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Medical Service

MEDICAL EVALUATION BOARDS (MEB) AND CONTINUED MILITARY SERVICE

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction describes how to evaluate service members who are not worldwide qualified due to a medical or physical defect, and the administrative matters dealing with a medical evaluation board (MEB). It outlines procedures for establishing, preparing, and conducting competency, sanity, and MEBs, and how to complete the after-board actions. It also describes the disposition and management of members who are found fit by the Air Force Disability Evaluation System (DES), but whose medical condition is so restrictive that it limits the member's assignability (Assignment Limitation Code-C). This instruction carries out the requirements of Title 10, United States Code (U.S.C.), Chapter 61, and the Department of Defense Directive 1332.18, *Separation or Retirement for Physical* and Department of Defense Instruction 1332.38, *Physical Disability Evaluation* and interfaces with Air Force Policy Directive 44-1, *Medical Operations*. This instruction also applies to those Air Reserve Components (ARC) members entitled to disability processing. Refer to appropriate ARC guidance for managing those ARC members not entitled to disability processing.

SUMMARY OF REVISIONS

This revision incorporates IC 2000-1 and incorporates inputs received since initial publication of AFI. A "|" indicates revised material since the last edition. The entire text of the IC is at the last attachment.

Chapter 1

GENERAL PROVISIONS

1.1. The purpose of the Medical Evaluation Board. In order to maintain a fit and vital force, the Secretary of the Air Force relies on disability laws to remove active duty and Air Reserve Component (Air Force Reserve and Air National Guard) members who can no longer perform their military duties because of a mental or physical defect. The Medical Evaluation Board (MEB) is the first step in the Air Force disability evaluation process to determine who is not worldwide qualified. AFI 48-123, Chapter 7, and Attachment 2, outlines those medical conditions which require a medical board. Air Force Reserve members must be entitled to disability processing to undergo MEB processing. Air Force Reserve members not entitled to disability processing will be evaluated IAW AFI 48-123, Chapter 14 and AFRC medical policy guidance. Air National Guard members not entitled to disability processing will be evaluated IAW AFI 48-123, Chapter 14 and ANG medical policy guidance.

1.2. Responsibilities.

1.2.1. It is the responsibility of every Air Force provider to become familiar with the medical standards for continued worldwide duty, and to identify members who are no longer worldwide qualified.

1.2.2. Every Medical Facility Commander must establish and maintain a viable Medical Evaluation Board process.

1.2.3. HQ AFPC/DPAMM will monitor, evaluate, and provide guidance and oversight to the medical evaluation board process and ensure that all MEBs presented to the Air Force DES are comprehensive, consistent, timely, and sufficiently complete so that they may be fairly adjudicated.

1.2.4. HQ AFPC/DPAMM is the sole approval authority for Assignment Limitation Code-C (ALC-C), Medical Hold, and non-emergent elective surgery during an active duty service member's final six months of service. HQ AFPC/DPAMM is the office of primary responsibility for implementing HQ USAF/SG policy on medical standards for continued active duty service, and may make exceptions to this instruction unless specifically prohibited by law.

1.2.4.1. For Air Reserve Component (ARC) personnel, the appropriate ARC/SGP (see **Attachment 5**, paragraph **A5.4.**) is the approval authority for ALC-C, medical hold, and non-emergent elective surgery. AD MTFs should contact the appropriate ARC/SGP when confronted with these issues involving ARC personnel. For ANG personnel, ANG/DP is the approval authority for Deployment Availability Code 42 (DAC-42) and medical hold. ANG/SGP will work in conjunction with ANG/DP when confronted with these issues involving ANG personnel.

1.3. Presumption of Fitness. The existence of a physical defect or condition does not of itself necessarily provide justification for or entitlement to an MEB. The law which provides for military disability, Title 10 U.S.C., Chapter 61, is not used to bestow additional benefits upon those approaching retirement or separation. If a member has performed his or her duty satisfactorily prior to scheduled retirement or an approved separation date, a presumption of fitness is established. This presumption of fitness can be overcome only if it is established by a preponderance of evidence that one of the following exists:

1.3.1. Within the presumptive period an acute, grave illness or injury occurs that would prevent the member from performing further duty, if he or she were not retiring, or a serious deterioration of a pre-

viously diagnosed condition occurs that would prevent the member from performing further duty immediately prior to or concurrent with the processing for normal retirement.

1.4. Special Considerations. Mental competency for pay and records requires a medical board if such a determination is warranted for specific medical and/or psychiatric illnesses. The competency determination is made in addition to a worldwide qualification determination. This competency determination is recorded on AF Form 618, *Medical Board Report*, Item 23. If the member is declared incompetent for pay and records, add to Item 22, "DFAS DEM 177-373."

1.4.1. Unsuiting Conditions. Some psychiatric (and other) conditions will render an individual "unsuiting" for military duty although they do not constitute a compensable physical or medical disability. These individuals are referred to their commander for consideration for administrative separation. See AFI 48-123, Attachment 2, paragraphs 2.12. and 2.20., and DoDI 1332.38, Enclosure 5, *Conditions Not Constituting a Physical Disability*.

1.4.2. If a military retiree on the Temporary Disability Retirement List (TDRL) requires a mental competency status determination, it will be accomplished in accordance with DFAS DEM 177-373. HQ AFPC/DPPD will designate a medical treatment facility (MTF) to conduct this board along with the TDRL periodic evaluation.

1.4.3. Legal proceedings against a member may require a sanity determination as specified in the Manual for Courts Martial (MCM) or current legal decisions. This determination is conducted by a sanity board. If the psychiatric findings bring into doubt the member's qualification for worldwide service or competency for pay or records, then an MEB must be convened.

1.4.4. If an MEB is required on a general officer, the MTF commander or administrator must immediately notify HQ AFPC/DPAMM personnel who will designate an MTF to conduct the board. DPAMM will forward initial notification to AFGOMO and AF/SG by electronic secure transmission or by telephone and provide final notification when the MEB/PEB action is complete.

1.4.4.1. The MTF commander will notify the appropriate ARC/SGP when an MEB is required on an ARC general officer.

1.4.5. Commanders at all levels and officers who have convening and approval authority for medical boards will not have an MEB or their clinical evaluation and board processing at an MTF that is within their command and control or official influence. HQ AFPC/DPAMM will designate an MTF to accomplish the board.

1.4.6. Officers assigned to the MTF staff will not receive an MEB or processing at their own medical facility. The MTF commander may submit a waiver request through HQ AFPC/DPAMM detailing why an MEB should be conducted at their own facility as well as why the commander has no concern for a conflict of interest. A hospital will not conduct an MEB on assigned enlisted staff if that member has been or is currently a disciplinary problem or where there would be concern for a conflict of interest. The case should be referred to HQ AFPC/DPAMM with a comment by the medical group commander as to the nature of the disciplinary problem. HQ AFPC/DPAMM will send disposition instructions.

1.4.7. ARC members who are entitled to disability processing will have MEBs conducted at active duty MTFs. Additional requirements for reserve and guard members are in **Attachment 5**.

1.4.8. ANG members non eligible for processing under AFI 36-3212, Chapter 8, will have MEBs convened by ANG authority to determine their eligibility for continued duty. Air Force Reserve medical units do not convene MEBs.

1.4.9. USAF Academy Cadets are not eligible for disability processing; however, a board may be held at the Air Force Academy to recommend the cadet's disposition to the Secretary of the Air Force.

1.4.10. Members under court martial charges are not eligible for disability processing unless there is a question of mental capacity or responsibility or when member's sentence of dismissal or punitive discharge is suspended. Refer to AFI 36-3212, paragraph 1.3.1. Members in Absent Without Leave (AWOL), in deserter status, or in the hands of civil authorities, disability processing does not continue until members return to military control and HQ AFPC/DPPD determines eligibility for disability processing. Refer to AFI 36-3212, paragraph 1.4.2.

1.4.11. Dual-Action Cases. Cases which are eligible for processing under this instruction and are pending involuntary separation or discharge. These cases are processed under both directives, and the Secretary of the Air Force will make final disposition. Refer to AFI 36-3212, Paragraph 1.4.4., and AFI 36-3208, *Administrative Separation of Airmen*, Paragraph 6.3. and 6.3.1., Section E, or AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*, Paragraph 4.15.5.

1.4.12. Members who refuse required professional, medical, dental care, and/or other options of treatment will have an MEB if all criteria in DoDD 1332.18, Paragraph 11, Enclosure 5, are met. These criteria are:

1.4.12.1. The service member was advised clearly and understandably of the proper course of treatment, therapy, medication, or restriction.

1.4.12.2. The member's failure or refusal was willful or negligent and not the result of mental disease or of physical inability to comply.

1.4.13. In instances when members have incidental findings or defects and it is not certain if an MEB is needed, the MTF may send a narrative summary (Review-In-Lieu of MEB) with an explanatory cover letter to HQ AFPC/DPAMM for disposition instructions. The Review-In-Lieu of MEB is used to receive a timely disposition when needed, e.g., separation, retirement, pending assignments, etc. The disposition by DPAMM is final, and has the same effect and authority as an MEB. Dispositions are:

1.4.13.1. Return to Duty (with or without an Assignment Limitation Code C)

1.4.13.2. Direct an MEB

1.4.13.3. Direct an MEB at another MTF

1.4.13.4. Returned without Action (reason will be specified)

1.4.13.5. Continued Military Medical Observation and Care

1.4.14. For ARC members, the Review-In-Lieu of MEB narrative summary will be forwarded to the appropriate ARC/SGP. The ARC/SGP will in-turn forward it to HQ AFPC/DPAMM. Cases on ARC members who have been found fit for duty will be returned to the appropriate ARC/SGP by HQ AFPC/DPAMM. The appropriate ARC/SGP will provide final disposition instructions (i.e., assignment of ALC-C, DAC-42, etc.) to the member's supporting ARC and AD medical facility.

1.4.15. MEBs may address active duty members of other branches of the Armed Forces and their reserve components who are eligible for processing under Title 10 U.S.C., Chapter 61.

1.4.16. Neither the evaluee nor anyone else shall attempt to influence the outcome or processing of an MEB.

1.5. Dispositions for Review of MEBs by HQ AFPC/DPAMM. HQ AFPC/DPAMM will review all MEBs recommending Return to Duty and all MEBs from non-referral medical facilities. DPAMM will evaluate these cases and provide a disposition. This disposition is final and may not be rebutted by the member unless new and compelling evidence or information is presented that would render consideration of a differing decision. The MTFs designated in Paragraph **3.5.** are authorized to send MEBs with the recommendation to refer to IPEB directly to HQ AFPC/DPPDS.

1.5.1. HQ AFPC/DPAMM disposition decisions are:

1.5.1.1. Return to Duty

1.5.1.2. Return to Duty with Assignment Limitation Code C

1.5.1.3. Return to Duty for Disposition under other Directives

1.5.1.4. Refer Case to the Informal Physical Evaluation Board (PEB)

1.5.1.5. Direct MEB

1.5.1.6. Direct Member to be boarded at another MTF

1.5.1.7. Continued Military Medical Observation and Care

1.5.1.8. Direct Case be Referred to Member's Commander for Possible Administrative Separation

1.5.1.9. Return Case without Action (reason will be specified)

1.6. Duty and Assignment of Members Undergoing MEB. Members undergoing MEB processing, whether outpatients still assigned to their normal unit of assignment, or attached or assigned to the patient squadron, and are available for duties or work in the MTF, or elsewhere on base as directed by the patient squadron commander, which are not medically contraindicated and do not interfere with evaluation and MEB processing.

1.6.1. Upon entry into the Disability Evaluation System (i.e., MEB sent to AFPC for processing), members who are undergoing MEB processing may not be placed on leave outside the local area or TDY without prior coordination with HQ AFPC/DPAMM, except for emergencies. The member must be available to report within one duty day.

Chapter 2

ESTABLISHING THE MEB

2.1. Appointment Authority. Members of MEBs are appointed in writing by the MTF commander under the authority of this paragraph. The appointing orders should cite this paragraph and identify specific individuals tasked for MEB duty. The number of appointees should be large enough to convene a three member board without delay. There must be only one current order at each MTF. New orders are not required for each board that is convened.

2.2. Composition of the MEB. The MEB will consist of three physicians. When mental competency (sanity) is an issue or there is an Axis I diagnosis, one member must be a psychiatrist. A check mark will be used to identify the psychiatrist member on the AF Form 618.

2.2.1. The board is made up of active duty Medical Corps officers of the United States Armed Forces (except interns). Civilian consultants and retired medical officers who are employees of the hospital staff may serve as board members, however, at least two active duty Medical Corps officers must serve with them on any given board.

2.2.2. The president of the MEB is the senior ranking active duty physician present. The president of the board may not serve as the final reviewing authority.

2.2.3. When competency for pay and records is considered, the board must consist of three Air Force medical officers, one of whom is certified by or eligible for certification by the American Boards of Psychiatry, Neurology, or Neurosurgery. Reevaluation of members previously judged to be incompetent require a psychiatrist on subsequent competency boards.

2.2.4. For a comatose patient, three Medical Corps officers will evaluate for competency determinations. If the patient is not comatose and has an organic mental disorder, a psychiatric evaluation is required and a competency board must be convened. A psychiatrist must sit on the convening MEB whenever a psychiatric condition is listed as the primary diagnosis under review. Further, the psychiatrist must indicate his/her presence as a member of the convening MEB on AF Form 618.

2.2.5. When there is a need to determine sanity, the board will include a psychiatrist. A clinical psychologist will not serve on the board.

2.3. Review and Approval Authority. The review and approval authority will be the MTF commander, or designee, if a Medical Corps officer. If the MTF commander is not a physician, the commander must delegate this authority in writing to a senior Medical Corps officer on his or her staff. This must be coordinated with AFPC/DPAMM. The MTF commander or designated review authority may not serve on the MEB under review.

2.4. Physical Evaluation Board Liaison Officer (PEBLO). The MTF commander will appoint on orders a PEBLO who is an experienced, mature individual suitable to handle the important tasks of counseling military members undergoing this complicated process. Medical facilities will send a copy of the published order to HQ AFPC/DPAMM and HQ AFPC/DPPDS prior to processing an MEB. The PEBLO will counsel the evaluee in accordance with **Attachment 2** of this instruction.

2.5. Administrative Support. Administrative support will be provided by an MEB clerk, who will also serve as the recorder. The clerk's function will be to assemble and provide all pertinent reports and records, schedule the case for hearing, and provide HQ AFPC with a completed AF Form 618 package. It will also be the clerk/recorder's responsibility to ensure the evaluee or next of kin has an opportunity to read the report, sign it, and be given an opportunity to write a letter of exception or support. Following this, the clerk or recorder will prepare five (six for ARC members) copies of the completed product and forward the original and three (four for ARC members) copies promptly to HQ AFPC/DPPDS or DPAMM for disposition. MEBs on ARC members will not be submitted directly to HQ AFPC but to the appropriate ARC/SGP who will in turn forward it to AFPC as appropriate. The DoD standard for MEB completion is 30 days from the date the narrative summary is completed.

Chapter 3

ACTIONS PRIOR TO A MEDICAL EVALUATION

3.1. Responsibilities. It is the responsibility of all Medical Corps officers to identify service members whose qualification for worldwide duty is in doubt and refer them for medical board action within 30 days of making a definitive diagnosis. The Medical Corps officer initiates notification of an MEB action via AF Form 570, Notification of Patient's Medical Status, and forward it to the action officer (PEBLO). He/she must also notify the Physical Exams and Standards section for active duty members and the ARC medical facility for ARC members of the need to complete a 4T profile on the members. When MEB notification is made on an ARC member, their supporting ARC medical unit will be notified by the PEBLO to determine the member's entitlement to disability processing. The MEB should arrive at HQ AFPC/DPPD or HQ AFPC/DPPAM (as appropriate) for active duty members or to the appropriate ARC/SGP for ARC members within 30 days from the dictation of the narrative summary. Under no circumstances will a case be accepted for adjudication if any part of the board package is older than 90 days without a recent update of patient's current medical status. The function of the MEB is to identify those members who are not worldwide qualified. The decision requiring fitness lies with the Air Force DES. Title 10 U.S.C., Chapter 61, provides for full and fair hearing and adjudication by a series of boards, with the Secretary of the Air Force or designee making the final decision on retention or separation.

3.2. Eligibility. AFI 48-123, Chapter 7, and Attachment 2, lists the conditions which will require an MEB. Since no listing is all inclusive, competent and experienced military medical judgment is needed.

3.2.1. AFI 48-123, Paragraph A2.20, lists general and miscellaneous conditions and defects and provides further guidance.

3.2.2. DoDD 1332.18, *Separation or Retirement for Physical Disability*, Paragraph D(3), and DoDI 1332.38, *Physical Disability Evaluation*, lists criteria which will not be used to constitute medical disqualification for continued military service.

3.3. Line of Duty Determination. An AF Form 348, *Line of Duty Determination (LOD)*, will be completed when misconduct, negligence, or AWOL may have occurred or when a member has a disease or injury which results in an inability to perform military duty for more than 24 hours, or there is the likelihood of permanent disability. AFI 36-2910, *Line of Duty Misconduct Determinations* provides instruction on LOD determinations as does Paragraph 3.20 of this instruction.

3.3.1. MEBs do not make LOD determinations. Completed LODs provided to the board must be included as part of the MEB package. Administrative LODs must be indicated on AF Form 618, Item 23. In cases that include injuries, an administrative LOD will not suffice if there is a potential for a permanent disability.

3.4. Where MEBs Should Be Accomplished. As a general rule, MEB candidates receive clinical evaluation and MEB processing at the medical facility at which they are receiving medical care. However, if that facility is not a physical evaluation board referral hospital (PEBRH) designated in paragraph **3.5.** (unless the case is administratively and clinically simple), the case may be referred to a PEBRH for further processing. Referral to a PEBRH is often appropriate if initial work-up indicates referral to a PEB is needed. Each case must be judged individually, realizing that referral to a PEBRH may result in family separation and possible family hardship until a disability determination is made. If the local MTF is able to provide

an adequate clinical evaluation, has the requisite MEB staffing, and has an experienced knowledgeable PEBLO to counsel the evaluee throughout the MEB and subsequent disability processing, then MEB processing at that facility is appropriate. Only PEBRH will submit cases directly to HQ AFPC/DPPDS. All other MTFs will forward MEBs to HQ AFPC/DPAMM. Smaller MTFs must request PEB direct-referral authority on MEBs accomplished at non-PEB Direct Referral Hospitals.

3.5. Designated PEBRHs:

FACILITY	FACILITY CODE
David Grant Medical Center	0664
Keesler Medical Center	2853
Malcolm Grow Medical Center	2451
Scott Medical Center	1756
Wilford Hall Medical Center	4865
Wright-Patterson Medical Center	3954
USAF Academy Hospital	0857
Davis Monthan Hospital	0451
Edwards AFB Hospital	0654
Eglin AFB Hospital	1252
Elmendorf AFB Hospital	0252
Fairchild AFB Hospital	5351
Hickam AFB Hospital	1551
Hill AFB Hospital	4951
Kirtland AFB Hospital	3552
Lakenheath AB Hospital	UK59
Langley AFB Hospital	5151
Luke AFB Hospital	0452
Nellis Federal Hospital	3251
Maxwell AFB Hospital	0155
MacDill AFB Hospital	1253
Minot AFB Hospital	3852
Offut AFB Hospital	3151
Ramstein AB Hospital	GE64
Shaw AFB Hospital	4552
Sheppard AFB Hospital	4871
Tinker AFB Hospital	4052
Yokota AB Hospital	JA63
Kadena AB Hospital	JA73

3.6. Required Medical Documentation for an MEB.

3.6.1. SF 502, Medical Record Narrative Summary. This summary must be current within 30 days when received by AFPC, and must describe a clear picture of the member's disease process. It must include all of the following: date and circumstance of the occurrence, response to treatment, current clinical status, proposed treatment, prognosis and the extent the condition interferes with the duty performance.

3.6.1.1. Chief Complaint

3.6.1.2. History of Present Illness

3.6.1.3. Past Medical History

3.6.1.4. Review of Systems

3.6.1.5. Pertinent Family History

3.6.1.6. Full Physical Exam to Include Right or Left Handed. See also DoDI 1332.38, paragraph E4.A1.1.3.

3.6.1.7. Laboratory and Radiology Findings

3.6.1.8. Hospital Course

3.6.1.9. Consultations (must bot be older than 90 days, unless updated by consultant). All consultations that were accomplished for diagnoses listed on the AF Form 618 should be forwarded to the MEB. Current profile (AF Form 422) should be attached.

3.6.1.10. Operations and Procedures

3.6.1.11. Current Medications

3.6.1.12. Other Diagnoses

3.6.1.13. Referring provider's name, duty title, AFSC, and phone number

3.6.1.14. Administrative LOD

3.6.1.15. Worldwide Qualification

3.6.1.16. Current Profile

3.6.1.17. Final Diagnosis/Recommendation

3.6.1.18. Prognosis, follow-up, restrictions and/or limitations involving current assigned military duties without stating fitness for duty.

3.6.2. The preparing physician will refrain from making comment (verbal or written) concerning fitness for duty or expected disability process outcome. The SF 502 must be signed, and the preparing physician's AFSC and duty title must be clearly discernible.

3.6.3. When non-physician providers prepare narrative summaries for medical board adjudication (optometry, podiatry, clinical psychology, physician assistant, nurse practitioner), they must be reviewed and counter-signed by a physician; e.g., ophthalmologist for optometry, orthopedics for podiatry, and psychiatry for psychology. Board certified family physicians and internists may countersign if they are currently holding privileges in fields related to the patient's condition.

3.6.4. Letters from the evaluee's commander is required. This letter should describe the impact of the member's medical condition on the member's ability to perform his or her normal military duties and to deploy or mobilize, as applicable.

3.6.5. The Chief of the Medical Staff will submit a statement regarding the current status of medical credentials for any credentialed medical provider. A DD Form 2499 is highly recommended if the provider is unlikely to return to full and unrestricted duty.

3.6.6. AF Form 1172, *Certificate of Medical Officer* (if necessary).

3.6.7. AF Form 2100 Series, *Health Records, Outpatient* (only required for the formal PEB, and ARC).

3.6.8. AF Form 565, *Record of Inpatient Treatment*, if available.

3.6.9. Other reports as needed or requested for ARC members (see **Attachment 5**).

3.6.10. The following special consultations and additional information are required for the diseases listed (these consults or updates must not be over 90 days old when received at HQ AFPC):

3.6.10.1. Asthma: Current pulmonary or allergy consult on complex cases (an experienced Family Practice Physician may accomplish the more routine asthma cases) to include steroid dependence or usage, level of control, exercise induced, or climate or locally induced symptoms, time lost from duty, frequency and severity of attacks, hospitalization, E.R./Acute Care visits, and functional impairment; also medications (including immunotherapy), dosages, and at least three pulmonary function tests (pre- and post-bronchodilator, if abnormal, with results within 5% of each other). If asthma diagnosis is in doubt, then a Methacholine or histamine Challenge Test may be appropriate.

3.6.10.2. *Burns*: Percent of body burned (by degree) and photographs for rating disfigurement. Include measurements of functional impairment, i.e., range of motion of extremities involved..

3.6.10.3. *Collagen Vascular Disease/Rheumatoid Disease*: Rheumatology consult.

3.6.10.4. Coronary Artery Disease and other Cardiac Diseases: Cardiology consult and New York or Canadian Heart Association Classification.

3.6.10.5. Diabetes: Include evaluation for end organ damage (Optometry or Ophthalmology evaluation required), therapeutic history and level of control (HgA1C). Endocrinology consult for insulin dependent conditions.

3.6.10.6. *Hearing*: Ear, Nose and Throat (ENT) evaluation for hearing and inner ear disease with evaluation of pure tone decibel loss at 500, 1000, 2000, 3000, 4000, and percent of speech discrimination without hearing aids.

3.6.10.7. *Eyes*: Ophthalmology consult to include visual acuity, degree of peripheral constriction, and perimeter charts.

3.6.10.8. Malignancies: Dermatology consult for melanoma; neurosurgery and psychiatry consult for brain tumor; ENT on all head and neck cancer, urology for renal, bladder, and testicular cancer; oncology consult on all other cancers. Consider including an oncology consult if patient is receiving chemotherapy.

3.6.10.9. *Multiple Sclerosis*: Neurology consult.

3.6.10.10. Seizure Disorder: Neurology consult, EEG and CT Scan (or MRI) to include date of last known seizure. MEB should be accomplished after two months of trial medication.

3.6.10.11. *Neuromuscular Injury*: Orthopedic consult with range of motion strength and functional impairment and EMG if appropriate; also note dominant extremity if applicable.

3.6.10.12. *Renal Disease*: Nephrology consult to include appropriate laboratory studies, i.e., serum BUN, creatinine, urine chemistrics.

3.6.10.13. Gastrointestinal Diseases: Gastroenterology consult on complex cases (an experienced family physician or internist may accomplish more routine cases). If endoscopy performed as part of the work-up, that specialist's consult will be included.

3.6.10.14. Psychiatric: Psychiatric evaluation, to include degree of social and industrial impairment and impairment for civilian life, and degree of impairment for military service. If a "Return to Duty" determination is anticipated, consider a 45-day trial of medication.

3.6.10.14.1. Special provisions for reporting psychiatric cases: Multiaxial DSM diagnosis reporting is required, all five Axis including personality assessment and global assessment of function (GAF). For the degree of impairment for civilian social and industrial adaptability for all boardable axis I cases are required. "Total," "severe," "considerable," "definite," "mild," or "none" are the only terms used. For degree of impairment for military service, use the degree of the evaluee's current and projected impairment for military service: "no impairment," "minimal," "moderate," and "marked."

3.6.10.15. *Special provisions for reporting psychiatric cases*: Multiaxial DSM diagnosis reporting is required, all five Axis including personality assessment and global assessment of function (GAF). Degree of impairment for civilian social and industrial adaptability for all boardable axis I cases are required. "Total," "severe," "considerable," "definite," "mild," or "none" are the only terms to be used. Degree of impairment for military service. Use the degree of the evaluee's current and projected impairment for military service: "no impairment," "minimal," "moderate," and "marked."

Chapter 4

CONDUCTING THE MEB

4.1. Procedures. Composition is as described in Paragraph **2.2.** The most senior medical officer will serve as the Board President. The MTF commander should attempt to have the same board president on every board for consistency of decisions, but this is not mandatory. The board will meet and discuss the medical problems which might render the evaluee not worldwide qualified and attempt to reach a unanimous decision. If that is not possible, dissenting votes and the reason for the dissent should be recorded by the MEB clerk on the reverse of AF Form 618, and Item 27 marked appropriately. More detailed instructions on how to complete the AF Form 618 and the medical board package are contained in **Attachment 2**.

4.2. Responsibility. It is the responsibility of the board president and the reviewing officer to ensure that the best available medical information is in the narrative summary. If the narrative summary is deficient in the laboratory or radiology results, or required reports or consults listing in paragraph **3.6.1.**, the board president or reviewing authority should return the narrative summary to the preparing physician for clarification or updating. The board report must stand alone during the adjudication process at the Informal PEB, Formal PEB, the Secretary of the Air Force Personnel Council (SAFPC), Assistant Secretary of Defense (Health Affairs), and the Physical Disability Appeals Board (PDAB). Any reports, consults, that are over 90 days old and MEB narrative summaries over 30 days old will not be adjudicated and will be returned to the MTF commander for correction.

4.3. MEB Recommendations. The medical board may choose from the following actions:

4.3.1. Return to Duty (fully worldwide qualified)

4.3.2. Forward to the Informal PEB (not worldwide qualified)

4.3.3. Deleted

4.3.4. Phrases such as “Continued military medical observation and care,” and “Refer to another hospital for evaluation,” will not be used on the AF 618 as these imply that the member was not ready to board, or the facility was not qualified to conduct the board.

4.4. Evaluee Personal Appearance. Personal appearance of the evaluee is not required, but the board president may allow (at his or her discretion) the evaluee to appear before the board for statements. There is no right to counsel or to challenge the MEB or its members.

4.5. MEB Clerk Responsibility. Following the recommendation of the MEB, the clerk should ensure that Items 1-27 of AF Form 618 are completed, and assemble the entire case in the appropriate order as listed in **Attachment 2**. The board report is signed by the president and other members and forwarded to the reviewing authority.

4.6. Reviewing Authority Responsibility. The reviewing official may disapprove the report and change the findings and recommendations, but cannot reverse a finding of competency or sanity. On taking any disapproval action, the reason for the action must be attached to the AF Form 618. Following the review,

the evaluee is asked to sign, signifying that he or she has been informed of the findings and recommendations of the MEB. The evaluee has three working days to submit comments or a letter of exception.

4.7. Cases Returned from HQ AFPC/DPAMM or DPPD. The MTF commander is required to respond by endorsement that the requested information was obtained. Since these medical evaluation boards are time sensitive a stringent suspense will be issued.

4.7.1. The MTF Commander will advise members of the MEB and examining physician that the case was returned, and the reason for its return.

4.7.2. A new MEB is not required unless the case will be over 90 days old when received by HQ AFPC or new information is considered. A new narrative is not required if an addendum will adequately document interim changes.

4.8. Recall of Cases from HQ AFPC. Only the MTF commander can request recall of a case from HQ AFPC before the SAF or designated representative finalized the case. No unsolicited information will be accepted after the MEB has entered the PEB system. If unsolicited information is received, HQ AFPC/DPPDS will return the entire case for a new MEB.

4.9. Physical Profiles After an MEB. It is the responsibility of the profile officer of the MTF to issue a correct AF Form 422, *Physical Profile Serial Report*, as described in AFI 48-123. While undergoing an MEB, the member must have a 4-T profile to prevent reassignment. When a member is returned to duty by HQ AFPC, after adjudication of the MEB, the profile must be revised. Neither HQ AFPC, nor the Boards or Council in the DES can direct cross training. This is a commander responsibility. If the unit commander feels that the member is not capable of performing in an AFSC, the commander requests retraining through the military personnel flight. The correct process to use is detailed in AFI 48-123, Paragraph 10.7.3., and AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*, Paragraph 4.1.7. A new MEB is not required.

4.10. Medical Hold. Medical Hold is a method of retraining a service member beyond an established retirement or separation date for reason of disability processing, for conditions when presumption of fitness does not apply (DoDI 1332.38, Paragraph E3.P3.5.1.). It will not be used for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective treatment of remedial defects, non-emergent elective surgery or its subsequent convalescence, civilian employment issues, preservation of terminal leave, or for any other condition which does not warrant termination of active duty.

Chapter 5

ASSIGNMENT LIMITATION CODE-C

5.1. Definition. When an active duty member has been returned to duty by the Air Force DES as fit, HQ AFPC/DPAMM will review the case to determine if an Assignment Limitation Code (ALC)-C (DAC-42 if ANG member) needs to be placed in the Personnel Data System (PDS). This action is taken by the appropriate ARC/SGP when the member is an ARC member. This code will prevent reassignment without prior HQ AFPC/DPAMM or ARC/SGP medical clearance. The intent of the ALC-C (DAC-42 for ANG) is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-worldwide qualified personnel to overseas locations. This will further ensure the safe and effective accomplishment of the Air Force mission.

5.2. Authority. HQ AFPC/DPAMM is the authority to assign or remove the ALC-C on active duty members and the appropriate ARC/SGP is the authority to assign or remove the ALC-C or DAC-42 for ARC members. Active duty and ARC medical facility commanders are responsible for tracking and keeping wing commanders updated on those members of the command who are on ALC-C or DAC-42 and will assure timely medical review during the birth month of the member or as specified by HQ AFPC/DPAMM during the year indicated. The active duty or ARC medical facility is the focal point for the management of ALC-C or DAC-42 reviews for all members assigned to the installation including those geographically separated.

5.2.1. Medical reviews are conducted periodically, as specified by DPAMM, depending on the diagnosis, and are usually due during the member's birth month.

5.3. Request for Exception to Policy. Assignment Limitation Codes (Deployment Availability Codes for ANG) are used to protect our service members. Requests for exception to policy of the limitation may be sent to HQ AFPC/DPAMM, 550 C Street West, Suite 26, Randolph AFB, TX 78150-4718 for active duty members. Send requests on ARC members to the appropriate ARC/SGP. All requests will be reviewed on a case-by-case basis, and the individual's well being will be paramount. Request must be endorsed by a general officer, wing commander, or civilian equivalent (preferably from the gaining command) and should state that the individual named is essential for mission accomplishment, and that the member is the best one qualified and available for the job. The request must also indicate that the member will not be going to a mobility position and that adequate medical care has been coordinated with the gaining unit's Medical Treatment Facility commander and will be available to meet the member's needs. The memorandum should indicate that the requesting individual is aware of the member's medical assignment restriction. HQ AFPC/DPAMM is the final approval authority for the exception to policy of ALC-C on active duty members and the appropriate ARC/SGP for the exception to policy of ALC-C or DAC-42 for ARC members.

5.4. Eligibility of ALC-C (DAC-42) Members for Retention, Retraining, and Separation. Personnel who have a 4-T profile in conjunction with an ALC-C, and are profiled as stated in Paragraph **5.5.**, are eligible for retraining, promotion, and separation if the 4-T profile in question is in direct support of the ALC-CC. Otherwise, the normal limitations will apply. 4-T profiles are not used in conjunction with an ALC-C for Air Force Reserve members. Profiling will be accomplished as indicated in AFI 48-123, Chapter 10, for Air Force Reserve members, a 3-T profile will be used in conjunction with a DAC-42.

5.5. Medical Facility Action for Return to Duty with an ALC-C. The MTF will publish a profile on AF Form 422 appropriate for the member's current condition. Worldwide qualified will be marked "NO." The release date will contain the phrase "To be determined by HQ AFPC/DPAMM after next review." The remarks section will have the following statement: "Member has been found fit and was returned to duty by officials within the Office of the Secretary of the Air Force. However, member's condition is considered restrictive and will require an Assignment Limitation Code. Member will not be mobility qualified and will not be assigned (PCS or TDY) overseas except to Alaska (Elmendorf AFB only), Hawaii, or Puerto Rico. HQ AFPC/DPAMM must coordinate on all PCS movements for all members. The appropriate ARC/SGP must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. All Assignment Limitation Code-C personnel will require a narrative summary review or MEB during his/her birth month _____ (year), with specialty evaluation by _____."

5.5.1. The appropriate ARC/SGP must coordinate all Palace Chase/Front assignment actions in to the ARC prior to final approval.

5.5.2. ARC members are placed on ALC-C or DAC-42 by the appropriate ARC/SGP. The appropriate ARC/SGP will provide profiling instructions and other guidance required to be recorded on AF Form 422.

Chapter 6

PATIENT SQUADRON ASSIGNMENT

6.1. Authority. This section contains the authority for assigning patients to an Air Force medical unit. These patients are assigned on official orders to the Patient Squadron. IAW AFI 36-2113, *The First Sergeant*, First Sergeants will assume responsibility of member's assigned to a facility's patient squadron. In facilities where more than one First Sergeant is assigned/authorized, commanders will determine First Sergeant oversight.

6.2. Hospital Admission and TDY. For purposes of this section, the word "attached" signifies the member is an inpatient in the hospital in a TDY status, and "assigned" means the patient is admitted to the Patient Squadron on official orders in a PCA or PCS status. Patients who are not assigned to the Patient Squadron remain assigned to their parent unit and the Patient Squadron Commander will return to their control and management when released from the hospital. The MTF commander may publish TDY orders to move patients between hospitals. Overseas patients are moved to CONUS hospitals in TDY status. The gaining CONUS MTF commander or HQ AFPC/DPAMM will determine if PCS to the Patient Squadron is required. A transfer to CONUS hospital is indicated under one or more of the following conditions.

6.2.1. Medical care is not available in the overseas area

6.2.2. It is likely the member will be hospitalized for more than 90 days

6.2.3. Member is not expected to return to active duty

6.2.4. Hospitalization beyond DEROS is expected

6.2.5. HQ AFPC/DPAMM directs

6.3. Patient Squadron Assignments. When a patient is to be assigned to a hospital, the MTF commander of the gaining hospital requests (by memorandum) the losing military personnel flight to publish PCS or PCA orders, citing this AFI and the MTF commander's memorandum as authority. No assignment action number is required. Reporting identifier for officers is 93P0, and for enlisted is 9P000. Fund cite is obtained from the servicing accounting and finance officer. Other action, as needed, is in accordance with AFM 36-2622, *Base Level Military Personnel System, Users Manual*. A member may not be assigned to the Patient Squadron if an LOD (formal or informal) is pending.

6.3.1. Officers pending judicial or adverse administrative action may not be assigned to the Patient Squadron unless approved by the court martial convening authority or discharge authority.

6.3.2. Airmen pending judicial or adverse administrative action are attached TDY or assigned PCS without PCA to the Patient Squadron unless PCA is approved by the court martial convening authority or discharge authority.

6.3.3. The Patient Squadron commander in each case above is required to continue the administrative or discharge action.

6.3.4. Officers or Airmen in a non-Air Force MTF who meet requirements for assignment to a Patient Squadron are administratively attached to the nearest Air Force MTF and must be assigned to the Patient Squadron if warranted.

6.4. Assignment from Patient Squadron to Duty. Reassignment of the patient from the hospital when a member is available for duty: The MTF commander coordinates with the military personnel flight and reports the following information to HQ AFPC/DPAMM. NOTE: Members must have PCS retainability.

6.4.1. Patient's grade, last name, first name, middle initial

6.4.2. Social security number

6.4.3. Date gained to the MTF

6.4.4. Duty AFSC

6.4.5. Other AFSC

6.4.6. Last overseas tour and number of days served

6.4.7. ODSD and STRD (overseas duty selection date and short tour return date)

6.4.8. Control roster, administrative or judicial action pending

6.4.9. PRP or Special Security Certification

6.4.10. Hospital administrative date

6.4.11. ICD coded disposition

6.4.12. AF Form 422, Physical Profile Serial Report with duty limitations

6.4.13. Follow-up medical care recommended

6.4.14. Assignment preferences

6.4.15. Location of dependents and household goods

6.4.16. Social security number of spouse if also active duty

6.4.17. Leave requested

6.4.18. Rated aviation service rating or medical qualification for flying

6.4.19. Memorandum of concurrence by unit commander for assignment of member who is retained after recommendation for administrative disposition under other directives has been made

6.4.20. When medically cleared by HQ AFPC/DPAMM, officer or enlisted assignments section will send a message to the local military personnel flight with assignment instructions.

6.4.21. If the member is assigned to the hospital for MEB or PEB action, make no request for orders until the hospital receives a return to duty disposition from HQ AFPC/DPAMM.

6.4.21.1. Members will not be retained as hospital patients for rehabilitation in order to gain retention on active duty, but will be returned to their MAJCOM functional control as soon as satisfactory inpatient treatment is completed.

6.5. Members will not be placed in the Patient Squadron in order to preserve terminal leave or otherwise to retain a member beyond his or her date of separation or retirement without specific guidance from HQ AFPC/DPAMM. Once a member is placed on terminal leave, he or she is not permitted to change duty status without prior approval for medical hold or admission to a hospital for an emergency.

Table 6.1. Attachment and Assignments of Patients to Hospital.

Rule	*If the member is:*	*Then the member is:*
1	Admitted to an MTF and is expected to stay less than 90 calendar days and is expected to be returned to the parent unit	Attached to the MTF (see notes 1 and 2).
2	Likely to be hospitalized for 90 calendar days or more	Assigned to the MTF (see notes 1, 2, 3, and 4)
3	Unlikely to return to the unit	Assigned to the MTF (see notes 1,2,3, and 4)
4	Hospitalized as a result of injury in a combat area	Attach to the MTF (see notes 1 and 2)
5	Hospitalized while PCS en route or otherwise separated from the unit and assignment to the MTF is necessary to ensure efficient personnel management	Assigned to the MTF (see notes 1,2,3, and 4)
6	Undergoing physical evaluation for retention, retirement, or separation	Attached to the MTF as determined by the gaining DBMS or as directed by HQ AFPC/DPAMM (see notes 1, 2, 3, and 4)
7	Overseas and must be evacuated to CONUS hospital	Attach to the MTF as determined by the gaining DBMS or as directed by AFPC/DPAMM (see note 1, 2, 3, and 4)
8	At or en route to CONUS port for PCS overseas and expected to be disqualified for worldwide duty for more than 30 calendar days (time in hospital PLUS convalescence)	Attached to the MTF (see note 5)

NOTES:

1. If an established length of service date of separation or retirement is within 60 calendar days, the MPF tells the MTF which then requests medical hold, if appropriate, from HQ AFPC/DPAMM. If medical hold is approved the military personnel flight immediately notifies HQ AFPC/DPPRS and the order publishing agency so that the separation or retirement orders may be revoked before the effective date.

2. If a prior to expiration of term of service (PETS) separation is pending, the military personnel flight tells the MTF which then informs the discharge authority about the patient's medical status. The discharge authority may determine if discharge should be delayed.

3. If officer is subject of judicial or adverse administrative action he or she will remain assigned to the unit initiating the action and will be attached to the medical facility.

4. If moved to a non-Air Force hospital by the Armed Services Medical Regulation Office (ASMRO) and assignment to patient squadron is indicated, patient is attached to the non-Air Force hospital but assigned to the nearest Air Force hospital.

5. The hospital patient administration office notifies the servicing MTF and provides brief medical statement from attending physician together with physician's name and telephone number. MTF relays this to the assignment authority and requests assignment instructions.

Table 6.2. Administrative Determination to PCS or TDY to Hospital Patients Assigned Overseas.

Rule	*If the member:*	*And*	*Then:*
1	Has served any length of time	Cannot be treated in overseas area (see note 1)	TDY to CONUS hospital for final PCS determination and disposition (see note 3)
2	Is likely to be hospitalized in excess of 90 calendar days (see note 1)	Is not expected to be retained on active duty	Assign to CONUS hospital
3	Can be treated in overseas area and hospitalization is expected to be less than 90 calendar days (see note 1)	Is expected to remain on active duty	TDY to overseas hospital for treatment (see note 4)
4	Within two calendar days of DEROS (see note 1)	Can be treated in overseas area and return to duty is expected before DEROS (see note 1)	PCS to gaining unit
5	Can be treated in overseas area (see note 1)	Return to duty is expected after DEROS (see note 2)	PCS to gaining unit with TDY en route to CONUS hospital (see note 3)
6	Cannot be treated in overseas area (see note 1)	Hospitalization is expected to be less than 60 calendar days and is expected to remain on active duty	TDY to CONUS hospital

NOTES:

1. Overseas MTF determines.

2. Servicing military personnel flight provides assistance.

3. Air Force MTF serving medical facility designated by Armed Service Medical Regulating Office provides personnel support.

4. May result in further TDY or CONUS medical facility for final PCS or separation determination.

Chapter 7

TRI-SERVICE MEDICAL EVALUATIONS

7.1. General. Tri-Service MEB processing is permitted under agreements between the Army, Navy, Air Force, Marine Corps, and Coast Guard. When an MEB is completed, it is sent to the nearest PEB referral hospital of the evaluee's parent service.

7.2. Exceptions. Exceptions to this policy will be:

7.2.1. General Officers – the parent service usually states where the MEB will be conducted.

7.2.2. Coast Guard MEBs can be done only at a PEB referral hospital.

7.3. Reviewing Authority Responsibility. Once the completed MEB is received, the Air Force MTF commander may do one of the following:

7.3.1. Accept the report and process it as written

7.3.2. Accept the report but with a different recommendation

7.3.3. Return the report for more information

7.3.4. Disagree with the report and direct transfer of the member to a PEB referral hospital

7.3.5. Forms used will be those forms used by the service conducting the MEB. The parent service of the evaluee will provide MEB control and support.

7.4. PEBLO Counseling. PEBLO counseling is the responsibility of the parent service unless a joint agreement can be reached. All funds spent for TDY will be obtained from the parent service.

Chapter 8

THE VETERAN'S ADMINISTRATION (VA)

8.1. Eligibility for VA Care. Normally members are eligible for VA care if they will soon be released from active duty and have a service connected disability that was incurred while receiving basic pay or was aggravated by LOD circumstances and discharge was anything but dishonorable. The VA may also treat active duty members by means of interservice agreements.

8.2. Request for Bed. A VA bed may be obtained for a service member if prolonged hospitalization will be required. This request is through the Armed Service Medical Regulating Office (ASMRO) of the Defense Medical Regulating Information System.

8.3. Movement of Patient. Movement to a VA bed must not occur until after the member or next of kin concurs with the PEB findings or submits a rebuttal. If movement is critical, the MTF commander must contact HQ AFPC/DPPDS and the PEB referral hospital nearest the VA hospital to which the patient is being moved.

8.4. Patient Status. Active duty members who must be treated at a VA Hospital prior to retirement are ordered PCS without PCA. The servicing military personnel flight retains responsibility. If prolonged disability processing ensues, the member may be PCA to the VA hospital, but will be assigned to the patient squadron of the nearest PEB referral hospital.

8.5. Required Records. Records transmittal to include all appropriate medical records and completed VA Form 10-1204, *Referral for Community Nursing.*

8.5.1. The PEBLO will establish a positive communication link with the VA and follow patient until final Air Force disposition is made.

8.6. Spinal Cord Injuries. Significant spinal cord injuries should be moved to a VA spinal cord center as soon as possible, but not later than 12 days post injury. Movement of members should be via the most expeditious means of suitable convenience. ASMRO will assist. Categorize the patient as urgent or priority. Patients are then assigned or attached as described in Paragraph 2.10.

PAUL K. CARLTON, JR., Lt General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 36-2910, *Line of Duty Misconduct Determinations*

AFI 36-3022, *Transition Assistance Program*

AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*

AFI 36-3208, *Administrative Separation of Airmen*

AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services Systems*

AFI 48-123, *Medical Examinations and Standards*

AFMAN 36-2622, *Base Level Military Personnel System, Users Manual*

DoDD 1332.18, *Separation or Retirement for Physical Disability*

DoDI 1332.38, *Physical Disability Evaluation*

DODMRPM, *DoD Military Retired Pay Manual*

DSM, *Diagnostic and Statistical Manual of Mental Disorder*

ICD 9-CM, *International Classification of Diseases, 9th Revision, Clinical Modification*

Title 10, *United States Code*

Abbreviations and Acronyms

AB—Air Base

AF—Air Force

AF/SG—Air Force Surgeon General

AFB—Air Force Base

AFGOMO —Air Force General Officer Matters Office

AFI—Air Force Instruction

AFM—Air Force Manual

AFRC—Air Force Reserve Command

AFRES—Air Force Reserve

AFSC—Air Force Specialty Code

ALC—Assignment Limitation Code

ANG—Air National Guard

ARC—Air Reserve Component (Air Force Reserve and Air National Guard)

ARC/SG—ARC Surgeon General

ARC/SGP—Medical Authority delegated by ARC/SG

ART—Air Reserve Technician

ASMRO—Armed Services Medical Regulation Office

AWOL—Absent Without Leave

CONUS—Continental United States

DAC-42 —Deployment Availability Code 42

DBMS—Director Base Medical Services

DEROS —Date Expected Return from Overseas

DES —Disability Evaluation System

DNIF—Duty Not Involving Flying

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DoDMRPM —DoD Military Retired Pay Manual

DOS—Date of Separation

DPAMM—HQ AFPC, Medical Officer Assignment Division, Medical Standards Branch

DSM —Diagnostic and Statistical Manual of Mental Disorder

E.R.—Emergency Room

EMG —Electromyelogram

ENT—Ear, Nose, and Throat

EPTS —Existed Prior to Service

ETS—Expiration of Term of Service

GAF—Global Assessment of Function

ICD 9-CM—International Classification of Diseases, 9th Revision, Clinical Modification

IPEB—Informal Physical Evaluation Board

LOD—Line of Duty

MAJCOM—Major Command

MCM—Manual for Courts Martial

MEB—Medical Evaluation Board

MTF—Medical Treatment Facility

NOK—Next of Kin

PCA—Permanent Change of Assignment

PCS—Permanent Change of Station

PDS—Personnel Data System

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PEBRH—Physical Evaluation Board Referral Hospital

PEDAB—Physical Evaluation Disability Appeal Board

PETS—Prior to Expiration of Term of Service

PRP—Personnel Reliability Program

Reg AF—Air Force Regular

RMU—Reserve Medical Unit

SAFPC —Secretary of the Air Force Personnel Council

SF—Standard Form

SSN—Social Security Number

TDRL—Temporary Disability Retirement List

TDY—Temporary Duty

U.S.C.—United States Code

USA—United States Army

USAF—United States Air Force

USCG—United States Coast Guard

USMC—United States Marine Corps

USN—United States Navy

USPHS—United States Public Health Service

VA—Veteran’s Administration

Attachment 2

HOW TO COMPLETE A MEDICAL EVALUATION BOARD PACKAGE

A2.1. MEB Clerk Responsibilities. When an MEB is anticipated, the MEB clerk should ensure an LOD is completed and attached. Verify separation or retirement date and request a physician obtain medical hold from HQ AFPC/DPAMM if the active duty member is within 60 days of ETS or DOS. Contact the appropriate ARC medical facility prior to initiating MEB processing when the individual is a member of the ARC. For ANG members, ANG/DP is the approval authority for medical hold. Obtain all health records, including dental records if needed. Request records held by the Veteran's Administration if applicable. Notify member of impending MEB and advise member to report to the Family Support Center for Pre-Separation Transition Assistance Counseling as per AFI 36-3022, *Transition Assistance Program*, Paragraph 2.9. Notify physician conducting the board of time constraints. Notify MEB members of date, time, and place of the board. Notify member's commander of leave and TDY restrictions. Ensure a 4-T profile is sent to the military personnel flight.

A2.1.1. Additional Responsibilities for Imminent Death Processing. When it is determined that a member's death is imminent, the MEB clerk should notify the PEBLO, the Casualty Assistance Representative, and the Mortuary Services Officer to brief the member or the next of kin immediately. The member or next of kin then request expeditious processing through the AF DES. (See AFI 36-3212, Attachment 2)

A2.2. AF Form 618, *Medical Board Report.* The proceedings of the MEB, reviewed and signed by the appointing authority and acknowledged by the evaluee are reported on AF Form 618. All AF Form 618 items must be completed. An entry of "NA" may be used for items which are not applicable. Any erasures or significant changes must be initialed by a board member or the reviewing authority.

A2.2.1. Instructions for completing the AF Form 618.

A2.2.1.1. Item 1. Installation at Which Convened. Identify the MTF where the MEB was convened.

A2.2.1.2. Item 2. Date Convened. State the exact date the MEB convened and not the date the AF Form 618 is typed.

A2.2.1.3. Item 3. Name. Give last name, first name, and middle name or middle initial of the evaluee.

A2.2.1.4. Item 4. Grade. For USAF and USN members, abbreviate the proper grade (E5, O3, etc.). For USA members add the member's corps (SSgt, Ord; Capt, Inf; etc.).

A2.2.1.5. Item 5. SSN. Enter social security number. If not otherwise available, it may be obtained from the evaluee's servicing military personnel flight.

A2.2.1.6. Item 6. Component. Enter Reg AF, ANG, or AFRC for Air Force Regular, Air National Guard, or Reserve Components, and similar abbreviations for US Army and Navy counterparts.

A2.2.1.7. Item 7. Department of Service. Enter USAF, USA, USN, USMC, NOAA, USPHS or USCG. For members of a foreign military service, the nation is shown. For example, French AF, etc.

A2.2.1.8. Item 8. Organization. Enter the military organization to which the evaluee is assigned and its location, e.g., 347th CRS, Moody AFB GA. Avoid nonstandard abbreviations.

A2.2.1.9. Item 9. Sex. Enter "M" for male or "F" for female.

A2.2.1.10. Item 10. Date of Birth. Enter year, month, and day of birth. For example, 2000 Jan 25.

A2.2.1.11. Item 11. Age. Enter age at last birthday in years only.

A2.2.1.12. Item 12. Separation and Retirement Date. Enter the evaluee's established nondisability separation or retirement date. Secure it from the evaluee's services MPF. Enter "NA" or "none" if none has been established.

A2.2.1.13. Item 13. Hospital Initially Admitted. Enter the name and location of the hospital to which the evaluee was first admitted due to the condition for which he or she is being evaluated by the MEB. If the same as Item 1, enter "NA."

A2.2.1.14. Item 14. Transferred From. If transferred as an inpatient or outpatient from another hospital, enter the name and location of that hospital. If that hospital is the one identified in Item 13, enter "Same as Item 13." If not transferred, enter "NA."

A2.2.1.15. Item 15. Home Address. This is the permanent address and should not be confused with current military organization or current mailing address. For ARC members include the home, military duty section, and civilian work section phone numbers here also.

A2.2.1.16. Item 16. Military Occupational Specialties. Enter title and number for primary and secondary Air Force Specialty Codes (AFSC). If not otherwise available, obtain from the servicing MPF. If no secondary AFSC, list primary only.

A2.2.1.17. Item 17. Total Years' Military Service. Separate active service from inactive service. Show in years and in fractions of years. For example: 3 years 5 months will be shown as 3 5/12.

A2.2.1.18. Item 18. Date Entered Active Duty Current Tour. This is the date from which the member has been on continuous duty without a break in service, or the date a member of a Reserve component entered the current period of active duty orders.

A2.2.1.19. Item 19. Aeronautical Rating. Do not abbreviate. Enter "NA" if none.

A2.2.1.20. Item 20. On Flying Status on Admission. This item is to indicate if an evaluee with an aeronautical rating or designation was on flying status when admitted to the hospital. Temporary removal from flying duty (DNIF, or duty not involving flying) is not removal from flying status. If temporary removal from flying status led to permanent removal from flying status, permanent removal or suspension will have been certified by proper authority.

A2.2.1.21. Item 21. **Date Relieved from Flying Status.** If the evaluee has an aeronautical rating (Item 19) and is now on flying status (Item 20), enter the date relieved from flying status. If no aeronautical rating, enter "NA."

A2.2.1.22. Item 22. Applicable Directives and Purpose.

A2.2.1.22.1. Column A. Directives: AFI 48-123 and this instruction are specified for all cases. The Manual for Courts Martial is utilized for sanity cases. DFAS-DSM 177-373 is specified for mentally incompetent members.

A2.2.1.22.2. Column B. Purpose: Check "Continued Active Duty" for members on active duty when separation, discharge, or retirement for nondisability reasons is not pending. Check "EPTS" when a defect existed prior to service and is the principal reason for the MEB. Check "Other" and enter "Sanity" or "Competency" for a sanity or competency case. Enter "ANG Duty" or "AFRES Duty" If the evaluee is a member of one of these components and is not eligible for disability processing under this instruction.

A2.2.1.23. Item 23. Diagnosis and Findings. These appear in Column A of Item 23. List all diagnoses which contribute or may contribute to disqualification for worldwide duty. Use terminology in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD 9-CM), the current Diagnostic and Statistical Manual of Mental Disorder (DSM). Administrative LOD.

A2.2.1.24. Item 24. Sanity Determination. Complete for sanity cases only.

A2.2.1.25. Item 25. Actions Recommended by Board. Enter only "Return to Duty," "Refer to PEB," or "Disposition Under Other Directives."

A2.2.1.26. Ite**m 26. Board Members.** Each member of the MEB signs the original AF Form 618. In sanity or competency cases, place a check mark after the signature of the board member(s) who is/are a psychiatrist(s).

A2.2.1.27. Item 27. Minority Report. If the board recommendation is not unanimous, "Yes" is checked and the minority report with substantiating rationale is entered on the reverse side of AF Form 618 or on an attached sheet. For unanimous recommendation, check "No."

A2.2.1.28. Item 28. Hospital Commander or Designee.

A2.2.1.29. Item 29. Except in mentally incompetent or deleterious cases, the findings and recommendations of the medical board and any subsequent changes by the review authority are explained to the evaluee. The evaluee is also advised that if exception is taken to the narrative summary, findings, or recommendation of the medical board, three work days will be allowed to prepare a letter of exception, which will be attached to the board report forwarded to HQ AFPC/DPPAM or HQ AFPC/DPPDS. By completing A, B, and C of Item 29, the evaluee acknowledges that he or she has been informed of the findings and recommendation of the board and of the option to submit a letter of exception. The MEB recorder signs opposite the footnote below Item 29 to show that he or she has thoroughly briefed the evaluee on the findings, recommendation, and options referenced above. If the evaluee is unable, refuses, or is not available to sign AF Form 618, enter "Signature Unavailable" or "Refuses to Sign" in Item 29B and explain circumstances on the reverse of AF Form 618 with signatures of two additional witnesses to the evaluee's briefing and refusal to sign.

A2.3. Actions Following the MEB.

A2.3.1. After the MTF commander or physician designee, if commander is not a physician, reviews and approves the MEB report, the MEB recorder or PEBLO ensures the evaluee has an opportunity to read the MEB report and narrative summary and assists the evaluee in resolving any questions con-

cerning the content of the report and summary. The PEBLO advises the evaluee that he or she may submit a signed statement within three work days for consideration by the disposition authority if the evaluee takes exception to the content of the board report or narrative summary. The original narrative summary will not be altered in any way at the member's request without the unanimous agreement of the member's treating physician, all MEB members and the reviewing authority. The PEBLO obtains evaluee's signature on AF Form 618 acknowledging understanding. Within five work days after the reviewing authority signs, the PEBLO forwards the completed MEB package (original and three copies) to HQ AFPC for active duty members or (original and four copies) to the appropriate ARC/SGP for ARC members.

A2.3.2. If the evaluee has been determined to be incompetent (Items 22 and 23 of AF Form 618), or the case has been designated deleterious (AF Form 1172, *Certificate of Medical Officer*), the MEB recorder or PEBLO addresses the above mentioned actions to the evaluee's next of kin (NOK) or legal guardian, who is entitled to the same rights, privileges, and counseling benefits as the evaluee.

A2.3.3. When incompetency is determined, additional copies of AF Form 618 are distributed to accounting and finance authorities. This must be done without delay. Failure to safeguard the pay of members declared mentally incompetent to manage their own affairs has caused serious hardship to members and their families. Send copies to: SFAS-CL/ROC, P.O. Box 99191, Cleveland, OH 44199-1126.

A2.3.4. Content and Distribution of the MEB Package.

A2.3.4.1. AF Form 618, with attachments, is assembled into five sets (six for ARC members) and distributed as indicated below.

A2.3.4.1.1. Original Set:

A2.3.4.1.1.1. AF Form 618 (original)

A2.3.4.1.1.2. Evaluee's letter of exception (original)

A2.3.4.1.1.3. Commander's letter

A2.3.4.1.1.4. AF Form 1185, Statement of Record Data

A2.3.4.1.1.5. SF Form 502, *Medical Record – Narrative Summary* (Clinical Resume)

A2.3.4.1.1.6. Consultation or special studies relevant to case (original copies)

A2.3.4.1.1.7. Copy of SF 88, *Report of Medical Examination* (from original induction physical)

A2.3.4.1.1.8. Copy of SF 93, *Report of Medical History* (from original induction physical)

A2.3.4.1.1.9. AF Form 348 or NGB 348, *Line of Duty Determination*, or DD Form 261, *Report of Investigation Line of Duty and Misconduct Status* (with all exhibits attached), when LOD applies. (The appropriate LOD form is required for all ARC members undergoing disability processing). For ANG, NGB 348 must be signed by ANG/SGP.

A2.3.4.1.1.10. AF Form 1172, *Statement of Medical Officer*, if deleterious

A2.3.4.1.1.11. NOK information, if mentally incompetent or deleterious case, include name, address, relationship, and whether advised or not advised that the case is being

referred to the PEB, and available or not available for PEBLO counseling. Following PEB action, if NOK is not known or cannot be contacted, provide a complete summary of all attempts made to identify or contact the NOK.

A2.3.4.1.1.12. Copy of AF Form 618 from prior MEB convened under AFM 177-373 to determine competency, if one had been convened and there has been no change in the evaluee's mental status since that board was convened.

A2.3.4.1.1.13. All current health records (required for PEB adjudication, AFRES and ANG personnel)

A2.3.4.1.1.14. If an enlisted evaluee has served on active duty in a grade higher than current grade, send a copy of the promotion (to the higher grade) order, document authorizing demotion and the last four enlisted performance reports.

A2.3.4.1.1.15. Copies of military orders placing the ARC member in a military duty status at the time of the injury, illness, or disease. If military orders are not available, then a statement signed by the member's commander verifying that the member was ordered to military status by competent military authority at the time of the onset of the member's medical condition is required.

A2.3.4.1.1.16. Request for VA bed designation stating possible duration of hospitalization, if VA hospitalization is indicated

A2.3.4.1.1.17. Personnel Rip for ARC members

A2.3.4.1.1.18. Supporting civilian medical documentation for ARC members

A2.3.4.1.1.19. Other items as necessary.

A2.3.4.1.2. Sets 2, 3, and 4:

A2.3.4.1.2.1. AF Form 618 (copy)

A2.3.4.1.2.2. Evaluee's letter of exception

A2.3.4.1.2.3. Commander's letter

A2.3.4.1.2.4. AF Form 1185

A2.3.4.1.2.5. SF 502

A2.3.4.1.2.6. Consultation or special studies relevant to the case

A2.3.4.1.2.7. SF 88 and SF 93

A2.3.4.1.2.8. AF Form 1172, if needed

A2.3.4.1.3. Set 5 (MTF Copy):

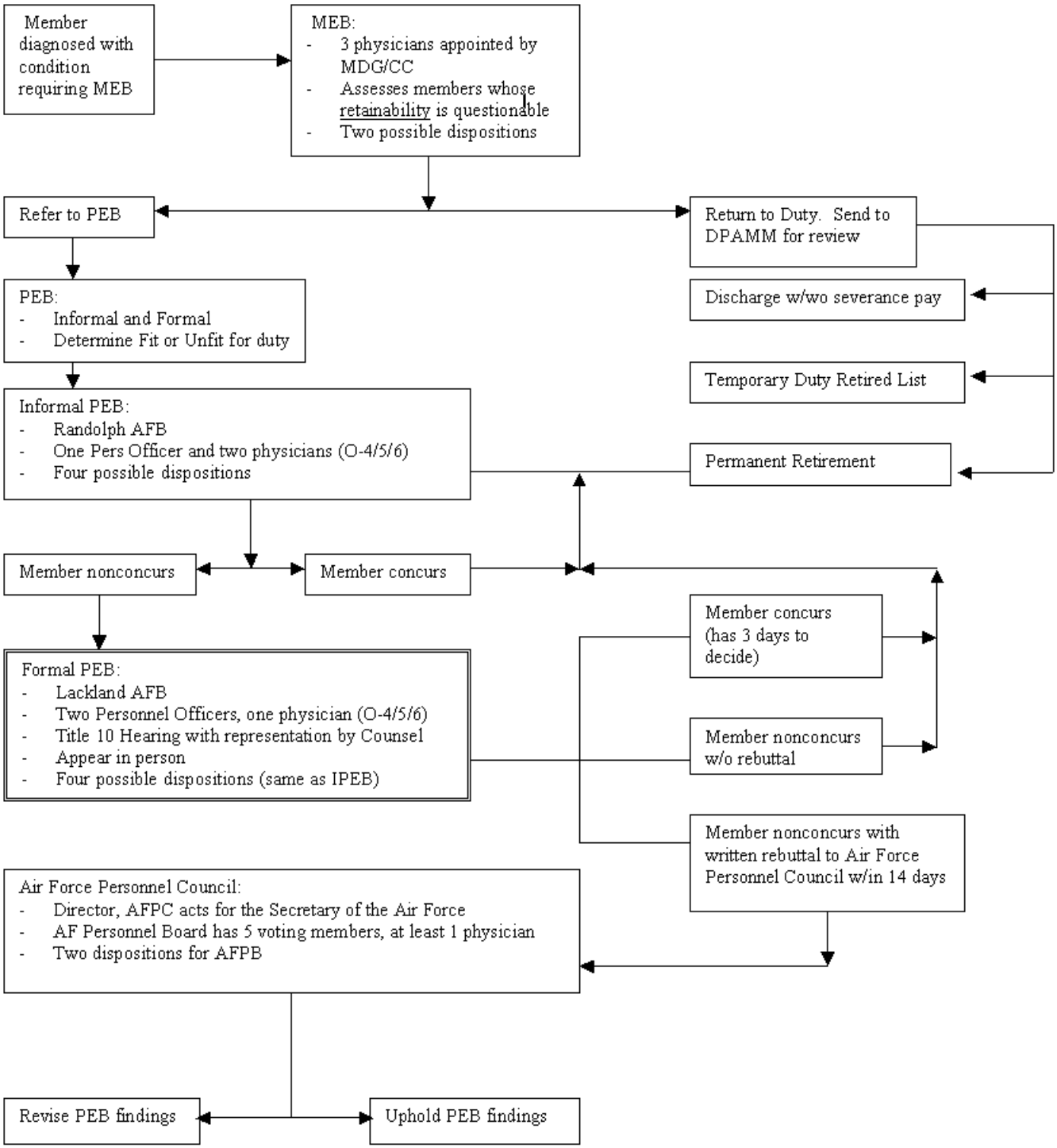
A2.3.4.1.3.1. Same as Sets 2, 3, and 4 with any additional items desired by the MEB, recorder, or PEBLO

A2.3.4.1.4. Set 6 (ARC/SGP Copy)

A2.3.4.1.4.1. Same as Set 1. Do NOT make copies of the military medical record

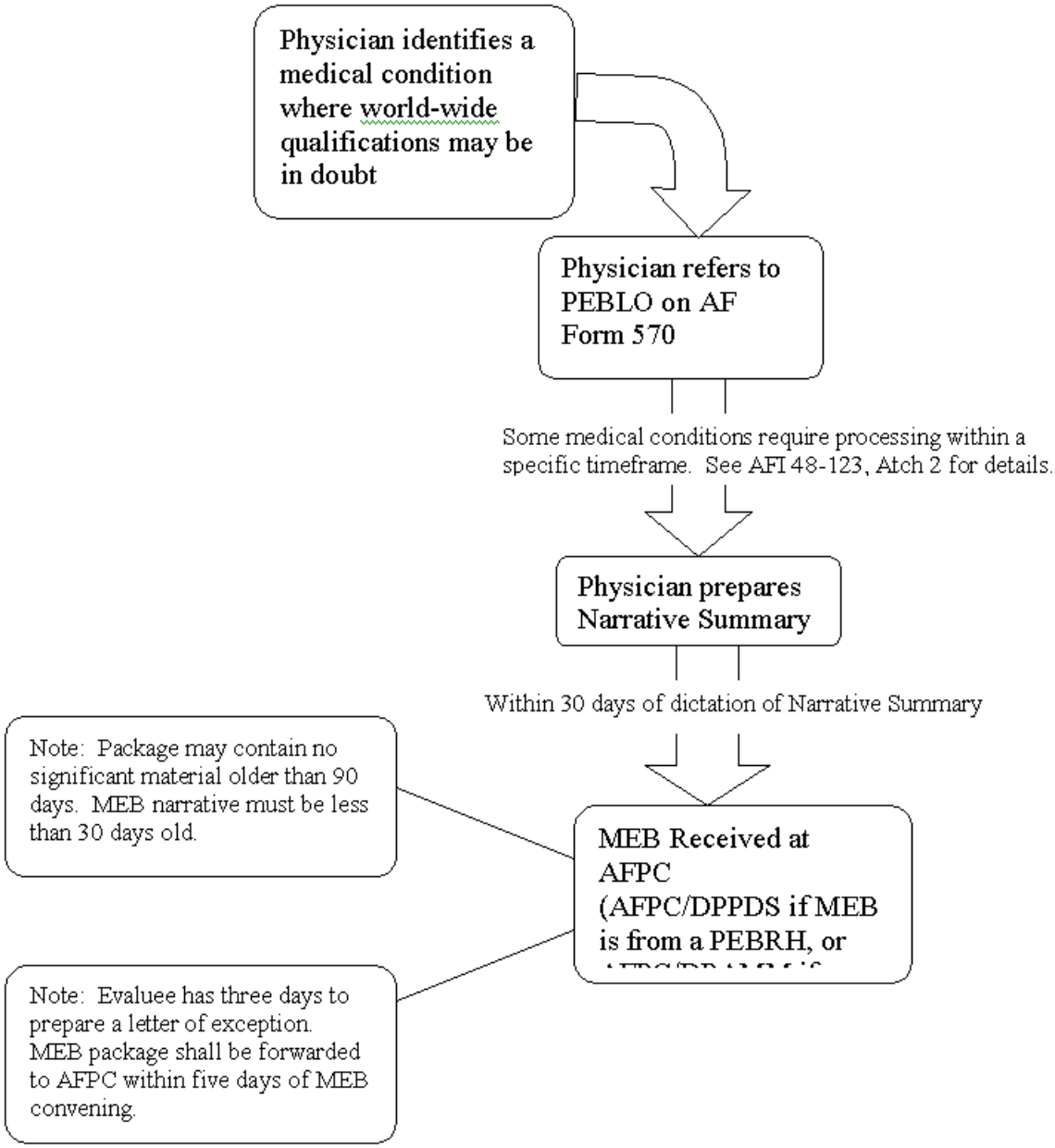
Attachment 3

MEB FLOW CHART



Attachment 4

MEB PROCESSING TIMELINE



Attachment 5

PROCEDURES FOR AIR RESERVE COMPONENT (ARC) MEMBERS

A5.1. Eligibility. When processing MEBs on ARC members, the PEBLO will first determine if the member is entitled to receive military medical care. Guidance on ARC member's entitlements to military medical care is in AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services Systems.* The PEBLO will also ensure the member has a valid AF Form 348 (NGB 348), *Line of Duty Determination*, or DD Form 261, *Report of Investigation Line of Duty and Misconduct Status*, in the medical record prior to initiation of the MEB. Whenever an ARC member is referred for an MEB, the PEBLO will establish contact with the medical Air Reserve Technician (ART) for unit assigned reservists and Senior Health Technician for guardsmen at the member's supporting ARC Medical Facility or HQ ARPC/SGSP for IMA personnel. The medical ART/SR Health Technician will assist the PEBLO in confirming the member's eligibility for medical care, disability processing, maintaining contact with the member and obtaining all required documentation to be included in the MEB package and administrative orders. The PEBLO will contact the medical ART/SR Health Technician prior to initiating the MEB. If the member does not have a supporting ARC medical facility, or the PEBLO is unable to contact the medical ART/SR Health Technician, the appropriate ARC/SGP will be contacted for assistance.

A5.2. LOD. ARC members are required to have an AF Form 348 (NGB 348) or DD Form 261 with an "In Line of Duty" determination made to be eligible for disability processing. If an AF Form 348 (NGB 348) or DD Form 261 is not in the medical records, or it is unclear if the medical condition was determined to be "Not in the Line of Duty," the member will be referred to his or her supporting ARC medical facility for appropriate disposition. After entitlement to disability processing has been established, only those medical diagnosis(es) which have been determined to be "In Line of Duty" following completion of AF Form 348 (NGB 348), or DD Form 261, shall be identified on the AF Form 618 as the reason for initiation of the MEB processing.

A5.2.1. All MEBs and reviews in lieu of MEB accomplished on ARC members will be forwarded to the appropriate ARC/SGP for review and action. If it is determined that the member is not entitled to disability processing, then the appropriate ARC/SGP will stop disability processing and initiate the ARC process for evaluating ARC members with disqualifying non-duty related medical conditions. Otherwise, the ARC/SGP will forward the MEB report to HQ AFPC/DPPDS or DPAMM as appropriate.

A5.3. Medical records on ARC members undergoing MEB or review in lieu of MEB will be forwarded along with the MEB report, supporting documentation, and the additional information listed below:

A5.3.1. A copy of the orders or other directives placing a member in a duty status at the time of onset of illness, injury, or disease

A5.3.2. A completed and signed copy of AF Form 348 (NGB 348) or DD Form 261, as appropriate

A5.3.3. All available medical documentation and medical information unique to Reserve personnel

A5.4. Appropriate ARC/SGP

A5.4.1. HQ AFRC/SGP, 155 2nd Street, Robins AFB, GA 31098-1635, DSN 497-0603, commercial (912) 327-0603, or 1-800-223-1784, for unit assigned reservists.

A5.4.2. HQ ARPC/SGPS, 6760 E. Irvington Place #7200, Denver, CO 80280-7200, DSN 926-7236/7237, commercial (303) 676-7236/7237, or 1-800-525-0102, extension 235, for individual mobilization augmentees (IMAs).

A5.4.3. ANG/SGPS, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157, DSN 278-8549 or commercial (301) 836-8549, for guardsmen.

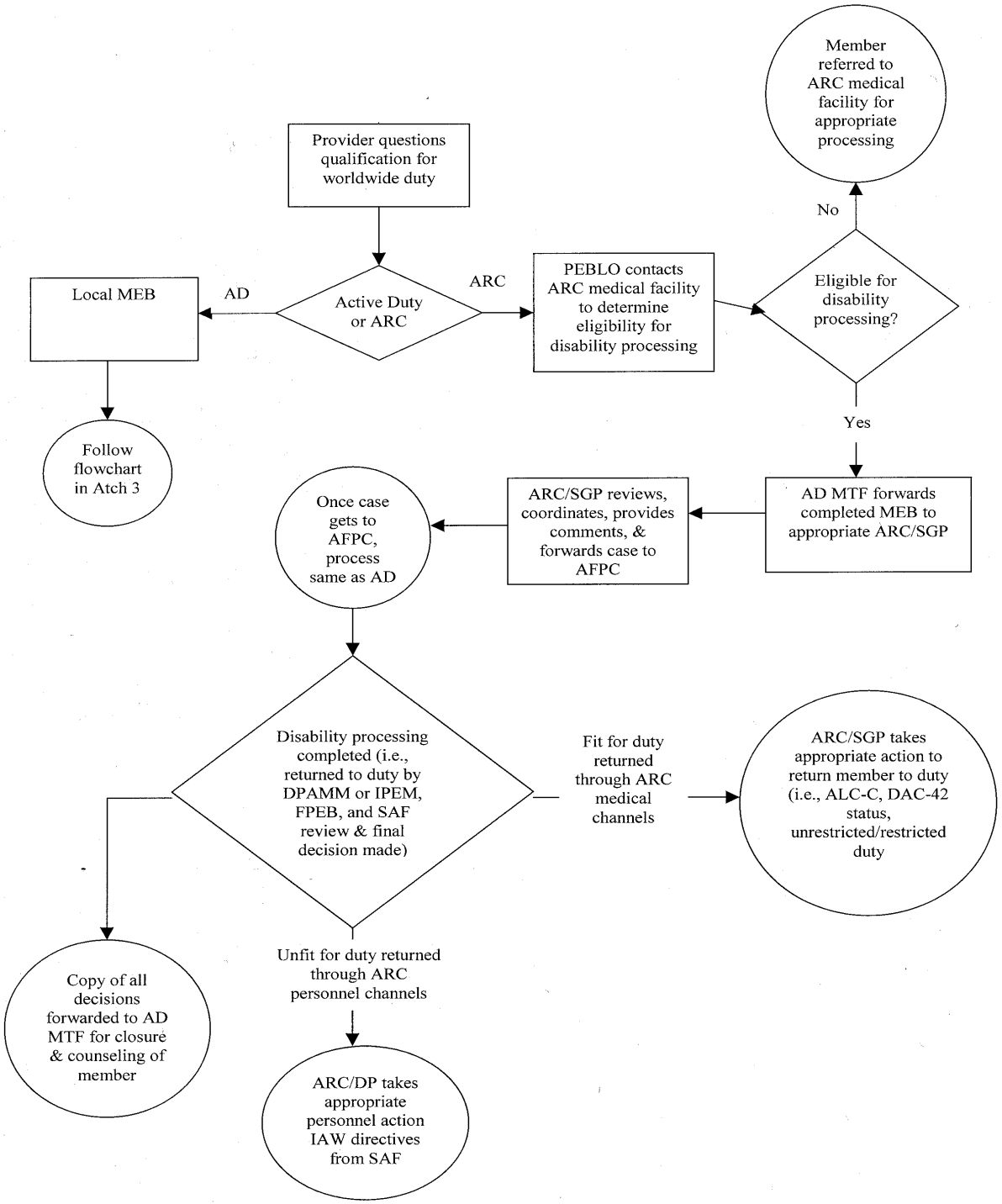
A5.5. Appropriate ARC Medical Facility.

A5.5.1. Go to **http://w3.afrc.af.mil/hq/sg/units.htm** on the web to determine the appropriate reserve medical facility and POC for unit assigned reservists.

A5.5.2. Contact ARPC/SGSP for IMAs.

Attachment 6

ARC MEB FLOW CHART



Attachment 7

IC 2000-1 TO AFI 44-157, MEDICAL EVALUATION BOARDS (MEB) AND CONTINUED MILITARY SERVICE

12 DECEMBER 2000

SUMMARY OF REVISIONS

This change incorporates inputs received since initial publication of AFI. A "|" indicates revised material since the last edition.

This instruction describes how to evaluate service members who are not worldwide qualified due to a medical or physical defect, and the administrative matters dealing with a medical evaluation board (MEB). It outlines procedures for establishing, preparing, and conducting competency, sanity, and MEBs, and how to complete the after-board actions. It also describes the disposition and management of members who are found fit by the Air Force Disability Evaluation System (DES), but whose medical condition is so restrictive that it limits the member's assignability (Assignment Limitation Code-C). This instruction carries out the requirements of Title 10, United States Code (U.S.C.), Chapter 61, and the Department of Defense Directive 1332.18, *Separation or Retirement for Physical* and Department of Defense Instruction 1332.38, *Physical Disability Evaluation* and interfaces with Air Force Policy Directive 44-1, *Medical Operations*. This instruction also applies to those Air Reserve Components (ARC) members entitled to disability processing. Refer to appropriate ARC guidance for managing those ARC members not entitled to disability processing.

1.2.4.1. For Air Reserve Component (ARC) personnel, the appropriate ARC/SGP (see attachment 5, paragraph A5.4.) is the approval authority for ALC-C, medical hold, and non-emergent elective surgery. AD MTFs should contact the appropriate ARC/SGP when confronted with these issues involving ARC personnel. For ANG personnel, ANG/DP is the approval authority for Deployment Availability Code 42 (DAC-42) and medical hold. ANG/SGP will work in conjunction with ANG/DP when confronted with these issues involving ANG personnel.

1.3.1. Within the presumptive period an acute, grave illness or injury occurs that would prevent the member from performing further duty, if he or she were not retiring, or a serious deterioration of a previously diagnosed condition occurs that would prevent the member from performing further duty immediately prior to or concurrent with the processing for normal retirement.

1.4.1. Unsuiting Conditions. Some psychiatric (and other) conditions will render an individual "unsuiting" for military duty although they do not constitute a compensable physical or medical disability. These individuals are referred to their commander for consideration for administrative separation. See AFI 48-123, Attachment 2, paragraphs 2.12. and 2.20., and DoDI 1332.38, Enclosure 5, *Conditions Not Constituting a Physical Disability*.

1.4.10. Members under court martial charges are not eligible for disability processing unless there is a question of mental capacity or responsibility or when member's sentence of dismissal or punitive discharge is suspended. Refer to AFI 36-3212, paragraph 1.3.1. Members in Absent Without Leave (AWOL), in deserter status, or in the hands of civil authorities, disability processing does not continue until members return to military control and HQ AFPC/DPPD determines eligibility for disability processing. Refer to AFI 36-3212, paragraph 1.4.2.

1.4.13. In instances when members have incidental findings or defects and it is not certain if an MEB is needed, the MTF may send a narrative summary (Review-In-Lieu of MEB) with an explanatory cover letter to HQ AFPC/DPAMM for disposition instructions. The Review-In-Lieu of MEB is used to receive a timely disposition when needed, e.g., separation, retirement, pending assignments, etc. The disposition by DPAMM is final, and has the same effect and authority as an MEB. Dispositions are:

1.6. Duty and Assignment of Members Undergoing MEB. Members undergoing MEB processing, whether outpatients still assigned to their normal unit of assignment, or attached or assigned to the patient squadron, and are available for duties or work in the MTF, or elsewhere on base as directed by the patient squadron commander, which are not medically contraindicated and do not interfere with evaluation and MEB processing.

1.6.1. Upon entry into the Disability Evaluation System (i.e., MEB sent to AFPC for processing), members who are undergoing MEB processing may not be placed on leave outside the local area or TDY without prior coordination with HQ AFPC/DPAMM, except for emergencies. The member must be available to report within one duty day.

2.2.3. When competency for pay and records is considered, the board must consist of three Air Force medical officers, one of whom is certified by or eligible for certification by the American Boards of Psychiatry, Neurology, or Neurosurgery. Reevaluation of members previously judged to be incompetent require a psychiatrist on subsequent competency boards.

2.2.5. When there is a need to determine sanity, the board will include a psychiatrist. A clinical psychologist will not serve on the board.

2.3. Review and Approval Authority. The review and approval authority will be the MTF commander, or designee, if a Medical Corps officer. If the MTF commander is not a physician, the commander must delegate this authority in writing to a senior Medical Corps officer on his or her staff. This must be coordinated with AFPC/DPAMM. The MTF commander or designated review authority may not serve on the MEB under review.

3.1. Responsibilities. It is the responsibility of all Medical Corps officers to identify service members whose qualification for worldwide duty is in doubt and refer them for medical board action within 30 days of making a definitive diagnosis. The Medical Corps officer initiates notification of an MEB action via AF Form 570, Notification of Patient's Medical Status, and forward it to the action officer (PEBLO). He/she must also notify the Physical Exams and Standards section for active duty members and the ARC medical facility for ARC members of the need to complete a 4T profile on the members. When MEB notification is made on an ARC member, their supporting ARC medical unit will be notified by the PEBLO to determine the member's entitlement to disability processing. The MEB should arrive at HQ AFPC/DPPD or HQ AFPC/DPPAM (as appropriate) for active duty members or to the appropriate ARC/SGP for ARC members within 30 days from the dictation of the narrative summary. Under no circumstances will a case be accepted for adjudication if any part of the board package is older than 90 days without a recent update of patient's current medical status. The function of the MEB is to identify those members who are not worldwide qualified. The decision requiring fitness lies with the Air Force DES. Title 10 U.S.C., Chapter 61, provides for full and fair hearing and adjudication by a series of boards, with the Secretary of the Air Force or designee making the final decision on retention or separation.

3.2.2. DoDD 1332.18, *Separation or Retirement for Physical Disability*, Paragraph D(3), and DoDI 1332.38, *Physical Disability Evaluation*, lists criteria which will not be used to constitute medical disqualification for continued military service.

3.4. Where MEBs Should Be Accomplished. As a general rule, MEB candidates receive clinical evaluation and MEB processing at the medical facility at which they are receiving medical care. However, if that facility is not a physical evaluation board referral hospital (PEBRH) designated in paragraph 3.5. (unless the case is administratively and clinically simple), the case may be referred to a PEBRH for further processing. Referral to a PEBRH is often appropriate if initial work-up indicates referral to a PEB is needed. Each case must be judged individually, realizing that referral to a PEBRH may result in family separation and possible family hardship until a disability determination is made. If the local MTF is able to provide an adequate clinical evaluation, has the requisite MEB staffing, and has an experienced knowledgeable PEBLO to counsel the evaluee throughout the MEB and subsequent disability processing, then MEB processing at that facility is appropriate. Only PEBRH will submit cases directly to HQ AFPC/DPPDS. All other MTFs will forward MEBs to HQ AFPC/DPAMM. Smaller MTFs must request PEB direct-referral authority on MEBs accomplished at non-PEB Direct Referral Hospitals.

3.6.1. SF 502, Medical Record Narrative Summary. This summary must be current within 30 days when received by AFPC, and must describe a clear picture of the member's disease process. It must include all of the following: date and circumstance of the occurrence, response to treatment, current clinical status, proposed treatment, prognosis and the extent the condition interferes with the duty performance.

3.6.1.6. Full Physical Exam to Include Right or Left Handed. See also DoDI 1332.38, paragraph E4.A1.1.3.

3.6.1.9. Consultations (must bot be older than 90 days, unless updated by consultant). All consultations that were accomplished for diagnoses listed on the AF Form 618 should be forwarded to the MEB. Current profile (AF Form 422) should be attached.

3.6.1.18. Prognosis, follow-up, restrictions and/or limitations involving current assigned military duties without stating fitness for duty.

3.6.3. When non-physician providers prepare narrative summaries for medical board adjudication (optometry, podiatry, clinical psychology, physician assistant, nurse practitioner), they must be reviewed and counter-signed by a physician; e.g., ophthalmologist for optometry, orthopedics for podiatry, and psychiatry for psychology. Board certified family physicians and internists may countersign if they are currently holding privileges in fields related to the patient's condition.

3.6.5. The Chief of the Medical Staff will submit a statement regarding the current status of medical credentials for any credentialed medical provider. A DD Form 2499 is highly recommended if the provider is unlikely to return to full and unrestricted duty.

3.6.7. AF Form 2100 Series, *Health Records, Outpatient* (only required for the formal PEB, and ARC).

3.6.8. AF Form 565, *Record of Inpatient Treatment*, if available.

3.6.10. The following special consultations and additional information are required for the diseases listed (these consults or updates must not be over 90 days old when received at HQ AFPC):

3.6.10.1. Asthma: Current pulmonary or allergy consult on complex cases (an experienced Family Practice Physician may accomplish the more routine asthma cases) to include steroid dependence or usage, level of control, exercise induced, or climate or locally induced symptoms, time lost from duty, frequency and severity of attacks, hospitalization, E.R./Acute Care visits, and functional impairment; also medications (including immunotherapy), dosages, and at least three pulmonary function tests (pre- and post-bronchodilator, if abnormal, with results within 5% of each other). If asthma diagnosis is in doubt, then a Methacholine or histamine Challenge Test may be appropriate.

3.6.10.4. Coronary Artery Disease and other Cardiac Diseases: Cardiology consult and New York or Canadian Heart Association Classification.

3.6.10.5. Diabetes: Include evaluation for end organ damage (Optometry or Ophthalmology evaluation required), therapeutic history and level of control (HgA1C). Endocrinology consult for insulin dependent conditions.

3.6.10.8. Malignancies: Dermatology consult for melanoma; neurosurgery and psychiatry consult for brain tumor; ENT on all head and neck cancer, urology for renal, bladder, and testicular cancer; oncology consult on all other cancers. Consider including an oncology consult if patient is receiving chemotherapy.

3.6.10.10. Seizure Disorder: Neurology consult, EEG and CT Scan (or MRI) to include date of last known seizure. MEB should be accomplished after two months of trial medication.

3.6.10.13. Gastrointestinal Diseases: Gastroenterology consult on complex cases (an experienced family physician or internist may accomplish more routine cases). If endoscopy performed as part of the work-up, that specialist's consult will be included.

3.6.10.14. Psychiatric: Psychiatric evaluation, to include degree of social and industrial impairment and impairment for civilian life, and degree of impairment for military service. If a "Return to Duty" determination is anticipated, consider a 45-day trial of medication.

3.6.10.14.1. Special provisions for reporting psychiatric cases: Multiaxial DSM diagnosis reporting is required, all five Axis including personality assessment and global assessment of function (GAF). For the degree of impairment for civilian social and industrial adaptability for all boardable axis I cases are required. "Total," "severe," "considerable," "definite," "mild," or "none" are the only terms used. For degree of impairment for military service, use the degree of the evaluee's current and projected impairment for military service: "no impairment," "minimal," "moderate," and "marked."

4.2. Responsibility. It is the responsibility of the board president and the reviewing officer to ensure that the best available medical information is in the narrative summary. If the narrative summary is deficient in the laboratory or radiology results, or required reports or consults listing in paragraph 3.6.1., the board president or reviewing authority should return the narrative summary to the preparing physician for clarification or updating. The board report must stand alone during the adjudication process at the Informal PEB, Formal PEB, the Secretary of the Air Force Personnel Council (SAFPC), Assistant Secretary of Defense (Health Affairs), and the Physical Disability Appeals Board (PDAB). Any reports, consults, that are over 90 days old and MEB narrative summaries over 30 days old will not be adjudicated and will be returned to the MTF commander for correction.

Deleted Paragraph 4.3.3.

4.9. Physical Profiles after an MEB. It is the responsibility of the profile officer of the MTF to issue a correct AF Form 422, *Physical Profile Serial Report*, as described in AFI 48-123. While undergoing an MEB, the member must have a 4-T profile to prevent reassignment. When a member is returned to duty by HQ AFPC, after adjudication of the MEB, the profile must be revised. Neither HQ AFPC, nor the Boards or Council in the DES can direct cross training. This is a commander responsibility. If the unit commander feels that the member is not capable of performing in an AFSC, the commander requests retraining through the military personnel flight. The correct process to use is detailed in AFI 48-123, Paragraph 10.7.3., and AFI 36-2101, *Classifying Military Personnel (Officers and Airmen),* Paragraph 4.1.7. A new MEB is not required.

4.10. Medical Hold. Medical Hold is a method of retraining a service member beyond an established retirement or separation date for reason of disability processing, for conditions when presumption of fitness does not apply (DoDI 1332.38, Paragraph E3.P3.5.1.). It will not be used for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective treatment of remedial defects, non-emergent elective surgery or its subsequent convalescence, civilian employment issues, preservation of terminal leave, or for any other condition which does not warrant termination of active duty.

5.2.1. Medical reviews are conducted periodically, as specified by DPAMM, depending on the diagnosis, and are usually due during the member's birth month.

5.3. Request for Exception to Policy. Assignment Limitation Codes (Deployment Availability Codes for ANG) are used to protect our service members. Requests for exception to policy of the limitation may be sent to HQ AFPC/DPAMM, 550 C Street West, Suite 26, Randolph AFB, TX 78150-4718 for active duty members. Send requests on ARC members to the appropriate ARC/SGP. All requests will be reviewed on a case-by-case basis, and the individual's well being will be paramount. Request must be endorsed by a general officer, wing commander, or civilian equivalent (preferably from the gaining command) and should state that the individual named is essential for mission accomplishment, and that the member is the best one qualified and available for the job. The request must also indicate that the member will not be going to a mobility position and that adequate medical care has been coordinated with the gaining unit's Medical Treatment Facility commander and will be available to meet the member's needs. The memorandum should indicate that the requesting individual is aware of the member's medical assignment restriction. HQ AFPC/DPAMM is the final approval authority for the exception to policy of ALC-C on active duty members and the appropriate ARC/SGP for the exception to policy of ALC-C or DAC-42 for ARC members.

5.4. Eligibility of ALC-C (DAC-42) Members for Retention, Retraining, and Separation. Personnel who have a 4-T profile in conjunction with an ALC-C, and are profiled as stated in Paragraph 5.5., are eligible for retraining, promotion, and separation if the 4-T profile in question is in direct support of the ALC-CC. Otherwise, the normal limitations will apply. 4-T profiles are not used in conjunction with an ALC-C for Air Force Reserve members. Profiling will be accomplished as indicated in AFI 48-123, Chapter 10, for Air Force Reserve members, a 3-T profile will be used in conjunction with a DAC-42.

5.5. Medical Facility Action for Return to Duty with an ALC-C. The MTF will publish a profile on AF Form 422 appropriate for the member's current condition. Worldwide qualified will be marked "NO." The release date will contain the phrase "To be determined by HQ AFPC/DPAMM after next review." The remarks section will have the following statement: "Member has been found fit and was returned to duty by officials within the Office of the Secretary of the Air Force. However, member's condition is considered restrictive and will require an Assignment Limitation Code. Member will not be mobility qualified and will not be assigned (PCS or TDY) overseas except to Alaska (Elmendorf AFB only), Hawaii, or Puerto Rico. HQ AFPC/DPAMM must coordinate on all PCS movements for all members. The appropriate ARC/SGP must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. All Assignment Limitation Code-C personnel will require a narrative summary review or MEB during his/her birth month _____ (year), with specialty evaluation by _____."

5.5.1. The appropriate ARC/SGP must coordinate all Palace Chase/Front assignment actions in to the ARC prior to final approval.

5.5.2. ARC members are placed on ALC-C or DAC-42 by the appropriate ARC/SGP. The appropriate ARC/SGP will provide profiling instructions and other guidance required to be recorded on AF Form 422.

6.2. Hospital Admission and TDY. For purposes of this section, the word “attached” signifies the member is an inpatient in the hospital in a TDY status, and “assigned” means the patient is admitted to the Patient Squadron on official orders in a PCA or PCS status. Patients who are not assigned to the Patient Squadron remain assigned to their parent unit and the Patient Squadron Commander will return to their control and management when released from the hospital. The MTF commander may publish TDY orders to move patients between hospitals. Overseas patients are moved to CONUS hospitals in TDY status. The gaining CONUS MTF commander or HQ AFPC/DPAMM will determine if PCS to the Patient Squadron is required. A transfer to CONUS hospital is indicated under one or more of the following conditions.

8.6. Spinal Cord Injuries. Significant spinal cord injuries should be moved to a VA spinal cord center as soon as possible, but not later than 12 days post injury. Movement of members should be via the most expeditious means of suitable convenience. ASMRO will assist. Categorize the patient as urgent or priority. Patients are then assigned or attached as described in Paragraph 2.10.

Attachment 1

Glossary of References and Supporting Information

References

AFI 36-2910, *Line of Duty Misconduct Determinations*

AFI 36-3022, *Transition Assistance Program*

AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*

AFI 36-3208, *Administrative Separation of Airmen*

AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services Systems*

AFI 48-123, *Medical Examinations and Standards*

AFMAN 36-2622, *Base Level Military Personnel System, Users Manual*

DoDD 1332.18, *Separation or Retirement for Physical Disability*

DoDI 1332.38, *Physical Disability Evaluation*

DODMRPM, *DoD Military Retired Pay Manual*

DSM, *Diagnostic and Statistical Manual of Mental Disorder*

ICD 9-CM, *International Classification of Diseases, 9th Revision, Clinical Modification*

Title 10, *United States Code*

Abbreviations and Acronyms

AB	Air Base
AF	Air Force
AF/SG	Air Force Surgeon General
AFB	Air Force Base
AFGOMO	Air Force General Officer Matters Office

AFI	Air Force Instruction
AFM	Air Force Manual
AFRC	Air Force Reserve Command
AFRES	Air Force Reserve
AFSC	Air Force Specialty Code
ALC	Assignment Limitation Code
ANG	Air National Guard
ARC	Air Reserve Component (Air Force Reserve and Air National Guard)
ARC/SG	ARC Surgeon General
ARC/SGP	Medical Authority delegated by ARC/SG
ART	Air Reserve Technician
ASMRO	Armed Services Medical Regulation Office
AWOL	Absent Without Leave
CONUS	Continental United States
DAC-42	Deployment Availability Code 42
DBMS	Director Base Medical Services
DEROS	Date Expected Return from Overseas
DES	Disability Evaluation System
DNIF	Duty Not Involving Flying
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDMRPM	DoD Military Retired Pay Manual
DOS	Date of Separation
DPAMM	HQ AFPC, Medical Officer Assignment Division, Medical Standards Branch DSM Diagnostic and Statistical Manual of Mental Disorder
E.R.	Emergency Room
EMG	Electromyelogram
ENT	Ear, Nose, and Throat
EPTS	Existed Prior to Service
ETS	Expiration of Term of Service

GAF	Global Assessment of Function
ICD 9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
IPEB	Informal Physical Evaluation Board
LOD	Line of Duty
MAJCOM	Major Command
MCM	Manual for Courts Martial
MEB	Medical Evaluation Board
MTF	Medical Treatment Facility
NOK	Next of Kin
PCA	Permanent Change of Assignment
PCS	Permanent Change of Station
PDS	Personnel Data System
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PEBRH	Physical Evaluation Board Referral Hospital
PEDAB	Physical Evaluation Disability Appeal Board
PETS	Prior to Expiration of Term of Service
PRP	Personnel Reliability Program
Reg AF	Air Force Regular
RMU	Reserve Medical Unit
SAFPC	Secretary of the Air Force Personnel Council
SF	Standard Form
SSN	Social Security Number
TDRL	Temporary Disability Retirement List
TDY	Temporary Duty
U.S.C.	United States Code
USA	United States Army
USAF	United States Air Force
USCG	United States Coast Guard
USMC	United States Marine Corps
USN	United States Navy

USPHS	United States Public Health Service
VA	Veteran's Administration

Attachment 2

HOW TO COMPLETE A MEDICAL EVALUATION BOARD PACKAGE

A2.1. **MEB Clerk Responsibilities.** When an MEB is anticipated, the MEB clerk should ensure an LOD is completed and attached. Verify separation or retirement date and request a physician obtain medical hold from HQ AFPC/DPAMM if the active duty member is within 60 days of ETS or DOS. Contact the appropriate ARC medical facility prior to initiating MEB processing when the individual is a member of the ARC. For ANG members, ANG/DP is the approval authority for medical hold. Obtain all health records, including dental records if needed. Request records held by the Veteran's Administration if applicable. Notify member of impending MEB and advise member to report to the Family Support Center for Pre-Separation Transition Assistance Counseling as per AFI 36-3022, *Transition Assistance Program*, Paragraph 2.9. Notify physician conducting the board of time constraints. Notify MEB members of date, time, and place of the board. Notify member's commander of leave and TDY restrictions. Ensure a 4-T profile is sent to the military personnel flight.

A2.1.1. Additional Responsibilities for Imminent Death Processing. When it is determined that a member's death is imminent, the MEB clerk should notify the PEBLO, the Casualty Assistance Representative, and the Mortuary Services Officer to brief the member or the next of kin immediately. The member or next of kin then request expeditious processing through the AF DES. (See AFI 36-3212, Attachment 2)

A2.2. **AF Form 618, *Medical Board Report*.** The proceedings of the MEB, reviewed and signed by the appointing authority and acknowledged by the evaluee are reported on AF Form 618. All AF Form 618 items must be completed. An entry of "NA" may be used for items which are not applicable. Any erasures or significant changes must be initialed by a board member or the reviewing authority.

A2.2.1. **Instructions for completing the AF Form 618.**

A2.2.1.1. **Item 1. Installation at Which Convened.** Identify the MTF where the MEB was convened.

A2.2.1.2. **Item 2. Date Convened.** State the exact date the MEB convened and not the date the AF Form 618 is typed.

A2.2.1.3. **Item 3. Name.** Give last name, first name, and middle name or middle initial of the evaluee.

A2.2.1.4. **Item 4. Grade.** For USAF and USN members, abbreviate the proper grade (E5, O3, etc.). For USA members add the member's corps (SSgt, Ord; Capt, Inf; etc.).

A2.2.1.5. **Item 5. SSN.** Enter social security number. If not otherwise available, it may be obtained from the evaluee's servicing military personnel flight.

A2.2.1.6. **Item 6. Component.** Enter Reg AF, ANG, or AFRC for Air Force Regular, Air National Guard, or Reserve Components, and similar abbreviations for US Army and Navy counterparts.

A2.2.1.7. **Item 7. Department of Service.** Enter USAF, USA, USN, USMC, NOAA, USPHS or USCG. For members of a foreign military service, the nation is shown. For example, French AF, etc.

A2.2.1.8. **Item 8. Organization.** Enter the military organization to which the evaluee is assigned and its location, e.g., 347th CRS, Moody AFB GA. Avoid nonstandard abbreviations.

A2.2.1.9. **Item 9. Sex.** Enter "M" for male or "F" for female.

A2.2.1.10. **Item 10. Date of Birth.** Enter year, month, and day of birth. For example, 2000 Jan 25.

A2.2.1.11. **Item 11. Age.** Enter age at last birthday in years only.

A2.2.1.12. **Item 12. Separation and Retirement Date.** Enter the evaluee's established nondisability separation or retirement date. Secure it from the evaluee's services MPF. Enter "NA" or "none" if none has been established.

A2.2.1.13. **Item 13. Hospital Initially Admitted.** Enter the name and location of the hospital to which the evaluee was first admitted due to the condition for which he or she is being evaluated by the MEB. If the same as Item 1, enter "NA."

A2.2.1.14. **Item 14. Transferred From.** If transferred as an inpatient or outpatient from another hospital, enter the name and location of that hospital. If that hospital is the one identified in Item 13, enter "Same as Item 13." If not transferred, enter "NA."

A2.2.1.15. **Item 15. Home Address.** This is the permanent address and should not be confused with current military organization or current mailing address. For ARC members include the home, military duty section, and civilian work section phone numbers here also.

A2.2.1.16. **Item 16. Military Occupational Specialties.** Enter title and number for primary and secondary Air Force Specialty Codes (AFSC). If not otherwise available, obtain from the servicing MPF. If no secondary AFSC, list primary only.

A2.2.1.17. **Item 17. Total Years' Military Service.** Separate active service from inactive service. Show in years and in fractions of years. For example: 3 years 5 months will be shown as 3 5/12.

A2.2.1.18. **Item 18. Date Entered Active Duty Current Tour.** This is the date from which the member has been on continuous duty without a break in service, or the date a member of a Reserve component entered the current period of active duty orders.

A2.2.1.19. **Item 19. Aeronautical Rating.** Do not abbreviate. Enter "NA" if none.

A2.2.1.20. **Item 20. On Flying Status on Admission.** This item is to indicate if an evaluee with an aeronautical rating or designation was on flying status when admitted to the hospital. Temporary removal from flying duty (DNIF, or duty not involving flying) is not removal from flying status. If temporary removal from flying status led to permanent removal from flying status, permanent removal or suspension will have been certified by proper authority.

A2.2.1.21. **Item 21. Date Relieved from Flying Status.** If the evaluee has an aeronautical rating (Item 19) and is now on flying status (Item 20), enter the date relieved from flying status. If no aeronautical rating, enter "NA."

A2.2.1.22. **Item 22. Applicable Directives and Purpose.**

A2.2.1.22.1. **Column A. Directives:** AFI 48-123 and this instruction are specified for all cases. The Manual for Courts Martial is utilized for sanity cases. DFAS-DSM 177-373 is specified for mentally incompetent members.

A2.2.1.22.2. **Column B. Purpose:** Check "Continued Active Duty" for members on active duty when separation, discharge, or retirement for nondisability reasons is not pending. Check "EPTS" when a defect existed prior to service and is the principal reason for the MEB. Check "Other" and enter "Sanity" or "Competency" for a sanity or competency case. Enter "ANG Duty" or "AFRES Duty" If the evaluee is a member of one of these components and is not eligible for disability processing under this instruction.

A2.2.1.23. **Item 23. Diagnosis and Findings.** These appear in Column A of Item 23. List all diagnoses which contribute or may contribute to disqualification for worldwide duty. Use terminology in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD 9-CM), the current Diagnostic and Statistical Manual of Mental Disorder (DSM). Administrative LOD.

A2.2.1.24. **Item 24. Sanity Determination.** Complete for sanity cases only.

A2.2.1.25. **Item 25. Actions Recommended by Board.** Enter only "Return to Duty," "Refer to PEB," or "Disposition Under Other Directives."

A2.2.1.26. Ite**m 26. Board Members.** Each member of the MEB signs the original AF Form 618. In sanity or competency cases, place a check mark after the signature of the board member(s) who is/are a psychiatrist(s).

A2.2.1.27. **Item 27. Minority Report.** If the board recommendation is not unanimous, "Yes" is checked and the minority report with substantiating rationale is entered on the reverse side of AF Form 618 or on an attached sheet. For unanimous recommendation, check "No."

A2.2.1.28. **Item 28. Hospital Commander or Designee.**

A2.2.1.29. **Item 29.** Except in mentally incompetent or deleterious cases, the findings and recommendations of the medical board and any subsequent changes by the review authority are explained to the evaluee. The evaluee is also advised that if exception is taken to the narrative summary, findings, or recommendation of the medical board, three work days will be allowed to prepare a letter of exception, which will be attached to the board report forwarded to HQ AFPC/DPPAM or HQ AFPC/DPPDS. By completing A, B, and C of Item 29, the evaluee acknowledges that he or she has been informed of the findings and recommendation of the board and of the option to submit a letter of exception. The MEB recorder signs opposite the footnote below Item 29 to show that he or she has thoroughly briefed the evaluee on the findings, recommendation, and options referenced above. If the evaluee is unable, refuses, or is not available to sign AF Form 618, enter "Signature Unavailable" or "Refuses to Sign" in Item 29B and explain circumstances on the reverse of AF Form 618 with signatures of two additional witnesses to the evaluee's briefing and refusal to sign.

A2.3. **Actions Following the MEB.**

A2.3.1. After the MTF commander or physician designee, if commander is not a physician, reviews and approves the MEB report, the MEB recorder or PEBLO ensures the evaluee has an opportunity to read the MEB report and narrative summary and assists the evaluee in resolving any questions concerning the content of the report and summary. The PEBLO advises the evaluee that he or she may submit a signed statement within three work days for consideration by the disposition authority if the evaluee takes exception to the content of the board report or narrative summary. The original narrative summary will not be altered in any way at the member's request without the unanimous agreement of the member's treating physician, all MEB members and the reviewing authority. The PEBLO obtains evaluee's signature on AF Form 618 acknowledging understanding. Within five work days after the reviewing authority signs, the PEBLO forwards the completed MEB package (original and three copies) to HQ AFPC for active duty members or (original and four copies) to the appropriate ARC/SGP for ARC members.

A2.3.2. If the evaluee has been determined to be incompetent (Items 22 and 23 of AF Form 618), or the case has been designated deleterious (AF Form 1172, *Certificate of Medical Officer*), the MEB recorder or PEBLO addresses the above mentioned actions to the evaluee's next of kin (NOK) or legal guardian, who is entitled to the same rights, privileges, and counseling benefits as the evaluee.

A2.3.3. When incompetency is determined, additional copies of AF Form 618 are distributed to accounting and finance authorities. This must be done without delay. Failure to safeguard the pay of members declared mentally incompetent to manage their own affairs has caused serious hardship to members and their families. Send copies to: SFAS-CL/ROC, P.O. Box 99191, Cleveland, OH 44199-1126.

A2.3.4. **Content and Distribution of the MEB Package.**

A2.3.4.1. AF Form 618, with attachments, is assembled into five sets (six for ARC members) and distributed as indicated below.

A2.3.4.1.1. **Original Set:**

A2.3.4.1.1.1. AF Form 618 (original)

A2.3.4.1.1.2. Evaluee's letter of exception (original)

A2.3.4.1.1.3. Commander's letter

A2.3.4.1.1.4. AF Form 1185, Statement of Record Data

A2.3.4.1.1.5. SF Form 502, *Medical Record – Narrative Summary* (Clinical Resume)

A2.3.4.1.1.6. Consultation or special studies relevant to case (original copies)

A2.3.4.1.1.7. Copy of SF 88, *Report of Medical Examination* (from original induction physical)

A2.3.4.1.1.8. Copy of SF 93, *Report of Medical History* (from original induction physical)

A2.3.4.1.1.9. AF Form 348 or NGB 348, *Line of Duty Determination*, or DD Form 261, *Report of Investigation Line of Duty and Misconduct Status* (with all exhibits attached), when LOD applies. (The appropriate LOD form is required for all ARC members undergoing disability processing). For ANG, NGB 348 must be signed by ANG/SGP.

A2.3.4.1.1.10. AF Form 1172, *Statement of Medical Officer*, if deleterious

A2.3.4.1.1.11. NOK information, if mentally incompetent or deleterious case, include name, address, relationship, and whether advised or not advised that the case is being referred to the PEB, and available or not available for PEBLO counseling. Following PEB action, if NOK is not known or cannot be contacted, provide a complete summary of all attempts made to identify or contact the NOK.

A2.3.4.1.1.12. Copy of AF Form 618 from prior MEB convened under AFM 177-373 to determine competency, if one had been convened and there has been no change in the evaluee's mental status since that board was convened.

A2.3.4.1.1.13. All current health records (required for PEB adjudication, AFRES and ANG personnel)

A2.3.4.1.1.14. If an enlisted evaluee has served on active duty in a grade higher than current grade, send a copy of the promotion (to the higher grade) order, document authorizing demotion and the last four enlisted performance reports.

A2.3.4.1.1.15. Copies of military orders placing the ARC member in a military duty status at the time of the injury, illness, or disease. If military orders are not available, then a statement signed by the member's commander verifying that the member was ordered to military status by competent military authority at the time of the onset of the member's medical condition is required.

A2.3.4.1.1.16. Request for VA bed designation stating possible duration of hospitalization, if VA hospitalization is indicated

A2.3.4.1.1.17. Personnel Rip for ARC members

A2.3.4.1.1.18. Supporting civilian medical documentation for ARC members

A2.3.4.1.1.19. Other items as necessary.

A2.3.4.1.2. **Sets 2, 3, and 4:**

A2.3.4.1.2.1. AF Form 618 (copy)

A2.3.4.1.2.2. Evaluee's letter of exception

A2.3.4.1.2.3. Commander's letter

A2.3.4.1.2.4. AF Form 1185

A2.3.4.1.2.5. SF 502

A2.3.4.1.2.6. Consultation or special studies relevant to the case

A2.3.4.1.2.7. SF 88 and SF 93

A2.3.4.1.2.8. AF Form 1172, if needed

A2.3.4.1.3. **Set 5 (MTF Copy):**

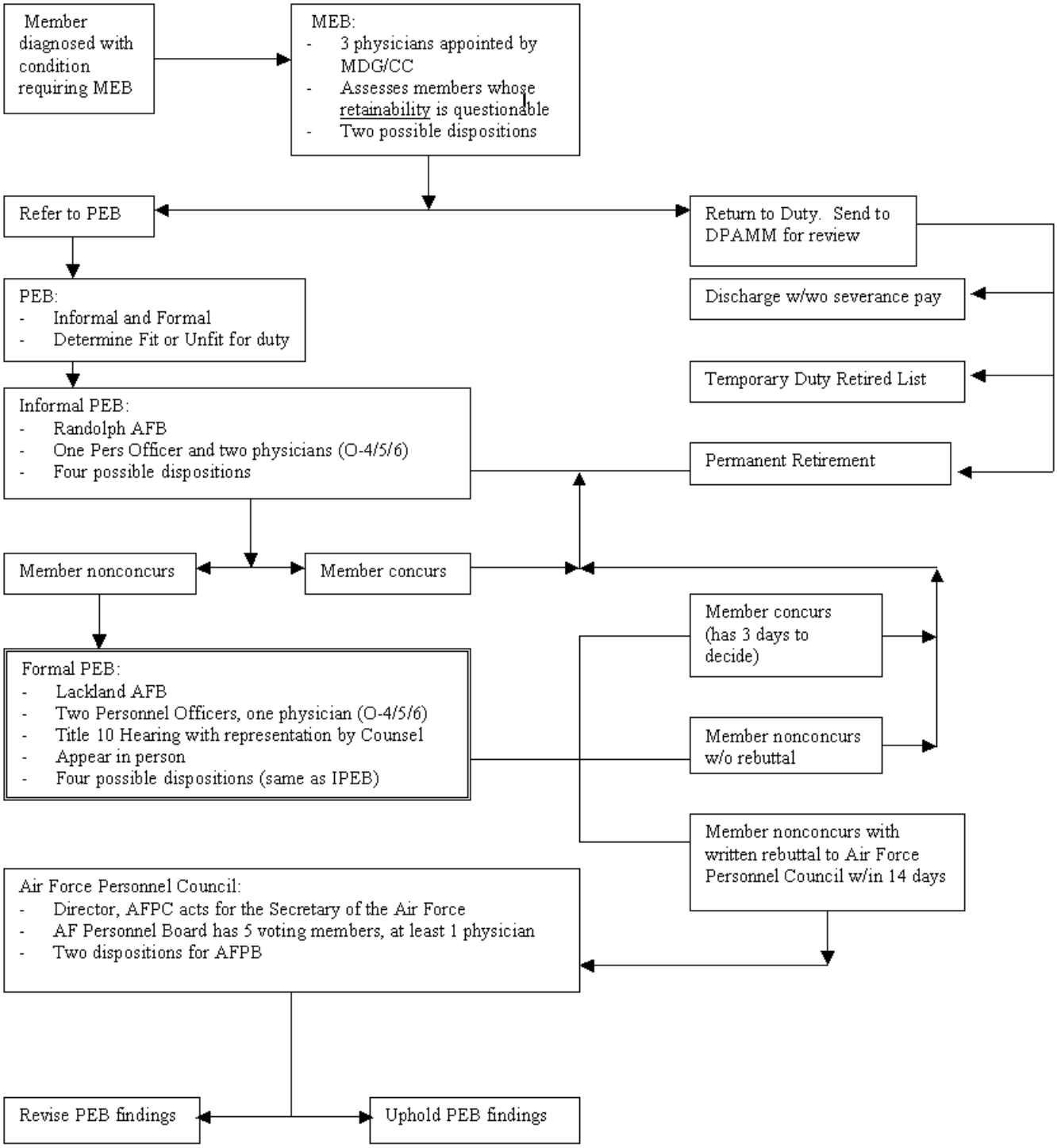
A2.3.4.1.3.1. Same as Sets 2, 3, and 4 with any additional items desired by the MEB, recorder, or PEBLO

A2.3.4.1.4. **Set 6 (ARC/SGP Copy)**

A2.3.4.1.4.1. Same as Set 1. Do NOT make copies of the military medical record

Attachment 3

MEB Flow Chart



Attachment 4

MEB Processing Timeline