

(a) APPLICANTS:

Repeatedly mimic a series of forceful heel strikes, also known as “can crushes”. Do not touch or hit the floor with the heel of the foot. When directed, begin by

1. Flex right thigh at least 90 degrees at hip, bringing the knee up, with at least 10 degrees of ankle dorsiflexion of the same ankle; flex at the knee; then forcefully lower the foot, leading with the heel, kicking down and forward. Repeat until told to stop. Then repeat the maneuver with the knee up and flexed, this time kicking down and rearward. Repeat until told to stop.

2. Repeat these maneuvers with opposite leg.

(b) PROVIDERS: This is a provocative test intended to aggravate or induce knee subluxation and knee pain in those applicants with knee problems or concealed history thereof. Observe each applicant for:

1. Limited Hip Flexion with incapacity to achieve the 90 degree hip flexor minimum
2. Limited Knee Flexion with incapacity to achieve the 110 degree knee flexion minimum
3. Limited Knee Extension with incapacity to lock the knee at 0 degrees knee extension
4. Anterior Knee Subluxation when attempting to extend and lock the knee forwardly at 0 degrees
5. Posterior Knee Subluxation when attempting to extend and lock the knee rearwardly at 0 degrees

6. Apprehension to BRISKLY perform the maneuver

7. Primary Knee Joint Pain manifesting as Facial Discomfort or Facial Grimacing

8. Hesitancy to perform the maneuver

9. Knee joint integrity and stability

10. Inability to upwardly dorsiflex the ankle to at least 10 degrees

9) Tiptoe walk and Heel walk

(a) APPLICANTS: Stand on toes as high as possible, and walk on tiptoes five steps forward. Turn 180 degrees and return walk on tiptoes five steps to original position. Then walk five steps forward on your heels maintaining both toes and forefeet as high as possible. Turn 180 degrees and return walk on your heels five more steps to original position.

(b) PROVIDERS: Observe each applicant for:

1. At least 30 degrees of plantar flexion

2. At least 10 degrees of ankle dorsiflexion

3. Plantar Flexor weakness

4. Foot Drop weakness

5. Spastic Weakness with or without clonus

6. Uncoordinated limb movement (from Appendicular Ataxia)

7. Uncoordinated torso movement (from Truncal Ataxia)

8. Atrophy and/or muscle wasting

10) Squats

(a) APPLICANTS: Repeatedly mimic the motion of a baseball catcher by alternating between standing straight and squatting positions several times.

(b) PROVIDERS: Observes each applicant for:

1. Pain from the hips, knees, or ankles upon squatting and standing

2. Lateral patellar motion
3. Integrity of the knees and hips
4. Hesitancy to fully squat or to stand
5. Imbalance

(11) Duck walk

(a) APPLICANTS: Duck walk five steps forward while maintaining balance in a squatting position. Applicants are to keep their rear end low to the floor without touching the floor with their hands at any time. Each leg movement has three {3} distinct components of motion, namely 1) leading with the heel, then 2) rolling from the heel of the same foot to the toes of the same foot, and finally 3) side shifting one’s body weight to same leg in a waddling twisting motion; followed by a pivot/turn and duck walking back five steps to original position.

(b) PROVIDERS: Observe each applicant for:

1. Medial knee (medial collateral ligament and/or medial meniscal) pain brought on by initiating a heel motion

2. Lateral knee (lateral collateral ligament and/or lateral meniscal) pain brought on by initiating a shifting of body weight laterally (initiating a waddling motion)

3. Patellar subluxation

4. Inability of each hip joint to rotate at least 60 degrees with the combined internal and external waddle motion

5. Inability of each hip to abduct at least 45 degrees lateral to applicant’s neutral center of mass

6. Incapacity to flex each hip individually at least 90 degrees

7. Incapacity to flex each knee individually at least 110 degrees

8. Shortening of the Achilles’ Tendon(s)

9. Tendonopathy of the Achilles’ Tendon(s)

10. Plantar Fasciitis

11. Symptomatic Plantar Warts

12. Deconditioning

13. Overweight status

14. Uncoordinated movements
15. Imbalance

(12) Knee drop

(a) APPLICANTS: Applicants form a row with their feet together and simultaneously squat with both knees together. One at a time, each applicant drops onto the floor while hitting both knees simultaneously upon the floor.

(b) PROVIDERS: Observe each applicant for:

1. Apprehension to simultaneously drop onto both knees
2. Knee and/or hip pain
3. Hesitancy to have both knees simultaneously strike the floor (involuntary guarding)
4. Tibial Tuberosity pain (Symptomatic Osgood-Schlatter’s Disease)
5. Facial grimace

(13) Knee walk

(a) APPLICANTS: Applicants walk forward five steps on their knees and stop.

(b) PROVIDERS: This is a provocative test intended to aggravate or induce knee pain and symptomatic Osgood-Schlatter’s disease. Therefore, providers observe each applicant for:

1. Posterior knee subluxation
2. Tibial Tuberosity pain (Symptomatic Osgood-Schlatter’s Disease)
3. Knee pain
4. Apprehension
5. Facial grimace
6. Hesitancy to crawl on their knees

(14) Stand up from kneeling position

(a) APPLICANTS: From the kneeling position, applicants tuck their toes under both feet (namely, dorsiflex their toes) and, when instructed to rise, then one applicant at a time will rise to standing position in one smooth motion, without taking any extra steps or hops and without touching their hands to the floor. Applicant may separate feet for better balance.

(b) PROVIDERS: Observes each applicant for:

1. Rigid great toes and/or additional rigid toes
2. Rigid ankles unable to dorsiflex at least 10 degrees

3. Uncoordinated movements

4. Imbalance

5. Apprehension to stand because of anticipated pain will be stopped by the provider prior to attempting the maneuver.

6. Deconditioning

7. Overweight status

(15) Sole of foot examination

(a) APPLICANTS: In a standing position, flex the knee and grab an ankle with the corresponding hand so that the sole of the foot may be inspected (repeat for the other ankle/foot).

(b) PROVIDERS: Observe each applicant for:

1. Plantar warts

2. Athlete’s foot fungus

3. Open or unhealed wounds

(16) Repeat number 15 with the other foot

(17) Palms up/down

(a) APPLICANTS: Facing the examiner, flex elbows to right angles with elbows touching the torso with all fingers separated and extended, first palms up and then palms down:

(b) PROVIDERS: Observe each applicant for:

1. Missing digits, incomplete digits, extra digits, or digit deformities

2. Restricted Supination surpassing 45 degrees of impaired motion

3. Restricted Pronation surpassing 45 degrees of impaired motion

4. Skin eruptions, including eczema, psoriasis, atopic dermatitis, tinea versicolor, ashy dermatosis, lichen planus, and other skin abnormalities

(18) With palms up, repeatedly flex and extend fingers (make a fist). Repeatedly open and close until instructed to stop.

(19) Turn palms down and extend fingers, with elbows remaining at right angles against the body.
(20) Turn palms up and touch each fingertip in turn to the thumb tip; continue until told to stop.

(21) Turn palms down, fingers extended, and repeatedly flex and extend hands up and down at the wrists. Repeat until told to stop.

(22) Turn palms down, fingers extended, and repeatedly move hands left and right at the wrists. Repeat until told to stop.

**PROVIDERS:** Observe steps (18-22 above) each applicant for:

(a) Impaired Up Down Wrist Range of Motion less than 60 degrees

(b) Impaired Left Right Wrist Range of Motion less than 30 degrees

(c) Impaired Pronation greater than 45 degrees (from the vertical plane)

(d) Impaired Supination greater than 45 degrees (from the vertical plane)

(e) Inability to touch the thumb to any of the fingertips

(f) Compromised finger dexterity

(g) Inability to clench a fist

(h) Median Nerve Neuropraxia

(i) Ulnar Nerve Neuropraxia

(j) Radial Nerve Neuropraxia

(k) Muscle atrophy

(23) Brisk walk

**APPLICANTS:** Walk briskly, one by one, in a straight line toward the examiner; stop in front of the examiner, turn, and walk away from the examiner.

**PROVIDERS:** Observes each applicant for:

1. Limping

2. Gait apraxia or imbalance

3. Deconditioning

4. Lower extremity pain

5. Spasticity/hyperreflexia at the ankles
(24) Optional Maneuver (if scapula issue discovered during “arm circles” maneuver)

(a) APPLICANT: Assume a half push up hold position on the floor. An acceptable alternative is to stand upright and lean into a wall at a 45 degree angle with elbows flexed at least to 45 degrees.

(b) PROVIDERS: Observes each applicant for:

1. Winging of the scapula
2. Full range of elbow flexion to no less than 130 degrees
3. Position and movement of scapulae
4. Muscular Atrophy of the paraspinal musculature
5. Muscular Atrophy of the shoulder girdle
6. Posterior Subluxation of the shoulders
Chapter 13
Consultations

When appropriate, MEPS medical personnel may request specialty consultations and other medical services. These consults and/or services must be approved by the CMO. The MEPS profiler, and not the consultant, makes the final determination if the applicant meets accession standards for military service. Specify in the consult request that the consultant will not comment on the applicant’s fitness for military service. Applicable charges for consultation services are payable from Defense Health Program (DHP) funds made available to USMEPCOM when said consults are obtained for the purposes of determining whether or not an applicant meets qualification standards or if requested by SMWRA in order to make a waiver determination.

Note: All applicants will be checked-out to a "CON" status in USMIRS when departing the MEPS for a consult appointment and will be checked-in upon return.

a. An applicant may be required to return to the MEPS for a consultation that cannot be done on the same day as the initial physical.

b. Applicants who need consultations or medical records will be profiled “0” under the appropriate letter.

c. All consult data must be entered into USMIRS upon initiation and updated once the consult has been completed.

d. SMWRA requests for consults must be analyzed for appropriateness and need by the CMO. The CMO will determine if the consult request makes clinical sense. If not, the consult request should not be approved. When a detailed and legibly documented history and physical has been performed, and the provider feels that a consult is not necessary, the SMWRA will be contacted directly by the provider.

Note: No medical testing/consults will be scheduled until the applicant receives a qualifying Armed Services Vocational Aptitude Battery (ASVAB) score.

13-1. Using Consultants
MEPS may use specialty physicians, either military or civilian, to perform consultations necessary to determine an applicant’s medical fitness.

a. Those MEPS medical departments that do not schedule consultations from a local MTF must use contracted consult providers for applicant consults. If contracted consultants are not available, either due to provider non-availability or the requested specialty is not a contracted service, then the MEPS medical department must submit a MOC ticket to J-7/MEMD requesting the use of a local provider. The consultant must be board certified in his/her specialty and will render expert medical opinion regarding the specific medical condition.

b. A MEPS provider may make a final determination of an applicant’s x-rays if he/she has the requisite training (e.g., board certification or residency in family practice, orthopedics, radiology, emergency room physician) and feels comfortable with this responsibility. If the provider does not feel comfortable or have the requisite training and the reading is needed for qualifications determination, request a radiology report. X-rays will not be ordered or performed on pregnant female applicants.
c. If a non-contracted consultation has a combined cost of more than $1,500.00 (test and consultation), J-7/MEMD approval is required before scheduling the appointment.

**13-2. Payment of Consultants**

a. Consultants are paid negotiated rate under the Medical Specialty Consultation contract, Government Purchase Card (GPC) or Standard Form 1034, (Public Voucher for Purchases and Services Other Than Personal). In some cases, non-contracted consultants require payment for missed appointments. This type of payment should be negotiated by the local MEPS prior to scheduling the applicant’s appointment.

b. FBPs shall not conduct consultations even if the consult required is in their particular specialty.

c. All vendor consult vouchers must be kept on file for one year.

d. See SOP on SPEAR for instructions on the use of the Invoice Reconciliation Portal (IRP).

**13-3. Specialty Consultations**

a. If possible, consultations will be obtained on the day of the physical examination. Consultations are valid as long as the condition for which it was obtained has not changed.

   (1) It is advisable that the MEPS medical department designate an individual to contact the Service Liaisons to confirm the applicant’s desire to complete the consultation, in order to decrease the consult no-show rate. Each MEPS medical department will receive the applicant’s email address and cell phone number from either the applicant or Service Liaison prior to scheduling an appointment with the vendor. The applicant’s email address and cell phone number will be recorded on the SF 513 (Medical Record Consultation Sheet).

   (2) The first missed consultation appointment by the applicant can be rescheduled at the request of the Recruiting Service. If a second consultation appointment is missed, the MEPS Commander will notify the appropriate IRC level Commander in writing or by email that the applicant’s processing has been placed in an ‘N’ status. Further appointments will not be scheduled without a written request from the IRC-level Commander. If the applicant misses a third appointment, further processing will be discontinued unless directed by J-7/MEMD.

   (3) Applicants will not be tested or receive consultations to determine qualification for special duty or programs.

   b. Exercise Pulmonary Function Tests (PFTs, pre- and post-bronchodilators) may be obtained by MEPS providers to determine the status of asthma. Requests for additional testing (e.g. Methacholine Challenge Tests (MCTs)) by the SMWRA will require J-7/MEMD approval through a MOC request.

   c. The CMO will review all consult requests. The CMO will ensure thorough training of all MEPS providers that consultations are written professionally and the exact purpose of the consult is relayed to the consultant. The SF 513 will state exactly what the MEPS provider expects from the consultant. Request appropriate ICD coding, and attach copies of applicable records to the SF 513.
d. Consultations will not be scheduled if there is a valid RJ date.

e. Specialty consultations and test results, civilian treatment, and hospitalization records pertaining to the applicant’s health are part of the medical examination and will be filed in the applicant’s packet.

13-4. Consult Contractual Timeframes
IAW the current contract, the contractor shall make every effort to schedule and complete consultations on a same day basis. The following consults and all associated services should be accomplished within the following guidelines:

a. The following specialties for only the specified services listed below shall be available for scheduling and completing a same day consultation. Request for same day service must be submitted before 1200.

   (1) ENT: Ear Wash/Irrigation

   (2) Optometry: Refraction, Stereoscopic, Spherical Equivalent, Motility Measurement, Keratometric-Reading, Contact Tonometry, Corneal Mapping

   (3) Cardiology: EKG w/interpretation

Note: In the event that a same day service is requested, but the applicant is unavailable for a same day consultation appointment, the MEPS will notify the vendor when the order is submitted. The specified services shall then be available for consultation completion within 10 business days (1 Day for Schedule + 9 days to complete consultation and medical testing and/or laboratory service).

b. The following specialties for only the specified services listed below shall be available for consultation completion within 10 business days (1 day for schedule + 9 days to complete consultation and medical testing and or laboratory service). All appointments scheduled will include 3 business days advance notice to the MEPS to allow an appropriate notification timeframe for the applicant and respective Recruiting Service Liaison.

   (1) Orthopedics: Consult with X-ray

   (2) Psychology: Consultation

   (3) Psychiatry: Consultation

   (4) Audiology: Hearing Test

   (5) Cardiology: Echo with interpretation

c. Dental consultations shall be available for consultation completion within 19 days (1 day for schedule, 18 days to complete consultation and x-rays if necessary. All appointments scheduled will include 3 business days advance notice to the MEPS to allow an appropriate notification timeframe for the applicant and respective Recruiting Service Liaison.
d. All other specialties not listed above shall be available for consultation completion within 24 business days (1 day for schedule + 23 days to complete consultation and medical testing and/or laboratory services). All appointments scheduled will include 3 business days advance notice to the MEPS to allow an appropriate notification timeframe for the applicant and respective Service Liaison.

e. The MEPS must complete a Specialty Consultation Contract/Ancillary Services Contract Performance Report (UMF 40-1-5) anytime the contractor is not performing to established contractual standards. Examples include not meeting contractual timelines, invoice errors or not receiving the correct consultation that was ordered. The completed form must be sent to the consult COR in J-7/MEMD.

13-5. Consultation MOC Ticket Procedures
The MEPS medical department will submit a MOC ticket request if they receive a response from the vendor scheduling portal or the scheduling staff representative that they cannot support the request IAW the established timelines of the consultation contract (same-day, 10-day, or 24-day services – see consult contractual timeframes above). The MOC ticket may be submitted for either informational purposes to notify the COR of the timeline failure or to submit a formal request for approval to use a non-contract provider for faster service.

13-6. How to order a Consult from the Contracted Consult Provider
Follow the SOP found on SPEAR to order a consult from the contracted consult provider.

13-7. Non-Contracted Consult Provider Consults
Non-contracted consult payments will be completed by using the Standard Form 1034, Public Voucher for Purchases and Services Other Than Personal or Government Purchase Card (GPC). The MEPS medical department must ensure that only those services not covered by contract are obtained using this method.

13-8. Invasive and Other Special Procedures
MEPS providers will not order (or consent to a consultant ordering or performing) any of the following procedures without first obtaining the consent of J-7/MEMD:

a. Endoscopy.

b. Nuclear medicine procedures.

c. Cardiac stress tests (except if requested by the SMWRA for over-40 year-old applicants).

13-9. Ancillary and Laboratory Services

a. Ancillary and laboratory services can be ordered in conjunction with a specialty consultation or as a stand-alone service. When ordered with a consultation, from the contracted provider or MTF, the results will be provided with the overall consultation results.

b. Stand-alone ancillary and laboratory services are ordered without an associated specialty consultation visit. For example, if the CMO requests “x-rays only” for an applicant, these tests are ordered without a specialty consultation, and will be received with a radiology report/interpretation from the facility providing the x-rays. These stand-alone services are not covered in the current consult contract, and should not be ordered from the contract provider.
13-10. Payment of Ancillary and Laboratory Services

a. Ancillary and laboratory services are paid locally negotiated rates with the Government Purchase Card (GPC) or SF 1034, (Public Voucher for Purchases and Services Other Than Personal). In some cases, facilities require payment for missed appointments. This type of payment should be negotiated by the local MEPS prior to scheduling the applicant’s appointment.

b. All vendor consult vouchers must be kept on file for seven years.

c. See SOP on SPEAR for instructions on the use of the Invoice Reconciliation Portal (IRP).

13-11. Transportation

a. Transportation to/from consults, ancillary services, and laboratory services, scheduled by the MEPS, will be provided by the MEPS IAW UMR 715-4.

b. USMEPCOM has the funding responsibility to pay transportation costs for applicant transportation to medical consult, ancillary, and laboratory appointments.
Chapter 14
Medical Check Out

Applicants will be biometrically checked out of the MEPS medical department using e-Security. The medical packet will be reviewed for completeness upon checkout.

Note: Applicants will not carry their medical packets from the medical department (excluding shippers) to operations/Service liaisons. After check-out, if the medical packets need to be transferred from the medical department to operations/Service liaisons for any reason, only MEPS staff will hand carry the packets.

14-1. Shipper Check Out

    a. The shipper’s medical packet will have previously been reviewed at QRP. At the time of check-out, the medical technician will review the day-of medical data in the medical packet to ensure that all data is present and that the applicant is medically qualified to ship.

    b. The medical technician will assign a WKID based on the PULHES. USMIRS will be updated with the shipper’s height, weight, body fat (if applicable), HCG (for females), and waiver (if applicable). A current 680-3ADP may be printed and added to the applicant’s medical packet.

    c. The complete medical packet will be given back to the shipper.

14-2. Inspect Check Out

    a. The applicant’s medical packet will have previously been reviewed at QRP. A review of why the applicant is returning must be made to expedite medical processing.

    b. The medical technician will assign a WKID based on the PULHES and the most recent data from the applicant’s packet will be transcribed into USMIRS. A current 680-3ADP may be printed and added to the applicant’s medical packet.

    c. When finished processing through the medical department, applicants may receive a copy of the DD Form 2807-1 and DD Form 2808, stamped or printed, "Working Copy", and any pertinent medical documents.

14-3. Full Physical Check Out

    a. The applicant will report to the medical control desk with their medical packet. The medical technician will assign a WKID based on the PULHES and the data from the applicant’s packet will be transcribed into USMIRS. A current 680-3ADP may be printed and reviewed against the DD Form 2808 and corrected in USMIRS if necessary.

    b. A thorough QC will be done on the medical packet before the applicant leaves the medical department. Instructions for completing the QC can be found in the Training Standardization Job Task Sheet.

    c. For further MEPS processing, applicants will receive a copy of the DD Form 2807-1, DD Form 2808, and UMF 40-1-15-1-E (MHPI), stamped or printed "Working Copy", and any pertinent medical documents.
d. Once medical processing is complete, keep original medical jacket (DA Form 3444 or DA Form 8005 series) to include all forms in the medical department in a secured/locked cabinet until the HIV and drug results are posted to the DD Form 2808 IAW UMR 40-8.

14-4. Temporary Check Out
If the applicant has to leave the medical department for a short period of time (but is not leaving the premises), he/she must check out with a medical technician. The medical technician must take control of the applicant’s medical packet.

14-5. Quality Check and Scanning of UMF 40-1-15-1-E

a. MEPS Medical Department personnel can make certain corrections to the form if they find an error upon daily QC out of the Medical Department. These are:

   (1) If the date in block 3 of the front side of the form is not present or incorrect

   (2) If the MEPS bubble in the MEPS CODES block is not present or incorrect

   (3) If the bubbles that designate CMO/ACMO/FBP in the PROVIDER 3 INITIALS block are missing (not the actual initials the actual title above the initials boxes)

b. MEPS medical department must scan the UMF 40-1-15-1-E daily (or at least by the next working day at noon). MEPS medical department must ensure sheets are filed in the applicant’s medical packet after scanning. The use of Testing 2000 scanners is not authorized.

14-6. Reconciliation

a. Reconciliation is the process whereby the transactions performed on a daily basis are compared with computer generated products and data is reentered when needed.

b. The Medical NCOIC/SUP MT must ensure medical reconciliation has been accomplished each morning and before COB and must ensure medical transactions have been entered and committed in USMIRS IAW UMR 680-3.

c. The medical department personnel is responsible to reconcile on a daily basis the UMF 727-E, Processing List against the system electronic data.

14-7. Common USMIRS Entries
There is a sheet of common USMIRS transaction codes and their meaning on the J-3/MEOP SPEAR site.
Chapter 15
Inspects and Shipping

There are three types of inspections done at the MEPS: physical inspection, medical inspection, and shipping inspection.

15-1. Physical Inspection and Shipping Inspection

These types of inspections consist of an interval medical history review and limited reexamination (visual inspection) of an applicant, required for:

a. Any processing at the MEPS (such as applicant has returned for entrance into the Delayed Entry Program (DEP)), if more than 30 days has elapsed from the initial examination or subsequent inspection.

b. Entry on Active Duty (AD) and Active Duty Training (ADT) if more than 72 hours has elapsed from the initial examination or from a subsequent physical inspection. This is commonly called a “shipper.” For non-processing training days or holidays (includes Monday or Friday only), the shipping inspect will be valid for a maximum of 96 hours.

c. Applicants whose initial examination was processed by an overseas military facility.

15-2. Scope of Physical and Shipping Inspections

The scope of a physical or shipping inspection includes:

a. Current height and weight. If the measured height is at least 1 inch shorter than the height recorded on the physical examination, the MEPS medical staff will re-measure the height ensuring proper quality control procedures (refer to Chapter 8 for height/weight instructions).

b. Temperature (shippers only). See section for more guidance.

c. Significant interval history since last physical exam, to include at a minimum:

(1) Surgeries

(2) Medical treatments or hospitalizations/ER visits

(3) Any visits to mental health professionals

(4) Injuries

(5) Drug or alcohol-related legal troubles

(6) New wounds, to include recent tattoos or piercings

(7) Encounters with law enforcement agencies other than minor traffic tickets

d. A physical inspection will be performed by a provider on each applicant with clothing removed (except for undergarments for males and bra and undergarments for females) to detect any changes from
the previous examination. Hands and feet are to be inspected for any lesions or abnormalities that may interfere with training.

e. The results and findings of the physical inspection will be entered on DD Form 2808, item 80 (item 88 may also be used if necessary). When disqualifying defects are discovered upon inspect, they will be recorded and explained to the applicant and annotated in items 76, 77, and 78 accordingly with appropriate information and recommendations. The profile will be updated appropriately (see Profile). When conducting a medical inspection, and there is a “3” in the PULHES, block 80 is checked as “disqualified.” The use of a “w” in the disqualified block is acceptable but not required.

Note: Any positive findings from any of the above must be discussed in private and not in a group setting and annotated on DD Form 2808 in item 88.

f. Females only: an HCG test will be obtained and results recorded on DD Form 2808 in item 80 (HCG block). The MEPS medical department must ensure that the HCG testing is not compromised. If the HCG test is positive, the applicant will be informed by the provider that the test indicates that she might be pregnant and instructed to see her private physician.

15-3. Medical Inspection
A medical inspection is required when an applicant returns to the MEPS for a medical reevaluation or to complete medical processing but less than 30 days have elapsed from initial full physical or subsequent inspection. In these cases, the MEPS Medical Department only needs to address the new medical requirement of the applicant. A physical inspection is not required.

a. Common reasons for a medical inspection:

(1) To complete a deferred full physical.

(2) Applicant returns for a consultation, ancillary services, or other outside medical services.

(3) Applicant has an RJ date that must be cleared and less than 30 days has elapsed from the initial examination or subsequent inspection.

(4) Applicant needs to repeat DAT/HIV test and less than 30 days has elapsed from the initial examination or subsequent inspection.

b. A medical inspection of any kind is not required for:

(1) Applicants with a qualifying medical examination who have returned to the MEPS to process and less than 30 days has elapsed from initial physical or subsequent inspection. These applicants may be returning for additional aptitude testing or any additional non-medical Service-specific processing.

(2) Hometown/direct shippers (applicants entering active duty when on orders to proceed from school or home directly to duty).

(3) An applicant prior to the RJ date.
15-4. Shipping Issues

a. Disqualification of an applicant during a medical shipping inspect is a highly disruptive event significantly impacting the applicant, their Service Recruiting Command, and their receiving Service Training Command.

b. To reduce disruption from late shipping disqualifications, regardless of the cause or the condition, CMOs, ACMOs, and FB-CMOs will work with the respective Service partners to resolve the applicant’s medical disqualification for shipping as soon as possible.

15-5. No Shipping on (Working) Copies

a. When original medical documents are not available for all applicants, the applicant must complete a new physical exam including drug and HIV testing. The applicant will be allowed to ship once qualified and negative drug and HIV results are documented on the physical examination. The Service Liaison has the responsibility of ensuring original documents are on hand before projecting an applicant for shipping.

b. Medical documents marked as “working copy” are NOT acceptable for inclusion into the applicant's enlistment packet. If there is doubt concerning authenticity or legibility of documents, the MEPS will conduct a new physical.

c. For guidance regarding shipping on copies for National Guard and Reserve, see UMR 55-2.
Chapter 16
Special Physicals

16-1. Released From Active Duty

a. This is an Army Reserve (USAR) and Army National Guard (ARNG) only program which allows USAR and ARNG soldiers medically released from Basic Training (BT) or Advanced Individual Training (AIT) to receive treatment and recover at their home station/state unit for a medical condition discovered during training. Soldiers in Released from Active Duty (REFRAD) program are given a return date and/or recalled to training.

b. An accession physical needs to be performed to ensure that the medical condition no longer exists and the Soldier has met the standards for the purposes of completing BT, AIT or both. REFRAD Soldiers will be referred to the MEPS by USAREC/NGB recruiters for medical evaluation.

c. The applicant must be identified as a REFRAD through the QRP process, and the following documents must be submitted to the Medical staff by the Service Liaison along with the DD Form 2807-2 along with all documentation from the soldier’s physician pertaining to the treatment and recovery from the medical condition must be submitted for prescreen evaluation. The MEPS physician can determine if additional documentation is needed for the REFRAD soldier to come to the MEPS for a physical:

   1. All training base medical documentation, to include doctor’s evaluation notes
   2. All documentation from the Soldier’s physician pertaining to the treatment and recovery from the medical condition
   3. Medical documentation indicating that treatment has been completed and no additional treatment is necessary.
   4. Type of medical condition will be stated in a USAREC/NGB approved REFRAD Memorandum for Record (MFR).

d. If the REFRAD prescreen is incomplete, the MEPS will return it to the appropriate Service Liaison with instructions on what action needs to be taken.

e. When the Medical read prescreen review has been completed and the REFRAD soldier is authorized to physical by a MEPS physician, the applicant will be projected by the Service Liaison with the remarks REFRAD in the projection.

16-2. Service Members Processing for Commission and Warrant Officer
These candidates will be processed according to Accession Medicine physical standards using prior service height/weight standards. Service-specific instructions may accompany these candidates and will be incorporated into the initial physical assessment.

16-3. Disenrolled Reserve Officers’ Training Corps Processors (DROTC)

a. Disenrolled Reserve Officers’ Training Corps (DROTC) processors are processed according to Accession Medicine standards for enlistment.
b. MEPS will process Army DROTC and US Military Academy (USMA) scholarship recipients ordered to Active Duty (AD) as PS applicants. The respective cadet command will provide the AD orders.

c. MEPS will typically process non-Army DROTC students as Non-Prior Service (NPS) applicants unless projected differently by the particular recruiting service.

16-4. Army Airborne Screening

a. This is a MEPS process for all Army components and will be done for Airborne training only at the request of the Service liaison based on an applicant receiving an Airborne reservation. The MEPS Medical Departments should develop an Airborne screening process that best fits their daily workflow. The Airborne screening will occur after an accession physical is completed. In some instances, the Airborne screening may be performed while the physical is being conducted if the Medical Department authorizes it. The MEPS-established Airborne processing standard will be communicated to the Army and Army National Guard IRC by the MEPS Commander or designated representative at the local level. The Airborne physical qualification will be conducted IAW AR 40-501, Paragraph 5-3.

Note: MEPS personnel are not authorized to conduct screenings for Airborne consideration on current active duty Service members, with the exception of Blue to Green candidates.

b. Airborne eligible applicants must have an SF 507 Airborne Training Checklist (can be found on SPEAR in the airborne section) that will be used to facilitate proper Airborne screening procedures by the MEPS providers. This checklist is to be used as a supplement to the DD Forms 2807-1, 2807-2, and 2808 and will become a part of the applicant’s medical packet. The CMO will ensure that all FBPs are trained on the proper use of this checklist and are familiar with AR 40-501, Paragraph 5-3.

c. Airborne screenings will include:

   (1) Performing the valsalva on both ears and annotating in item 72b on the DD Form 2808.

   (2) Ensuring that applicant has passed their color vision test. An applicant must pass either the PIP, FALANT, or Red/Green test.

Note: If the applicant has failed the PIP and FALANT tests they cannot have an Airborne screening due to failed color vision, even if they passed the Red/Green test (per AR 40-501, Paragraph 5-3). An additional eye consult will not be requested to determine Airborne training qualification. The MEPS examining provider will note the failed color vision for Airborne in item 78 of the DD Form 2808 (and any other condition that prevents the applicant from being screened for Airborne consideration will be documented in item 88). Failing color vision is not an accession physical disqualification and will not change the overall profile of the applicant.

d. If the applicant is found to meet the standards for Airborne training, the examining provider will stamp the corresponding DD Form 2808, “Airborne Qualified” in item 78 of the DD Form 2808 followed by the provider’s initials and date.

e. If Airborne eligibility cannot be determined without the provider requesting an additional procedure, testing, or consultation, the Medical Department will not perform such testing solely in order to
determine Airborne physical qualification. The condition needing additional testing or consultation will be noted on the Airborne training checklist and in item 78 of the DD Form 2808.

f. If the applicant does not meet accession medical standards, then he/she is not eligible for Airborne screening at the MEPS, even with a medical waiver. Any other condition that prevents the applicant from being screened for Airborne consideration will be documented in item 88 of the DD Form 2808.

16-5. Army Blue to Green

a. The purpose of the Army Blue to Green program is to transfer current Air Force and Navy Service members into the Army with no break in service.

b. Army Service liaison is responsible to project applicant at least three days prior to operational processing and shipping in order to prevent any delays on day of shipping. Liaison will project with no testing and/or medical required (B0M0).

c. If Army Blue to Green candidate will be attending basic training, the candidate must receive a full physical (B0M0 not authorized).

16-6. Military Accessions Vital to National Interest (MAVNI) Recruitment Program

a. The Secretary of Defense authorized the Services to implement a program temporarily permitting enlistment of certain legal non-immigrant aliens (LNIA) into the military with certain skills as Health Care Professionals (HCP) and personnel with Critical Foreign Language (CFL) skills. USMEPCOM and the Services will require alternative processing procedures to ensure efficient implementation of this program.

b. If the applicant does not comprehend English well enough to complete medical processing, refer to Paragraph 3-9 for guidance on deferring the medical exam. For specific information on the MAVNI program, refer to UMR 601-23.

16-7. General Officer

a. This is an Army National Guard only program for Senior Officers (O-6 promotable/select and above).

b. MEPS medical department will make arrangements with the senior officer for the physical appointment and will advise the senior officer to complete the applicant portion of the DD Form 2807-1. The form and medical records must be brought to the MEPS by the officer on the date of the physical.

c. MEPS medical department must submit a request via MOC ticket for authorization to conduct a General Officer (G.O.) physical.

d. When MEPS receives approval to perform physical, MEPS medical department will notify Battalion Commander of pending date and time of the G.O. physical.

e. G.O. processor must be projected a minimum of 24 hours in advance. The officer will be projected/processed as “Special Category”.

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f. G.O. physical examinations will not be scheduled on any of the Services’ mission days. CMO/ACMO/MEPS Commander will determine when G.O. physical exam will not interfere with normal daily processing in the MEPS.

g. All G.O. physical processors will be processed as a VIP and will have individualized processing. General Officer physicals will be completed, but will not include the profile section of DD Form 2808. The G.O. physical must be conducted by a CMO/ACMO (FB-CMO is not authorized to conduct the physical) IAW AR 40-501, Chapter 3.

h. A DD Form 2807-1, DD Form 2808, and all supporting medical documentation must be completed and reviewed by the submitting CMO before sending to J-7/MEMD for review. Completion of a prescreen DD Form 2807-2 is not required. All documentation must be sent to osd.north-chicago.usmepcom.list.hq-j7-memd- physicians@mail.mil for profiling by J-7/MEMD military physician.

16-8. Over-40 Examinations

a. An Over-40 examination is required for the following applicants:

(1) Applicants who have their 40th birthday on or before their MEPS physical date.

(2) Applicants who are less than 40 years of age at the time of the physical and who will ship to active duty on or after their 40th birthday.

b. The following documentation is available to assist in conducting an Over-40 physical examination:

(1) The 40 year old and Over Applicant Questionnaire (UMF 40-1-10 ) will be completed by the applicant and submitted with the prescreen or completed at the time of interview. The Over-40 Guidance Table can be found on SPEAR and assist the provider in completing the 40 year old and Over Applicant Questionnaire.

(2) The SF 507 overprint is a profiling worksheet to assist in completing the information required for the Over-40 examination. If the provider would prefer not to use the SF 507 overprint, the information collected must be included on the DD Form 2808 item 88.

(3) Once completed, the Over-40 Applicant Questionnaire and the SF 507 overprint (if used) will become a part of the applicant’s medical packet.

c. Over-40 applicants will have the following tests in addition to the accession physical:

(1) Additional blood tests (fasting blood sugar and fasting lipid panel)

(2) 12-lead resting electrocardiogram (EKG). EKGs must be interpreted by a board-certified cardiologist or internist if the MEPS provider is not comfortable performing his/her interpretation.

(3) Cardiovascular risk assessment history documentation

(4) For females, mammography and Pap smear test within last twelve months
(5) Intraocular pressure (IOP)

d. Over-50 applicants will also have a Digital Rectal Exam (DRE) with Fecal Occult Blood Sampling (FOBS).

16-9. Overseas Applicant Processing Procedures
Overseas processors are applicants processing outside the continental United States, Alaska, Hawaii, or Puerto Rico. People processing overseas already have Service commitments. All Services have agreed to accept overseas processors with their medical examinations as completed in the overseas treatment facility without further action by USMEPCOM. A DD Form 2807-1 and DD Form 2808 must be provided. The MEPS medical staff will enter the physical examination information in USMIRS using a B040 transaction code (non-MEPS physical examination). The MEPS must complete a physical inspect on the applicant prior to shipping. Refer to UMR 40-8 for more information on HIV/DAT requirements. Contact J-7/MEMD for additional guidance.

16-10. Non-MEPS Medical Applicants
Non-MEPS medical applicants are applicants given a medical examination at a location other than the MEPS. Non-MEPS physical must be approved by CMO/ACMO/FB-CMO before entering data into USMIRS using the “B040P” transaction. If the applicant requires any further medical processing, an inspect will be done.

16-11. National Oceanic and Atmospheric Administration
National Oceanic and Atmospheric Administration (NOAA) physical examinations have time-sensitive deadlines. MEPS Commanders will be responsible for establishing a workable process for the MEPS medical department to contact NOAA candidates to determine the date and time for the candidate to schedule their exam at the MEPS. Additionally, MEPS medical department personnel must inform MEPS operations personnel of the agreed upon date so they can enter the projection into USMIRS (using Code ZZZ). An information sheet on how to complete the NOAA candidate physical can be found on SPEAR. MEPS medical department must contact J-7/MEMD Battalion Support Accession Medicine Branch to review that all medical processing is complete and accurate prior to the candidate leaving the MEPS on the day of the physical examination.

16-12. Public Health Service

a. The MEPS are authorized to conduct physicals for all Public Health Service (PHS). The PHS applicant will need to be projected in USMIRS with Code ZPZ. Any Service can enter the projection. Submission of DD Form 2807-2 Medical Prescreen is not required. The applicant will complete a DD Form 2808 and DD Form 2807-1 during the medical brief. The MEPS provider can do an individualized ortho-neuro exam.

b. The following will be the only tests conducted at the MEPS on the applicants:

  (1) Urine Protein/Glucose/HCG Testing

  (2) Height/Weight/Body Fat (leave min/max WT and Max BF blank)

  (3) Blood Pressure, Pulse, and Temperature
(4) Vision – Distant/Near/Heterophoria/Color/Depth Perception/IOP

(5) Hearing - one test only (If applicant receives an H3 result there is no need to re-test applicant)

c. Any other tests and exams requested on the PHS medical data checklist are not authorized to be done at the MEPS. The applicants are responsible to get those tests outside of the MEPS.

d. Specialty consults are **not** authorized on these applicants.

e. The MEPS provider will document any medical conditions for the applicant. Qualification decisions on these applicants will be made by PHS Physical Examination Branch as they do not fall within the current version of DoDI 6130.03 standards. For USMIRS entry the MEPS medical department will use WKID "2L" and place "0" in the PULHES. Do not enter them into e-Security.

f. The medical department will provide the original forms to the applicant on the day of examination and does not need to keep copies of the physical. The medical department will ensure that the medical record has been signed out “off-site” in USMIRS.

16-13. Reserve Officer Training Corps

a. Any student attempting to enroll in a program leading to a commission or who receives monies towards tuition and books is considered to be receiving scholarship funds. These students must go through the DoD Medical Examination Review Board (DoDMERB) for medical processing.

b. Students not receiving scholarship funds may have their physicals completed at the MEPS.

c. Students who require a pre-commissioning physical may be completed at the MEPS.

d. Simultaneous Member (Military) Participant (SMP) physicals may be done at the MEPS.

16-14. DoDMERB FALANT Tests

When DoDMERB determines an applicant requires testing, the MEPS will be contacted in order to determine the best time for the applicant to come in for the FALANT test. The MEPS medical department will be responsible for notifying the control desk of the name, date, and time the applicant is coming to the MEPS. The applicants will not be projected in USMIRS and no applicant data needs to be entered into the system. The applicant will bring a DD Form 2489 for completion.
Chapter 17
Quality Review Program

Medical personnel will ensure they review the applicant’s automated record (in USMIRS) in conjunction with the applicant's packet. QRP will be accomplished 48 hours before the applicant processes at the MEPS. To conduct successful QRP, one MEPS representative from each processing department (testing, medical, and operations) will gather in a room away from distractions.

17-1. Prescreens
The DD Form 2807–2 will be completed by each individual who requires medical processing at the MEPS. The DD Form 2807–2 must be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed. Use of this form will also facilitate efficient, timely, and accurate medical processing of individuals applying for military service. If supporting documentation (for example, private physician’s paperwork, treatment records, consultations, and so forth) is required to augment the CMO's review, the MEPS medical department will inform the Service Liaison of an estimation of the time required for review.

17-2. Full Physical Packets
The applicant packet will contain a DD Form 2807-2 and any additional medical treatment records. The documents required for the applicant’s physical examination can be printed at this time and placed in the applicant packet. See QRP Training Standardization Job Task Sheet for procedures.

17-3. Physical and Medical Inspects
These packets need to be scrutinized carefully in order to ascertain if the applicant needs an inspect upon his/her return to the MEPS. The applicant packet will be compared with the QRP screen in USMIRS for accuracy. In some cases, a conversation with the applicant’s Service Liaison is necessary to find out why the applicant is returning to the MEPS. See QRP Training Standardization Job Task Sheet for procedures.

17-4. Shipper Inspects
It is the function of the QRP process to ensure that the original version (for regular components) or copies (for Reserve/Guard components) of the DD Forms 2808/2807-1 are present and must be examined thoroughly as a last check to ensure completeness. This examination is essential to avoid shipper delays to the Services. No “working copies” are permitted. The documentation MUST match the QRP screen in USMIRS. If applicant or provider needs to make annotations/corrections, then the record will be put in “N” status to reflect that corrections must be completed by ship day. See QRP Training Standardization Job Task Sheet for procedures.
Chapter 18
Fee Basis Provider (FBP) Projections, Payment, and Duties

18-1. Projections
FBPs may be requested as required to assist the CMO in accomplishing his/her daily medical department duties. MEPS medical department personnel will update the FBP Application to indicate if the CMO and any ACMOs are available (contributing to the workload) to process applicants for each processing day. If the CMO/ACMO are not available or need administrative time, MEPS medical department personnel must update the planning calendar to reflect absences. The FBP Application calculates projected FBPs based on projected workload, CMO/ACMO availability, set number of walk-ins, and a percentage of workload for record and consult reads to arrive at the number of FBPs authorized. The FBP Application must be used to request approval from J-7/MEMD for any additional FBP requirements such as using service over-projection percentages. MEPS medical department personnel must request additional FBP requirements for providers scheduled for initial training. In the request justification area, state who the provider is and that the provider is being requested as an additional FBP due to initial training. The computation formula for projecting daily requirements for MEPS CMO, ACMO, Fee Basis CMO (FB-CMO), and FBP requirements is in Figure 18-1.

<table>
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<th></th>
<th>Projected Work</th>
<th>Weighting Factor</th>
<th>Total Weighted Points</th>
<th>Total Weighted Exam Points</th>
<th>Practitioners Authorized</th>
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<td>A. Male exams, age 39 or less</td>
<td>x 1.0 =</td>
<td></td>
<td>0-18 = 1</td>
<td>(CMO/ACMO/FB-CMO)</td>
<td></td>
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<tr>
<td>B. Male exams, age 40 or over</td>
<td>x 2.0 =</td>
<td></td>
<td>19-42 = 2</td>
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<td></td>
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<tr>
<td>C. Male inspections</td>
<td>x 0.1 =</td>
<td></td>
<td>43-66 = 3</td>
<td></td>
<td></td>
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<tr>
<td>D. Female exams, age 39 or less</td>
<td>x 2.0 =</td>
<td></td>
<td>67-90 = 4</td>
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<td>E. Female exams, age 40 or over</td>
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<td>91-114 = 5</td>
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<td>x 0.2 =</td>
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<td>115-138 = 6</td>
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</tr>
<tr>
<td>G. Records review/consults (each)</td>
<td>x 0.3 =</td>
<td></td>
<td>139-162 = 7</td>
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<tr>
<td>H. Total weighted exams</td>
<td>XXXX</td>
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</table>

Notes: MEPS with an Assistant CMO will consider one FBP position met. A FBP undergoing initial training will not be considered as a provider present for duty (indicate “Initial Training” on the Provider Work Record Sheet). FBPs doing initial training must have their work hours entered into the FBP Application. Each MEPS has a set number of walk-ins (not pictured here).

Figure 18-1. Computation Formula for MEPS FBP Requirements

Note: The FBP Application determines the next two processing days by accessing USMIRS for MEPS open/closed schedule information. MEPS personnel must accurately maintain when they are open and closed in USMIRS in order for the FBP Application to project for the correct “next” processing day.

18-2. Daily FBP Requests in FBP Application

a. For each day a MEPS is open and processing applicants, the MEPS medical department personnel must complete a Daily FBP Schedule Request. The number of FBPs requested should be manually adjusted down based on the MEPS no-show rates when finalizing a daily request for FBPs. The daily FBP request is the government order for services under the FBP contract and each MEPS medical department staff must submit the FBP order 48 hours in advance to the contractor using the FBP IV application.
If either FBP IV or USMIRS is down, email the request by 1400 local time to J-7/MEMD (email OSD North Chicago USMEPCOM List HQ-J7-MEMD-FBP-Cor) and the designated contractor, or as directed by J-7/MEMD. An FBP order must be sent even for days when the requirement is for zero FBPs. Name requests must only be made in cases where a particular FBP is needed for training or requires an evaluation and coordination occurred to have the CMO available for the training and/or evaluation.

b. MEPS medical department personnel should wait until all projections are entered into USMIRS after QRP or resubmit the order after QRP and prior to 1430 local time to ensure all projections are accounted for. In the FBP IV application, each MEPS has until 1430 local time to submit the daily FBP order. If the order is submitted prior to the completion of QRP, it should always be reviewed at the 24-hour mark. For example, if Wednesday’s projection was submitted on Monday, a quick review of the order should be done Tuesday morning to ensure there were no last minute changes to Wednesday’s projections.

c. If a Daily FBP Schedule Request has been submitted to the contractor and the medical department section becomes aware of a FBP requirement change, the MEPS medical department personnel must email another request to the OSD North Chicago USMEPCOM List HQ-J7-MEMD-FBP-COR and the contractor and then call the contractor scheduler to verify they received the change (if after hours, use the scheduler’s cell phone number). Additionally, if the requirements for providers changes causing a reduction in the need for providers, the MEPS medical department personnel must utilize the FBP IV Order Screen to adjust the FBP Count to reflect the number of providers actually needed on a given day. If additional support is needed, the MEPS medical department personnel must request providers via the FBP IV Workload screen. The request must be approved by J-7/MEMD prior to coordinating additional support with the vendor. MEPS medical staff are required to include comments/justifications any time additional providers are needed. If the change happens on the morning of the processing day, the MEPS medical department personnel must immediately call their FBP scheduler and the FBP COR to notify the scheduler of the issue and then send an email to the contractor and OSD North Chicago USMEPCOM List HQ-J7-MEMD-FBP-Cor.

Note: Requests for additional Fee Basis Provider support outside the allotted points indicated on the FBP IV Workload screen must be authorized by J-7/MEMD FBP COR before coordinating additional support with the vendor. Requests for additional FBP support can be made up to 12 hours before a provider is needed.

d. If the MEPS medical department personnel determine the need for provider support is less than what has already been confirmed, they will immediately notify J-7/MEMD FBP COR and the vendor/scheduling POC. The FBP Adjusted Order Count should be updated only if the provider scheduled to work has been canceled prior to his/her arrival for work. To use this function, log into the FBP IV Application Order Details screen and enter the number of FBPs actually required. This box is used to remove FBP slots for any given work day, and does not impact FB-CMO slots if any are present. Adjusting the FBP order to reduce the amount of providers needed will not be utilized when the vendor is unable to fill a request for FBP support. Do not adjust the order count if the vendor cannot fill the request; otherwise, Command fill rate data will be negatively impacted which inhibits USMEPCOM’s ability to hold the vendor accountable.

e. The FBP Application allows users to create ‘Auto Process’ requests for future dates where Fee Basis Provider support is anticipated. These automatic requests must not be used on a routine basis because they may not capture any subsequent changes. This function is intended for emergency situations or extenuating circumstances only. The expectation is for MEPS medical department personnel to review the daily FBP orders to ensure efficient ordering of FBP resources. For example, if a MEPS has a large
applicant no-show rate, the FBP order may be lowered by one provider because the provider is not needed. In other cases, a MEPS may be behind on medical prescreen processing and needs to request an additional FBP. Overall, a review of each order must be completed by the MEPS medical department personnel to ensure the order is correct which is why the auto-order feature is only for emergency/extenuating circumstances.

f. After duty hours, if the MEPS is notified of an issue with a provider, call the FBP scheduler on their cell phone. For example, a provider’s family calls on a Saturday stating the FBP has a medical emergency and can’t work the following week. The MEPS medical staff would then call their FBP scheduler to notify the scheduler of the issue.

g. Depending on the issue, the MEPS medical staff must also call the FBP COR in J-7/MEMD for information purposes or to intervene on behalf of the MEPS to resolve an issue. For example: only an FB-CMO was requested and on the processing day, no provider arrives; therefore, no government or contract providers will be at the MEPS.

h. The MEPS medical staff must document the impact to the medical mission by submitting an Impact Statement form via email to the FBP COR (OSD North Chicago USMEPCOM List HQ-J7-MEMD-FBP-COR) when the number of providers who report for work is less than the number of providers requested/authorized. Examples of impact include MEPS government personnel working longer/overtime required in order to process applicants; Marine applicants not shipping until the next week; Services asked to move applicants to another processing day, “Service slice” being implemented; no applicants can be given physicals or inspect that day. The email must be sent within one working day after the processing day in question for all situations except when there are no providers, in this situation contact the FBP COR immediately. The Impact Statement form can be found on SPEAR.

18-3. FBP Provider Work Records (PWRs)

a. Medical NCOIC/SUP MTs will be designated by the MEPS Commander to act as Fee Basis Provider Government Points of Contact (GPOC). GPOCs will act as an ACOR at their MEPS and are responsible for oversight of FBP work records/timekeeping, and general FBP performance oversight.

b. Medical NCOIC/SUP MTs will obtain a 3 ring binder or clipboard approximately 8.5 by 11 inches and clearly label it “FBP Provider Work Record”. The “MEPS FBP Contract – Provider Work Record” is UMF 40-1-12-R-E (MEPS Fee Basis Provider Work Record). It is the only authorized provider work record to be used at the MEPS for FBPs. UMF 40-1-12-R-E will be placed and kept as the record copy. Copies of PWRs will be kept on file for one year. The appropriate UMF 40-1-12-R-E will be labeled (MEPS Name, Month, Date, Day) each day and placed in the binder or clipboard before FBPs arrive to work. All entries made on the UMF 40-1-12-R-E will be printed legibly in black or blue ink. Each completed UMF 40-1-12-R-E must match the data entered into the FBP IV Application Provider Work Record screen.

c. FBPs are not to sign in each time they arrive at the MEPS, or sign out each time they leave the MEPS. Only MEPS medical personnel may complete the “Time In, Time Out, Total Hours Worked” columns on the UMF 40-1-12-R-E.

d. FBPs will report to work at the time scheduled by the contractor and no earlier than 15 minutes before their scheduled start time. If FBPs report for work earlier than 15 minutes before their scheduled time, or they are late reporting for work, the MEPS will immediately complete and submit a Contractor Provider Quality Management Form (UMF 40-2-4-E). Increments of 15 minutes will be calculated and
recorded on the UMF 40-1-12-R-E as follows:

(1) Between 1 and 7 minutes: after the hour, 15, 30, and 45 minutes after the hour - round backwards

(2) Between 8 and 14 minutes: after the hour, 15, 30, and 45 minutes after the hour - round forward

(3) Examples

(a) A FBP arriving at 0501 would be recorded as 0500 on the PWR because for 1 minute after the hour, round back.

(b) A FBP arriving at 0607 would be recorded as 0600 on the PWR because for 7 minutes after the hour, round back.

(c) A FBP arriving at 0717 would be recorded as 0715 on the PWR because for 2 minutes after 15 after the hour, round back.

(d) A FBP arriving at 0835 would be recorded as 0830 on the PWR because for 5 minutes after 30 after the hour, round back.

(e) A FBP arriving at 0652 would be recorded as 0645 on the PWR because for 7 minutes after 45 after the hour, round back.

(f) A FBP departing at 1314 would be recorded as 1315 on the PWR because for 14 minutes after the hour, round forward.

(g) A FBP departing 1423 would be recorded as 1430 on the PWR because for 8 minutes after 15 after the hour, round forward.

e. The night before the next processing day, or early in the morning on the processing day before any FBPs report for work, the Medical NCOIC/Sup MT or the alternate scheduling POC will complete a UMF 40-1-12-R-E for the next/same day. The PWR must clearly indicate the MEPS name, the month, and the day and this information contained on the PWR prior to any FBPs arriving at the MEPS.

f. When the FBP arrives to work for the first time each day, the Medical NCOIC/Sup MT will print the provider’s first and last name (in that order) and enter the time while remembering to round back or forward as described above on the “Time In (1)” column on the UMF 40-1-12-R-E for the appropriate date/day. The Medical NCOIC/Sup MT needs to print the FBPs name legibly. If they remain at work all day, then depart, the Medical NCOIC/Sup MT will sign out in the “Time Out 1” column rounding back or forward as described above. Then the Medical NCOIC/Sup MT will calculate “Total Hours Worked” (in 15 minute increments) and record this in the appropriate column of the PWR. The PWR will be updated with new names or deleting names no longer needed as appropriate. The 15 minute increments will be recorded as: 00 minutes = .00 hours, 15 minutes = .25 hours, 30 minutes = .50 hours, 45 minutes = .75 hours. The PWR comment section must contain comments as to the type of position the FBP is filling: FB-CMO, FBP (regular FBP), or training. Other comments can also be included, if necessary, to clarify to J-7/MEMD and the contractor what took place. For example, “No lunch taken”, “FBPs sent home due to weather”, etc.
g. At the end of each day the Medical NCOIC/Sup MT will calculate and record total hours worked for that day and record it in the “Total Hours Worked” Column. The Medical NCOIC/Sup MT is responsible for calculating and recording the total hours worked each day at the end of each workday. The Medical NCOIC/Sup MT will then sign or print their initials in the appropriate column verifying the information they recorded is truthful and accurate.

h. If the FBP is scheduled and works as the FB-CMO, the Medical NCOIC/Sup MT will write “FB-CMO” under the “Comments” column on the same row they use to enter their “Time In” and “Time Out” for that day. Only one provider can be designated as the FB-CMO for each day and a FB-CMO must be designated only when the CMO and assistant CMO(s) are not available all day.

i. All FBPs who work four consecutive hours will be allowed to take a 30 minute unpaid lunch break, if desired.

j. On days when a FBP works and they stop working (for example - taking a lunch or other break, or leaving the MEPS and returning to work) the FBP will be signed in and out each time they arrive, and each time they stop working or leave work. Examples include:

   (1) Lunch break. FBP reports to work and are signed in. FBP stops work to eat lunch so is signed out. FBP returns to work and is signed in again. FBP leaves work for the day and is signed out. The Medical NCOIC/Sup MT calculates and records total hours worked.

   (2) Split work session with lunch. FBP would like to work, but takes an hour off in the middle of the work session. The FBP must receive permission ahead of time from the CMO or FB-CMO to do this. FBP reports to work and is signed in. FBP stops work to eat lunch and is signed out. FBP returns to work and is signed in again. FBP leaves work for preapproved personal business and is signed out after letting CMO or FB-CMO know they are leaving. FBP returns to work from personal business and is signed in. FBP completes work and is signed out. Medical NCOIC/Sup MT calculates and records total hours worked.

18-4. MEPS Provider Work Record Verification

a. Periodically throughout each day, and at the end of each workday, the medical NCOIC/SUP MTs (or the alternate scheduling POC in their absence) will review the PWR to ensure FBPs are properly signed in and out as described above, and the times recorded are accurate. The medical NCOIC/SUP MTs (or the alternate scheduling POC in their absence) will also always review for each FBP that the “Total Hours Worked” column has been properly calculated and recorded on the PWR. The MEPS Commander has overall responsibility for releasing the FBPs, but may delegate this responsibility to the OPSO, CMO, ACMO, FB-CMO, or the Medical NCOIC/Sup MT. If, for any reason, where a FBP does not appropriately complete their work and leave the MEPS, immediately complete and submit a UMF 40-2-4-E.

b. At the end of each work day and after the final review of the PWR, the medical NCOIC/SUP MTs (or the alternate scheduling POC in their absence) will verify that the information contained on the PWR is correct and accurate. This includes all of the following:

   (1) The MEPS name, month, year, and date are properly filled in, and the correct day of week is circled. The month and date listed on the PWR must properly correspond to the day of week circled.
(2) All entries are made in black or blue ink.

(3) Each FBP who worked that day has his/her name printed with first name first, then last name. All printing is legible.

(4) Each time the FBP reported to work, and stopped working, he/she was signed in and out on the **UMF 40-1-12-R-E**.

(5) All times listed for FBPs signed in and out are in military time format.

(6) The “Total Hours Worked” were calculated and entered on the **UMF 40-1-12-R-E** by the MEPS medical personnel FBP.

(7) Validate that the “Total Hours Worked” were properly calculated. If not, the verifier may correct this entry only by following the guidance directly below for “correcting UMF 40-1-12-R-E errors”.

(8) If the FBP worked as the FB-CMO that day, “FB-CMO” is listed under the “Comments” column on the same row as the FBPs name.

c. If there are problems on the PWR that need to be corrected, circle them and correct them as soon as possible by working with the appropriate people. Include initials and a date for any corrections made to the PWR. The PWR cannot be verified until the last FBP was signed out for the day. The PWR must not be verified until all the information above is correct. The PWR must not be submitted until it has been properly verified.

d. After all the information listed above is verified and correct, the Medical NCOIC or Sup MT (or the alternate scheduling POC in their absence) will sign or print their initials in the appropriate block at the bottom of the PWR, and print the date and time he/she printed/signed his/her initials in the appropriate blocks at the bottom of the PWR. Verification of the PWR validates all the information directly above was reviewed and is correct.

e. The PWR also includes additional information that needs to be recorded each processing day to monitor contract compliance. This information will be accurately and legibly completed each processing day on the PWR before being submitted:

(1) Date/Time the Daily FBP Schedule Request was sent via FBP IV application or by email to the contractor for the FBPs who worked on the day the PWR is completed (for most days, the date would be the previous processing day).

(2) Number of FBPs requested on the Daily FBP Schedule Request to (this will always be the number of FBPs the MEPS needs based on the workload projection, not the number of FBPs the MEPS thinks the contractor will send to the MEPS).

(3) Number of FBPs the contractor scheduled (number of FBPs the contractor fills in on the Daily FBP Schedule Request and sends back to the MEPS).

(4) Number of FBPs who actually reported to work that day.
f. After the PWR has been properly verified, MEPS staff will electronically scan the PWR into a PDF document and upload the document to the corresponding Provider Work Record screen in the FBP Application. Scanned PWRs must be uploaded to the FBP Application at the end of each processing day, and no later than the 16th day of the month for the 1st through 15th of the month and no later than the 1st day of the following month for the 16th through the last day of the month. J-7/MEMD personnel will lock the PWR for invoicing purposes bi-weekly, so it is critical for MEPS medical personnel to upload PWR PDF files on time.

g. If a FBP is required to work after all the MEPS Medical staff have departed for the day, the OPSO will ensure additional non-medical MEPS staff are properly trained in the Provider Work Record verification process so the process described above is completed the same processing day in which the work occurs.

h. If government personnel makes an error on the PWR, the individual must correct it using the commonly accepted method used in correcting errors in health care documentation which is also used at the MEPS:

(1) Draw a single line through the error – do not make more than one line through it.

(2) Print “error” as close as possible by the error with the line through it.

(3) Place your initials by the error.

(4) Print the correct information.

i. The MEPS will maintain the PWR on file in the Medical Department under RN 40-1a/500A, “Professional Consultant Records” (see Appendix A, Section III). for 1 year.

j. FBPs are paid only for actual hours worked. There are two exceptions:

(1) If a MEPS closes on short notice and the FBP was not contacted and reported for work

(2) If the FBP reports for work and is sent home within one hour after reporting to work due to the MEPS workload. In this case, the FBP will be paid for one hour of work.

k. Other than these two exceptions, any other unusual circumstances must be coordinated with the FBP COR.

18-5. Duties.

a. All FBPs will conduct applicant physicals IAW the current version of DoDI 6130.03 and this regulation.

b. Profiling duties are usually conducted by the CMO and ACMOs (if authorized). When profiling proficiency has been demonstrated by a FBP to the satisfaction of the CMO, a modification of DPC Level to profiling can be requested. A FBP will not profile unless specifically approved for DPC Level 3 to do so by the Command Surgeon. A FBP will not be designated as FB-CMO if not assigned as a DPC Level 4 FBP. MEPS can choose to have FBPs with profiling DPC Level 3 qualifications accomplish profiling as a regular FBP in the interest of efficient processing. Profiling providers will determine an examinee’s qualification for entry or retention in service. CMOs will ensure profiling providers are familiar with the contents of the current version of DoDI 6130.03 and this regulation.
18-6. Designation of FB-CMO
If the CMO is absent from the MEPS, MEPS with ACMOs will have the ACMO be administratively in
charge of the medical department section and perform any required CMO duties as designated by the
MEPS Commander or OPSO. If there is no ACMO, then a FB-CMO can be requested from the
contractor. Only FBPs with DPC Level 4 authority will be designated as the FB-CMO. FB-CMOs will
conduct applicant physicals and are administratively responsible for the MEPS medical department section
and will respond to requests from the MEPS Commander to attend meetings and provide
technical advice and medical guidance to the medical department section. Medical processing questions
that cannot be resolved at the local level will be referred to a J-7/MEMD physician.
Chapter 19  
**Medical Training Program**

19-1. **General**  
Training is a critical part of having a successful Medical Qualification Program. All MEPS medical department personnel will be trained on how to perform all functions of his/her position description.

19-2. **Initial Lead/Medical Technician Training**  
Initial Training: The Medical NCOIC/SUP MT must establish an initial training program based on a 90 day training plan. On the medical employee start date (or non-medical employee assignment date), a training plan must be discussed that informs the employee of the medical functions that he/she must be trained on within the first 90 days of employment.

a. All functional areas in which the new employee must complete training are located on Training Standardization Job Task Sheets found on SPEAR.

b. The Medical NCOIC/SUP MT will assign the employee a medical staff member as a trainer on all the medical functions found on the Training Standardization Job Task Sheets, and to familiarize the employee with MEPS specific processes. The Medical NCOIC/SUP MT can authorize the trainer to utilize other medical staff members or rotate trainers so that more than one medical staff member is assigned to train the new employee.

c. The trainer will give a progress report to the Medical NCOIC/SUP MT on Training Standardization Job Task Sheet completion at the 30 day and 60 day mark after the employee’s start date. All Training Standardization Job Task Sheet training as well as training in all medical tasks must be completed within 90 days of start date and notated in the employee’s training record.

d. After the 90 day training period, the Medical NCOIC/SUP MT will draft a **Confirmed Training Order** (CTO) that needs to be signed by the MEPS Commander and kept in the employee training record.

**Note:** While the employee is in their initial training cycle they will be operating under the CTOs (both UMRs 40-1 and UMR 40-8) of the person(s) training them. It is imperative that all employees designated as trainers understand that if a new employee makes critical mistakes, the trainer(s) can be held dually responsible resulting in possible disciplinary action up to their CTOs being revoked.

19-3. **Initial Medical NCOIC/Supervisory Medical Technician Training**  
The MEPS medical department will notify via email the J-7/MEMD Battalion Support Accession Medicine Branch of the arrival of a new NCOIC/SUP MT. The Medical NCOIC/SUP MT will have their initial training reviewed and signed by a J-7/MEMD MMA during an Individual Training Visit (ITV).

a. Initial 60 day training for the NCOIC/SUP MT will be completed by the medical department LMT/Medical NCO.

b. The LMT/Medical NCO will conduct all Training Standardization Job Task Sheet training within 60 days of start date and ensure training is recorded in the official training record.

c. Medical NCOIC/SUP MT must read UMR 40-1, 40-2, 40-8, 40-9, 601-23 and DoDM 6440.02 Clinical Laboratory Improvement Program prior to their 90 day mark.
d. A J-7 MEMD MMA will send via email:

   (1) An open book/regulation pre-test that must be completed prior to the ITV.

   (2) Information on the dates and times the ITV will be conducted. The Medical NCOIC/SUP MT will inform the MMA if the dates of the visit need to be adjusted due to their availability during this week. It is imperative that the Medical NCOIC/SUP MT is present for training to maximize the time the MMA will have with them, as a standard ITV is only 3 full working days long.

   e. Upon completion of the ITV, a signed training checklist will be completed and placed in the Medical NCOIC/SUP MT official training record.

   f. After the ITV training checklist is signed, a CTO will be drafted, signed by the MEPS Commander, and kept in the Medical NCOIC/SUP MT’s training record.

   g. The medical NCOIC/SUP MT is authorized a five day crosswalk at another MEPS. J-7/MEMD can help a Battalion/MEPS Commander with selecting a MEPS for the crosswalk visit and Battalion Commanders can coordinate with other Battalion Commanders if a MEPS outside their Battalion is recommended.

   h. A MEPS Commander can request an ITV through the Command Surgeon for LMTs, Medical NCOs, or other personnel detailed into the Medical NCOIC/SUP MT position.

19-4. Confirmed Training Orders

   a. Confirmed Training Orders (CTO): Required training that must be signed off by the MEPS Commander has been consolidated in a CTO. A signed/initialed appointment order by the Commander confirms that the employee is fully trained on specific duties and understands the additional regulatory and/or legal standards of these particular duties. The CTO will remain in effect throughout the period of employment at the MEPS unless otherwise revoked by the MEPS Commander.

      (1) The CTO will be initiated after the employee has completed their 90 day training and the Medical NCOIC/SUP MT has completed all training per medical Training Standardization Job Task Sheets and associated regulations.

      (2) The Commander will review the employee training record to ensure that the training tasks on the CTO have been annotated in the employee’s training folder and that the trainee and trainer have initialed on the Trainee/Trainer lines of the CTO are present. Once the review is complete, the MEPS Commander will initial and sign the CTO.

      (3) The CTO will then be signed and dated by the employee and the completed CTO will be filed in the employee training record.

      (4) The required training on the CTO can be found in Paragraph 19-5.

   b. Sustainment Training: The Medical NCOIC/SUP MT must establish a training calendar IAW UMR 350-1, Command Training Program. The training calendar must have, at a minimum, one hour of uninterrupted training per week. Training completion will be documented in the employee training record.
c. The most current Training Standardization Job Task Sheets can be accessed on SPEAR under the Medical Technician position.

19-5. Required Approval Medical Training for All Medical Technicians

a. This medical training is required to be reviewed and signed by the MEPS Commander and is conducted IAW the Training Standardization Job Task Sheets and associated regulations and UMR 350-1.

   (1) Body Fat Technician: Authorized to conduct body fat taping procedures on all applicants using the Gulick II measuring tape.

   (2) Chaperone: Authorized to observe an applicant of the same gender during the medical examination process when the provider and applicant are different genders or when requested by the applicant or medical provider.

   (3) Cerumen Removal: Authorized to conduct cerumen removal procedures on an applicant.

   (4) Medical Briefer: Authorized to give the USMEPCOM standardized medical brief to applicants.

   (5) Standard Precautions (gloves and bloodborne pathogens): Understands the minimum standard precautions needed to conduct medical processing where the risk of bloodborne pathogens is reasonably anticipated.

   (6) Protein/Glucose/HCG: Authorized to test, read and annotate results of all protein, glucose, and HCG testing on applicants. This includes performance of the QC on all these tests and proper annotation on laboratory QC control logs.

b. Weekly medical training will be conducted using the most current Training Standardization Job Task Sheets.

c. Within each FY quarter medical training will include the HIV and Drug Training Standardization Job Task Sheets and PowerPoint presentations (HIV/Drug page on SPEAR).

d. Twice-a-year training will include the following:

   (1) CLIP/CAP (specific for urine protein/glucose/HCG).

   (2) Run a mock drill for a HIV-positive applicant (5D).

   (3) Run a mock drill for manual processing of an applicant (without electronics).

e. Annual refresher training will include the following:

   (1) Body Fat Technician

   (2) Cerumen Removal

   (3) Chaperone
(4) Medical Briefer

(5) Standard Precautions (bloodborne pathogens) to include review of Safety Data Sheets (SDS)

(6) Breathalyzer (ref. UMR 40-8)

Note: A guide to assist the Medical NCOIC/SUP MT and Medical Technicians in the creation of a medical department training record can be found on SPEAR. The set up of an internal medical department training record will not replace the unit training record, but is meant to give the Medical NCOIC/SUP MT a comprehensive document of all medical (and other) training in order to assist HQ USMEPCOM visits. All training that is in the medical department training record must also be present in the unit training record, which is overseen by the MEPS Senior Enlisted Advisor (SEA).

Note: For CMO/ACMO/FBP training requirements, see UMR 40-2.

19-6. Chief Medical Officer Quarterly Review

a. The CMO will conduct a quarterly review of all assigned MEPS medical personnel in the first month of each quarter (every three months) of each fiscal year. An example of a CMO Quarterly Review Checklist can be found on SPEAR. Once complete, the CMO will review findings with the Medical NCOIC/SUP MT and determine if any training is required. Training will be conducted in the deficient areas within the same quarter of the CMO review. Training rosters will be attached to the report and will be annotated in each employee’s training record.

b. After training has been completed, the report will go to the MEPS Commander for review and signature. The Commander must sign the report during the same quarter that the quarterly review was completed. After the report has been signed by the CMO and Commander, it must be maintained for two years. The report will be available for review during inspections and staff assistance visits.

c. If there is no government physician at the MEPS, the MEPS Commander will coordinate with J-7/MEMD Clinical Operations Division to determine the way forward for quarterly review/training. In instances where training requirements cannot be met each quarter, the MEPS Commander will complete a memorandum (example on SPEAR in the General Information section) and forward to J-7/MEMD for review and concurrence (email the memorandum to osd.north-chicago.usmepcom.list.hq-j7-memd-battalion-support@mail.mil). The memorandum will be retained on file for review by Staff Assistance visit and Inspector General personnel. The Medical NCOIC/SUP MT will perform a limited review consisting of medical technician processing areas and provide training as needed.

d. File the CMO quarterly review report/Commander’s memorandum (to include attached training rosters if applicable) in the medical department under RN 1-201a/800D, Inspection, Survey, and SAV Files – CMO Quarterly Review (see Appendix A, Section III).
Chapter 20
Medical Equipment, Supplies, and Cleaning

For any equipment that falls under the Medical Standby Equipment Program (MEDSTEP) located on the MMAL, reference the Equipment Maintenance Program TSJTS for instructions on exchanges and replacements.

20-1. Audiometric Equipment Calibration and Audiobooth Maintenance

a. Both electroacoustical calibrations (completed by Tobyhanna) and DD Form 2217 (Biological Audiometer Calibration Check) (using the Bio-Acoustic Simulator, or BAS), of audiometers are required to be filed (individual folder) in the audio room for validation of audiometric reference thresholds. The MEPS must establish a primary and secondary baseline calibration with a BAS once machines are received from Tobyhanna and document results on a DD Form 2217 identifying “primary” and “secondary” results.

b. An electroacoustical calibration will be performed annually on audiometers. The supporting medical maintenance division operated by the United States Army Medical Materiel Agency will perform the calibration. Audiometers will be calibrated to American National Standards Institute (ANSI) S3.1-1999 standards. A DD Form 2163 (Medical Equipment Verification/Certification) label, indicating the date of the last electroacoustical calibration, will be prominently displayed on the audiometers. The calibration verification demonstrates that the audiometer meets specific requirements stated in the applicable sections of ANSI S3.1-1999. The electroacoustical calibration is good for one year plus a one-time extension of up to 30 days. The electroacoustical calibration paperwork must be filed with the DD Form 2217.

c. Upon receipt of replacement audiometers, an initial (baseline) calibration check will be performed using two different a BAS simulators. One calibration check will be marked primary and the other marked secondary and will be annotated in the top right hand corner of the DD Form 2217. A bioacoustic calibration check, using the same BAS simulator that was used for the primary check, will be completed every calendar week. The weekly calibration check will be recorded on DD Form 2217. If an audiometer fails (greater than ± 5db) the calibration check, ensure that the headsets have been correctly placed on the simulator and that connectors are fully plugged in before repeating the test with the primary BAS. If the repeated test fails, the failure must be noted in the ‘Remarks’ block on the DD Form 2217, and the audiometer will be taken offline. Follow the Equipment TSJTS for further troubleshooting. File electroacoustic calibration records with DD Form 2217 under RN 40-61/500A, Medical Equipment Maintenance – DD Form 2217 (see Appendix A, Section III), and an additional test performed with the alternate BAS simulator. In case of failure, the audiometer will be immediately reported for repair to Tobyhanna by sending an email citing MEPS name, audiometer serial number (not booth position number), and symptoms of malfunctioning unit(s) to USARMY Tobyhanna AD USAMC Mailbox USAMMATECH and/or by telephone to (570) 615-8509. Prior to exchange with Tobyhanna (either annually scheduled or because of needed replacement), the MEPS must delete all applicant data stored on each audiometer. Instructions for deleting applicant data can be found on SPEAR in the audiogram section. File electroacoustic calibration records with DD Form 2217s for each audiometer. Keep filed in medical department for two years, then destroy.

d. The ambient background noise check (sound level) of the audio booth ensures the environment within the booth is sufficiently quiet to perform hearing tests. The appropriate supporting Army Medical Treatment Facility (MTF) is responsible for measuring ambient noise with a sound level meter annually and every time an audiometric booth is installed, moved, or changes in ambient noise are reasonably suspected (for example, highway construction next to MEPS). Sound level certification is only good for
one year plus a one-time extension of up to 30 days from the date of issuance and must be prominently displayed outside the audio booth. Allowable background noise levels for audiometric testing rooms are as follows:

Figure 20-1. Background Noise Levels

<table>
<thead>
<tr>
<th>Octave Band Center Frequencies</th>
<th>Level in dB re 20 micro pascals</th>
</tr>
</thead>
<tbody>
<tr>
<td>500</td>
<td>21</td>
</tr>
<tr>
<td>1000</td>
<td>26</td>
</tr>
<tr>
<td>2000</td>
<td>34</td>
</tr>
<tr>
<td>4000</td>
<td>37</td>
</tr>
<tr>
<td>8000</td>
<td>37</td>
</tr>
</tbody>
</table>

e. The interiors of audiometric testing environments will be illuminated with low wattage bulbs (less than 60 watts) to reduce heat radiation.

f. Audiometers are calibrated to a specific headset. The headset that was calibrated to the audiometer is the only authorized headset for that specific audiometer. If the headset becomes unusable, the audiometer will no longer be used for testing applicants and must be reported to Tobyhanna.

g. Ensure audiometers are connected to the battery backup (UPS) outlets with surge protection.

20-2. Height/Weight Measurement Equipment

a. Height measurement devices will be the wall-mounted type, SECA MDL 222 or SECA MDL 216. The device must be properly installed and verified for accuracy after installation. The MEPS medical department is to attach a level perpendicular (only for SECA MDL 222) to the wall to ensure the measuring device is level.
Figure 20-2. Height Device

b. Digital scales will be calibrated daily by a medical technician using the 25-pound weight issued with the scale and documented per Height/Weight/Body Fat/BMI Training Standardization Job Task Sheet.

20-3. Gulick II Tape
This is the only authorized tape for measuring all service applicant’s body fat as identified in the MMAL. Further instructions on using the Gulick tape can be found in the Height/Weight/Body Fat/BMI Training Standardization Job Task Sheet and the manufacturer’s instructions.

20-4. Proteinuria Qualitative Test

a. Qualitative urine tests for protein will be done using the Siemens Uristix (stock number 6650-00-226-1203). When a medical technician opens a new bottle, annotate the date and their initials on the side of the bottle. Refer to MMAL for Uristix ordering information.

b. MEPS Medical Technician must complete quality control tests whenever a new Uristix bottle is first opened and every 30 days thereafter until the Uristix bottle is empty, expired, or no longer passes the controls.

c. Record all quality controls test results/Uristix bottle lot number and open date on (UMF 40-1-8) and file under RN 40-24a2/500A, “Medical Laboratory Performance Files” (see Appendix A, Section III) for two calendar years from the date of last test in Medical Department, then destroy.

20-5. Glucosuria Qualitative Test

a. Qualitative urine tests for glucose will be done using the Siemens Uristix (stock number 6650-00-226-1203). When a medical technician opens a new bottle, annotate the date and their initials on the side of the bottle. Refer to MMAL for ordering information for Uristix.

b. MEPS Medical Technician must complete quality control tests whenever a new Uristix bottle is first opened and every 30 days thereafter until the Uristix bottle is empty, expired, or no longer passes the controls.

c. Record all quality controls test results/Uristix bottle lot number and open date on (UMF 40-1-8) and maintain on file for two calendar years from the date of last test in Medical Department, then destroy.

20-6. Pregnancy Determination Test

a. Authorized pregnancy test kits for MEPS use is the QuickVue+® One-Step HCG Combo test kits (stock number 6550-01-591-0962) listed on the MMAL.

b. The instructions contained in the product package insert of the MEPS preferred pregnancy determination test kits will be followed.

c. MEPS will acquire HCG Urine (Pregnancy) control set, NSN 6550-01-506-4951 for completion of external QC checks.
d. Controls will be run and documented in a control log (UMF 40-1-6) whenever a new box of test kits is first opened and every 30 days thereafter until the box is empty, expired, or no longer passes the controls.

e. The logs must be maintained in the Medical Department under RN 40-24a2/500A, “Medical Laboratory Performance Files” (see Appendix A, Section III), for two calendar years from date of last test in the Medical Department, then destroy. Use control information established by the Center for Clinical Laboratory Medicine in DoDM 6440.02 (Clinical Laboratory Improvement Program). Ensure the expiration date has not passed.

20-7. Point of Care Testing for Occult Blood

a. MEPS will order and use the Seracult Card and Developer Solution manufactured by Propper Manufacturing Company, Inc (stock number 6550-01-243-3204).

b. MEPS will run quality control (QC) for each use on an applicant.

c. All MEPS will use a control log (UMF 40-1-7) to annotate results and keep the control log (UMF 40-1-7) in the Medical Department under RN 40-24a2/500A, “Medical Laboratory Performance Files” (see Appendix A, Section III) for two calendar years, then destroy. Only the CMO/ACMO/FBP will perform the tests on applicants.

20-8. Safety Data Sheets (SDS)
Please refer to UMR 385-1 and OSHA Hazard Communication Standard 29 CFR 1910.1200 a2 and h1 for more information on the requirements for Safety Data Sheets.

20-9. Virtual Medical Library
The Army Medical Department online library in Army Knowledge Online (AKO) is available to anyone with a Common Access Card (CAC). It can be accessed through the following link: https://medinet.amedd.army.mil/. A free subscription to Up-To-Date is included with this access. Up-To-Date is a state of the art online subscription medical reference, including over 10,000 topics in 20 specialties. Instructions on how to access the online library and additional medical resources can be found on SPEAR.

20-10. Cleaning

a. It is J-7/MEMD’s intent to provide a safe and sanitary environment for all applicants processing through the MEPS, and all medical department employees. A properly maintained area also minimizes the spread of infectious agents by adhering to proper Preventive Health/Infection Control Guidelines.

b. The health-care facility environment is rarely implicated in disease transmission. Nonetheless, inadvertent exposures to environmental pathogens or airborne pathogens can result in adverse applicant outcomes and cause illness among medical department section staff and applicants. Preventive health care and proper cleaning of the MEPS medical departments are the optimal methods of the spread of infectious agents.

c. Environmental infection-control strategies can effectively prevent these infections. The incidence of health-care-associated infections and pseudo-outbreaks can be minimized by appropriate use of cleaners and disinfectants and appropriate maintenance of medical equipment.
d. Routine cleaning and disinfection of the environmental, frequently touched surfaces is important. Cleaning will be done daily by the local MEPS housekeeping department and medical personnel. Routine cleaning should primarily be directed toward those items that have been in direct contact with the applicant or in contact with the applicants’ excretions, secretions, blood, or body fluids.

e. Cleaning and Disinfecting Strategies for Environmental Surfaces in Medical Section Department Areas:

(1) Select EPA-registered disinfectants, and use them in accordance with manufacturer instructions.

(2) Follow manufacturers’ instructions for cleaning and maintaining medical equipment and supplies.

(3) In the absence of manufacturers’ cleaning instructions, the following procedures will be adhered to:

(a) Clean medical equipment surfaces with a detergent/disinfectant.

(b) Do not use alcohol to disinfect large environmental surfaces.

(c) Use barrier protective coverings for noncritical surfaces that are touched frequently with gloved hands during the delivery of applicant/patient care likely to become contaminated with blood or body substances or difficult to clean (e.g. computer keyboards).

(4) Keep housekeeping surfaces (e.g., floors, walls, tabletops) visibly clean on a regular basis and clean up spills promptly.

(5) Use a one-step process and an EPA-registered detergent/disinfectant designed for general housekeeping purposes in medical department section areas where uncertainty exists as to the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or uncertainty exits regarding the presence of multidrug resistant organisms on such surfaces.

(6) Detergent and water is adequate for cleaning surfaces in nonpatient-care areas (e.g., administrative offices).

(7) Clean and disinfect high-touch surfaces (e.g., doorknobs, bed rails, light switches, and surfaces on and around toilets) on a more frequent schedule than minimal-touch housekeeping surfaces.

(8) Clean walls, blinds, and window curtains in medical department section areas when they are visibly dusty or soiled.

(9) Avoid large-surface cleaning methods that produce mists or aerosols, or disperse dust in medical department section areas.

(10) Prepare cleaning solutions daily or as needed, and replace with fresh solution.
(11) Change the mop head at the beginning of each day, or after cleaning up large spills of blood or other body substances.

(12) Clean mops and cloths after use and allow to dry before reuse; or use single-use, disposable mop heads and cloths.

f. MEPS medical departments must properly maintain their work area to present a professional and safe environment for applicants while they are conducting medical processing. This includes removing unnecessary obstructions and clutter. MEPS medical department must be mindful of unnecessary equipment and supplies placed in hallways, examination and ortho/neuro rooms, and the laboratory.

g. All medical department personnel, fee basis providers, ASTs, and any non-medical department personnel assigned to duty in the medical department (i.e. chaperones, QC officers), must complete training on Standard Precautions for Infection Control in the MEPS. This training must be annotated on a CTO signed by the MEPS Commander and placed in the employee training record. Standard Precaution training must be conducted for each employee initially and annually thereafter. See Paragraph 19-5 for details on standard precaution training.
Support and Assistance

21-1. **Battalion Support Accession Medicine Branch (BSB)**

a. The **BSB Accession Medicine Branch** is made up of physicians and medical management analysts to support the medical processing at the MEPS.

b. The primary means of contacting the **BSB Accession Medicine Branch** is via MEPCom Operations Center (MOC) request. An urgent MOC ticket should be immediately followed with a phone call to J-7/MEMD. **Note:** Applicant PII (to include SSN, DOB, medical records, etc.) must NOT be included as an attachment to a MOC ticket. Once the ticket has been assigned to an Accession Medicine Branch **BSB** member, any applicant PII relevant to the issue must be sent via encrypted email to the **BSB Accession Medicine branch** (osd.north-chicago.usmepcom.list.hq-j7-memd-battalion-support@mail.mil).

c. See Training Standardization **Job Task Sheet** for additional guidance on submitting a MOC ticket.

21-2. **Assessment of Sick or Injured Shipper**

a. Any recruit who has sworn in and is now accessed to their respective Service who becomes ill and/or injured, whether still at the MEPS or a MEPS-sponsored facility (such as the contract hotel), or returns to the MEPS after beginning transport from their place of departure for recruit training/duty station is to be evaluated by the MEPS medical department.

b. The MEPS CMO/ACMO/FB-CMO will evaluate the recruit to determine if continued shipping is practical. If the recruit’s shipping is stopped due to illness and/or injury, or other medical concern, the MEPS will contact J-7/MEMD for guidance if necessary.

c. If assistance is requested, a J-7/MEMD Physician will contact the SMWRA and/or the Recruiting Service Operations personnel (G-1) and/or the Training Base Medical In-Processing Unit and discuss the status of the recruit. The discussion between the J-7/MEMD Physician and the higher level authority will be disseminated to the involved MEPS to include courses of action the applicant needs to take in order to be cleared to re-ship and any additional instructions for the MEPS CMO, if applicable. The Service Liaison and/or MEPS Operations department will provide the MEPS Medical department the applicant’s medical paperwork on any recruit whose shipping is stopped. The CMO will change the PULHES to “Open” or “3T” with a RJ date, as appropriate (this update to the paper record must be entered into USMIRS). The MEPS will place the applicant in an “N” status with comment “DO NOT SHIP UNTIL CLEARED BY MEPS CMO”.

d. The Service Liaison Office and MEPS Operations Officer must be notified of the recruit’s medical status for determination of disposition (revocation, amendments, hold-over, re-projection, etc.) in accordance with USMEPCOM Regulations and Recruiting Service policy. If the applicant was given an RJ date, the applicant must return to the MEPS medical department for evaluation before shipping out.
21-3. 911 Emergencies in the MEPS

a. The CMO, ACMO, or FB-CMO will determine if emergency treatment is necessary for illnesses and injuries that occur at the MEPS. MEPS personnel will only provide life-sustaining emergency procedures until emergency medical service (EMS) arrives.

b. If the applicant is at another facility for a consultation, the contracted consultant will determine if emergency treatment is necessary for illness and injuries that occur at their facilities. The contracted consultant will arrange for appropriate transportation to a nearby treatment facility, if the illness or injury took place in their facility.

c. The MEPS staff member will arrange for appropriate transportation to a nearby treatment facility and inform the respective Recruiting Service liaison of the applicant’s disposition. The CMO, ACMO, or FB-CMO may also contact the emergency room physician to provide details of the illness or injury, if appropriate.

Note: The Recruiting Services is responsible for transportation of the applicant after discharge from the hospital.

d. The MEPS Commander or his/her designee will submit a station advisory report (STAR) IAW UMR 380-1 (USMEPCOM Security Program), using the station advisory reporting network (STARNET).

e. Any medical treatment costs associated with injuries sustained at a MEPS or consultant’s office shall be addressed IAW UMR 27-1.

f. Each MEPS should implement their own Falls Prevention Program which should include but in no way is limited to the AWARE Program. This Falls Prevention Program should be based off consideration of available personnel, furniture, work space, floor plan, and work flow unique to each MEPS. This Falls Prevention Program should implement policy (work flow) adjustments as well as engineering (arrangement of furniture) adjustments in lieu of personnel or equipment shortfalls.
Appendix A

Section I
Publications referenced in, or related to this regulation

AR 40-501
Standards of Medical Fitness

DoDI 1308.3
DoD Physical Fitness and Body Fat Program Procedures

DoDI 6130.03
Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces

DoDM 6440.02
Clinical Laboratory Improvement Program (CLIP) Procedures

UMR 25-50
Official Mail and Distribution Management Program

UMR 40-2
Provider Quality Management Program

UMR 40-8
DoD HIV Testing Program and Drug and Alcohol Testing Program

UMR 40-9
Bloodborne Pathogen Program

UMR 55-2
Recruit Travel

UMR 350-1
Command Training Program

UMR 380-1
USMEPCOM Security Program

UMR 385-1
Safety and Occupational Health Program

UMR 601-23
Enlistment Processing

UMR 680-3
United States Military Entrance Processing Command Integrated Resource System (USMIRS)

UMR 715-4
Applicant Meals and Lodging Program
Section II – Forms

Forms referenced in or related to this regulation

CLMS Form 2
Clinical Laboratory Improvement Program – Change Request Form

DD Form 1966
Parental Consent

DD Form 2005
Privacy Act Statement - Health Care Records

DD Form 2217
Biological Audiometer Calibration Check

DD Form 2489
DoDMERB Farnsworth Lantern and Red/Green Color Vision Tests

DD Form 2807-1
Report of Medical History

DD Form 2807-2
Medical Prescreen of Medical History Report

DD Form 2808
Report of Medical Examination

PCN 680-3ADP
Request for Examination (USMIRS generated report)

SF 507
Medical Record

SF 513
Medical Record Consultation Sheet

SF 1034
Public Voucher for Purchases and Services Other Than Personal

UMF 40-1-2
Report of Medical Examination/Treatment

UMF 40-1-4
Refractive Eye Surgery Work Sheet

UMF 40-1-5
Specialty Consultation Contract/Ancillary Services Contract Performance Report
UMF 40-1-6
HCG Control Log

UMF 40-1-7
Guaiac Control Log

UMF 40-1-8
Uri-Stix Control Log

UMF 40-1-9
40yo and Over Physical Exam Supplemental Information Worksheet

UMF 40-1-10
40yo and Over Applicant Questionnaire

UMF 40-1-12-R-E
MEPS Fee Basis Provider Work Record

UMF 40-1-15-1-E
Supplemental Health Screening

UMF 40-2-4-E
Contract Provider Quality Management Form

UMF 40-8-1-E
DAT/HIV Acknowledgement

UMF 601-23-E
Report of Additional Information

UMF 680-3A-E
Request for Examination

UMF 727-E
Processing List (PL)

Section III
Recordkeeping Requirements

RN 1-201a/800D: “Inspection, Survey, and SAV Files – CMO Quarterly Review”
PA: N/A
Keep in office file for 2 years, then destroy.
(Referenced in Paragraph 19-6d)

RN 11-2a3/800B: “Management Control Program”
PA: N/A
Keep in office file until next management control evaluation, not more than 6 years, then destroy.
(Referenced in Appendix B-6)
RN 40/500A: “General Medical Services Files” (may insert applicant info to file by applicant)
PA: N/A
Keep in office file for 2 years, then destroy.
(Referenced in Paragraph 11-1d(51))

RN 40-1a/500A: “Professional Consultant Records”
PA: A0040-1DASG
Upon transfer or termination of individual, keep in office file for 1 year, or no longer needed for conducting business, then destroy.
(Referenced in Paragraph 18-4i)

RN 40-24a2/500A: “Medical Laboratory Performance Files”
PA: N/A
Keep in office file for 2 years, then destroy.
(Referenced in Paragraphs 20-4c, 20-5c, 20-6c, 20-7c)

RN 40-61i/500A: “Medical Equipment Maintenance - DD Form 2217”
PA: N/A
Keep in office file for 2 years, then destroy.
(Referenced in Paragraph 20-1c)

RN 40-66z/500C: “Entrance and Separation X-Ray Films”
PA: A0040-66bDASG
Keep in office file for 2 years, then destroy.
(Referenced in Paragraph 3-14)
Appendix B
Internal Control Evaluation Checklist - Medical

B-1. Function. The function covered by this checklist is medical processing at the MEPS.

B-2. Purpose. The purpose of this checklist is to assist the J-7 Medical Directorate in evaluating the key internal controls identified below. It is not intended to cover all controls.

B-3. Instructions. Answers must be based on actual testing of key management controls (e.g., document analysis, direct observation, sampling). Answers that indicate deficiencies must be explained and corrective actions indicated in the supporting documentation. These controls must be evaluated at least every 2 years. Certification that the evaluation has been conducted must be accomplished on DA Form 11-2-R, Management Control Evaluation Control Evaluation Certification.

B-4. Questions

a. Are the providers reviewing the medical prescreen forms correctly? (Chapter 2)

b. Is the chaperone/consent stamp filled out correctly? (Chapter 3)

c. Are applicant packets reviewed for minor and prior service documentation upon medical check-in? (Chapter 4)

d. Is the medical briefing conducted? (Chapter 5)

e. Are the medical technicians conducting hearing and vision testing on all applicant physical examinations? (Chapters 6 and 7)

f. Are all applicants shipping from the MEPS having temperature taken? (Chapter 8)

g. Is current CLIP certification on file? Is a laboratory director identified? Is semi-annual CAP testing performed and results on file? (Chapter 9)

h. Are the providers conducting the applicant interviews properly? (Chapter 10)

i. Are the applicants and medical staff completing DD Form 2807-1 (Report of Medical History), DD Form 2808 (Report of Medical Examination), and UMF 40-1-15-1-E (History Provider Interview) correctly? (Chapter 11)

j. Is notification of disqualified applicants being conducted? (Chapter 11)

k. Are the providers making medical qualification/disqualification decisions according to current policy? (Chapter 11)

l. Does the provider/technician/demonstrator ask all applicants as a group, prior to beginning the orthopedic/neurologic maneuvers, if they have had any of the listed medical conditions? (Chapter 12)

m. Is the exact purpose of the consult relayed to the consultant by the MEPS medical provider on the SF 513? (Chapter 13)
n. Is a medical technician completing the required daily quality review process on all applicant records projected to process at the MEPS? (Chapter 17)

o. Are the daily FBP requests accomplished? Are typical “no show” rates taken into consideration when determining the number of FBPs requested? (Chapter 18)

p. Are the work hours used for invoice reconciliation and fill rate data verified as accurate in the FBP applications? (Chapter 18)

q. Are the medical technicians receiving the required medical training as outlined in this regulation and the training SOP? (Chapter 19)

r. Is audiometric equipment calibrated and maintained? (Chapter 20)

s. Are the protein/glucose/HCG tests QCed (not expired) and then performed by a trained medical staff member? Are test controls analyzed and documented as recommended by the manufacturer? Is laboratory documentation (controls/logs) retained for at least two years in Medical Department? (Chapter 20)

t. Are recruits that have sworn in and are now accessed to their respective Service who become ill and/or injured, whether still at the MEPS or a MEPS-sponsored facility (such as the contract hotel), or returns to the MEPS after beginning transport from their place of departure for recruit training/duty station returned to the MEPS medical department for evaluation? (Chapter 21)

B-5. Comments
Users may submit comments to

HQ USMEPCOM, ATTN:
J-7/MEMD, 2834 Green Bay Road
North Chicago, IL 60064-3091

B-6. DA Form 11-2
DA Form 11-2 is designed to document any management control evaluation. Evaluations of the MEPS Medical Department area must be documented on this form. Fill in the appropriate items, as needed. The assessable unit is the MEPS Medical Department. The methodology used to conduct the evaluations could be the Internal Control Evaluation Checklist questions (B-4 above) and other methods used to review this area (e.g. manufacturer’s instructions). Block 6 lists who completed the evaluation and when it was conducted. Block 7 is used to document and explain the methods used for evaluating this functional area. Item 8 is competed by the assessable unit manager (e.g. Commander). File completed DA Form 11-2 under RN 11-2a3/800B, “Management Control Program” (see Appendix A, Section III). Disposition of DA Form 11-2’s are IAW local MEPS SOP and are subject to audit and/or inspection. DA Form 11-2’s are retained until next management control evaluation, but no more than 6 years, then destroy.
Appendix C
Glossary

Section I Abbreviations

ACMO
Assistant Chief Medical Officer

ACOR
Alternate Contracting Officer’s Representative

ADT
Active Duty for Training

AFSC
Air Force Specialty Code

AKO
Army Knowledge Online

AMO
Assistant Medical Officer

ANSI
American National Standards Institute

AR
Army Regulation

ARNG
Army National Guard

BAS
Bio-Acoustic Simulator

BF
Body Fat

BP
Blood Pressure

BSB
Battalion Support Branch

BT/AIT
Basic Training/Advance Individual Training
CAP
College of American Pathology

CD
Considered Disqualifying

CLIP
Clinical Laboratory Improvement Program

CMO
Chief Medical Officer

CNP
Certified Nurse Practitioner

COR
Contracting Officer’s Representative

CTO
Confirmed Training Orders

DA
Department of the Army

DAT
Drug and Alcohol Test

DD/DoD
Department of Defense

DEP
Delayed Entry Program

DO
Doctor of Osteopathy

DoDI
Department of Defense Instruction

DoDMERB
Department of Defense Medical Examination Review Board

DPC
Designated Provider Category

EEG
Electroencephalogram
EKG
Electrocardiogram

ELS
Entry-Level Separation

EMS
Emergency Medical Services

EPTS
Existed Prior to Service

ER
Emergency Room

FB-CMO
Fee Basis Chief Medical Officer

FOIA
Freedom of Information Act

FBP
Fee Basis Provider

GPC
Government Purchase Card

GPOC
Government Point of Contact

GTT
Glucose Tolerance Test

GU
Genitourinary

HIPAA
Health Insurance Portability and Accountability Act

HIV
Human Immunodeficiency Virus

HT
Height

IAW
In Accordance With
ICD
International Classification of Diseases

IG
Inspector General

ILD
Incremental Lifting Device

IOT
Intraocular Tension

IRC
Inter-service Recruitment Committee

IT
Information Technology

ITV
Individual Training Visit

J-1/MEHR
J-1/Human Resources Directorate

J-3/MEOP
J-3/Operations Directorate

J-7/MEMD
J-7/Medical Plans and Policy Directorate

J-8/MERM
J-8/Resource Directorate

JKO
Joint Knowledge Online

MAX WT
Maximum Weight Authorized

MD
Doctor of Medicine

MEB
Medical Evaluation Board

MEPS
Military Entrance Processing Station
MMA
Medical Management Analyst

MMAL
Medical Materiel Allowance List

MOC
Military Entrance Processing Command Operations Center

MT
Medical Technician

MTF
Military Treatment Facility

MRV
Medical Reassessment Visit

NCD
Not Considered Disqualifying

NCOIC
Non-Commissioned Officer in Charge

NG
National Guard

OPSO
Operations Officer

OPTEC
Stereoscope Vision Testing

OSHA
Occupational Safety & Health Administration

PA
Physician Assistant

PDRL
Permanent Disability Retirement List

PDQ
Permanently Disqualified

PEB
Physical Evaluation Board
PFT
Pulmonary Function Test

PIP
Psuedoisochromatic Plate Ishihara Compatible

POC
Point of Contact

PWR
Provider Work Record

QRP
Quality Review Process

RAT
Reading Aloud Test

RJ/RBJ
Return Justified/Reevaluation Believed Justified

ROTC
Reserve Officers’ Training Corps

SAV
Staff Assistance Visit

SMPG
Supplemental Guidance

SMWRA
Service Medical Waiver Review Authority

SOP
Standard Operating Procedure

SPEAR
Sharing Policy Experience and Resources (USMEPCOM intranet)

STAR
Station Advisory Report

STARNET
Station Advisory Report Network

SUP MT
Supervisory Medical Technician
Section II Terms

Accession Medicine
A phrase coined by J-7/MEMD to epitomize the activities of USMEPCOM centered on evaluating the suitability of the moral, physical, and mental condition of prospective applicants for entry into military service. Accession medicine is unique to the USMEPCOM medical departments for performing accession medical services. USMEPCOM accession medicine physicians ensure accession standards as defined in the current version of DoDI 6130.03 are applied appropriately for each applicant.

Accession Medical Services
USMEPCOM medical services provided during the medical examination processing of applicants for the Armed Services. Medical services include but are not limited to prescreen reviews of applicant medical history, medical history interviews, physical screening examinations, reviews of medical test results, determinations of whether an applicant does or does not meet accession medical standards, physical inspections, and overseeing MEPS medical department regulatory compliance.
Assistant Chief Medical Officer
Government civil service physician located at larger MEPS in the medical department. The ACMO uses their professional training and judgment to apply medical qualification standards set forth by the Department of Defense policy. The ACMO is supervised by the CMO, but the Commander has complete authority, within the rules and regulation of USMEPCOM, to direct the ACMO regarding administrative matters. After initial training, ACMOs are expected to be DPC-4 providers. ACMOs are subject to review by HQ USMEPCOM physicians.

Assistant Medical Officer
Government civil service physician assistants and certified nurse practitioners located at MEPS in the medical department. The AMO uses their professional training and judgment to perform assigned accession medical services. AMOs are supervised by the CMO, but the Commander has complete authority, within the rules and regulations of USMEPCOM, to direct the AMO regarding administrative matters. After initial training, AMOs are expected to be DPC-2 providers. AMOs are subject to review by HQ USMEPCOM physicians, physician assistants and certified nurse practitioners.

Audiogram
A hearing test or the printed test results from the audiometer.

Bottom-Line
The signature by the profiling provider on an applicant’s physical when PULHES are complete.

Chaperone
A third party who is authorized to observe an applicant of the same gender during the medical examination process when the provider and applicant are different genders or when requested by the applicant or medical provider.

Chief Medical Officer
Government civil service physician responsible for medical operations at each MEPS or processing facility. The CMOs use their professional training and judgment to apply medical qualification standards set forth by the Department of Defense policy. The CMO is supervised by the MEPS Commander who has complete authority, within the rules and regulation of USMEPCOM, to direct the CMO regarding administrative matters. After initial training, CMOs are expected to be DPC-4 providers. CMOs are subject to review by HQ USMEPCOM physicians.

Confirmed Training Orders
Appointment orders signed by the MEPS Commander that confirm the employee is fully trained in and authorized to perform all duties identified on the CTO.

Consultation
A special medical examination provided by a physician who is qualified to evaluate the medical limitations of an individual. This includes consultations performed within the MEPS as well as those performed outside the station. Other medical procedures, including but not limited to laboratory procedures, EKG, electroencephalogram (EEG) interpretations, x-ray interpretations (special orthopedic films, GI x-rays, IVP, tomograms, etc.), CT scans, body fat determinations, ear irrigations, pulmonary function tests, and eye refractions, are referred to as ancillary services.
**Disqualified**
Applicant does not meet established criteria under the standards prescribed by the sponsoring military service.

**Fee Basis Chief Medical Officer**
An FBP (contract employee) who is assigned for a specified work day as the “temporary CMO” when the CMO is absent and the MEPS does not have an ACMO available. An FB-CMO must be a physician with a DPC-4 assignment (is assigned to profile) approved by USMEPCOM. FB-CMOs will accomplish medical histories; physical medical examinations; reviews of required medical tests and documents pertaining to consultations and medical histories; assessing applicant medical documentation and rendering their medical opinion on an applicant’s medical qualification for serving in the Armed Forces. FB-CMOs apply set DoD medical standards when determining medical qualifications. When medical standards are unclear or ambiguous regarding the medical qualifications of an applicant the FB-CMO will consult with a HQ USMEPCOM physician.

**Fee Basis Provider**
Medical Doctor (MD) or (Doctor of Osteopathy (DO), Physician Assistant (PA), or Certified Nurse Practitioner (CNP), all of which are contract employees, who conduct enlistment physical medical examination screenings at a MEPS. FBPs will accomplish medical histories; physical examinations; reviews of required medical tests and documents pertaining to consultations and medical histories; assessing applicant medical documentation to render a medical opinion on an applicant’s medical qualification for serving in the Armed Forces by using qualification standards set forth by Department of Defense policy under the general supervision of the MEPS CMO or designated representative.

**Front-Loading**
Front loading refers to medical tests that are authorized to be performed before the Medical Brief but are not authorized during “night” aptitude testing timeframes.

**Hometown Shipper**
An individual who has been authorized by his/her Service to ship from his/her hometown to a Reception/Training Center or other duty location without returning to the MEPS. Also known as a “direct shipper” for the National Guard.

**Individual Training Visit**
A visit by USMEPCOM/Sector/Battalion staff member(s) to provide guidance, training and assistance in a particular MEPS staff member's functional area of responsibility.

**Medical Examination**
A full medical examination or inspection that includes all required basic elements, including the evaluation of consultations, additional tests and determinations, and outside medical documentations if any, and including a completed physical profile and qualification decision. (Same as a completed medical evaluation.)

**Medical Inspection**
A reassessment of a new medical requirement of an applicant who returns to the MEPS for a medical reevaluation or to complete medical processing but is less than 30 days from initial full physical or subsequent inspection.
Medical Non-Commissioned Officer in Charge/Supervisory Medical Technician
Individual (Government employee) responsible for the administrative operation of the MEPS medical department and general supervision of paraprofessional staff (lead medical technicians, medical technicians) conducting physical screening examinations.

Medical Provider
Medical practitioners providing accession medical services within USMEPCOM. Includes government and contracted physicians, certified nurse practitioners, and physician assistants.

Medical Read (Med Read)
A “med read” is any applicant medical documentation that has been requested and/or supplied following the initial physical examination.

Medical Reassessment Visit
A visit by USMEPCOM J-7/MEMD staff member(s) to improve the unsatisfactory functional areas within 90 days of a “Not-In-Compliance” IG inspection.

Medical Waiver
A service waiver of a medical defect that disqualifies an individual for enlistment or Service job assignment.

N Status
This indicates the applicant has been placed on administrative hold, pending resolution of a discrepancy or that additional enlistment paperwork may be required. MEPS personnel will notify the appropriate recruiting Service liaison/guidance counselor that until the disqualifying discrepancy and/or condition is cleared, the applicant is ineligible for further enlistment processing. If the medical examination was initiated while the applicant was in an “N” status, the medical examination will be completed. Upon completion of the medical examination, the applicant will be placed in an “N” status until cleared for further processing.

No-show
An individual projected for processing who fails to arrive on the scheduled date at the prescribed time.

Overseas Processor
Applicants processing outside the continental United States, Alaska, Hawaii, or Puerto Rico.

Physical Inspection
A limited reexamination and evaluation of interval medical history of an applicant who meets one of the following conditions: returning to the MEPS for any processing if more than 30 days has elapsed from the initial examination or subsequent inspection; entry on Active Duty/Active Duty Training if more than 72 hours has elapsed from the initial examination or subsequent physical inspection; initial examination was processed by an overseas military facility.

Profiler
Government physician or FBP physician who has been granted either DPC-3 or DPC-4.
Profiling
A system for classifying individuals according to functional abilities. It is based primarily upon the function of body systems and their relation to military duties. It is applicable for physical exams for enlistment, appointment or induction, and is used to specify whether an applicant meets the relevant physical standards or not.

Projection
The scheduling of an individual applicant for entrance processing at a USMEPCOM Processing Location.

PULHES
The physical profile (PULHES) is a system for classifying individuals according to functional abilities as defined by Accession Medicine standards. The letter designators are to be considered for the following factors:

(1) P—Physical capacity or stamina. Includes conditions of the heart, respiratory system, gastrointestinal system, genitourinary system, nervous system, allergic, endocrine, metabolic and nutritional diseases, diseases of the blood and blood forming tissues, dental conditions, diseases of the breast, and all other organic defects and diseases that do not fall under other specific factors of the system (e.g., underweight/overweight)

(2) U—Upper extremities. Includes the hands, arms, shoulder girdle, and upper spine (thoracic and cervical) with regard to strength, range of motion and general efficiency

(3) L—Lower extremities. Includes the feet, legs, pelvic girdle, lower back and lower spine (lumbar and sacral) with regard to strength, range of motion and general efficiency

(4) H—Hearing and ears. Includes auditory acuity and diseases and defects of the ear

(5) E—Eyes. Includes visual acuity and diseases and defects of the eye

(6) S—Psychiatric. Includes personality, emotional stability, psychiatric diseases, and any substance abuse disorders.

(7) X – Air Force Incremental Lifting Device. This is not used by the medical department.

Return justified/reevaluation believed justified
A term applied to an individual found not qualified for military service, due to a remedial medical or non-medical condition, and whom MEPS personnel believe should be reevaluated at a later date.

Shipping Inspection
A limited reexamination and evaluation of interval medical history of an applicant who meets one of the following conditions: returning to the MEPS for any processing if more than 30 days has elapsed from the initial examination or subsequent inspection; entry on Active Duty/Active Duty Training if more than 72 hours has elapsed from the initial examination or subsequent physical inspection; initial examination was processed by an overseas military facility. Temperatures are also taken on applicants receiving shipping inspections.
Staff Assistance Visit
A visit by USMEPCOM/Sector/Battalion staff members to assist, teach, and train MEPS staff departments sections on how to meet the standards required to operate effectively within a particular functional area.

Walk-In
An individual who arrived early enough for examination and/or processing, but was not scheduled by name with the MEPS prior to close of business on the preceding workday.
Appendix D
Proteinuria / Glucosuria

Proteinuria:

1. If dipstick done at the MEPS is positive for protein (greater than trace) and applicant is hypertensive, then DQ. Refer applicant to their PCP for evaluation.

2. For any applicant with a protein level of 30 mg/dL (1+), that applicant should be given the opportunity to provide another sample that day (ideally within 2 hours of the first sample). If the second test indicates trace or negative results, the applicant may be deemed qualified. If the applicant has a positive protein dipstick and has participated in strenuous exercise within the past 24 hours, then instruct applicant to stay well hydrated, avoid strenuous exercise, and return no sooner than 2 business days for repeat dipstick.

3. For an applicant with a protein level of greater than 30 mg/dL (2+ or above), instruct applicant to stay well hydrated, avoid strenuous exercise, and return no sooner than 2 business days for repeat dipstick. If there is no history of strenuous exercise within the past 24 hours and the applicant is not hypertensive, then a second dipstick can be repeated the same day once the applicant has been well hydrated (at the MEPS). Qualify if trace/negative results are obtained.

4. If second dipstick is positive and blood pressure is within normal limits, applicant will then be referred to a lab for spot urine protein/creatinine ratio test and a microscopic urinalysis. If the results of both tests at outside lab are normal, then qualify (a fresh urine sample supplied at the outside lab may be used).

5. If urine protein/creatinine ratio is abnormal (greater than 0.2) or micro urinalysis is abnormal, then DQ and refer to their PCP for evaluation of proteinuria.

Glucosuria:

1. MEPS urine glucose test: A normal result is qualifying.

2. Applicants with a positive urine dipstick for glucose must be referred to the CMO/ACMO/FB-CMO for evaluation of possible uncontrolled diabetes. If so, then the applicant will be immediately referred to an emergency room for evaluation.

3. If the applicant appears well, then order a fasting blood sugar (FBS)/2 hour glucose tolerance test (GTT). Upon return to the MEPS a repeat dipstick for glucose will be conducted. If either the 2 hour GTT or repeat dipstick are abnormal, then DQ and refer to PCP for evaluation.

4. If the FBS is less than 110 and the 2 hour GTT is less than 140 and repeat urine glucose dipstick is normal, then they meet the standard.

5. If FBS, 2 hour GTT, or repeat dipstick is abnormal, advise applicant to see their PCP as soon as possible for evaluation. Document the discussion and/or send a certified letter with copy of lab results advising the applicant to see their PCP as soon as possible for evaluation.
July 24, 2017

Appendix E
Letters

Month Day, Year

(Insert Applicant Name)
(Insert Applicant Street Address)
City/State/zip code

Dear Mr./Mrs./Ms. (Insert Applicant Last Name):

This letter is in regard to the advice given to you by the (Insert MEPS Name) Military Entrance Processing Station physician during your recent medical examination. On (Insert exam date), you were medically examined to determine your qualification for entry into the Armed Forces of the United States. During the examination, the examining physician discovered you had a medical condition which should be examined or treated by your private physician. The possible condition you should bring to the attention of your physician is (Insert medical condition).

For your physician’s convenience, copies of your medical history and medical examination are enclosed.

To protect your health, you are urged to obtain professional medical help regarding your medical condition as soon as possible.

Sincerely,

(Insert CMO Name)
Chief Medical Officer

Enclosures:
1. DD Form 2808
2. DD Form 2807-1

cc:
MEPS Commander

Figure E-1. Example of Dangerous or Life-Threatening Medical Condition Disqualification Letter
Dear Mr./Mrs./Ms. (Insert Applicant Name):

This letter notifies you that, as a result of your recent military entrance medical examination, you have been found medically disqualified for entry in the Armed Forces of the United States. The reason for your medical disqualification is the finding of (Insert medical condition). Although this condition may not affect your current or future employability in civilian life, it is considered disqualifying for military service under current medical standards for enlistment. Should you desire further information concerning your medical disqualification, we will be happy to provide a copy of your medical records to your physician upon written request from you.

Sincerely,

(Insert CMO Name)
Chief Medical Officer

cc:
MEPS Commander

Figure E-2. Example of Medical Disqualification Letter