General Information. The medical conditions listed are cause to reject an examinee for flying training (all classes), or continued flying duty (classes II or III) unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification for flying training or temporarily restricting the individual from flying until the problem is resolved. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the judgment of the examining flight surgeon. Any condition that in the opinion of the flight surgeon presents a hazard to flying safety, the individual's health, or mission completion is cause for temporary disqualification for flying duties. To be considered waiverable, any disqualifying condition should meet the following criteria:

Not pose a risk of sudden incapacitation.
Pose minimal potential for subtle performance decrement, particularly with regard to the higher senses.
Be resolved or be stable and be expected to remain so under the stresses of the aviation environment.
If the possibility of progression or recurrence exists, the first symptoms or signs must be easily detectable and not pose a risk to the individual or the safety of others.
Cannot require exotic tests, regular invasive procedures, or frequent absences to monitor for stability or progression.
Must be compatible with the performance of sustained flying operations in austere environments.
Flying Class I qualifies for selection into Enhanced Flight Screening and commencement of undergraduate pilot training (UPT).

Flying Class IA qualifies for selection and commencement of undergraduate navigator training.

Flying Class II qualifies undergraduate flight training students, rated officers, and physician applicants for Aerospace Medicine Primary training.

Flying Class III qualifies individuals for non-rated duties in ASC 9D, 9E and 9W.

Physiologic training standards (Attachment 8) qualifies individuals for non-rated duties in ASC 9G.

Categorical Flying Class II qualifies rated officers for duty in certain restricted aircraft categories.

Flying Class IIA qualifies rated officers for duty in low-G aircraft (tanker, transport, bomber, T-43 and T-1).

Flying Class IIB qualifies rated officers for duty in non-ejection seat aircraft.

Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042, and as annotated on the AMS, SF 88, Report of Medical Examination, or AF Form 1446, Medical Examination - Flying Personnel. These waivers are coordinated with HQ USAF/XOAA.

Medical examinations are required when:
Individual applies for initial flying duty (all classes). (Initial rated flying or Initial non-rated flying.).
Officers holding comparable status in other US military services apply for Air Force aeronautical ratings (FC II, SF 88/SF 93, etc.).
Personnel, including personnel of the ARC, are ordered to participate in frequent and regular aerial flight
Flying personnel, including personnel of the ARC, are suspended from flying status for 12 months or more for medical reasons, applying for return to flying duties (Periodic Flying, long for ARC and PHA with AMS for AD/AF).

Flying personnel are ordered to appear before a Flying Evaluation Board (FEB). (See AFI 11-401, Flight Management). (Periodic flying (long) for ARC and PHA with AMS for AD/AF).

All members on flying status, annually, within 3 months preceding the last day of the birth month or 6 months for special circumstances, such as permanent change of station (PCS), temporary duty (TDY), retirement or waiver renewal, etc.

RAir Force Flying Physical

Medical Examination Standards

Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III).

Injuries to the head (See paragraph A7.23.).

Loss or congenital absence of bone substance of the skull.

Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

Congenital cysts of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

Chronic draining fistulae of the neck, regardless of cause.

Contraction of the muscles of the neck if persistent or chronic. Cicatricial contracture of the neck to the extent it interferes with function or the wear of equipment.

Cervical ribs if symptomatic or symptoms can be induced by abduction, scalenus, or costo clavicular maneuvers.

Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

Information derived from Air Force Flying Physical

Medical Examination Standards

Nose, Sinuses, Mouth, and Throat.

Flying Classes II and III.

Allergic rhinitis, unless mild in degree and considered unlikely to limit the examinee’s flying activities. Waivers are considered if symptoms are controlled by desensitization or topical medication (or both).

Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction. Waivers are considered if symptoms are controlled by topical medication.

Nasal polyps.

Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.
Chronic sinusitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

Recurrent calculi of the salivary glands or ducts.

Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, easily understood speech, or mastication and swallowing of ordinary food.

Atrophic rhinitis.

Perforation of the nasal septum.

Anosmia or parosmia.

Salivary fistula.

Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

Chronic pharyngitis and nasopharyngitis.

Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

Aphonia or history of recurrent aphonia if the cause was such as to make subsequent attacks probable. Painful Dysphonia Plicae Ventricularis.

Tracheostomy or tracheal fistula.

Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

Flying Classes I and IA. In addition to the above:

A verified history of allergic, nonallergic, or vasomotor rhinitis, after age 12. A7.2.2.2. Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. Waiver may be considered if recovery is complete and individual has been asymptomatic for 1 year.

Air Force Flying Physical

Medical Examination Standards

Ears

Flying Classes II and III.

History of surgery involving the middle ear, excluding cholesteatoma below.

Residual of mastoid surgery.

Inability to perform the VALSALVA maneuver.

Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

Tinnitus when associated with active disease.
Abnormal labyrinthine function.

Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

Any conditions that interfere with the auditory or vestibular functions. A7.3. 1.9. Cholesteatoma or history of surgical removal of cholesteatoma.

Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

Classes I, IA, II (flight surgeon applicants) and III (initial applicants). In addition to the above:

Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

History of radical mastoidectomy.

History of abnormal labyrinthine function, unexplained or recurrent vertigo.

Air Force Flying Physical

Medical Examination Standards

Hearing, Flying Class II and III. Hearing loss greater than H-1 profile or asymmetric hearing loss requires work-up by an audiologist (audiology evaluation for initial waiver and waiver renewals must have been accomplished within 12 months of submission to waiver authority). Waivers are required for H-3 hearing loss or greater. Indefinite waivers are not authorized.

H-2 profile alone does not require waiver. However, an evaluation sufficient to rule-out conductive or retrocochlear pathology should be conducted. This includes full audiologic evaluation and, where appropriate, referral for ENT consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from flying is not required during work-up.

H-3 profile requires waiver.

For members with new H-3 profiles (i.e., those whose hearing has recently changed to H-3, and who have not been previously worked-up), restriction from flying is appropriate.

NOTE: Members with long-standing, stable H-3 not previously evaluated, require work-up and waiver, but need not be restricted from flying, unless in the opinion of the flight surgeon they represent a danger to flying safety. Interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (occupational aircrew hearing assessment), pending complete audiology evaluation (indefinite waivers are not authorized).

Validate hearing proficiency in one of two ways prior to issuance of medical waiver for H-3 profile:

Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned aircrew duties in the flying environment.

Waiver is contingent upon complete audiologic and where appropriate, ENT evaluation.

NOTE: The audiologist must rule out conductive and retrocochlear disease. The audiologist may defer ENT evaluation.
The occupational aircrew hearing assessment is deferred for inactive flyers. They may receive a Flying Class IIC waiver specifying the completion of the occupational aircrew hearing assessment before return to active flying.

Asymmetric hearing loss (greater than, or equal to, 25dB difference, comparing left and right ear, at any two consecutive frequencies) requires full audiologic work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized).

The following tests are suggested as a complete audiologic evaluation:

- Pure tone air and bone conduction thresholds.
- Speech reception thresholds.
- Speech discrimination testing, to include high intensity discrimination.
- Immittance audiometry.
- Air Force Flying Physical

Medical Examination Standards

Dental

- Flying Classes II and III.

Personnel wearing orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

Severe malocclusion which interferes with normal mastication or requires protracted treatment.

Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

Aircrew members in Dental Class III or who have a significant dental defect which may be expected to cause a dental emergency during flight will be grounded. ARC members are managed JAW paragraph 14.14.1. of this instruction.

Classes I and IA. In addition to the above:

- Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prosthesis, until corrected.

- Anticipated or ongoing treatment with fixed orthodontic appliances.

- Information derived from Air Force Instruction 48-2

- Tympanograms.

- Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB IL).
- Acoustic reflex decay (500 and 1000 Hz, with levels not exceeding 110 dB IL).
- Otoacoustic emissions (transient evoked or distortion product).

The following tests may be required if indicated by the above:
Auditory brainstem response.

MRI

NOTE: Audiology reevaluation is required for waiver renewals if a shift of greater than 10dB is noted from the "initial" audiology evaluation used for the initial waiver in any one frequency from 1,000 Hz to 4,000 Hz. Additionally, audiology evaluations submitted to the waiver authority must have been accomplished within 12 months. These rules apply to all hearing waivers.

Surgical repair of perforated tympanic membrane within the last 120 calendar days.

Information derived from Air Force Instruction 48-23, Current as of Dec 2000. Turn to flying status after a break in flying duties.

Air Force Flying Physical

Medical Examination Standards

Eye, Flying Classes I, IA, II, and III.

Sponsored Links
Pass A Color Blind Test
100% Success rate with ColorCorrection System
www.ColorMax.org
Medical Flight Services
24/7 Anytime Anywhere. We Handle All Arrangements. Call Toll Free!
www.MedwayAirAmbulance.com
Della Optique Optometry
Optometrist in Kitsilano, Vancouver, family & child eye exams, eyewear
www.dellaoptique.com

Lids/Adnexa.

Any condition of the eyelids which impairs normal eyelid function or comfort or potentially threatens visual performance.

Epithora, nasolacrimal duct obstruction.

Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision in any field of gaze or direction.

Dacryocystitis, acute or chronic.

Dacryostenosis

Conjunctiva.

Conjunctivitis, chronic, seasonal.

Trachoma, unless healed without scarring.

Xerophthalmia.

Pterygium which encroaches on the cornea more than 1mm or interferes with vision, or is progressive, or causes refractive problems

Cornea.
Keratitis, chronic or acute, including history of.

Corneal ulcer of any kind, including history of recurrent corneal ulcers or recurrent corneal erosions.

Vascularization or opacification of the cornea, from any cause, when it is progressive, interferes with vision or causes refractive problems.

History of traumatic corneal laceration unless it does not interfere with vision, nor is likely to progress.

Corneal dystrophy of any type, including keratoconus of any degree.

NOTE: UPT Applicants who demonstrate a topographical pattern suggestive of keratoconus, referred to as TPSK, but who do not have any other clinical signs of keratoconus, may be eligible for waiver. However, these members must have been processed through EFS-Medical for eligibility. Test results from outside agencies, or civilian sources do not qualify. Members identified with TPSK may be waived into the ACS TPSK Study/Management Group, only after evaluation by the ACS. Members identified with TPSK will be informed that their participation in this study group is mandatory for consideration of waiverability into UFT and continued flying. Reevaluation periodically at the ACS will be required for waiver renewal.

History of radial keratotomy (RIK) or any other surgical or laser procedure, such as photorefractive keratectomy (PRIK) and laser in situ keratomileusis (LASIK) accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratectomy (PTK), are not waiverable.

Orthokeratology, active or a history of within six months of application to UFT. A7.6.3.8. Lamellar or penetrating keratoplasty (corneal transplant).

Uveal Tract. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

Retina/Vitreous.

Retinal detachment and history of same.

Degenerations and dystrophies of the retina including retinoschisis and all types of central and peripheral pigmentary degenerations.

Degenerations and dystrophies of the macula, macular cysts, and holes.

Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless single episode which has healed, is expected not to recur, and does not impair central or peripheral vision.

Angiomasoses, phakomatoses, retinal cysts and other conditions which impair or may impair vision.

Hemorrhages, exudates or other retinal vascular disturbances.

Vitreous opacities or disturbances which may cause loss of visual acuity. A7.6.6. Optic Nerve.

Congenito-hereditary conditions that interfere or may interfere with central or peripheral vision.

Optic neuritis, of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

Optic atrophy (primary or secondary) or optic pallor.
Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2.

Optic neuropathy.

Lens.

Aphakia, unilateral or bilateral.

Dislocation of a lens, partial or complete.

Opacities or irregularities of the lens which interfere with vision or are considered to be progressive.

Pseudophakia (intraocular lens implant).

Posterior capsular opacification.

Other Defects and Disorders.

Asthenopia, if severe.

Exophthalmos, unilateral or bilateral.

Nystagmus of any type, except on versional end points.

Diplopia in any field of gaze, either constant or intermittent, including history of

Visual field defects, any type, including hemianopsia.

Abnormal pupils or loss of normal pupillary reflexes, with the exception of physiological anisocoria.

Retained intraocular foreign body.

Absence of an eye.

Anophthalmos or microphthalmus.

Any traumatic, organic, or congenital disorder of the eye or adnexa, not specified above, which threatens to intermittently or permanently impair visual function.

Migraine or its variants, to include acephalgic migraine (See paragraph A7.23.). A7.6.8.12. History of any ocular surgery to include lasers of any type.

VISION & REFRACTIVE ERROR STANDARDS.

<table>
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<tr>
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<th>Refraction Limits</th>
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20/70 20/20 20/20 - +2.00
-1.50 1.50 2.00 Note 1
IA
Note
2, 10, 12,13
20/200 20/200 20/200 +3.00
-2.75 2.00 2.50 Note 1
II (Pilot) Note 1,13
20/400 20/20
Note
3,11 - 20/20 Notes:3,9 +3.50
-4.00 2.00 2.50 Note 4
II (other than pilot) and III Note 1,13 20/400 20/20
Note
3,12 - 20/20
Notes: 3,
9 +5.50
-5.50
Note 8 3.00 3.50 Note 4

Notes:
1. Use of hard, rigid, or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before examination is prohibited. Document SF 88 appropriately to ensure this requirement has been met.

2. These medical standards apply for USAFA, AFROTC cadets at the time of AF commissioning physical, AF active duty members, civilian applicants for flying training, and applicants from the Reserve and Guard components during the initial flying physical.

3. Individuals found on routine examination to be 20/20 in one eye and 20/25 in the other but correctable to 20/20 in each eye may continue flying until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means. Be advised that this policy should only be used if the condition does not cause acute change in stereopsis performance (i.e., failure of depth perception screening tests).

4. Anisometropias greater than Flying Class II or III standards may be considered for waiver if the OVI (or VTA) stereopsis is normal and the aviator has no asthenopic symptoms due to poor fusional control, or diplopia.

5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.

6. All aircrew members are prohibited from using contact lenses for treatment of medical conditions unless they have been specifically prescribed and issued or approved by the ACS.

7. Optional wear of contact lenses for aircrew members is outlined in Attachment 17.

8. Waivers may only be considered after the individual has a normal ophthalmological examination to include a dilated fundus exam and possesses plastic lens spectacles which correct them to 20/20 in each eye and meets the USAF standards for approved commercially obtained spectacles for aircrew duties (see attachment 17.7).

9. Actively flying personnel should be corrected to 20/20 at the nearest cockpit working distance.

10. The Air Force Chief of Staff retains Exception To Policy (ETP) authority for vision and refractive limits
for UFT applicants.

11. Flying Class II aviators should be refracted to their best corrected visual acuity. Use of spectacles to correct to better than 20/20 is at the discretion of the crewmember.

12. For qualification purposes, cycloplegic refraction readings should be recorded for that required to read the 20/20 line in each eye. However, continue refraction to best visual acuity and report the best achievable corrected visual acuity as a clinical baseline. (Thus, acuity and refractive error numbers may not correlate). Cycloplegic refractions that cannot achieve the 20/20 line will need clinical evaluation or re-evaluation.

13. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties, see AFI 11-206, paragraph 6.3.3. Additionally, only 15 percent (N-iS) transmittance neutral density gray spectacle lenses are approved for flying duty, see AFR 167-3, para 2-4d. Consult other guidance, such as AFMOA or MAJCOM policy letters pertaining to aircrew spectacles.

Heterophoria and Heterotropia.

Flying Class III except InFlight Refuelers:
Esophoria greater than 15 prism diopters.
Exophoria greater than 8 prism diopters.
Hyperphoria greater than 2 prism diopters.
Heterotropia greater than 15 prism diopters.

Flying Class I, IA, II, Inflight Refuelers and individuals required to perform scanner duties.
Esophoria greater than 10 prism diopters.
Exophoria greater than 6 prism diopters.
Hyperphoria greater than 1.5 prism diopters.
Heterotropia, including microtropias.

Point of convergence (PC) greater than 100mm.

NOTE: Accomplish and record PC measurements only at the time of initial flying class 1, IA, 11-Flight Surgeon, and III - Inflight Refueler applicant exams. The PC is no longer required on periodic examinations.

History of extraocular muscle surgery is cause for complete evaluation of ocular motility by a competent eye care professional to look for residual heterophorias, heterotropias (including microtropias), and motor sensory problems.

NOTE: The evaluation must include all of the motility tests listed in A7.11. Further processing of such cases will proceed in accordance with A7.11. as well.

Near Point of Accommodation.

Flying Classes II and III. No standards.
Flying Classes I and IA. Near point of accommodation less than minimum for age specified in attachment 11.

Color Vision, Classes I, IA, II and III. Color vision testing must be performed monocularly under an approved and standardized illuminant (i.e., Illuminant C). Five or more incorrect responses in either eye (including failure to make responses in the allowed time interval) in reading the 14 test plates versions of one of the following Pseudoisochromatic Plate (PIP) sets is considered a failure: Dvorine, the original version of the AO (excludes Richmond PIP version), or Ishihara (record responses as correct! total).

NOTE: No other PIP versions, such as the Richmond PIP, or Beck Engraving versions, or other tests for color vision are authorized for qualification purposes. Also note that the Farnsworth Lantern (FALANT) has been dropped as an USAF qualifying test.

Flying Class I/IA/III/III: Must possess normal color vision as demonstrated by passing the approved PIP.

Flying Class II-Flight Surgeon Applicants: Same as above.

NOTE: FS applicants with mild color vision defects may be considered for a FCIIA waiver. FCIIA waiver authority is delegated to HQ AETC/SG. Controversial cases will be referred to AFMOA/SGOA.

Depth Perception/Stereopsis.

Flying Class III (other than Inflight Refuelers and individuals required to perform scanner duties). No standard.

Flying Class I, IA, II-Flight Surgeon Applicant and III-Inflight Refueler Applicants and individuals required to perform scanner duties. Failure of the Vision Test Apparatus (VTA-DP) or its newer replacement, the Optec Vision Tester (OVT), screening depth perception test with uncorrected refractive errors should be retested with refraction correction in place, regardless of level of unaided visual acuity. Failure even with correction is disqualifying, but may be considered for waiver consideration by higher waiver authorities, only after completion of a full evaluation by an ophthalmologist or optometrist, to include all of the following: ductions, versions, cover test and alternate cover test in primary and 6 cardinal positions of gaze, AO Vectograph Stereopsis Test at 6 meters (4 line version), AO Suppression Test at 6 meters, Randot or Titmus Stereopsis Test, Red Lens Test, and 4 Diopter Base out Prism Test at 6 meters. These tests are designed to identify and characterize motility/alignment disorders, especially microtropias and monofixation syndrome. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate should be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required.

NOTE: A prospective Undergraduate Flying Training (UFT) Microtropia Study/Management Group is established at the ACS with minimally defective stereopsis secondary to monofixation syndrome or microstrabismus that are considered appropriate for waiver consideration. Potential Study Group members must meet the criteria established by the ACS to be eligible for this Study/Management Group. All potential candidates must be evaluated at the ACS Ophthalmology Branch if recommended and approved by HQ AETC/SGPS. AETC/SGPS is the waiver authority.

Flying Class II and III-Inflight Refuelers and individuals required to perform scanner duties. A new failure of the VTA-DP or OVT requires evaluation by an ophthalmologist or optometrist to determine the cause of the failure and to rule out correctable causes, i.e., refractive error and astigmatism. If any new failure still is unable to pass the VTA or OVT with proper optical correction, then all of the motility tests listed above under Flying Class I in A7. 11. must be accomplished as a prerequisite for any further waiver consideration.

A7. 11.4. If the aviator has previously failed the VTA or OVT, and has previously been evaluated, and has either, normal motility or a stable previously knownwaived motility disorder, and can pass another
stereopsis test, such as the Verhoeff, Titmus, Randot, or Howard Dolman, no further work-up or waiver is required. However, such cases should already have been granted an initial waiver for this consideration. If not, a waiver is required.

NOTE: If the local flight surgeon feels that the degree of depth perception may not be compatible with the present aircraft or duties of assignment, further work-up and waiver will be required. Consultation at the ACS is indicated for any rated aircrew member with defective, questionable or change in stereopsis or depth perception or a significant change in the level of stereopsis performance.

Field of Vision.

Flying Classes I, IA, II and III.

Contraction of the normal visual field in either eye to within 30 degrees of fixation from any meridian.

Central scotoma, whether active or inactive, including transitory migraine related or any other central scotoma which is due to active pathological process.

Night Vision, Flying Classes I, TA, II, and III. Unsatisfactory night vision as determined by history for initial flying. In trained aviators, this history is confirmed by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

Red Lens Test.

Flying Classes II and III (except Inflight Refuelers). No standards.

Flying Classes I and IA and Inflight Refuelers and individuals required to perform scanner duties. Any diplopia or suppression during the Red Lens Test which develops within 20 inches of the center of the screen (30 degrees) is considered a failure. Complete evaluation of ocular motility/alignment by a qualified ophthalmologist or optometrist is required as a prerequisite for higher waiver authorities to determine if ACS evaluation is required.

Intraocular Pressure, Flying Classes I, IA, II, and III.

Glaucoma. As evidenced by intraocular pressures of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma. Trained aircrew with glaucoma require consultation (review or evaluation) with the ACS prior to waiver consideration.

NOTE: Pigmentary dispersion syndrome (PDS) is not medically disqualifying for flying (includes Initial Flying Classes) unless associated with elevated intraocular pressures above 22 mmHg. PDS with elevated TOP, referred to as Pigmentary Glaucoma Suspect, (PGS) requires local ophthalmology evaluation. A confirmed diagnosis of Pigmentary Glaucoma Suspect (PGS) is disqualifying for all initial Flying Classes. Trained aircrew with PGS require consultation (review or evaluation) with the ACS prior to waiver consideration.

Ocular hypertension (Preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. (See paragraph 16.4.).

NOTE: Abnormal pressures obtained by a noncontact (air puff) tonometer or Schiotz must be verified by applanation.

Air Force Flying Physical
Medical Examination Standards
Lungs and Chest Wall

Flying Classes II and III.

Pulmonary tuberculosis, including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test.

History of spontaneous pneumothorax. A single episode of spontaneous pneumothorax does not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

Pulmonary blebs or bullac, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

Bronchiectasis, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

Sarcoidosis.

Pleural effusion.

Empyema, residual sacculation or unhealed sinuses of the chest wall following surgery for empyema.

Chronic bronchitis if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

Asthma of any degree, or a history of asthma, reactive airway disease, intrinsic or extrinsic bronchial asthma, exercise-induced bronchospasm, or IgE (Immunoglobulin E) mediated asthma.

Bullous or generalized pulmonary emphysema, demonstrated by pulmonary function tests.

Cystic disease of the lung.

Silicosis or extensive pulmonary fibrosis with functional impairment or abnormal pulmonary function tests.

History of lung abscess.

Chronic mycotic infection of the lung. Residuals of infection, including cavitation, except for scattered nodular parenchymal and hilar calcifications.

Foreign body in the trachea, bronchus, lung, or chest wall. Chronic adhesive (fibrous) pleuritis of sufficient extent to interfere with pulmonary function and exercise tolerance.

History of bi-lobectomy, lobectomy or multiple segmental resections if there is significant reduction of vital capacity, timed vital capacity, or maximum breathing capacity, or if there is residual pulmonary pathology.

Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicle, scapulae, or vertebræ.

Congenital malformation or acquired deformities which reduce the chest capacity or diminish respiratory or cardiac functions to a degree which interferes with vigorous physical exertion or produce disfigurement when the examinee is dressed.
Chronic cystic mastitis.

History of pulmonary embolus.

Silicone implants, injections, or saline inflated implants in breasts for cosmetic purposes. See paragraph A3.12.

Flying Classes I and IA. In addition to the above:

History of spontaneous pneumothorax. A single episode may be considered for waiver after 3 years if pulmonary evaluation shows complete recovery with full expansion of the lung and no demonstrable pathology that would predispose to recurrence.

Chronic adhesive pleuritis which produces any findings except minimal blunting of the costophrenic angles.

History of sarcoidosis.

Air Force Flying Physical

Medical Examination Standards

Cardiovascular System

Flying Classes II and III.

History of cardiac surgery.

Heart pump failure, regardless of cause.

Hypertrophy or dilatation of the heart verified by echocardiogram, unless evaluation demonstrates it to be normal physiological response to athletic conditioning.

Persistent tachycardia with a resting pulse rate of more than 100.

Elevated blood pressure (measured in the sitting position) as follows:

In applicants for flying training or initial flying duty, evidenced by average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 5-day blood pressure check.

History of elevated blood pressure requiring chronic medication for control. A7.17.1.5.3. In trained flying personnel evidenced by:

Average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg.

NOTE: Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying Status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values.
Any elevation in blood pressure due to secondary metabolic or pathologic causes until the underlying cause has been corrected, provided the primary condition is not disqualifying.

Orthostatic or symptomatic hypotension or recurrent vasodepressor syncope. A7.17.1.5.5. Pericarditis, myocarditis, or endocarditis, or history of these conditions.

Any significant congenital abnormalities of the heart and vessels, unless corrected by surgery without residuals or complications. A minimum recovery period of 6 months following surgery is mandatory before waiver is considered together with repeat studies including invasive testing as applicable, demonstrating functional correction. Uncomplicated dextrocardia and minor atrial and ventricular septal defects may be acceptable without surgical correction.

Acute rheumatic fever; a verified history of rheumatic fever or chorea within the previous 2 years; recurrent attacks of rheumatic fever or chorea at any time; evidence of residual cardiac damage.

Coronary artery disease, symptomatic or asymptomatic. History of myocardial ischemia. Coronary artery disease strongly suspected by symptoms or tests for myocardial ischemia or infarction unless ruled out by angiography (other definitive evaluation of coronary patency and function will be considered on a case-by-case basis). History of coronary artery surgery or other intervention is generally not waiverable, but will be reviewed by ACS on request of MAJCOM SGPA or AFMOA/SGOA.

History of symptomatic major dysrhythmia. Asymptomatic major dysrhythmias require ACS review. Major dysrhythmias include supraventricular tachycardia, atrial flutter or fibrillation, ventricular tachycardia or fibrillation, and asystole.

Verified history of major electrocardiographic conduction defects, such as Mobitz II second-degree A-V block, third degree A-V block, Wolff-Parkinson-White (WPW) syndrome, or Lown-Ganong-Levin (LGL) syndrome. W-P-W pattern may be waiverable if ACS evaluation reveals no dysrhythmias; either WPW or LGL syndrome may be waiverable if corrected.

Left anterior and posterior fascicular block and left bundle branch block may be considered for waiver if ACS evaluation reveals no underlying disease.

Right bundle branch block may be waiverable after local cardiologic evaluation.

History of valvular heart disease to include pulmonic, mitral, and tricuspid valvular regurgitation greater than mild, aortic regurgitation greater than trace, and any degree of valvular stenosis. Mitral valve prolapse (MYP) and bicuspid aortic valve are also medically disqualifying.

Resting ECG findings considered to be "borderline," or known to be serial changes from previous records unless a cardiac evaluation as directed by the ECG Library reveals no underlying disease. Refer to ACS "Disposition for ECG findings."

All electrocardiographic tracings read as abnormal. Waiver is not considered until evaluation recommended by ACS has been completed.

Borderline or abnormal noninvasive cardiac studies.

NOTE: For rated officers, copies of any study, i.e., ECG, holter monitor, thallium scan, ETT-TM, or echocardiogram video tape MUST be forwarded to the ECG Library, Brooks AFB TX for review.

History of recurrent thrombophlebitis or thrombophlebitis with persistent thrombus, evidence of circulatory obstruction, or deep venous incompetence in the involved veins.

Varicose veins with complications or if more than mild.
Peripheral vascular disease, including Raynaud's disease, thromboangiitis obliterans, erythromelalgia, arteriosclerotic, or diabetic vascular disease.

Aneurysm of any vessel or history of correction by surgery.

Syphilitic heart disease.

History of significant traumatic heart disease.

Hypersensitive carotid sinus.

Arteritis of any artery.

Inadequate arterial blood supply to any extremity.

Vasculitis.

Flying Classes I and IA. In addition to the above:

Wolff-Parkinson-White electrocardiographic pattern; may be waiverable for flying training if corrected.

Air Force Flying Physical

Medical Examination Standards

Blood, Blood-Forming Tissue, and Immune System Diseases. Flying Classes I, IA, II and III:

Hematocrit values outside the range of 38 to 50 percent for men and 36 to 47 percent for women should be evaluated. The lowest permissible hematocrit for certification is 32 percent. Decreasing hematocrit values, even within the range of normal, may be an indication for work-up. Loss of 200 cc or more of blood is disqualifying for at least 72 hours. Platelet phoresis is disqualifying for 72 hours.

Anemia of any etiology.

Polycythemia. Waiver is not favorably considered if the hematocrit is above 55 percent.

Hemoglobinopathies and thalassemias.

Homozygous hemoglobin abnormalities.

Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomology attributable to intravascular sickling during decompression in an altitude chamber. Review and certification by proper authority (see Attachment 9) is required for all aircrew members with sickle cell trait after evaluation as outlined in paragraph 16.7.

Hemorrhagic states and thromboembolic disease:

Coagulopathies.

Thromboembolic disease, except for acute, non-recurrent conditions.

Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm3 or greater than 400,000 mm3 should be evaluated. Thrombocytosis greater than 750,000/mm3 is not waiverable.
Platelet dysfunctions.

Leukopenia (granulocytopenia). White blood cell counts should fall within the range of 3,500 to 12,000 cells/mm3—counts in the range of 750 to 3500 cells/mm3 should be fully evaluated. Granulocyte counts of less than 750 cells/mm3 are not waiverable.

All leukemias and other myeloproliferative disorders.

All lymphomas including mycosis fungoides and Sezary syndrome.

Plasma cell dyscrasias.

Multiple myeloma.

Macroglobulinemia.

Immunodeficiency syndromes, primary or acquired. Confirmed presence of Human Immunodeficiency Virus (HIV) or antibody. AFMOA/SGOA retains waiver authority for all flying classes.

Generalized lymphadenopathy or splenomegaly until the cause is corrected.


Elevated blood pressure.

Air Force Flying Physical

Medical Examination Standards

Abdomen and Gastrointestinal System.

Flying Classes II and III.

Gastrointestinal hemorrhage or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause.

Peptic ulcer disease, active or refractory.

Peptic ulcer complicated by hemorrhage, obstruction or perforation.

Hernia other than small asymptomatic umbilical or hiatal.

History of viral hepatitis, with carrier status, persistent transaminase elevation or evidence of chronic active or persistent hepatitis.

Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

Sinus or fistula of the abdominal wall.

Chronic or recurrent esophagitis including reflux esophagitis.

Chronic gastritis.
Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying if there is no residual dysfunction.

Crohn's disease (regional enteritis).

Malabsorption syndromes (see paragraph A7.28).

Irritable bowel syndrome.

Ulcerative colitis or proctitis or verified history of same.

Chronic diarrhea, regardless of cause.

Megacolon.

Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum.

Any chronic liver disease whether congenital or acquired. Marked enlargement of the liver from any cause. Hepatic cysts. Congenital hyperbilirubinemias, e.g. Gilbert's disease, do not require waiver if asymptomatic.

AChronic cholecystitis.

Cholelithiasis.

Sphincter of oddi dysfunction or bile duct abnormalities or strictures.

Pancreatitis or history of same.

Congenital anomalies, disease of the spleen. Chronic enlargement of the spleen.

Splenectomy, for any reason except the following:

Trauma to an otherwise healthy spleen.

Hereditary spherocytosis.

History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

Symptomatic esophageal motility disorders.

History of partial resection of the large or small intestines for chronic or recurrent disease.

Air Force Flying Physical

Medical Examination Standards

Perianal, Rectum, and Prostate, Flying Classes I, IA, II, and III.

Proctitis, chronic or symptomatic.

Stricture or prolapse of the rectum.

Hemorrhoids which cause marked symptoms or internal hemorrhoids which hemorrhage or protrude intermittently or constantly until surgically corrected.
Fecal incontinence.

Anal fistula.

Ischiorectal abscess.

Chronic anal fissure.

Symptomatic rectocele.

Pilonidal cyst if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

Chronic prostatitis, prostatic hypertrophy, with urinary retention or abscess of the prostate gland. Information derived from Air Force Instruction 48-23, Current as of Dec 2000.

Flying Class I and IA. See above.


Air Force Flying Physical

Medical Examination Standards

Perianal, Rectum, and Prostate, Flying Classes I, IA, II, and III.

Proctitis, chronic or symptomatic.

Stricture or prolapse of the rectum.

Hemorrhoids which cause marked symptoms or internal hemorrhoids which hemorrhage or protrude intermittently or constantly until surgically corrected.

Fecal incontinence.

Anal fistula.

Ischiorectal abscess.

Chronic anal fissure.

Symptomatic rectocele.

Pilonidal cyst if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

Chronic prostatitis, prostatic hypertrophy, with urinary retention or abscess of the prostate gland. Information derived from Air Force Instruction 48-23, Current as of Dec 2000.

Air Force Flying Physical

Medical Examination Standards

Genitourinary System, Flying Class I, IA, II and III.
History of recurrent or bilateral renal calculus. Uncomplicated single episode of renal calculi does not require waiver, but should be evaluated.

Retained renal calculus. Retained calculus located in a papillary duct or any more distal portion of the collecting system may be considered for a flying Class IIA waiver.

Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

Persistent or recurrent hematuria.

Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

Chronic nephritis.

Stricture of the urethra.

Urinary fistula.

Urinary incontinence.

Absence of one kidney. Functional impairment of either or both kidneys.

Horseshoe kidney.

Chronic pyelitis or pyelonephritis.

Renal ptosis (floating kidney) causing impaired renal drainage, hypertension or pain.

Hydronephrosis or pyonephrosis.

Polycystic kidney disease.

Chronic cystitis.

Amputation of the penis.

Hermaphroditism.

Epispadias or hypospadias with unsatisfactory surgical correction.

Hydrocele, unless small and asymptomatic

Large or painful left varicocele. Any right varicocele unless significant underlying pathology has been excluded.

Undescended testicle. Absence of both testicles.

Chronic orchitis or epididymitis.

Urinary diversion.

Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (such as adhesions or disfiguring scars) residual to surgical correction of these conditions.
Pregnancy or other symptomatic enlargement of the uterus due to any cause. Pregnancy waivers for trained flying personnel may be requested under the following guidelines: the request is voluntary and must be initiated by the crewmember with concurrence by the squadron commander, flight surgeon, and obstetrician. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi-engine, non-ejection seat aircraft; and crewmembers are released from all mobility commitments. The waiver is valid for the 13th through 24th week of gestation.

NOTE: Refer to AFRCI 48-101 for further guidance on unit assigned reservists.

Chronic symptomatic vaginitis.

Chronic salpingitis or oophoritis.

Symptomatic uterine fibroids.

Ovarian cysts.

All symptomatic congenital abnormalities of the reproductive system.

Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea.

Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

Endometriosis, if symptomatic or controlled medically.

Malposition of the uterus, if symptomatic.

Vulvitis, chronic.

Flying Class I and IA. In addition to above, history of endometriosis.
Disturbances of consciousness (not due to head injury).

An isolated episode of neurocardiogenic syncope associated with venipuncture or prolonged standing in the sun (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities.

Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

High G loss of consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty unless there are neurologic sequelae or evidence that the G-LOC occurrence is associated with coexistent disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver or a disconnect of the anti-G protective gear is not disqualifying and is managed as a physiological incident. The local flight surgeon completes appropriate post-incident medical evaluation and reports the incident according to applicable directives.

All other loss or disturbance of consciousness. For rated personnel, waivers are considered by AFMOAISGOA only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion.

NOTE: Flying training applicants and students with a history of syncope evaluated according to table 16.1 and certified acceptable for Flying Class I or IA by HQ AETC/SG do not require a waiver for flying Class II for the same history of syncope.

History of any of the following types of headaches:

1. Recurrent headaches of the vascular, migraine, or cluster (Horton’s cephalgia or histamine headache) type.

2. A single incapacitating headache of any type (e.g., loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

3. Headache of any type which are of sufficient severity to likely interfere with flying duties.

4. Acephalgic migraines.

NOTE: A waiver for migraines may be considered following one year of symptom free observation. Migrainous strokes and migraines complicated by neurological deficits other than transient visual changes are not waiverable.

Electroencephalographic abnormalities.

Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikes, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6Hz positive spikes are not disqualifying. Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

History of head injury.

Head injury associated with any of the following are not waiverable:

1. Post-traumatic seizures. (Exception: seizures at the time of injury)
2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.


Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years:

1. Unconsciousness or amnesia or the combination of the two equal to or exceeding 24 hours duration.

NOTE: In cases which are defined as severe only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, or moderate, a waiver at 2 years may be considered.

2. Radiographic evidence of retained metallic or bony fragments. A7.23.1.6.2.3. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

3. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with or without dural penetration.

4. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

5. Focal neurological signs.

6. Epidural, subdural, subarachnoid, or intracerebral hematoma.

NOTE: A small epidural collection of blood found only on CT-scan or magnetic resonance imaging (MRI) and without evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for flying class II or III waiver at two years as in the moderate head injury group.

7. CNS infection such as abscess or meningitis within 6 months of head injury.

8. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 calendar days.

Moderate head injury. Head trauma associated with the below criteria may be considered for Flying Class II or III waiver in 2 years.

1. Unconsciousness for a period of 30 minutes or greater, but less than 24 hours.

2. Amnesia for a period of 1 hour or greater but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.)

Exception: Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury.

NOTE: In cases which are defined as moderate only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, a waiver at 6 months may be considered.

Mild head injury. Head trauma which does not meet criteria for more severe injury may be considered for waiver after 1 month.

Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not
Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome are disqualifying, but may be considered for waiver when full recovery has been confirmed by complete neurological and neuropsychological evaluation.

Craniotomy and skull defects.

Neurosyphilis in any form (meningovascular, tabes dorsalis, or general paresis).

Narcolepsy, cataplexy, and similar states.

Injury of one or more peripheral nerves unless it is not expected to interfere with normal function in any practical manner.

History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

History of tumor involving the brain or its coverings.

Personal or family history of hereditary disturbances such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis.

Probable evidence or history of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

History or evidence of such defects as basilar invagination, hydrocephalus, premature closure of the cranial sutures, meningocele, and cerebral or cerebellar agenesis if there is evidence of impairment of normal functions or if the process is expected to be progressive.

Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

The condition has completely subsided and the cause is determined to be of no future concern.

There is no residual which could be deemed detrimental to normal function in any practical manner. Polyneuritis, whatever the etiology, unless:

Limited to a single episode.
The acute state subsided at least 1 year before examination.

There is no residual which could be expected to interfere with normal function in any practical manner.

History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process if there is any indication such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent, or if there is a significant neurological residual which would interfere with aviation duties.

Tremors, chorea, dystonia or other movement disorders which could interfere with aviation or normal function.
Flying Classes I and IA. In addition to the above, paroxysmal convulsive disorders. Seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and electroencephalogram (EEG) including awake and sleep samples are normal.

A History of severe head injury is usually not waiverable and may not be considered until at least 10 years post injury.


Air Force Flying Physical

Medical Examination Standards


Flying Classes II and III.

Eating Disorders.

Gender Identity Disorders.

Mental Disorders due to a General Medical Condition.

Delirium, Dementia, and Amnestic Disorders, and Other Cognitive Disorders. Alcohol Dependence or Abuse (DSM IV) or any disease the proximate cause of which is alcoholism. These conditions may be waived by MAJCOMISG if the following conditions have been met:

The MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program treatment team determines that the individual has made satisfactory progress and has maintained abstinence without the aid of medications for a period of 6 months from the date of entering treatment.

NOTE: Any relapse (as determined by the treatment team) or use of medication to deter alcohol use resets the 6-month observation period for waiver consideration.

In the opinion of the flight surgeon, privileged mental health provider, and flying unit commander, and based on the ADAPT program assessment, the individual has a low potential for recidivism and can be expected to remain stable under stress.

The individual has no medical complications or sequelae due to past alcohol abuse or dependence.

The individual states in writing that he or she understands the waiver is valid only if total abstinence from alcohol is maintained and that a verifiable break in abstinence once the waiver period has begun is considered medically disqualifying and not waiverable. This written statement by the individual must be accomplished at the initial waiver request and reaccomplished each time a request is submitted for renewal of the waiver, and is included with the waiver request. To ensure flying unit commanders are aware of the need to observe individuals with past alcohol problems, new commanders are briefed on those in their units with waivers for this condition when the individual changes assignment or there has been a change in command.

All other drug abuse or use. These conditions are not waiverable.

Schizophrenia and other Psychotic Disorders.

Mood Disorders.

Depressive disorders including major depression, dysthymia, cyclothymia, and depression not otherwise
specified.

Bipolar disorder.

Anxiety Disorders. Non-phobic fear of flying is considered an administrative not medical problem.

Somatoform Disorders.

Dissociative Disorders.

Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

Sexual dysfunctions and sexual disorders not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

Sleep disorders if of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than an adjustment disorder.

Factitious Disorders.

Impulse Control Disorders Not Elsewhere Classified.

Adjustment Disorders of more than 60 days duration.

Unsatisfactory adaptability rating for military aviation (ARMA) if maladaptive personality traits (not meeting diagnostic criteria for a personality disorder) or a pattern of maladaptive behavior is present that significantly interferes with safety of flight, crew coordination, or mission completion. Motivational issues are referred to administrative channels.

Psychological Factors Affecting Medical Condition.

Personality disorders are not medically disqualifying; however, if social and occupational, administrative or legal ramifications are operant, a psychiatric evaluation may be warranted to clarify suitability for future flying or other duty.

History of attempted suicide or suicidal behavior.

Flying Classes I and IA. In addition to the above:

History of any of the above diagnoses excluding verifiable simple adjustment disorders not requiring hospitalization.

History of schizophrenia or bipolar disorder in both parents.

Unsatisfactory adaptability rating for military aviation.

History of persistent learning disorder.

Evidence of any condition causing serious chronic impairment of educational goals or chronic behavioral difficulties requiring hospitalization or prolonged treatment.


Menu
Air Force Flying Physical
Medical Examination Standards

Extremities, Flying Classes I, IA, II, and III.

General Conditions.

1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

2. Documented history or findings of rheumatoid arthritis.

3. Active osteomyelitis or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

4. Osteoporosis.

5. Osteochondromatosis or multiple cartilaginous exostoses.

6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint if not satisfactorily corrected.

8. Instability of a major joint if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

9. Malunited fractures which interfere significantly with function.

10. Symptomatic nonunion of fractures.

11. Any retained orthopedic fixation device, that interferes with function or easily subject to trauma.

12. Muscular paralysis, paresis, contracture, or atrophy if progressive or of sufficient degree to interfere with the performance of flying duties.

13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

14. Synovitis with persistent swelling or limitation of motion.

15. Osteonecrosis.

16. Chondromalacia, if symptomatic or there is verified history of joint effusion, interference with function, or residuals from surgery.

17. Joint replacement.

18. Myotonia congenita.

19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).
Upper Extremity.

1. Absence of any segment of the hand or digits.

2. Resection of a joint other than that of a finger.

3. Hyperdactylia.

4. Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

6. Limitation of motion. Same as A3.27.

Lower Extremity.

1. Amputation or absence of any portion of the foot or lower extremity in excess of I of the 2nd through 5th toes.

2. Clubfoot of any degree.

3. Rigid or spastic flatfoot, Flatfoot, tarsal coalition.

4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

5. Elevation of the longitudinal arch (pes cavus) if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

6. Inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

8. Verified history of hip dislocation within 2 years of examination or degenerative changes on X-ray from old hip dislocation.

9. Difference in leg length of more than 2.5 cm (from anterior superior iliac spine to the distal tip of the medial malleolus).

10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or range of motion less than specified in A3.27; or other symptoms of internal derangement or a condition which would interfere with the performance of flying duties.

11. Osteochondritis dessicans of the knee or ankle if there are X-ray changes.

12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragments.
13. Limitation of motion same as A3.27.

14. Toes-stiffness which interferes with walking, marching, running, or jumping.

Air Force Flying Physical

Medical Examination Standards
Extremities, Flying Classes I, IA, II, and III.

General Conditions.

1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

2. Documented history or findings of rheumatoid arthritis.

3. Active osteomyelitis or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

4. Osteoporosis.

5. Osteochondromatosis or multiple cartilaginous exostoses.

6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint if not satisfactorily corrected.

8. Instability of a major joint if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

9. Malunited fractures which interfere significantly with function.

10. Symptomatic nonunion of fractures.

11. Any retained orthopedic fixation device, that interferes with function or easily subject to trauma.

12. Muscular paralysis, paresis, contracture, or atrophy if progressive or of sufficient degree to interfere with the performance of flying duties.

13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

14. Synovitis with persistent swelling or limitation of motion.

15. Osteonecrosis.

16. Chondromalacia, if symptomatic or there is verified history of joint effusion, interference with function, or residuals from surgery.

17. Joint replacement.
18. Myotonia congenita.

19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).

Upper Extremity.

1. Absence of any segment of the hand or digits.

2. Resection of a joint other than that of a finger.

3. Hyperdactyilia.

4. Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

6. Limitation of motion. Same as A3.27.

Lower Extremity.

1. Amputation or absence of any portion of the foot or lower extremity in excess of 1 of the 2nd through 5th toes.

2. Clubfoot of any degree.

3. Rigid or spastic flatfoot, Flatfoot, tarsal coalition.

4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

5. Elevation of the longitudinal arch (pes cavus) if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

6. Inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

8. Verified history of hip dislocation within 2 years of examination or degenerative changes on X-ray from old hip dislocation.

9. Difference in leg length of more than 2.5 cm (from anterior superior iliac spine to the distal tip of the medial malleolus).

10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or range of motion less than specified in A3.27; or other symptoms of internal derangement or a condition which would interfere with the performance of flying duties.
11. Osteochondritis dessicans of the knee or ankle if there are X-ray changes.

12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) if symptomatic or with obvious prominence of the part and X-ray evidence of separated bone fragments.

13. Limitation of motion same as A3.27.

Air Force Flying Physical

Medical Examination Standards

Spine and Other Musculoskeletal.

History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

Arthritis of the spine, all types.

Lumbar scoliosis of more than 20 degrees or thoracic scoliosis of more than 25 degrees as measured by the Cobb method

Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive. Symptomatic spondylolisthesis or spondylolysis.

History of frank herniated nucleus pulposus or history of surgery or chemonucleolysis for that condition.

Fractures or dislocations of the vertebrae. Compression fractures more than 25 percent or of more than a single vertebra may be considered for categorical IIB waiver. History of fractures of the transverse processes is not disqualifying if asymptomatic.

Spina bifida when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

Juvenile epiphysitis with any degree of residual change indicated by X-ray or kyphosis.

Weak or painful back requiring external support.

Recurrent disabling low back pain due to any cause.

Skin.

Flying Classes II and III.

Any chronic skin disorder which is severe enough to cause recurrent grounding from flying duties, or is aggravated by or interferes with the wearing of military equipment.

Extensive, deep, or adherent scars which interfere with muscular movements, with the wearing of military equipment, or show a tendency to breakdown.

Atopic dermatitis with active or residual lesions in characteristic areas or a verified history.
Dermatitis herpetiformis.

Eczema which is chronic and resistant to treatment. Fungus infections of the skin, systemic or superficial, that interfere with duty performance or the wear of life support equipment.

Furunculosis which is extensive, recurrent or chronic.

Hyperhidrosis if chronic or severe.

Leukemia cutis; mycosis fungoides; Hodgkin's disease.

Lichen planus.

Neurofibromatosis.

Photodermatosis unless due to medication.

Psoriasis.

Scleroderma.

Air Force Flying Physical Medical Examination Standards

Endocrine and Metabolic.

Flying Classes II and III.

Adiposogenital dystrophy (Frohlich's syndrome).

Adrenal dysfunction of any degree, including pheochromocytoma.

Cretinism.

Diabetes insipidus.

Diabetes mellitus, see note at A3.32.

Gigantism or acromegaly.

Thyroid disorders.

Goiter if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

Hyperthyroidism or thyrotoxicosis.

Thyroiditis, acute and subacute.

Hypothyroidism.

Gout

Hyperinsulinism, confirmed, symptomatic.
Parathyroid dysfunction.

Hypopituitarism.

Myxedema, spontaneous or postoperative, with clinical manifestations. A7.28I.13. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy or in which permanent pathological changes have been established.

Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service or which require frequent or prolonged treatment.

Hypercholesterolemia requiring medication for control. (See Chapter 16)

Osteopenia.

Flying Classes I and IA. In addition to the above:

Diabetes mellitus (see Note in A3.32). Persistent glucosuria from any cause including fasting renal glucosuria is disqualifying. Glucosuria post-prandially or during glucose loading challenge is not disqualifying in the absence of any renal disease or history of recurrent genitourinary infections. However, this finding requires evaluation.

Any confirmed (repeated) serum cholesterol in excess of 230 mg/dl with one or both of the following criteria present:

- Air Force Flying Physical

Medical Examination Standards

Sponsored Links
Army Weight Height Chart
Search multiple engines for army weight height chart
www.webcrawler.com
Slimband Weight Loss
Canada's leading Laparoscopic Band Centre for Weight Loss
Slimband.com
PPL In 2 Weeks
Accelerated Flight Training. 2 Week Course. Gold Seal CFI's. Florida
www.tailwheelsetc.com
Height and Weight.

Flying Class III.

Height less than 64 inches or more than 77 inches. Waivers should be considered when appropriate based on crew position. Note: Combat Control and Pararescue have no standard.

Weight.

A7.29. 1.2.1. For initial qualification a weight in relation to height applies (Air Force Normal Standards). Body fat standards are considered for individuals who exceed their maximum allowable weight.

A7.29.2. Flying Class II.

Height less than 64 inches or more than 77 inches.

Weight.
For trained personnel refer to Air Force Weight Standards. Additional weight restrictions may apply in certain ejection systems. Note: Refer overweight personnel to their unit commanders by letter for appropriate action under appropriate directives.

Flying Class I.

Height less than 64 inches or more than 77 inches.

Sitting height greater than 40 inches or less than 34 inches.

Buttock to knee measurement no greater than 27 inches.

Weight in relation to height applies and body weight may not exceed 232 pounds. Body fat standards are considered for individuals who exceed their maximum allowable weight.

Flying Classes IA and Initial II (Flight Surgeon).

Height less than 64 inches or more than 77. Waivers may be considered by weapons system.

Sitting height greater than 40 inches or less than 33 inches.

Weight in relation to height applies and body weight may not exceed 232 pounds. Body fat standards are considered for individuals who exceed their maximum allowable weight.

HDL cholesterol equal to or less than 15 percent of total cholesterol. A7.28.2.2. LDL cholesterol greater than 170 mg/dl.

Xanthoma if symptomatic or accompanied by hypercholesterolemia or hyperlipoproteinemia.

Chronic urticaria.

Flying Classes 1 and IA. In addition to above, psoriasis or verified history of same.

Air Force Flying Physical

Medical Examination Standards

Systemic and Miscellaneous Causes for Rejection.

Flying Classes II and 111.

1. Recurrent decompression sickness (DCS). A single episode of DCS does not require waiver. All episodes of DCS require a minimum of 72 hours DNIF. Consultation with USAF SAMIAFIC (Hyperbaric Medicine) and concurrence of MAJCOMISG is required before RTFS. In cases of DCS with neurological manifestations, a normal examination by a neurologist is required before RTFS.

2. Malignancies. History or presence of malignant tumor, cyst or cancer of any sort. Basal cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curetage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action but are reported to tumor registry and are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

3. Benign tumors which interfere with function or the wear of equipment and tumors which are likely to
enlarge or be subjected to trauma during military service or show malignant potential.

4. Following bleomycin chemotherapy, AFMOA/SGOA may consider granting a FCJJC waiver with the following restrictions:

"No assignment to aircraft requiring routine use of oxygen equipment. Waiver from altitude chamber exposure. Ground training without supplemental oxygen is acceptable." These restrictions must be annotated in the remarks section of the AF Form 1042.

5. Bone marrow donation, aircrew may be returned to flying duty after 24 hrs after the procedure upon clearance of the attending flight surgeon.

6. Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. If airsickness is of such chronicity or severity as to interfere with the performance of flying duties by a rated officer, his or her potential for further use in rated duties are addressed by a Flying Evaluation Board. Copies of these cases are sent through medical channels to AFMOA/SGOA for review before convening a board. Airsickness experienced by nonrated personnel (other than UPT or UNT students) while enrolled in flying courses is medically disqualifying if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases are made by the MAJCOM/SG.

7. Any allergic condition which requires desensitization therapy.

8. Eosinophilic granuloma.


10. Schuller-Christian disease.

11. Letterer-Siwe's disease.

12. Chronic metallic poisoning.

13. Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticana.

14. Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

15. History of malignant hyperthermia.

16. Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

The examinee has no symptoms of disease.
There are no signs of active disease and no residual thereof.
Serologic VDRL testing rules out reinfection.
There is a verified history of adequate treatment.
There is no evidence or history of CNS involvement.

17. Parasitic infestation, all types until adequately treated.
18. History of sensitivity or a demonstrated sensitivity of sufficient severity to require permanent exemption from any immunization required by appropriate directives.


20. Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of flying duty.

21. Miscellaneous conditions such as porphyria, hemochromatosis, amyloidosis.

22. Inflammatory idiopathic diseases of connective tissue.

23. Lupus erythematosus (acute, subacute, or chronic).

24. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

25. Sarcoidosis.

26. History of malignancy.

Flying Classes I and IA. In addition to the above:

1. Motion sickness experienced in aircraft, automobiles, or water craft after the age of 12 with any significant frequency. Any history of motion sickness is completely explored.


Any surgical fusion.

Air Force Flying Physical

Medical Examination Standards

Medication. Use of any medication, except as described below is cause for medical disqualification for flying duty until the grounding condition has been resolved, the medication is no longer required and the effects of the drugs have dissipated.

Aircrew members cannot fly for at least 8 hours after receiving a local or regional anesthetic agent.

Aircrew and individuals on the sensitive duty program are not cleared for a minimum of 3 weeks following the use of Ketamine.

Medications which may be used without medical consultation.

Skin antiseptics, topical antifungals, 1 percent Hydrocortisone cream (more potent topical steroids require waivers), or benzoyl peroxide for minor wounds and skin diseases which do not interfere with the performance of flying duties or wear of personal equipment.

Single doses of over-the-counter aspirin, acetaminophen or ibuprofen to provide analgesia for minor self-limiting conditions.

Antacids for mild isolated episodes of epigastric distress.

Hemorrhoidal suppositories.

Bismuth subsalicylate for mild afebrile cases of diarrhea.

Oxymetazoline or phenylephrine nasal sprays may be used by aircrew as "get me downs" should unexpected ear or sinus block occur during flight. These should not be used to treat symptoms of head congestion existing prior to flight.

Multivitamin, no more than one per day.
Dietary supplements should only be used with the approval of a flight surgeon. The flight surgeon should consider aeromedical implications of the supplement as well as the probability the supplement will actually enhance performance.

Medication prescribed by a flight surgeon which may be used without removal from flying duty once the potential for idiosyncratic reaction has been excluded.

Isoniazid for prophylactic therapy of tuberculin converters who do not have active tuberculosis. Minimum of 7 days ground trial.

Oral contraceptives, implantable timed release progestin, injectable sustained duration progestin (for contraception only), estrogen alone or with progestin, as replacement therapy. Minimum of 28 days ground trial is required. Changes of dosage or brand requires an additional 28-day observation period.

Chloroquine phosphate, primaquine phosphate, or doxycycline (100 mg daily) for antimalarial prophylaxis. Single dose ground trial is advised.

Pyridostigmine for chemical warfare prophylaxis. Single dose ground trial is advised.

Scopolamine alone or in combination with dextroamphetamine or ephedrine for air sickness in formal flying training programs. Not authorized for solo flight.

Doxycycline (100 mg) administered twice a day for 5 days may be used to treat mild diarrhea. Doxycycline may also be used for prophylaxis against diarrhea in deployed personnel. One hundred milligrams should be administered daily during the period of exposure and for at least 2 days following exposure, with the total period of use not to exceed 2 weeks.

Topical antibiotics for control of acne.

Topical tretinoin for control of acne as long as local irritation does not interfere with wear of the life-support equipment.

Topical acyclovir.

Completion of a course of oral penicillin, oxacillin, dicloxacillin, erythromycin, sul famethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline, or cephalaxin, once the acute infectious process is asymptomatic.

Vaginal creams or suppositories for treatment of vaginitis once asymptomatic.

Temazepam, or zolpidem if such use is essential for the safe performance of mission, and only after MAJCOM/SG coordination and approval. MAJCOM/SG may delegate this approval to wing and detachment level if unit mission so warrants. Single dose ground trial is required for use.

Dextroamphetamine use may be allowed for certain missions. Check with MAJCOM/SG prior to prescribing. Single dose grounding trial is required.

Immunobiologics.

Nicorette or transdermal nicotine. Minimum of 72 hours ground trial.

Resin binding agents such as cholestyramine for control of hyperlipidemia. Note: Niacin is not approved for use by flyers.

Maintenance medication requiring waiver. Those medications for conditions listed below may be waived
Chlorothiazide or hydrochlorothiazide for control of hypertension or hypercalciuria. A7.3 1.5.2. Triamterene for control of hypertension.

Lisinopril for treatment of hypertension (ACS review or evaluation may be required for Flying Class II, refer to current ACS policy). Flying Class II waiver requires a medically monitored centrifuge evaluation. If a medically monitored centrifuge evaluation has not been performed, rated individuals will be considered for a categorical Flying Class IIC waiver (Member must undergo a medically monitored centrifuge evaluation required prior to return to assignment to Fighter, Attack, Reconnaissance (FAR), or trainer aircraft (except T-1).

Probencid for treatment of gout or hyperuricemia.

Allopurinol for treatment of gout or hyperuricemia.

A7.3 1.5.6. Combination therapy of thiazide with triamterene, probenecid, allopurinol, or oral potassium supplements.

Epinephrine derivatives without added action agents, or betablockers (Timolol, Levobunolol, Betaxolol) all for topical use only, to control glaucoma.

Synthroid for treatment of thyroid hypofunction or for thyroid suppression. A7.3 1.5.9. Tetracycline, erythromycin, doxycycline in standard doses for acne management. A7.31 .5.10. Sulfamethoxazole-trimethoprim, tetracycline, ampicillin, doxycycline for chronic genitourinary infectious or prostatitis once asymptomatic.

Folic acid in the treatment of sprue.

Sucralfate (1 gram once daily) for prevention of recurrent, uncomplicated duodenal ulcers. Minimum 7 days observation required.

Ranitidine.

NOTE: Prior requirement for a FCIIA waiver is removed.

Pravachol (Note: May not be delegated locally).

Omeprazole (Note: Prior requirement for a FCIIA waiver is removed). Nasal steroids or cromolyn nasal spray for control of mild to moderate allergic rhinitis, nonallergic rhinitis, or vasomotor rhinitis. Observation for control of the rhinitis (usually 7 to 14 calendar days) is required. Claritin (loratidine) for the control of seasonal allergic rhinitis.

Griseofulvin for treatment of fungal infections may be granted a one year non-renewable waiver after a 4 week ground trial.

Clomiphene citrate for treatment of infertility.

Lovastatin or pravastatin for treatment of hypercholesterolemia.

Air Force Flying Physical

Medical Examination Standards

Ears
Flying Classes II and III.

History of surgery involving the middle ear, excluding cholesteatoma below.

Residual of mastoid surgery.
Inability to perform the VALSALVA maneuver.

Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

Tinnitus when associated with active disease.

Abnormal labyrinthine function.

Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

Any conditions that interfere with the auditory or vestibular functions. A7.3. 1.9. Cholesteatoma or history of surgical removal of cholesteatoma.

Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

Classes I, IA, II (flight surgeon applicants) and III (initial applicants). In addition to the above:

Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

History of radical mastoidectomy.

History of abnormal labyrinthine function, unexplained or recurrent vertigo.

Surgical repair of perforated tympanic membrane within the last 120 calendar days.


Gemfibrozil may be considered for categorical hA waiver by MAJCOM/SG.

Acyclovir (oral), for treatment of HSV or suppressive therapy.

14. Toes-stiffness which interferes with walking, marching, running, or jumping.