CHAPTER 1

MEDICAL CLASSIFICATION OF CANDIDATES

INTRODUCTION

1.1 A high level of medical fitness is a fundamental requirement for entry to and retention in the Australian Defence Force (ADF). Members who cannot meet the ADF medical fitness standards may jeopardise the safety of others, unfairly necessitate the performance of their duties by others or negatively impact operational effectiveness.

1.2 Members need to be medically capable of participating in arduous training and operational tasks, and performing inherently dangerous tasks in challenging environments. When assessing candidates, medical officers (MOs) are responsible for:

a. considering the inherent requirements of military service

b. assessing candidate medical fitness for service

c. allocating a recruiting medical classification based on each candidate's medical suitability for recruitment into the ADF.

1.3 Defence Force Recruiting (DFR) is responsible for the medical assessment of ab initio candidates to determine medical fitness for service in the ADF. The Services are responsible for the medical assessments of lateral transfer candidates. Garrison Health (GH) is responsible for the medical assessments of in-Service transfer candidates.

Aim

1.4 This chapter describes the recruiting medical classifications that apply to ab initio candidates, in-Service transfer candidates and lateral transfer candidates.

Scope

1.5 This chapter primarily applies to health personnel in DFR who are involved in the medical assessment of candidates on initial entry or re-entry into the ADF.

1.6 For in-Service transfer candidates and lateral transfer candidates, the medical assessment process is to comply with the principles of this chapter; however, the primary policy and procedures for these assessments is in Defence Health Manual (DHM) Level 2 Part 5 Chapter 3[1]—'Entry of candidates with previous military service'.

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POLICY

REQUIREMENTS OF SERVICE

Military duties

1.7 For information on the inherent requirements of service in the ADF and individual readiness, see:

a. Military Personnel Policy Manual (MILPERSMAN) Part 2 Chapter 1[2]—'Inherent requirements of service'

b. MILPERSMAN Part 3 Chapter 1[3]—'Individual readiness'.

1.8 Military duty often involves lengthy periods under operational conditions in extremes of climate, with minimal medical and dental support. In such conditions, sleep and rest periods may be severely curtailed or interrupted, and personnel may be subjected to excessive noise and other adverse environmental stressors.

1.9 Members must be able to contribute fully to the delivery of decisive combat capability in the right place and at the right time. Therefore, members in all service categories (SERCAT) and of all ranks must be medically fit to:

a. complete arduous training during initial entry courses and on an ongoing basis throughout their careers

b. be fitted with equipment appropriate to their likely tasks

c. perform general military duties and all of the duties of their primary occupation under the arduous physical and mental stresses associated with armed conflict

d. be ready and able to deploy at short notice on operations and exercises both in Australia and overseas

e. meet requirements for sudden and unusual deployments, perhaps in roles or environments for which they have little or no specific training or preparation.

Operational requirements

1.10 Although all members are required to acquire and maintain military skills, the operating environments of the Navy, Army and Air Force differ significantly. The

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medical requirements for operational service in the Navy, Army and Air Force are in annexes 1A, 1B and 1C.

Specialist requirements

1.11 Members in specialist occupations are also required to acquire and maintain specialist skills. The medical requirements for specialist occupations are in:

a. DHM Level 2 Part 5 Chapter 6[4]—'Health requirements for aviation-related occupations'

b. DHM Level 2 Part 5 Chapter 7[5]—'Health requirements for divers'

c. DHM Level 2 Part 5 Chapter 8[6]—'Health requirements for submariners'.

MEDICAL FITNESS FOR SERVICE

1.12 There are medical conditions which allow an individual to be physically fit in terms of their functional capacity for work, but which do not satisfy the medical fitness requirements for ADF operational or training conditions. This distinction is important when assessing each individual's suitability for military duties.

1.13 MOs must carefully assess the medical fitness of Defence candidates with a view to the factors identified in this section. If a DFR MO has concerns about an ab initio candidate's medical suitability for enlistment or appointment, the DFR MO is to seek advice from the Chief Medical Officer (CMO) DFR. Defence GH MOs who have concerns about in-Service or lateral transfer candidates are to seek advice in accordance with DHM Level 2 Part 5 Chapter 3.

1.14 The same enlistment medical standards apply to candidates applying for service in all SERCATs, as all members are expected to perform the same duties and achieve the same readiness requirements. For information on occupational medical standards and reasons for rejection, see:

a. DHM Level 2 Part 5 Chapter 4[7]—'Occupation-specific medical standards'

b. DHM Level 2 Part 5 Chapter 5[8]—'Causes of and reasons for rejection'.

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Functional capacity or disability

1.15 All members are expected to perform daily physical activities. MOs must consider the ability of the individual to perform the physical tasks required. In the medical assessment of the candidate, emphasis must be placed on functional capacity rather than on anatomical form or pathological abnormality. MOs must:

a. identify and note any medical condition that can hinder such activities, as it may be a cause for rejection

b. identify and note minor functional impairment that may deteriorate under the conditions of Defence service.

1.16 When noting medical conditions and functional impairments, MOs must refer to the relevant annex and serial of DHM Level 2 Part 5 Chapter 5.

Clothing and equipment

1.17 Service in the military is an active occupation and requires specific work wear. Defence mandates the wearing of particular footwear and outerwear by members, including a standard backpack. There is little discretion over what is worn or carried. Members must also be able to wear personal protective equipment under specific conditions to protect them from hazards.

1.18 MOs must identify and note any requirement for special clothing or equipment, as this may affect fitness for entry or suitability for military service.

Potential harsh living and climatic conditions

1.19 Conditions, including working and living accommodation and rations, are subject to variation throughout operational environments, particularly in times of war. Defence candidates must be capable of operating efficiently and effectively in potentially harsh living conditions, often exposed to inclement weather conditions for extended periods.

1.20 The climate in the field of operations may contribute to or aggravate some medical conditions. For example, many dermatological conditions are aggravated in hot or tropical environments. While most operations within Australia and its environs will be in tropical conditions, the effects of a cold environment must not be overlooked in any assessment.

1.21 Individuals are expected to be capable of prolonged physical activity, in extremes of environmental conditions for extended periods of time.

Safety

1.22 Members need to be able to perform their tasks without detriment to the safety and welfare of themselves or others. MOs must consider the following factors when assessing whether a Defence candidate with a particular medical condition is suitable for Defence service:

a. whether the functional capacity or health of the individual is dependent on uninterrupted access to medications, special dietary concessions, aids or equipment

b. whether the condition is prone to sudden deterioration (which raises issues of the individual's health, evacuation burden, loss of skills or capability to the mission, adverse threat to mission completion and availability of specialist medical treatment)

c. whether the environmental conditions under which the individual will work can be expected to aggravate an existing condition (occupational health and safety and duty of care principles)

d. whether the condition poses a risk to co-workers in the unique ADF workplace (ie the operational field environment) such as is the case with infectious diseases

e. whether the condition precludes any part of the necessary pre-operational preparation (note: all members must be vaccinated as part of their initial entry requirements and currency must be maintained during ADF service as per DHM Level 2 Part 8 Chapter 4[9]—'Vaccinations manual')

f. whether there is a risk of sudden or subtle incapacitation in an individual and the consequences of this.

Degree of medical support

1.23 Under operational conditions, medical support will be in high demand and relatively limited in extent. Sophisticated medical facilities within field operations are needed for operational casualties. Individuals who anticipate a career in Defence must, therefore, be free from any medical condition that is potentially capable of consuming health assets in an operational setting.

Physical fitness

1.24 Physical fitness is an important predictor of successful completion of military training. Therefore, assessing the physical fitness of candidates is an important component of the medical assessment process.

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1.25 High standards of physical fitness are necessary for members to carry out operational tasks. With the increasing focus on short notice deployments, all members must be capable of achieving and maintaining a prescribed level of physical fitness and operational preparedness. See annexes 1A, 1B and 1C for Service physical fitness standards.

Mental health

1.26 The initial and ongoing training demands, the nature of operations, and the variability of environments and threats require personnel to commence with, and maintain, a high level of medical and psychological fitness throughout their Service life.

1.27 The social and professional support available to an individual will vary frequently due to postings, training and deployments. Therefore, personnel require sound individual coping strategies on entry. Accordingly, there should be no indication of poor coping in the past 12 months, or unresolved trauma.

CLASSIFICATION SYSTEM

Recruiting medical classification

1.28 Recruiting medical classifications are a management tool that supports the administration of candidates. DFR MOs are responsible for allocating a recruiting medical classification to each candidate who is medically assessed for ADF entry. Defence MOs are to apply these classifications in assessments of in-Service transfer candidates and lateral transfer candidates.

1.29 The recruiting medical classifications are:

a. **Class 1.** Candidates who meet the medical fitness standards for entry to a specific occupation or Service.

b. **Class 2.** Candidates who do not meet the medical fitness standards required for Class 1, but may be appointed or enlisted subject to an approved waiver.

c. **Class 3.** Candidates who are temporarily medically unfit for ADF entry. Class 3 is to be amplified, where possible, with a review date and a sub-classification of:

(1) **Class 3 temporarily medically unfit.** The candidate is temporarily medically unfit due to a medical condition that is remediable and likely to resolve within 12 months. Code 3T is to be applied.

(2) **Class 3 report.** Medical fitness cannot be confirmed due to outstanding medical reports from a health professional considered appropriate to clarify the fitness of a candidate. Code 3R is to be applied.

(3) **Class 3 mandated specialist assessments.** Mandated specialist assessments are required to determine fitness for specialist occupations. Code 3M is to be applied.

d. **Class 4.** Candidates who are medically unfit for a specific occupation or military service. The medical condition(s) must be considered to be permanent, or not likely to resolve within 12 months. For ab initio candidates only, where appropriate Class 4 is to be amplified with a sub-classification of:

(1) **Class 4 questionnaire.** Candidates who are considered unfit on the basis of Form PM165—'Health questionnaire'. Code 4Q is to be applied.

(2) **Class 4 waiver.** Candidates assessed as Class 4 but are identified as suitable for waiver consideration. The code 4W is to be applied.

(3) **Class 4 entry.** Candidates who have completed medical assessment and are considered permanently unfit for any avenue of ADF entry. Code 4E is to be applied.

(4) **Class 4 job.** Candidates who have completed the medical assessment and are considered unfit for a specific Defence job, but may be fit for others. Code 4J is to be applied.

PULHEMS profile

1.30 For Army candidates, examining MOs must complete the PULHEMS profile (see Appendix 1B1) in addition to allocating a recruiting medical classification.

Military employment classification

1.31 The recruiting medical classification is used for recruitment purposes and is applied to ab initio, lateral transfer and in-Service transfer candidates. The assessing MO must also recommend a military employment classification (MEC) on Form AD363—'Medical attestation declaration', Form PM532—'Military employment classification (MEC) advice' or Form PM166-2—'Confirmation of medical fitness'. Form PM532 for in-Service transfer candidates is to be sent to MPB Employment Category Transfers[10].

1.32 Once a candidate has been enlisted or appointed in the role they have been assessed for, the receiving garrison health facility is to apply a MEC and, if relevant specialist employment classification (SPEC) to each member in accordance with MILPERSMAN Part 3 Chapter 2[11]—'Military employment classification system'.

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ALLOCATION OF RECRUITING MEDICAL CLASSIFICATION

Documenting and notifying decisions

1.33 The medical decision-making process must be transparent so that decisions can be reconsidered or reviewed when requested by a candidate or during the investigation of a complaint. MOs are to document the reason for decisions and notify the candidate of the decision, reason(s) and right of review. See DHM Level 2 Part 5 Chapter 2[12]—'Medical history and examination'.

1.34 Each candidate is to be provided with written confirmation of the medical classification and the reason(s) for the decision. For Class 3 or 4 candidates, MOs must also provide written advice about the candidate's right to request a review of decision (see DHM Level 2 Part 5 Chapter 9[13]—'Review of recruiting medical classification decision').

Change to classification

1.35 The recruiting medical classification allocated to a candidate may change during the medical assessment process. This may be due to receipt of further medical information, a differing opinion from the confirming authority, the outcome of an application for a waiver of medical standard, or a formal review of the decision.

1.36 MOs must document all changes to recruiting medical classification, including the reasons for the revised classification (see DHM Level 2 Part 5 Chapter 3 for ab initio candidates and DHM Level 2 Part 5 Chapter 3 for in-Service or lateral transfer candidates).

Confirming authorities

1.37 Medical examinations for specialist occupations require confirmation by the confirming authority. The confirming authorities are:

a. Commanding officer (CO) Institute of Aviation Medicine (IAM) (or MO delegate if CO IAM is not a registered medical practitioner) for the aviation-related occupations listed in DHM Level 2 Part 5 Chapter 6

b. Senior medical adviser – diving medicine and senior medical adviser – submarine medicine for all diver and submariner candidates (see DHM Level 2 Part 5 Chapter 7 and DHM Level 2 Part 5 Chapter 8).

1.38 If the confirming authority is in doubt as to a candidate’s suitability for enlistment or appointment, advice should be sought from the CMO DFR for ab initio

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candidates and from the relevant Service's senior medical adviser (SMA) for in-Service or lateral transfers.

WAIVER OF MEDICAL STANDARD

1.39 A waiver system is in place to allow the entry of candidates who do not meet entry level medical standards but who may represent an acceptable risk to the ADF. Waivers are designed to provide some flexibility when dealing with medical standards to maximally benefit the ADF. Candidates must be MEC 1 for entry unless a waiver is approved.

1.40 The Service career/personnel management agencies (CMA/PMA) are the authority for waiver determinations unless either of the following apply:

a. the Services have provided a delegation to CMO DFR, SMA diving medicine (or delegate), SMA submarine medicine (or delegate), CO IAM (or delegate), or the relevant lateral transfer medical adviser

b. for the Regional Force Surveillance List, the delegation rests with the unit commanding officer under Army Standing Instructions (Personnel) (ASI (P)) Part 7 Chapter 7[14]—'Regional force surveillance list personnel and training policy' (each time the waiver delegation is exercised, the unit CO is to notify the senior medical officer of the supporting joint health unit so there is visibility of members with potentially elevated clinical risk).

Standing waiver for specific conditions

1.41 The Services have authorised CMO DFR (or delegate), SMA diving medicine (or delegate), SMA submarine medicine (or delegate), CO IAM (or delegate) or the relevant lateral transfer medical adviser to permit ADF entry for candidates who are up to MEC J22 with any of the following employment restrictions:

a. 4–1: requires access to pharmaceutical resupply

b. 4–2: requires access to medical logistics support; requires access to pharmaceutical resupply or medial logistics support whilst deployed or at sea

c. 4–3: requires periodic access to specialist care

d. 4–4: requires pre-deployment medical officer review

e. 4–11: requires periodic MO review (additional text required to specify periodicity)

f. 4—12: refer to J07 for clearance for operational deployment.

[14] http://drnet.defence.gov.au/Army/EMPA/ASI/Pages/Overview.aspx

1.42 SMA diving medicine's delegation is for DFR candidates applying for a SPEC D role and is to permit ADF entry for candidates up to MEC J22, SPEC D2.

1.43 SMA submarine medicine's delegation is for DFR candidates applying for a SPEC S role and is to permit ADF entry for candidates up to MEC J22, SPEC S2.

1.44 CO IAM delegation is for DFR candidates applying for SPEC A/C roles and is to permit ADF entry for candidates up to MEC J22, SPEC A2/C2 with restrictions as above and additional employment restrictions as below:

a. 6—1: To wear and carry a spare pair of corrective spectacles when flying

b. 6—2: To wear contact lenses or corrective spectacles when flying and carry a spare pair of corrective spectacles

c. 6—3: May perform unrestricted flying duties when taking ADF-authorised medication

d. 6—4: Restricted to flying duties in aircraft types as specified (must be defined in additional text)

e. 6—13: Unfit for airborne air combat officer-air battle manager duties but fit for ground-based air combat officer-air battle manager duties (Royal Australian Air Force air defence officers only).

1.45 For candidates with asthma, the Services have authorised CMO DFR to permit ADF entry as part DHM Level 2 Part 5 Chapter 5 Annex 5B and its subordinate appendices.

Requesting a waiver

1.46 The senior military recruiting officer (SMRO), recruiting liaison officer (RLO), CMA/PMA or MO can request a waiver. Although SMRO, RLO or CMA/PMA may discuss the suitability of a candidate with health personnel, disclosure of health information is to be consistent with the privacy notice in the Form PM165, signed or electronically acknowledged by the relevant candidate.

1.47 For a waiver to be considered, generally the candidate must be medically fit for operational deployment and the medical condition must meet the following criteria:

a. it must not pose an increased risk to completion of the ADF mission

b. it must not pose an increased risk of sudden incapacitation to the individual

c. it must not pose any potential risk for subtle incapacitation that might not be detected by the individual but would affect alertness, special senses, or information processing

d. it must be stable at the time of the waiver

e. if the possibility of progression or recurrence exists, the first signs must be easily detectable and cannot, of themselves, pose a risk to the individual or the safety of others

f. requirement for medical care cannot interfere in initial training requirements or pose a significant increased risk to training failure, and must be compatible with deployed health support available

g. there must be minimal likelihood of exacerbation during recruit or initial officer training, initial employment training, unit physical training, or during ADF service.

1.48 For ab initio candidates, CMO DFR is to provide a health risk assessment and recommendation on each waiver to the relevant CMA/PMA delegate. For specialist employment stream candidates, the waiver recommendation is to include the confirming authority's medical opinion on the candidate's suitability for waiver.

1.49 For in service or lateral transfer candidates, DHM Level 2 Part 5 Chapter 3 provides the process for medical waivers.

REVIEW OF DECISION

1.50 A candidate who is Class 3 or Class 4 may submit a request for review of decision. DHM Level 2 Part 5 Chapter 9 provides policy on the review of decision for general entry candidates. Information for the review of decision for other forms of entry are in:

a. for specialist occupations: DHM Level 2 Part 5 Chapter 6, DHM Level 2 Part 5 Chapter 7 and DHM Level 2 Part 5 Chapter 8

b. for in-Service or lateral transfers: DHM Level 2 Part 5 Chapter 4.

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Annexes:
1A Medical considerations – Navy candidates
1B Medical fitness standards – Army candidates
1C Medical considerations – Air Force candidates

ANNEX 1A

MEDICAL CONSIDERATIONS – NAVY CANDIDATES

INTRODUCTION

1. Members of the Royal Australian Navy must be medically fit for normal seagoing service. This annex details the medical considerations associated with seagoing deployment.

SHIPBOARD DUTIES

2. Work requirements at sea are substantially different to those ashore. As all officers and sailors undertake seagoing duties to varying extents, a high degree of multi-skilling is required by all Navy members. Typical duties associated with seagoing duties are:

a. boat transfers from ship-to-ship, ship-to-shore, or vice versa, often in heavy sea states

b. handling heavy lines for mooring alongside, or during replenishments at sea

c. manual stores handling, often in confined spaces with the concomitant risk of injury in heavy sea states

d. damage control exercises and incidents, typically while wearing breathing apparatus with or without thick and heavy protective clothing

e. casualty movement during exercises and real incidents

f. data console monitoring (eg in machinery spaces or operations rooms) for prolonged periods.

3. Navy members can expect a high degree of sleep deprivation and fatigue associated with physical or psychological stress as all members of a ship's company share the same level of risk whether operating during peacetime or high intensity combat operations.

OPERATIONAL ENVIRONMENT

Geographical isolation

4. This not only refers to long distances from shore (up to 2000 nautical miles), but to visits to ports and other locations where local health services are often either non-existent or do not meet Australian standards.

Prolonged deployment absences

5. Most Navy members will be posted to a fleet unit for two to three years at a time approximately every five years. During this period they can be expected to be at sea for up to eight months of the year and/or on deployment for up to six months at a time.

6. While at sea, social and psychological support is limited to that which can be provided by the onboard health support (see below), supervisors or chaplain (if carried). Members who are likely to require more than this level of social or psychological support are, therefore, not fit for normal seagoing service or entry to the Navy.

Health support

7. Members who are at risk of sudden incapacitation and/or require frequent and complex monitoring or treatment of chronic conditions are not fit for normal seagoing service.

8. **Medical support.** Depending on the class of ship, medical support is limited to basic first aid by a non-medical sailor, advanced first aid by a junior medical sailor, or paramedical care by a senior medical sailor. Medical, nursing and dental officers are not routinely available on all ships at sea. This means that members who require frequent access to general practitioner care are not fit for normal seagoing service.

9. **Health logistic support.** Navy health logistic support is limited to the Maritime Health Logistics Instruction and Medical Allowance List[15] (MAL), which varies according to the class of ship. The MAL is designed only to provide:

a. routine treatment for minor conditions

b. short-term treatment for self-limited acute conditions

c. initial treatment of acute emergencies prior to evacuation

d. initial treatment of mass casualties brought about by accident or enemy action.

10. **Medical evacuation.** Medical evacuation from sea is difficult and may be delayed for up to 72 hours by weather, boat/aircraft availability, or distance from hospital. Members with a high likelihood of requiring evacuation for medical reasons are, therefore, not fit for normal seagoing service.

15 http://drnet/navy/FLD/FleetHealth/materielmanagement/Pages/currentmal.aspx#Current%20Medical%20Allowance%20List%20(MAL)

Living conditions

11. Living conditions at sea can be arduous, requiring a high degree of psychological maturity and tolerance of others. Although not a specific medical issue, members who may lack maturity or tolerance should be considered temperamentally unsuited for normal seagoing service pending further psychological or psychiatric assessment. Factors to consider related to living conditions include:

a. sleeping accommodation often involves three-tiered bunk accommodation for up to 30 people in confined spaces, with little or no privacy

b. hygiene facilities are often constrained by fresh water shortages, and many minor war vessels lack laundry facilities

c. ships are provisioned for up to several months at a time, with no scope for medically-prescribed or allergy-related special diets

d. there is limited space available for recreation

e. personnel live in close proximity to the workplace and co-workers for up to several months at a time, with no scope to avoid either while at sea.

Working conditions

12. **Confined space.** Navy members are exposed to generally confined workspaces, with access via large and heavy steel doors and hatches, the latter having to be opened or closed while climbing up or down steep ladders. Members with medical or physical conditions that limit their ability to function in confined spaces or to use ladders are not fit for normal seagoing service.

13. **Anaerobic fitness.** There are limited opportunities for physical exercise at sea; however, a high level of anaerobic fitness is required for damage control activities, manual stores handling, line handling and boat transfers.

14. **Sea states.** Heavy sea states increase the risk of injury from slips and falls while moving around the ship. Members are not fit for normal seagoing service if they either:

a. have a medical condition that precludes their safe movement in and about the ship in heavy sea states

b. suffer motion sickness for longer than 24 hours at a time, to the point where it is incapacitating and/or requires medical intervention.

15. **Working days.** Working days may extend for periods of up to 12 to 16 hours, with irregular or short work/rest schedules with the likelihood of significant sleep deprivation and fatigue over time. Members with medical conditions that are exacerbated by fatigue are not fit for normal seagoing service.

16. **Damage control.** The work associated with damage control and damage control training is physically and psychologically demanding. Members with medical or physical conditions that limit their ability to participate in damage control exercises and incidents are not fit for normal seagoing service. All Navy members undergo damage control training, including floods, fires, toxic gas and chemical, biological, radiological and nuclear (CBRN) incidents. Navy members need to be able to:

a. fight floods, which entails carrying, cutting and positioning heavy timbers

b. fight fires, which involves wearing breathing apparatus (which weighs over 20 kilograms), with or without thick and heavy protective clothing

c. respond to toxic gas incidents, which requires the wearing of breathing apparatus while evacuating casualties through narrow doors, small hatchways and steep ladders

d. respond to CBRN incidents, which entails the use of total facemasks, gloves and protective clothing.

17. **Heat and cold stress.** Heat stress is a particular problem in tropical environments, especially when protective clothing has to be worn for upper deck evolutions and boarding operations. Cold stress is an issue for normal operations off the southern Australian coast as well as in the sub-Antarctic. Members with medical conditions that are exacerbated by heat or cold are not fit for normal seagoing service.

18. **Sun exposure.** Notwithstanding precautions against excessive sun exposure, Navy personnel frequently have to work in direct sunlight plus reflected glare, especially in the tropics. Personnel with conditions that are exacerbated by excessive sun exposure are, therefore, unfit for normal seagoing service.

PHYSICAL FITNESS STANDARDS

19. All Navy members are required to meet physical fitness standards annually. Navy policy on physical fitness testing is in Australian Navy Publication 4104-3[16]— ‘Annex 1B – Conduct of the Royal Australian Navy physical fitness test’.

20. Navy physical fitness standards for male candidates are in Table 1A–1. Navy physical fitness standards for female candidates are in Table 1A–2.

[16] http://authoritdppweb/NL/index.htm#7639.htm

Table 1A–1: Minimum physical fitness standards for male Navy candidates

Component for male candidates	Age less than 35	Age 35–44	Age 45–54	Age 55 and over
Flexed arm hang (seconds) (note a)	25	20	15	10
Push-ups (number) (note a)	25	20	6	6
Sit-ups (number)	25	20	15	10
2.4 km run/walk (minutes : seconds)	13:00	15:00	17:00	19:00
5 km walk (minutes : seconds)	42:00	44:00	46:00	48:00
500 metre swim (minutes : seconds)	12:30	13:30	14:30	15:30
Beep test	7.4	6.10	6.4	5.9
Max VO2 (per cent)	37	36.4	34.3	32.9

Note:

(a) Candidates are required to perform either the flexed arm hang or the push-ups.

Table 1A–2: Minimum physical fitness standards for female Navy candidates

Component for female candidates	Age less than 35	Age 35–44	Age 45–54	Age 55 and over
Flexed arm hang (seconds) (note a)	25	20	15	10
Push-ups (number) (note a)	10	7	3	3
Sit-ups (number)	25	20	15	10
2.4 km run/walk (minutes : seconds)	15:00	17:00	19:00	21:00
5 km walk (minutes : seconds)	43:00	45:00	47:00	49:00
500 metre swim (minutes : seconds)	13:30	14:30	15:30	16:30
Beep test	6.9	6.2	5.4	5.0
Max VO2 (per cent)	36	33.6	31	30

Note:

(a) Candidates are required to perform either the flexed arm hang or the push-ups.

ANNEX 1B

MEDICAL FITNESS STANDARDS – ARMY CANDIDATES

INTRODUCTION

1. The Australian Army operates in remote areas with limited access to support services, such as medical, dental, psychological and chaplaincy services.

2. Army members must have no medical impediment to being able to endure the strain and fatigue of field duties and must be fit for duty anywhere. In addition to meeting the medical standards required for their military occupation they must also be able to complete training and successfully perform combat or combat-related duties. In general, personnel applying for entry to the Army will not be permitted to have any medical restrictions.

MEDICAL FITNESS

Physical capacity

3. There must be no medical impediment to endure locomotor strain over several days. Army members must be capable of being trained to undertake a forced march carrying a normal combat load (in excess of 40 kilograms) and personal weapon. Army members must also be capable of performing combat drills during or at the end of the march. They must also be able to run, climb, crawl and swim. Army personnel are required to adapt, overcome and thrive in situations of adversity, risk, complexity and danger.

Military skills and combatant duties

4. During their Defence career, all Army members are required to possess basic military skills and perform combatant duties additional to their specific occupations. They include:

a. carriage and operation of personal weapons

b. wearing personal protective equipment, eg helmets, basic order (to carry ammunition, water and daily rations), ballistic protection, eye protection and hearing protection

c. wearing military footwear and uniform

d. wearing other protective ensembles to deal with chemical, biological, radiological and nuclear (CBRN) threats.

5. Soldiers and officers must be fit enough to survive the rigours of modern military operations and be an effective member of a team. Operational conditions do not differentiate between rank, age or gender. It is fundamental for Army to prepare its personnel physically and mentally to meet the demands of contemporary operations and for the potential rigours of combat.

6. Seemingly minor or trivial medical conditions in the barracks/base environment can rapidly become major medical issues in the deployed environment, sometimes necessitating medical evacuation and the avoidable use of precious resources. Minor or trivial medical conditions may also be exacerbated in the deployed environment due to intense workloads, extremes of weather, sleep deprivation and alteration in diet. Therefore, when assessing a candidate's fitness for entry, the examining medical officer (MO) must be satisfied the candidate is fit for employment and deployment.

Fitness for deployment

7. Work requirements during deployment are substantially different to those in barracks. Typical duties associated with deployment include:

a. carrying heavy loads including combat backpacks for prolonged periods followed by preparation of a defensive position or base camp local defences, such as

(1) setting up tents, hootchies and field latrines

(2) intensive pushing, digging, dragging heavy equipment, climbing and filling of sandbags

b. hard physical work including manual stores handling, frequently in confined spaces with concomitant risk of injury

c. operating in difficult environmental conditions with limited access to washing and fresh drinking water

d. disrupted sleep and meal breaks leading to high levels of fatigue

e. assisting with casualty evacuation (manual carrying of casualties on stretchers) during exercises and real incidents

f. guard duties for prolonged periods with limited breaks

g. many operations are conducted at night

h. exposure to climatic extremes (note: deployments are usually to hot, humid regions but cold exposures can also be an issue, dependent on the locality of the deployment).

Medical support

8. Medical support during deployments may be limited to care provided by a medical assistant. This may vary from basic to advanced first aid depending on the medical assistant's level of training. Although medical, nursing and dental officers deploy, they are not necessarily accessible at all times. During overseas deployments, access to medical care may be extremely limited or non-existent.

9. Limited medical support means that members who require frequent access to general practitioner care, and/or are at risk of sudden incapacitation, and/or require

frequent and complex monitoring or treatment of chronic conditions, present an unacceptable health risk in a deployed environment and are generally considered not fit for Army service.

10. **Medical evacuation.** Medical evacuation from a remote area may be difficult and may be delayed or denied due to weather, aircraft availability, distance from hospital, accessibility and operational priorities. Candidates with a high likelihood that they will require evacuation for medical reasons are, therefore, not fit for Army service.

PULHEMS

11. Army candidates must meet the PULHEMS profile allocated to their employment designation. The acronym PULHEMS is derived from the first letters of the qualities assessed when a medical examination is carried out. The PULHEMS qualities are:

a. **P—Physical capacity.** This refers to a member's general physical development. It includes a member's potential, with training, to acquire a high level of physical stamina, and the capacity for hard work. This quality also embraces general health. In general, Army personnel should have no medical impediment to being able to endure the strain and fatigue of field duties. They should be fit for duty anywhere and should not have any permanent medical conditions. Factors to consider are age, build, strength, stamina, physical attributes and general health.

b. **U—Upper limbs.** This refers to the functional use of hands, arms, shoulders and upper spine and in general the member's ability to handle weapons, to lift and to carry. Those disabilities of the upper limbs which affect general physical capacity also affect assessment under 'P'. Factors to consider are strength, range of movement and efficiency of arms, shoulder girdle and upper back.

c. **L—Locomotion.** This refers to a member's ability to walk, run and lift and refers specifically to the functional use of the lower limbs, hips and lower spine. Those disabilities of locomotion, which affect general physical capacity, also affect assessment under 'P'. Factors to consider are strength, range of movement and efficiency of feet, legs, pelvic girdle and lower back.

d. **H—Hearing.** This quality records a member's unaided hearing acuity only. Diseases of the ear are assessed under P—Physical capacity.

e. **E—Eyesight.** This quality records a member's visual acuity in accordance with the minimal visual requirements (MVR) defined in Defence Health Manual (DHM) Level 2 Part 5 Chapter 4[17]—'Occupation specific – medical

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standards' and DHM Level 2 Part 5 Chapter 5[18]—'Causes of and reasons for rejection'. Diseases of the eyes are assessed under P—Physical capacity.

f. **M—Mental capacity.** This quality reflects a member's ability to learn skills for a specific military employment category. It is assessed at recruiting and only reviewed by psychometric testing following injury or illness that impacts cognitive function.

g. **S—Stability.** This quality reflects a member's mental health stability in the military environment (does not change for simple adjustment, behavioural or personality disorders).

12. Functional interpretation of degrees of each PULHEMS quality is in Appendix 1B1. Candidates for entry to the Army are to meet a minimum PULHEMS standard.

PHYSICAL FITNESS

13. To operate in arduous physical and mental conditions, Army members need to be physically conditioned in accordance with Army Standing Instruction (Personnel) (ASI (P)) Part 8 Chapter 4[19]—'Physical training'.

Basic fitness assessment

14. All Army members in the permanent force and reservists on Service Option C are required to pass the basic fitness assessment (BFA) once every six months. Other Reserve members (dependent on engagement type) may be required to pass the BFA once a year.

15. The minimum BFA standard is in Appendix 1B2. To pass the BFA, a person must achieve at least the minimum BFA pass standard for their age and gender in each activity.

Physical Employment Standards Assessment

16. The physical employment standards assessment (PESA) assesses the capability of individuals to meet the minimum level of physical capacity required by Army members to perform their duties. It is a task-based assessment, which is gender and age neutral. There are two baseline standards:

a. **All-corps (AC).** Based on the requirements of performing a range of basic military tasks including preparing defensive positions, local patrolling, fire and movement and conducting casualty evacuation.

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b. **Combat arms (CA).** Based on the higher physical demands of conducting combat operations, or operating in a high threat environment. This baseline is applied to most combat arms employment categories, but may also be applied for specific roles in support of combat operations.

17. All soldiers must complete the AC standard before completing recruit training at the Army Recruit Training Centre. All Army officer cadets must complete the AC standard prior to graduating from the Royal Military College – Duntroon. Those officer cadets seeking allocation to combat arms corps must attempt the CA standard, with the results taken into consideration during corps allocation.

18. The PESA consists of four core elements, each evaluating a key human performance capacity: weight load management, fire and movement, lift and carry, and box lift.

19. **Weight load march.** This assessment requires members to march a specified distance with a specified load in a specified time. It tests both aerobic power and load carrying capacity. Marching with load is a common military task that is expected of all Army members. This assessment also provides coverage for all other tasks where aerobic power is the dominant capacity limiting performance.

20. **Fire and movement.** This assessment tests anaerobic power and is closely modelled on the physical movement patterns associated with fire and movement. Army members are required to move (in accordance with a cadence track) from a prone firing position to a distance of six metres (m) in five seconds. This process is repeated until the designated number of bounds has been achieved. The test is not designed to be tactically correct, as it requires members to take a knee at the end of each bound as a control measure to limit injury. The standards are as follows:

a. **AC standard.** Based on moving forward under fire into a defensive position.

b. **CA standard.** Based on a 100 m section attack.

21. **Lift and carry.** This assessment tests local muscular endurance. It requires Army members to carry two 22 kilogram (kg) jerry cans or two 22 kg kettle bells for a prescribed distance in 25 m bounds. It is based on the requirement for all Army members to be capable of conducting a stretcher carry. An individual test is performed, as a group assessment, such as a stretcher carry, will not accurately assesses an individual's physical capacity. Other common military tasks included in this test are repetitive manual handling tasks during administrative resupply and movement of defensive stores.

22. **Box lift.** This is a test of muscular strength and requires personnel to lift a box from the ground so the top of the box is level to shoulder height then lowered to the ground under control. A prescribed lifting technique must be used. Members may commence the test by lifting lighter weights, progressing up to the mass prescribed for their employment category. This progressive assessment allows assessing staff to ensure that a correct and safe lifting technique is used. While the assessment is reflective of many trade tasks of lifting heavy equipment into vehicles, it also covers many other manual handling tasks associated with being a soldier.

Appendices:

1B1 Functional interpretation of degrees of each PULHEMS quality
1B2 Basic fitness assessment standards – Army

APPENDIX 1B1

FUNCTIONAL INTERPRETATION OF DEGREES OF EACH PULHEMS QUALITY

Table 1B1–1: Functional interpretation of degrees of each PULHEMS quality

Degree	P	U	L	H	E (a)	M	S
Factors to consider	Age, build, strength, stamina, physical attributes, general health. Normally the P value will reflect the lowest value of either U,L, H or S.	Strength, range of movement and efficiency of arms, shoulder girdle and upper back	Strength, range of movement and efficiency of feet, legs, pelvic girdle and lower back	Auditory acuity (hearing)	Visual acuity (eye sight)	Intelligence and ability to use it	Mental health stability (does not change for simple adjustment, behavioural or personality disorders)
1	Reserved	Reserved	Reserved	Reserved	Minimal visual requirements (MVR) 1 Unaided: 6/12 6/12 Aided: 6/6 6/6	Reserved	Reserved

Degree	P	U	L	H	E (a)	M	S
2	There is no medical impediment to being able to endure the strain and fatigue of field duties; fit for duty anywhere. Not to have any functional medical restrictions. Able to pass all components of the relevant physical assessments for their age and employment category.	There is no medical impediment to being able to handle a weapon, lift loads appropriate to employment, do heavy manual work including pushing, digging, dragging, heaving and climbing.	There is no medical impediment to being able to endure locomotor strain over several days. Capable of being trained to undertake a forced march and being able to fight at the end. Can carry a load appropriate to employment, run, jump, climb, crawl, dig and perform all arduous tasks efficiently.	The hearing thresholds in the worst ear using audiometers calibrated to International Organization for Standardization (ISO) standards are: 500 hz—35 1000 hz—35 2000 hz—35 4000 hz—50	MVR 2 Unaided: 6/120 6/120 Aided: 6/9 6/9	Under Army conditions, is able to assimilate training and successfully perform combat or combat-related duties.	Possesses mental health stability sufficient to satisfactorily endure the stress of combat and combat related duties.
3	Fit for ordinary work. May not have the capacity because of disability or physique to endure the strain and fatigue of all field duties.	Must be capable of using a weapon for offensive purposes. To be capable of performing tasks in U2 but to a lesser degree.	As per L2 but to a lesser degree. Able to stand for at least four hours. Assessed as able to train for and complete the All Corps Standard weight load march.	The hearing thresholds in the worst ear using audiometers calibrated to ISO standards are: 500 hz—45 1000 hz—45 2000 hz—45	MVR 3 Unaided: 6/120 6/120 Aided: 6/12 6/12	Reserved	Sufficiently fit and stable to endure the stress of combat-related duties, although having minimal symptoms, or minor risk of recurrence of an earlier illness.

Degree	P	U	L	H	E (a)	M	S
4	Fit for all duties of primary employment with minimal restrictions. Able to engage in clearing patrols and defensive actions.	Reserved	Able to walk unrestricted in patrol order and body armour. Able to walk short distances only in marching order.	The hearing thresholds in the worst ear using audiometers calibrated to ISO standards are: 500 hz—55 1000 hz—55 2000 hz—55	Unaided: 6/120 6/120 Aided: >6/12 in one eye but at least 6/12 in the other	Reserved	Reserved
5	Fit for most duties of primary employment with moderate restrictions. Able to engage in self-defence.	Must be capable of using a weapon for defensive purposes.	Able to walk at own pace in patrol order. Able to wear body armour for short distances. Fit for guard duty.	Sensori-neural deafness in one ear. The hearing thresholds in the functional ear using audiometers calibrated to ISO standards are: 500 hz—35 1000 hz—35 2000 hz—35 4000 hz—50	Unaided: >6/120 in one eye but at least 6/120 in the other Aided: >6/12 in one eye but at least 6/12 in the other	Reserved	Able to perform defensive combat duties in main support base.
6	Pregnancy	Reserved	Reserved	Reserved	Reserved	Reserved	Reserved

Degree	P	U	L	H	E (a)	M	S
7	Able to perform useful military duties within limits of disabilities. Not likely to break down if suitably employed, which includes time for regular meals and rest. Service outside of the area of operations only.	Able to perform sedentary and routine work of a lighter type. Includes personnel unable to bear arms on account of physical disability (ankylosis of elbow etc).	Able to walk 3 km a day at own pace, and able to stand for moderate but not prolonged periods.	The hearing thresholds in the better ear using audiometers calibrated to ISO standards are: 500 hz—55 1000 hz—55 2000 hz—55	Does not meet E5 standard	Reserved	Not fit for combat or combat-related duties due to a mental health condition. Has the potential to perform useful military duties outside the area of operations.
8	Fails to reach P7	Fails to reach U7	Fails to reach L7	Fails to reach H7	Reserved	Fails to reach M2	Fails to reach S7

Note:

(a) Refraction limits with cycloplegia are not considered.

APPENDIX 1B2

BASIC FITNESS ASSESSMENT STANDARDS – ARMY

Table 1B2–1: Minimum BFA standards for male Army candidates

Component	Level	Age 17–25	Age 26–30	Age 31–35	Age 36–40	Age 41–45	Age 46–50	Age 51–55	Age 56–60	Age 61–65
Push-ups	Baseline	40	35	30	25	20	10	6	5	3
Push-ups	Incentive level 1	48	42	36	30	24	12	7	6	4
Push-ups	Incentive level 2	56	49	42	35	28	14	8	7	5
Sit-ups	Baseline	70	65	60	50	35	25	20	15	10
Sit-ups	Incentive level 1	84	78	72	60	42	30	24	18	12
Sit-ups	Incentive level 2	97	90	84	70	49	35	28	21	14
2.4 km run	Baseline	11:18	11:48	12:18	12:42	13:12	13:48	14:30	15:30	16:30
2.4 km run	Incentive level 1	10:10	10:37	11:04	11:26	11:53	12:25	13:07	14:07	15:07
2.4 km run	Incentive level 2	9:02	9:26	9:50	10:10	10:34	11:02	12:44	13:44	14:44
5 km walk	Baseline	44:00 (note a)	44:00 (note a)	44:00 (note a)	44:00 (note a)	44:00:00	45:00:00	45:00:00	50:00:00	55:00:00

Note:

(a) Alternative assessment only

Table 1B2–2: Minimum BFA standards for female Army candidates

Component	Level	Age 17–25	Age 26–30	Age 31–35	Age 36–40	Age 41–45	Age 46–50	Age 51–55	Age 56–60	Age 61–65
Push-ups	Baseline	21	18	15	10	7	3	3	3	3
Push-ups	Incentive level 1	25	22	18	12	8	4	4	4	4
Push-ups	Incentive level 2	29	25	21	14	10	4	4	4	4
Sit-ups	Baseline	70	65	60	50	35	25	20	15	10
Sit-ups	Incentive level 1	84	78	72	60	42	30	24	18	12
Sit-ups	Incentive level 2	97	90	84	70	49	35	28	21	14
2.4 km run	Baseline	13:30	14:00	14:30	15:00	15:30	16:00	16:30	17:00	17:30
2.4 km run	Incentive level 1	12:09	12:36	13:03	13:30	13:57	14:24	14:51	15:30	15:57
2.4 km run	Incentive level 2	10:48	11:12	11:36	12:00	12:24	12:48	13:12	14:08	14:32
5 km walk	Baseline	45:00 (note a)	45:00 (note a)	45:00 (note a)	45:00 (note a)	45:00:00	47:00:00	47:00:00	52:00:00	57:00:00

Note:

(a) Alternative assessment only

ANNEX 1C

MEDICAL CONSIDERATIONS – AIR FORCE CANDIDATES

INTRODUCTION

1. All members of the Air Force (permanent and reserve forces) must be capable of undertaking the full range of military duties expected of them. These duties include specialist occupational functions and general military duties performed under the arduous physical and mental stresses associated with armed conflict or peace keeping responsibilities.

MEDICAL FITNESS REQUIREMENTS

General military duties

2. Medical fitness for general activities involves a capacity to:

a. undertake general training for, and be prepared to, engage in ground defence, including weapons proficiency

b. undertake sustained physical effort in emergencies such as those likely to occur during operations, major disasters and in survival situations

c. withstand the stresses arising from general factors such as the turbulence associated with the inherent mobility of the workforce, both in peace and war.

Deployment factors

3. Operational deployment may entail some, if not all of the following characteristics:

a. geographical isolation

b. medical support limited to general practitioner-level care

c. limited social/psychological support

d. limited or delayed logistics support

e. limited access to evacuation if required

f. basic living conditions which may include:

(1) tent/hootchie accommodation

(2) limited field or self-catering with unavailability of special diets

(3) limited provision for personal hygiene

g. conditions which are arduous and may include:

(1) minimum 12-hour working day, often extended to 16 hours

(2) irregular work/rest schedules with individuals likely to become chronically fatigued

(3) environmental extremes.

4. The work requirements on operational deployment are different to normal base activities in that they include a combatant role undertaken by officers, airmen and airwomen alike. These may be physically and psychologically arduous and involve extended work periods of patrolling, climbing, running, digging and similar tasks in environmental extremes with associated likelihood of acute fatigue.

5. Significant stress is associated with combat and related activities, particularly for support personnel. These tasks require strength, endurance and full mobility, and do not allow for any disability. Further tasks associated with base combatant duties include:

a. erecting large tents

b. filling sandbags

c. building defensive barricades

d. digging foxholes

e. constructing outdoor latrines and showers

f. loading and unloading supplies from vehicles and aircraft

g. erecting radio antennae, power poles, and camouflage nets

h. stretcher bearing.

PHYSICAL FITNESS STANDARD

6. All Air Force members are to pass a physical fitness test (PFT) annually. Table 1C–1 and Table 1C–2 provide the PFT standards for males and females. For further information on physical fitness, see the Air Force Physical Training and Testing Manual[20].

7. Candidates for physical training instructor roles and aircrew roles need to be competent swimmers, as they are required to pass a swim test at initial training.

[20] http://intranet.defence.gov.au/home/documents/data/RAAFPUBS/Manuals/_AFPTTMAN____Mst.pdf

Table 1C–1: Male operational readiness physical fitness standard

Component	Age under 25	Age 25–34	Age 35–44	Age 45–54	Age 55–59	Age 60 and over
Flexed arm hang (seconds) (note a)	30	25	20	15	10	5
Push-ups (number) (note a)	25	20	15	10	5	3
Sit-ups feet unsecured (number) (note b)	30	25	20	15	10	5
Sit-ups feet secured (number) (note b)	65	55	45	35	25	15
2.4 km run/walk (minutes: seconds) (note c)	12:00	13:00	14:00	15:00	16:00	17:00
5 km walk (minutes: seconds) (note c)	38:00	40:00	42:00	44:00	46:00	48:00

Notes:

(a) Either the flexed arm hang or the push-ups.

(b) Either the sit-ups feet secured or the sit-ups feet secured)

(c) Either the 2.4 km run/walk or the 5 km walk.

Table 1C–2: Female operational readiness physical fitness standard

Component	Age under 25	Age 25–34	Age 35–44	Age 45–54	Age 55–59	Age 60 and over
Flexed arm hang (seconds) (note a)	30	25	20	15	10	5
Push-ups (number) (note a)	10	8	6	4	3	1
Sit-ups feet unsecured (number) (note b)	30	25	20	15	10	5
Sit-ups feet secured (number) (note b)	65	55	45	35	25	15
2.4 km run/walk (minutes: seconds) (note c)	13:00	14:00	15:00	16:00	17:00	18:00
5 km walk (minutes: seconds) (note c)	39:00	41:00	43:00	45:00	47:00	49:00

Notes:

(a) Either the flexed arm hang or the push-ups.

(b) Either the sit-ups feet secured or the sit-ups feet secured.

(c) Either the 2.4 km run/walk or the 5 km walk.

CHAPTER 2

MEDICAL HISTORY AND EXAMINATION

INTRODUCTION

2.1 The medical aspects of processing candidates for entry into the Australian Defence Force (ADF) involve both administrative and clinical procedures. Whilst the prescribed components of medical testing are mandated, the order in which they occur within the recruiting service delivery model can be amended with approval from the chief medical officer, Defence Force Recruiting (CMO DFR). The initial administrative process involves a review of the candidate's medical history and a determination regarding the candidate's suitability to progress to a detailed medical examination at a Defence Force Recruiting Centre (DFRC).

POLICY

MEDICAL HISTORY QUESTIONNAIRE

2.2 Form PM165—'Health questionnaire' is a comprehensive medical questionnaire containing the privacy notice, consent and acknowledgment forms and statutory declaration. The aim of the Form PM165 is to collect personal medical information and relevant family history about the candidate to assist in assessing health and fitness suitability for service in the ADF as well as the beginning of a Defence health record (DHR) for successful candidates. Form PM165 is valid for 24 months. Candidates may receive an online medical history questionnaire (MHQ) which includes all the Form PM165 questions delivered in a staged process.

2.3 The privacy notice and acknowledgment and consent section aligns with the Defence Privacy Policy[21], in relation to the collection and management of medical information, and ensures the candidate has an understanding of the medical examination process. This section also outlines requirements for vaccinations and blood screening following entry into the ADF.

2.4 The intent of the privacy notice is to ensure the candidate is informed of:

a. how their personal information will be collected and stored

b. the law and Privacy Principles authorising its collection

c. the specific purpose or purposes for which the information is required

d. which internal Defence agencies will have access to the information

e. any further disclosure of information that will or may be permitted to take place outside the Defence organisation

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f. the right the person has to withhold consent or object to the collection of the information

g. the consequences for the person of refusing to supply or cooperate in the collection of this information.

2.5 The intent of the acknowledgment and consent section of the form is to ensure the candidate is aware of the requirement for, and can give informed consent to:

a. the recruiting medical examination process

b. the requirement for blood screening for specified infectious diseases pre-enlistment and the implications of a negative or positive test

c. the requirement for blood grouping and blood screening in accordance with ADF policies following entry to the ADF

d. the requirement for vaccinations dictated by ADF protocols following entry to the ADF

e. release of medical information to their treating medical practitioner should a medical condition be identified during the recruit medical assessment process.

2.6 Participation in the ADF blood screening and vaccination program is a requirement for operational deployment in the ADF, and accordingly the ADF can only consider those candidates who agree to undergo these procedures should they be successful in their application.

2.7 The routine and additional vaccination schedules for the ADF in the Defence Health Manual (DHM) Level 2 Part 8 Chapter 4[22]—'Vaccinations manual'.

2.8 Following entry to the ADF, all personnel are required to have blood grouping and blood screening for glucose-6-phosphate dehydrogenase (G6PD). Age-related blood screening is also required as part of routine individual health assessments and health examinations. Specific blood screening may also be required following some operational deployments.

Completion of medical history questionnaire

2.9 Form PM165 should be provided to the candidate as part of their online application or provided to the candidate at the DFRC. The candidate is to answer the questions on Form PM165 as fully and accurately as possible and provide it to DFRC medical staff at the earliest opportunity. As requested on Form PM165, existing medical reports, which provide further medical information on any question ticked

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‘yes’, can be provided to assist in informed and timely candidate assessments by DFRC medical staff. All copies of Form PM165 completed by the candidate are to be retained with other medical documentation and remain a part of the candidate’s medical record. Hardcopy versions are to be scanned into the candidate's medical record.

2.10 The DFRC nursing officer (NO) is to ensure the candidate has read and understood the privacy notice and signed the acknowledgment and consent prior to the collection of any medical information or conduct of any medical testing.

2.11 Candidates completing the form online are required to electronically acknowledge and provide consent. Failure to acknowledge online will result in the form not being progressed or received by the DFRC.

a. if the form is completed online and the candidate answers 'no' to all the questions the candidate is automatically progressed to Assessment Session

b. candidates who answer 'yes' to any questions will be vetted by the nurse.

2.12 The statutory declaration by the candidate is not to be signed until Form PM165 has been reviewed by the DFRC medical officer (MO) on assessment day.

2.13 Candidates who require Form PM165 to be vetted by the NO prior to assessment day will have the answers entered into their medical record by the NO. Forms completed manually are to be scanned into the candidate's medical record. Any significant question (listed in Annex 2A), regardless of its answer, are required to be asked again as part of the preliminary assessment requirements conducted by the nurse (these questions are often answered incorrectly by candidates). All ‘yes’ answers must be recorded by the NO. This entails taking and recording a full clinical history based on what the candidate says and noting if any medical reports have already been provided. It is most important to gain a detailed history at the first available opportunity should any dispute arise in the future; eg request for review of a decision.

2.14 The specific system questionnaires in Annex 2B are helpful in eliciting such a detailed history. In some cases the NO may request that a DFRC MO reads the report(s) if provided in case there is any doubt as to whether to progress the candidate. Otherwise, all medical reports must be saved onto the candidate’s medical record for review by the MO.

2.15 Candidates who are not automatically progressed via the online process will require their medical history to be vetted by the nurse, with the following outcomes possible:

a. suitable for further medical testing

b. unsuitable due to not meeting entry medical standards pending MO review of the information and confirmation of medical classification.

2.16 If the NO considers a candidate is unsuitable for further enlistment processing Form PM165 is to be referred to an MO for confirmation. The NO may

indicate that there is an issue which requires clarification by an MO but should not inform the candidate that they may be Class 4.

2.17 If the MO confirms the candidate is medically unfit for entry a classification of Class 4Q is to be recommended by DFR, as per DHM Level 2 Part 5 Chapter 1[23]— 'Medical classification of candidates'. The MO may inform the candidate verbally of their Class 4 status. However, the candidate must also be informed in writing of the reason for rejection and of their right for review of a decision (refer DHM Level 2 Part 5 Chapter 1).

2.18 Note that Class 4E is reserved for candidates who are unfit for ADF entry after the full medical assessment has been performed inclusive of MHQ and entry level medical examination (ELME) as per DHM Level 2 Part 5 Chapter 1.

2.19 A candidate who is classified by the NO as suitable to be progressed to the next stage of assessment is to be progressed. If they have medical conditions identified on the history questionnaire that are likely to require the provision of further reports, they are to be encouraged to obtain copies of any existing reports they or their treating medical practitioner may already have and bring them to their ELME. Candidates should not be prevented from progressing to ELME pending provision of any reports. Candidates should not be encouraged to get new reports until they have been examined by the MO on Assessment Day.

2.20 The candidate shall bear the costs of obtaining any reports unless otherwise approved by CMO DFR.

ENTRY LEVEL MEDICAL EXAMINATION

2.21 **Preliminary medical examination procedures.** The medical examination is divided into two parts. The first part involves preliminary tests, which are performed by appropriately trained health (NO and MO) staff at the DFRC. The second part involves a full physical examination of the candidate by an MO. Preliminary tests conducted on all candidates include:

a. height measurement

b. weight measurement

c. blood pressure measurement

d. cardiovascular point of care blood testing (non-fasting) - risk screening for candidates aged 35 years or more

e. colour perception

f. visual acuity

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g. point of care refractive error testing for candidates that fail to meet MVR1

h. urinary albumin creatinine ratio for candidates assessed as being at risk of renal disease

i. audiometry.

Note:

(a) This list is not exhaustive; additional testing defined in this manual may be required for specific jobs.

2.22 Guidelines for conducting preliminary medical examination procedures are in Annex 2C.

2.23 **Form PM 166.** Medical preliminary data is to be recorded on the candidate's record by DFRC NO or MO as appropriate. Medical examination findings and any cause(s) for rejection are to be clearly stated on Form PM166—'Entry level medical examination' by the examining MO.

Medical examination

2.24 The ELME is to be conducted by an MO at a DFRC or suitable facility (approved by CMO DFR) for remote testing. Guidelines for conducting the medical examination are in Annex 2D. Relevant application documentation together with the psychologist's report are to be made available, where possible, to the MO for the medical examination. Prior to the start of the ELME the MO has a responsibility to:

a. inform candidates that they will be making a declaration that the answers to the medical questions are correct and any false statement may incur dismissal from the ADF with forfeiture of all benefits. A candidate is guilty of an offence in accordance with the *Defence Force Discipline Act 1982*[24], section 57, if the person, with the intent to deceive, provides false information or does not disclose particulars of any prior service in the Defence Force and is appointed to or enlisted in the ADF. A member may also be precluded from qualifying for compensation for the condition or the aggravation of the condition about which they may give false information. The candidate is to sign the statutory declaration in the presence of the MO

b. explain to the candidate that their responses are confidential. The acknowledgement and consent by candidate should be checked for signature and date

c. confirm that the candidate is sufficiently counselled to give informed consent for pre-enlistment blood screening, see DHM Level 2 Part 5 Chapter 1. The consent for blood screening is part of Form PM165. In addition, the candidate should be made aware of the need for post-enlistment blood testing for blood

[24] https://www.legislation.gov.au/C2004A02711/latest/versions

grouping, blood screening for G6PD and immunisations necessary for ongoing military service

d. review Form PM165 by checking each box next to the NO's entry thereby confirming each answer. All questions where the answer is other than negative, and all the significant medical history questionnaire questions in Annex 2A, should be asked again. Comments and additional clinical notes should be included in the candidate's medical record. The specific system questionnaires in Annex 2B is helpful in eliciting further medical history.

Note:

The final and complete Form PM165 is to be included in the candidate's medical record and should accurately reflect all of the history provided by the candidate and comments made by NO and MO for future reference, in case of request for review of a decision or later compensation claims. The examining MO's name, signature and date must appear on the final printed page for Form PM165 for similar reasons, and scanned into the candidate's medical record.

2.25 DFRC MOs have a duty of care to inform a candidate at the earliest opportunity if medical or health problems are detected during the medical assessment process, as a result of either:

a. information disclosed in the medical history questionnaire

b. the candidate not meeting preliminary medical standards

c. the findings of the ELME

d. the blood screening results.

2.26 If the candidate is deemed to be medically unfit for entry during ELME, the MO is to provide an explanation of the reason the medical standards are not met following completion of the examination DHM Level 2 Part 5 Chapter 1.

2.27 As a general principle, all candidates should be encouraged to complete the ELME as it allows for:

a. detection of all medical conditions

b. assessment of medical suitability for alternate categories or trade

c. completeness in the case of a request for review of a decision.

Candidates requiring additional medical or dental opinion

2.28 Candidates may require additional medical or dental information either as a mandated requirement for a military occupation, to meet a specific military requirement or to clarify a candidate's fitness for entry to the ADF. Mandated investigations for entry to general and specific occupations are in Annex 2E.

2.29 Any medical condition identified on Form PM165 should be clarified by appropriate and relevant health professional reports provided by the candidate. DHM Level 2 Part 5 Chapter 5[25]—'Causes of and reasons for rejection' provides guidance as to the level of information required for specific medical problems. Any new or previously non-assessed medical condition found on examination should initially be referred to the candidate's treating medical practitioner for investigation, management and referral for specialist opinion as necessary. The treating medical practitioner should then provide a report to the candidate of the findings of these investigations and specialist opinions. The cost of further reports or investigations as detailed above will be borne by the candidate.

2.30 In some instances, repeated requests for information provided by general practitioners, specialists or other health providers might provide insufficient information to determine medical fitness for ADF entry. Additional specialist reports in these circumstances should only be required in those cases when a decision on fitness for ADF entry cannot be made on the reports and evidence available. These additional specialist opinions required for determination of medical fitness for the ADF may be funded by Defence. In some specific cases, such as in support of a request for waiver action, an ADF specialist opinion is deemed necessary. In all cases for Defence funding, approval should be sought from CMO DFR and if approved Defence shall cover the cost of the consultation. The cost of mandated specialist assessments for specific occupations as detailed in Annex 2E and DHM Level 2 Part 5 Chapter 6[26]—'Health requirements for aviation-related occupations', DHM Level 2 Part 5 Chapter 7[27]—'Health requirements for divers', and DHM Level 2 Part 5 Chapter 8[28]—'Health requirements for submariners', are to be borne by Defence.

2.31 **Advice to medical specialists.** Medical specialists are to be advised that the information they provide regarding a candidate will be used by a DFRC medical officer to inform the occupational medicine assessment of the candidate's suitability for military service. The following questions should be addressed at a minimum:

a. diagnosis – please confirm the condition diagnosis, including that of any secondary or associated conditions

b. sudden incapacity – please comment on the potential for sudden incapacity or rapid deterioration in relation to the condition(s)

c. functional capacity – please describe the system specific functional impact (including any functional limitation) of the condition and overall impact on

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general health and well-being. Please also note if any occupational restriction is recommended from the preventive health and safety perspective

d. treatment – please identify any treatment requirement (medication, surgery, etc.) and likely future treatment requirements

(1) If medication is currently used to treat the condition what is the implication for health and well-being should the medication not be available for a period of up to 21 days

e. monitoring – please identify the monitoring (type and frequency) requirements for the condition

f. prognosis – please discuss the short – long term prognosis for the condition.

Referral to ophthalmologist or optometrist

2.32 Minimum visual requirements (MVRs) for ADF entry are detailed in Appendix 2C1. Guidelines for an eye examination by an MO are in Annex 2D. Candidates who fail to meet MVR1 are required to undergo refractive error testing at the DFRC with the point of care testing device approved by CMO DFR. The required aided visual acuity must be attained using spectacles only. In order for an MVR to be allocated, referral to an optometrist or ophthalmologist is to be arranged for candidates (including Reservists) when:

a. testing at the DFRC identifies that the candidate's refractive error exceeds the equipment measuring range

b. a candidate wears contact lenses to ELME (needs to have not been wearing soft lenses for one week or hard contacts for two weeks prior to ELME)

c. clinical history or examination suggests an eye condition

d. ophthalmology/optometry examination is a mandated requirement to confirm fitness for the preferred military occupation

e. a candidate considered at risk or has a declared history of glaucoma. At risk includes a family history of glaucoma (first degree relative), Caucasian and Asian candidates aged 50 years or over and candidates of African descent 40 years or over.

Table 2–1: Requirements for eye assessments with an ophthalmologist or optometrist

Examination and assessment	Requirement for review	Conducted by
All candidates–to undergo initial visual acuity (VA) screening with CMO approved chart and see MO for visual field assessment (to confrontation).	If candidate's VA exceeds MVR1 refractive error testing with point of care testing device required.	DFRC medical staff
Refractive error testing at DFRC exceeds point of care device measuring range	Refractive error testing with cycloplegia	Ophthalmologist or optometrist
Specialist occupations aviation – related occupations (Class 1-3)	Mandatory specialist review is required for these occupations.	Ophthalmologist, or Civil Aviation Safety Authority approved optometrist
	If more than 12 months but less than 24 months have elapsed since initial ophthalmology examination for ADF entry, unless clinical indications for ophthalmology examination exist.	Optometrist
Special forces, diving candidates, non-destructive inspection (NDI) technicians	If a candidate for these occupations does not meet the standard for near vision (N5 at 30–35 cm and N14 at one metre with or without visual correction).	Optometrist
Other Ammunition technician ECN 401 Explosive ordnance disposal ECN 432 (in-service transfer)	Mandatory specialist review required for these occupations. Refer DHM Level 2 Part 5 Chapter 4[29]—'Occupation specific – medical standards' Appendix 4B4.	Ophthalmologist
Previous history of eye disease or surgery, including refractive surgery, corneal surgery, amblyopia	Review required	Ophthalmologist

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Examination and assessment	Requirement for review	Conducted by
Candidates considered at risk or a declared history of glaucoma	At risk includes a family history of glaucoma (first degree relative), Caucasian and Asian candidates aged 50 years or over and candidates of African descent 40 years or over	Optometrist unless ophthalmologist assessment is indicated.

2.33 Optometrists and ophthalmologists are to be provided with the relevant guidance for completion of eye assessments including:

a. For candidates other than aviation related occupations listed in DHM Level 2 Part 5 Chapter 5 Annex 5A:

(1) guidelines for examination by an ophthalmologist or optometrist in Annex 2F

(2) ADF minimum visual requirements in Appendix 2C1

(3) Form PM529

b. For aviation related occupations listed in DHM Level 2 Part 5 Chapter 6 Annex 6A:

(1) aviation visual requirements in DHM Level 2 Part 5 Chapter 6 Appendix 6B3

(2) guidelines for examination by an ophthalmologist for candidates for entry to the ADF in an aviation-related occupation DHM Level 2 Part 5 Chapter 6 Appendix 6B4

(3) Form PM086—‘Eye examination – aviation’.

2.34 Examination by an ophthalmologist or optometrist is valid:

a. For two years for non-specialist employment occupation candidates. If more than 12 months but less than 24 months elapse from the date of the eye examination to entry, another examination is not required unless there is a significant change in the VA. The cost of these reports is the responsibility of the candidate unless the report is defined as a mandatory (3M) requirement for specific roles

b. For 12 months when an eye examination is a mandated requirement to confirm fitness for a military occupation. If more than 12 months has elapsed, the candidate may be referred to an optometrist unless there are clinical indications for an ophthalmologist examination.

DETERMINATION OF RECRUITING MEDICAL CLASSIFICATION

2.35 A recruiting medical classification is to be allocated by the MO unless otherwise specified (refer paragraphs 3.9–3.18). Guidance for specific conditions is contained in DHM Level 2 Part 5 Chapter 5 annexes to inform this decision.

Class 3 and Class 4 candidates

2.36 The MO is to inform the candidate of the nature of any medical condition leading to allocation of Class 3 or 4 on the day of the examination, or as soon as possible once the determination is made. Written advice to candidates is to include the following:

a. an explanation of the medical reason(s) for the determination. Information should be presented in a manner which the candidate can understand

b. any candidate with a medical condition, who in the opinion of the examining MO or dental officer (DO) is in need of, but is not receiving, treatment or investigation should be advised to consult their treating medical practitioner or dentist. Where clinically appropriate the examining MO or DO may supply a referral letter. Details should be recorded on Form PM166 or on Form PM223—'Continuation' if there is insufficient space on Form PM166.

c. if the examining MO or DO decides against informing the candidate of the nature of the condition, they may advise the candidate that they will contact their nominated treating medical practitioner or request their treating medical practitioner or dentist to contact the MO or DO for details. DFRC MOs may only release information with the written consent of the candidate. Information should only be withheld in circumstances where the MO or DO judges on reasonable grounds that the candidate's physical or mental health might be seriously harmed by the information. Information may only be released without consent when consistent with Privacy legislation caveats.

d. temporarily medically unfit (Class 3). A candidate classified as Class 3T is to be advised that treatment will be at their own expense and that successful treatment of the condition, in itself, is no guarantee of future acceptance. For 3R candidates, a report or review (by one or more appropriate health professionals) is required before a final classification can be provided (refer DHM Level 2 Part 5 Chapter 1). An estimate of the time at which a candidate who has been assessed as temporarily unfit would be fit to present for re-examination should be indicated to the candidate and recorded on Form PM166 if possible. A candidate is not to be made Class 3 unless a full medical examination has been completed.

2.37 Candidates who may be suitable to be progressed under a waiver are fit for further recruiting assessment day testing requirements.

2.38 The DFRC MO is to provide a written explanation of the reasons for rejection for individual candidates. DHM Level 2 Part 5 Chapter 5 provides details of medical conditions that may give rise to Class 3 or Class 4 determinations.

Class 1 and Class 2 candidates

2.39 Candidates who are fully fit for entry (Class 1) or have been accepted for entry following approval of a medical waiver (Class 2), (refer DHM Level 2 Part 5 Chapter 1), are to be advised that their appointment or enlistment will be subject to an Attestation Medical (DHM Level 2 Part 5 Chapter 1). This is conducted at the time of enlistment or appointment and is usually directly prior to the start of ab initio military training (for Reservists, the Attestation Medical may occur many months before actually attending recruit training). The aim of this assessment is to identify the presence of any illness or injury, which will impair an entrant's ability to commence full and unrestricted training.

2.40 **Validity of medical examination.** A recruiting ELME is valid for 24 months from the date on which the entry medical examination was performed (note: for officer aviation roles, ELME validity is 12 months as per DHM Level 2 Part 5 Chapter 6). If more than 24 months have elapsed since the ELME, or there has been a significant illness or injury in the interim, a new ELME is to be performed. This should include confirmation that the MHQ remains current, including confirmation and documentation that the Acknowledgment and consent by the candidate and the Statutory Declaration remain applicable. There are circumstances under which this requirement may be waived with the approval of CMO DFR, eg prolonged delay in waiver process by the ADF. In cases where another ELME may be considered unnecessary, stressful or likely to delay a critical candidate's entry, advice and approval from CMO DFR must be sought before any action is taken by DFRC.

2.41 **Pre-enlistment blood screening.** All entrants to the ADF are to undergo blood tests after being assessed as Class 1 or Class 2 and prior to enlistment, or with approval from CMO DFR if earlier in the process to screen for Hepatitis B, Hepatitis C and human immunodeficiency virus (HIV). Discussion for the purpose of gaining informed consent for this testing is to be conducted as a component of the ELME. Following discussion, formal consent for the testing is to be given using the Form PM165. Informed consent in the ADF screening context requires that the candidate agrees to Hepatitis B, Hepatitis C and HIV testing based on:

a. an understanding of the testing procedure

b. an understanding of why the ADF requires the tests to be undertaken prior to enlistment or appointment

c. an understanding of the personal implications of the test results, whether positive, negative, or indeterminate (the presence or absence of infection is not established).

2.42 Further guidance regarding informed consent for these tests is provided in the Australian national testing policies, accessible through the testing portal[30]. Whilst negative test results may be advised in writing (unless State requirements do not

[30] http://testingportal.ashm.org.au/

permit) all other test results should be delivered in face-to-face communication with a medical practitioner where practicable.

2.43 Candidates with indeterminate or positive test results are to be followed up to determine their infection status. Candidates with a confirmed positive test result are to be referred, with the patient's consent, to their treating medical practitioner or an appropriate health service (eg sexual health clinic) for ongoing health care. If results have not been received by the date of entry, enlistment or appointment must not occur until negative serology is confirmed, unless provisional appointment or enlistment has been approved under regulation 17 (for appointment) or regulation 27 (for enlistment), of the *Defence Regulation 2016*[31], or a medical waiver has been granted. Pre-enlistment blood test results will be valid for 24 months (note: blood tests are valid for 12 months for officer aviation roles).

2.44 If the candidate declares at risk behaviour/concerns, repeat testing earlier than 24 months may be indicated. Note that blood testing for the presence of G6PD and blood grouping is not to be conducted pre-enlistment.

2.45 **Pre-enlistment fitness assessment.** The PFA must only be conducted following the MO assessment and the MO assessing the candidate as fit to attempt the PFA. The PFA is an important predictor of fitness for the ADF. Standards for the physical fitness assessment (PFA) are in ADF Recruiting Instruction 032[32]—'Pre-entry fitness assessment'.

2.46 **Attestation medical.** All successful candidates are to be medically reviewed within the 24 hours prior to entry to the ADF by the DFRC medical staff. This assessment is extremely important, as candidates must be fully fit to commence ab initio military training. The candidate is to be undressed (to underwear) and observed for signs of injury, intercurrent illness, new scars or identifying marks. A urinary pregnancy test is to be conducted on all female candidates (unless the uterus is absent). The review is to be recorded on the Form AD363—'Medical attestation declaration'. Further medical examination in addition to the mandated components is to be conducted if clinically indicated. Any changes to the medical history and examination are to be fully recorded. Form AD363 is to be filed in the candidates' medical record. Any candidate who has experienced a life crisis, has required counselling from a psychologist or social worker, or has been diagnosed with a personality disorder is to be reviewed by a psychologist to assess suitability for enlistment or appointment. If the candidate is found to not meet entry standards due to an intercurrent illness or injury, enlistment or appointment will be at the discretion of the initial training unit through the CMO DFR. The enlistment coordinator is to be informed of any candidate who is assessed as unfit to commence training. In cases of any doubt, CMO DFR should be contacted for advice.

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[31] https://www.legislation.gov.au/Series/F2016L01568

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Annexes:

ANNEX 2A

SIGNIFICANT MEDICAL HISTORY QUESTIONNAIRE QUESTIONS

1. Some questions on Form PM165—'Health questionnaire' are not seen as relevant or important by candidates. This occurs in spite of the directions for the system specific questions stating 'Have you ever had or are you now suffering from any of the following?' Often candidates perceive that a 'Yes' answer is only required if the condition or symptom has occurred in the last week or month, not at some time in their life; eg childhood or last year.
Therefore, candidates often answer with a 'No' when, in fact, there was a time when that condition or symptom existed, albeit now fully resolved. Such questions may be relevant to the Australian Defence Force (ADF) particularly if it relates to cardiorespiratory dysfunction or musculoskeletal injury. No matter how minor the candidate may consider a particular condition, it is important that the Defence Force Recruiting Centre Medical Officer understands that it may be significant for ADF entry purposes.

2. In some cases, candidates may not wish to reveal that a particular condition ever existed as it may jeopardise their entry. For all of the above reasons, particular attention should be paid to the following questions and repeated during medical examination.

3. Significant questions are:

a. **Question 4.** Have you ever had any operations? Includes extraction of wisdom teeth, tonsils and adenoids, hernia repairs as a baby, endoscopies. These are often forgotten or not seen as 'real' operations

b. **Question 9.** Are you receiving any treatment? Includes the oral contraceptive pill, hydrocortisone creams, homeopathic drops, nasal sprays, and vitamins. Many females forget that their 'pill' is a medication

c. **Questions 26 and 27.** Asthma and inhalers—needs to be asked (looking directly at the candidate), as this is the most common undisclosed condition

d. **Questions in musculoskeletal system.** Repeat the questions on major joints and shin symptoms eg injuries or pain, using words such as sprain, strain, twisting, breaks, cracks

e. **Question 102.** Frequent or severe headaches including migraines-often ignored as the headaches are deemed 'normal' to the candidate and because migraine has never been diagnosed they consider that their headaches are not severe like 'migraines' must be

f. **Question 150.** Allergic reaction including anaphylaxis or life threatening reaction—often forgotten until specifically questioned

g. **Question 153.** Sleep-walking— all candidates are to be asked this question even if a history is not declared on the MHQ. If a history is declared, it is essential that a detailed history of the event(s) is clearly documented, in particular the age when it last happened, and a detailed description of what occurred. A verbatim record of the given history is particularly useful in assessing any future request for a review of a decision.

ANNEX 2B

SYSTEM SPECIFIC QUESTIONNAIRES

1. The inclusion of these specific questionnaires is to assist in the collection of information in cases of conditions that have potential for rejection or need clarification; ie a 'Yes' answer on Form PM165—'Health questionnaire'. These questions are provided as guidance. The answers may be recorded on Form PM223—'Continuation' and should be as detailed as possible.

2. **Cardiovascular system:**

a. When did you become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen a heart specialist?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for the condition? Do you take any now? (List all medications and when last used.)

f. Is the condition completely cured or gone away?

3. **Respiratory system:**

a. When did you become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen a medical specialist? Do you know what type of specialist you saw? Respiratory, cardiology, etc?

d. Have you required special treatment/medication/hospitalisation/surgery for this condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications, frequency of use and when last used)

f. Is the condition completely cured or gone away?

4. **Gastrointestinal (GIT) system:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen a gastroenterologist or other medical specialist about it?

d. Have you required special treatment/medication/hospitalisation/surgery for your GIT condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for your GIT condition? Do you take any now? (List all medications and when last used)

f. Do you have any food allergies and/or require a special diet or do you avoid certain foods?

g. Is the condition completely cured or gone away?

5. **Musculoskeletal system:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. Was this condition related to an injury? Describe it. When, where, how, what level of activity and distance, what exercise do you do now that aggravates it?

c. What symptoms did you have? Do you have any now?

d. Have you ever seen a sports doctor/podiatrist/physiotherapist/orthopaedic surgeon/rheumatologist?

e. Have you required special treatment/medication/hospitalisation/surgery for your biomechanical/orthopaedic condition? If yes, when, where, what for, and any available reports?

f. Did you ever require any medication for your condition? Do you take any now? (List all medications and when last used)

g. Do you require the use of orthotics/other appliances to be able to do sport/be active? What happens if you do not use them? Specify if hard or soft type, in all shoes or just sports ones

h. Is the condition completely cured or gone away?

i. A detailed exercise history should be documented—what type of exercise including sport and training, how often and for how long?

6. **Nervous system:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen a neurologist/neurosurgeon?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications and when last used)

f. Is the condition completely cured or gone away?

7. **Gynaecological/urological system:** Ask questions to clarify information provided in the Form PM165 about the gynaecological and urological systems. Questions should be based on those in standard medical texts such as Talley & O'Connor's *Clinical Examination*.

8. **Eyes and ears, nose and throat (ENT) systems:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen an eye or ENT specialist?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications and when last used.)

f. Do you require special visual or hearing aids?

g. Is the condition completely cured or gone away?

9. **Dermatological system:**

a. Additional questions to clarify information provided in the health questionnaire (Form PM165) about the dermatological system can be found in standard medical texts such as Talley & O'Connor's *Clinical Examination*.

b. What symptoms did you have? Do you have any now?

c. Have you ever seen a dermatologist?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications, frequency of use and when last used.)

f. Is this condition associated with allergies/physical or emotional stress?

g. Is this condition affected by the weather or changes in climate, if so, how?

h. Is the condition completely cured or gone away?

10. **Haematological system:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen a haematologist/physician?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications and when last used)

f. Is the condition completely cured or gone away?

11. **Mental health:** Ask additional questions to clarify information provided in the health questionnaire (Form PM165). Questions about the mental health system can be found in standard medical texts such as Talley & O'Connor's *Clinical Examination*.

12. **Endocrine system:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen an endocrinologist/physician/surgeon for this condition?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications and when last used)

f. Is the condition completely cured or gone away?

13. **Immunological system:**

a. When did you first become aware of the condition? Is there a family history of this condition?

b. What symptoms did you have? Do you have any now?

c. Have you ever seen an allergy specialist/respiratory physician/other specialist?

d. Have you required special treatment/medication/hospitalisation/surgery for your condition? If yes, when, where, what for, and any available reports?

e. Did you ever require any medication for this condition? Do you take any now? (List all medications and when last used)

f. Is this condition associated with physical or emotional stress?

g. Do you require a special diet or do you avoid certain foods?

h. Is the condition completely cured or gone away?

ANNEX 2C

PRELIMINARY MEDICAL EXAMINATION PROCEDURES

1. **Height measurement.** Height is to be recorded with footwear removed. Candidates will be placed against the height standard with the feet together and the weight on the heels, and not on the toes or the outside of the feet. They should stand erect without rigidity, and with the heels, calves, buttocks and shoulders touching the height standard; the chin should be depressed to bring the head level under the horizontal bar, and the height should be recorded to the nearest centimetre.

2. Royal Australian Air Force firefighters also require a reach height measurement to be performed. The correct method for this is:

a. candidate must be tested without shoes on

b. candidate is to be facing the wall with feet together and flat on the floor. Toes placed against the wall

c. posture should be erect and not slouching

d. arms stretched straight upwards against the wall, palms and fingers stretched out. Anterior aspect of hand should be flat against the wall

e. measurement is taken from the floor to the top of the middle finger

f. minimum allowable reach height is 210 cm.

3. **Weight measurement.** The National Health and Medical Research Council has endorsed the body mass index (BMI) for determining an acceptable weight range for height for the general population. BMI standards are in Defence Health Manual (DHM) Level 2 Part 5 Chapter 5[33]—'Causes of and reasons for rejection' Annex 6H. Candidates are to have their weight measured with clothes on, pockets emptied, belts and shoes off. If the candidates BMI is of concern (ie exceeds or is marginally over or under the BMI entry standards) the weight of the candidate dressed in underwear is to be conducted. Weight is to be recorded to the nearest 0.5 kilogram. The BMI will be calculated as part of the entry level medical examination (ELME) by the appropriately trained Defence Force Recruiting Centre health staff and recorded on Form PM166—'Entry level medical examination' for the attention of the examining medical officer. BMI is derived by dividing weight in kilograms by the square of height in metres:

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Figure 2C–1: BMI calculation

$$BMI = \frac{\text{Weight (kg)}}{\text{Height (m)}^2}$$

4. **Blood pressure.** Blood pressure measurements should be taken in accordance with the Guideline for the Diagnosis and Management of Hypertension in Adults – 2016[34]. This document should be available to all Defence Force Recruiting Centre (DFRC) medical staff as a reference document.

5. **Cardiovascular risk screening.** Testing for random cholesterol, high-density lipoprotein (HDL) and glucose screening will be conducted by the nursing officer (NO) using chief medical officer (CMO) approved equipment.

6. **Random glucose testing.** Testing for random glucose is to be conducted for all aircrew candidates and all other candidates aged 35 years or over. Results of random glucose testing are to be scanned into the candidate's medical record for MO review. All candidates with elevated random glucose results are to be referred by the MO for further assessment.

7. **Random cholesterol and HDL testing.** Random cholesterol and HDL testing is to be conducted for all candidates aged 35 years or over. Results of random cholesterol and HDL testing are to be scanned into the candidate medical record for MO review. Candidates with lipid results outside of the normal range with an elevated overall cardiovascular risk (≥ five% over five years) are to be referred by the MO for further assessment. Where the overall risk is acceptable no referral is necessary.

8. Aircrew blood screening requirements for full blood count and films remains extant in accordance with DHM Level 2 Part 5 Chapter 6[35]—'Health requirements for aviation-related occupations'.

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34 https://assets.contentstack.io/v3/assets/blt8a393bb3b76c0ede/bltf610a915c0d751c5/65efd366a93acb316830f9b8/Guideline_for_the_diagnosis_and_management_of_hypertension_In_adults_-_2016.pdf

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9. **Examination of urine.** Candidates assessed as being at risk of renal disease are to have urinary albumin creatinine ratio (ACR) testing at the Defence Force Recruiting Centre (DFRC). ACR testing is only required for candidates determined to be in the at risk group in accordance with current clinical guidelines. Risk factors include BMI greater than 30, Aboriginal and Torres Strait Islanders 30 years of age or more, or candidates assessed as having an elevated cardiovascular risk (ie equal to or great than 5% over 5 years). Urinary pregnancy testing is to be conducted for all female candidates (unless uterus is absent). The procedures for urine examinations are as follows:

a. the urine is to be tested using ACR reagent strip by appropriately qualified health staff and results recorded on Form PM166. If the results are abnormal, the urine should be retested by DFRC medical staff following an opportunity for hydration

b. the instructions for use of the reagent strip must be strictly followed

c. if an abnormal result is detected by the reagent strip, the candidate is to be initially managed as follows:

(1) ACR – candidate is to be referred to their treating medical practitioner for further review, management from a recruiting perspective thereafter will depend on the findings.

(2) **Pregnancy test.** A urinary pregnancy test is to be carried out on all female candidates (unless uterus is absent) at both the initial medical examination and attestation medical examination. Retesting of a positive test may be conducted if the candidate does not believe that she may be pregnant. If the pregnancy test is positive the candidate is to be referred to her treating medical practitioner and managed from a recruiting perspective in accordance with DHM Level 2 Part 5 Chapter 5 Annex 5E

(3) Results of urine testing (ACR and pregnancy) are to be entered into the candidate's medical record for MO review and ongoing management as required.

10. When a definitive diagnosis is made, refer to DHM Level 2 Part 5 Chapter 5 for allocation of an appropriate recruiting medical classification.

11. **Audiometry.** Audiometric testing should be conducted in accordance with Australian Standard/New Zealand Standard 1269.4[36]—'Occupational noise management—auditory assessment' however, if the audiometer is not calibrated to record at 1500 hertz (Hz) this measurement is not required. Compensated audiometers are to be used. Results are to be recorded on Form PM166. Audiometry testing should only be performed by appropriately qualified personnel and is to be carried out as follows:

a. NO is to confirm with the candidate whether they have been exposed to loud noises within the last 24–48 hours. If a candidate has been exposed to loud noises testing is still to occur however repeat testing at a later date may be required. Candidate is to be advised if repeat testing is required

b. the candidate to be tested should be informed that they are going to be inside a booth, sitting on a chair, with headphones on

c. the candidate should be informed that they will then hear a series of tones through the earphone (right or left). They should be instructed to listen carefully and signal by pressing a button each time that they hear one of these sounds, no matter how faint it is

d. the headphones should be placed over the candidate's ears such that the correct earphone is over the appropriate ear (they are either colour-coded or have 'right' and 'left' written on them). The headphones should be level with the entrance to the ear canal and the headset securely in place

e. the person performing the test should note that where one ear is known to be considerably better than the other, commence by testing the best ear. If there is no difference between ears, begin with the right ear and commence testing at 500 Hz. Hearing standards are in DHM Level 2 Part 5 Chapter 4[37]—'Occupation specific – medical standards'.

f. unaided hearing is to be tested. The use of hearing aids or electronic maskers are not permitted.

12. **Hearing standards.** Unaided hearing standards are defined as follows:

Table 2C–1: Hearing standards

Standard	500 Hz	1000 Hz	1500 Hz (if applicable)	2000 Hz	3000 Hz	4000 Hz
HS1 (worse ear)	25 dB	25 dB	25 dB	25 dB	25 dB	25 dB
HS2 (worse ear)	35 dB	35 dB	35 dB	35 dB	40 dB	50 dB

[36] https://dpeintranet-seg.defence.gov.au/services-support/corporate-services/defence-library-service

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Standard	500 Hz	1000 Hz	1500 Hz (if applicable)	2000 Hz	3000 Hz	4000 Hz
HS3 (worse ear)	45 dB	45 dB	45 dB	45 dB	NA	NA
HS4 (better ear)	55 dB	55 dB	55 dB	55 dB	NA	NA

Note:

(a) If the audiometer is not calibrated to record the frequency of 1500 Hz, this measurement is not required.

13. While HS3 and HS4 are included in the above table they are normally unacceptable for recruiting purposes and are applied only to serving members whose hearing has deteriorated. Hearing levels tested at 6000 and 8000 Hz are not to be taken into consideration when determining hearing standards, but should be recorded on Form PM166 as they are useful for comparison purposes should hearing deterioration occur after entry. If a candidate is below HS2 the audiometry results are to be recorded on Form PM166 to assist in consideration of fitness if an appeal or waiver is submitted.

14. **Visual acuity.** Testing should only be performed by appropriately qualified personnel and carried out as follows:

a. The candidate is to be informed that their visual acuity (VA) will be tested for each eye separately using CMO approved chart. Where glasses are worn for distance vision, uncorrected and corrected VA will be recorded

b. The chart is to be placed in good light, required lighting conditions:

(1) illumination between 200 – 400 Lux

(2) Light evenly distributed (no shadows on the Chart)

(3) No glare source (eg lamps) on the Chart

c. The chart is to be placed at a distance of six metres from the eyes of the candidate. Vision occluder paddles are to be used to cover the untested eye. The unaided VA is to be tested first followed by corrected VA testing (if required).VA in the right eye is to be tested first; followed by VA in the left eye. The candidate is to read from the top line down (ie largest to smallest) from left to right. The candidate will continue reading towards the bottom of the chart until they complete all letters or are not able to continue. NO is to pay close attention to confirm the eye being tested is the correct eye and that the candidate moves the visual occlusion paddle from the right eye to the left eye. On completion candidate is to repeat the line above and the line below where the candidate can read all the letters correctly to confirm VA. The smallest line of letters that a candidate reads completely and accurately will determine the VA. For the 6/6 line one error may be accepted as 6/6 vision and similarly for the 6/9 line. Candidates are to be allocated a minimum visual requirement. Minimum visual requirement standards are to be applied in accordance with Appendix 2C1

d. vision occluder paddle is to be cleaned with an alcohol swab after use by each candidate

e. On completion of VA testing, candidates who do not meet minimum visual requirement (MVR) 1 are required to have refractive error testing

f. Candidates who wear spectacles and/or contact lenses are to bring their spectacles to the DFRC. Candidates who wear contact lenses should be informed not to wear them prior to preliminary visual testing at the DFRC and before consulting an ophthalmologist or optometrist. They should be advised that for soft contacts, they should not be worn for one week and for hard contacts, they should not be worn for two weeks prior to DFRC or specialist examination.

15. **Refractive error testing.** Candidates who do not meet MVR1 are required to undergo refractive error testing at the DFRC, using test equipment approved by CMO. Testing is to be conducted in a darkened room in accordance with the manufacturers operating instructions. Candidates requiring mandatory referral in accordance with Table 2C–1, who have acceptable refractive error as assessed at DFRC, will also have further visual assessment by an ophthalmologist/optometrist. Candidates whose refractive error exceeds the equipment measuring range are to be managed in accordance with DHM Level 2 Part 5 Chapter 2[38]—'Medical history examination'. Results from refractive error testing are to be scanned into the candidate medical record for MO review and ongoing management as required.

16. **Near vision.** Candidates for special forces (SF), non destructive inspection technicians, explosive ordnance and technician ammunition (ECN 432 and 401), diving and all aviation-related occupations are required to undergo near vision testing. The recommended near vision test procedure is to use the Sussex Vision Rayner near vision testing card which displays the N series of letters (faculty approved N5 to N48).

17. **Near test.** The near test is a small card containing a few short lines or paragraphs of text printed in high contrast and viewed at an appropriate reading distance using optimal illumination. To test near vision, the candidate will be asked to hold the card at normal reading distance. The candidate is to be tested in the range of 30–35 cm from the face and then at one metre from the face and read aloud the paragraph containing the smallest print they can comfortably read without squinting. The candidate is to be asked if they normally wear glasses or contact lenses for near vision. If visual correction is used, near vision is to be tested with correction, otherwise the test is to be conducted unaided.

18. **Standard for near vision.** The standard for near vision for SF, clearance diving candidates and aviation-related occupations for all ages is N5 at 30–35 cm and N14 at one metre with or without visual correction. If these candidates do not

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meet the required standard the candidate is to be referred for an assessment by an ophthalmologist or optometrist.

19. **Recording of results.** Test results for near vision testing are to be recorded on Form PM166 as ‘Pass’ or ‘Fail’.

COLOUR PERCEPTION

20. The Australian Defence Force (ADF) uses the Ishihara Pseudoisochromatic Plates Test (PIP Test), Konan Cone Contrast Test – High Definition (CCT-HD) and Farnsworth D15 test to screen for colour perception (CP) deficiencies. CP is only to be tested by an operator who is CP1. Candidates must be checked to ensure that they are not wearing contact lenses or tinted lenses, which may interfere with the accuracy of CP testing. The test is to be administered under natural daylight (not direct sunlight) or under lighting provided by daylight tubes. Table 2C–2 defines the CP classifications.

Table 2C–1: Colour perception classifications

Classification	Definition by test results	Result of test
CP1	PIP normal – pass	A pass is 12 or better correct responses from 14 plates
CP2	Fail PIP Pass Konan CCT-HD	If the PIP test result is less than 12 correct, Konan CCT-HD testing is required. A classification of CP2 is a score of 60 or more for both L-cones and M-cones.
CP2A	Fail PIP Fail Konan CCT-HD Pass D15	Army and Air Force only
CP3	Fail PIP Fail Konan CCT-HD (Navy) Fail D15 (Army and Air Force)	A classification of CP3 is a fail on PIP test, and a score of less than 60 for either L-cones or M-cones (or both) on the Konan CCT-HD.

Pseudoisochromatic plates test

21. The Ishihara colour test is a test for red-green colour deficiencies. Tritan testing is not conducted in the current ADF test series. The 38 plate series is to be used, specifically the ‘best plates’ listed in the table below. These plates have been shown to have the best sensitivity and specificity, and are divided into the following categories:

a. **Introduction plate.** Seen by all observers

b. **Transformation plates.** Those with abnormal colour vision give different responses to those with normal colour vision. These are the plates numbered two to nine inclusive

c. **Vanishing plates.** Only the normal observer is meant to recognise the coloured pattern. These are plates 10–17.

d. **Hidden digit plates.** Only those with abnormal colour vision should see the pattern. These are plates 18–21 inclusive. The test will determine those who are CP1 from those who are CP2 or CP3. The only acceptable PIP test is the Ishihara 38 plate series (NSN 6515–996639390) of which the 'best plates' listed in the following table are to be used.

Table 2C–2: Pseudo Isochromatic Plates to be used for Australian Defence Force colour vision testing

Category	38-plate series	Best plate
Introductory	1	1
Transformation	2	2
Transformation	3	3
Transformation	4	NA
Transformation	5	5
Transformation	6	6
Transformation	7	7
Transformation	8	8
Transformation	9	NA
Vanishing	10	10
Vanishing	11	11
Vanishing	12	12
Vanishing	13	NA
Vanishing	14	14
Vanishing	15	15
Vanishing	16	16
Vanishing	17	NA
Hidden	18	NA
Hidden	19	19
Hidden	20	20
Hidden	21	NA

22. **Procedure for PIPS Test.** The interpretation of error score holds only when the test is administered under the standard source of illumination, standard distance and standard timing. Operation of the plates is to be conducted as follows:

a. when the PIP Test is used, the test must be performed using a daylight fluorescent lamp (balanced spectral distribution approximating daylight).

Failure to do so may alter the test results, and particularly result in false positive results for deutan defects

b. the candidate's line of sight should be at right angles to the plates and the eyes should be at a distance of approximately one metre (plates just out of arms' reach). The candidate should not face an open window or other strong light. Nearby incandescent lights should be shielded so that they do not illuminate the plates.

23. **Administration of PIPS Test.** The test is to be conducted as follows:

a. CP is to be tested on both eyes at the same time unless an acquired cause is suspected (eg eye injury, head injury) in which case CP must be tested on each eye separately. Where the eyes are tested separately, the order of the plates must be different for each eye

b. the candidate to be tested should be told by the examiner to 'please read the numbers'. The candidate should not be given any further instructions or asked other questions. The candidate is not allowed to trace patterns or touch the test plates. When not in use the book of plates is to be kept under lock and key. Soiled or unserviceable books are to be replaced

c. the candidate should be shown the introductory plate first (a red 12 on a blue background). The selected 14 plates are then shown. About two seconds should be allowed for a response to each plate. If a candidate hesitates the examiner should ask them again to 'read the numbers'. If there is still no response or an incorrect answer, the examiner should turn the next plate without comment. If a candidate makes a partial completion error (eg reads a three as an eight) this is not strictly an error and should not be counted as such. In plates with two digit numbers incorrect responses to either number is a failure for the plate. Any queries about partial completion errors should be directed to CMO DFR

d. with the exception of the introductory plate which is always first, the examiner must change the order of the plates frequently. The change should be made at least weekly and more often if there is suspicion that the numbers have been learned in serial order by candidates.

24. **Interpretation of PIP Test.** The test is to be scored as follows:

a. a score of 12 or better from the 14 test plates correct represents a pass (CP1)

b. candidates who score less than 12 are considered to have failed the PIP test and must proceed to the Konan CCT-HD

c. the introductory plate is not considered in scoring.

25. **Recording tests results.** The test results of the 38 series PIP are to be recorded on the Form PM367—'Colour perception & stereopsis test record' for all candidates. The correct method of recording PIP results is to record the actual response by candidates. The correct number of responses from PIP testing is to be

transcribed onto the Form PM166 in addition to completing and enclosing Form PM367 into the candidate's medical file.

Konan Cone Contrast Test – High Definition

26. The Konan CCT-HD test is used for all candidates who fail the PIP Test to differentiate CP2 from CP3. The test provides instructions for set up and administration, including a User Manual and videos. The device is to be set up, with log-in details, internet connection (if desired) and printer connection.

27. The ADF standard for the Konan CCT-HD test is 60 for the L-cone (protan) and M-cone (deutan). To pass the test, both the L-cone and M-cone scores need to be at or above 60. Candidates with scores below 60 for either the L-cone or M-cone (or both) are deemed to have failed the test.

28. Calibration of the test must be verified every 30 days. The Konan CCT-HD will not allow testing to commence if verification of calibration has not been undertaken within the last 30 days. To verify calibration:

a. Turn the test on for 15 minutes before performing calibration. Select the Calibration tab.

b. Plug the calibration device into the monitor. Hang the device over the monitor using the counterweight to balance it. The calibration device must be facing the monitor in the area designed on the screen.

c. Commence verification of calibration. This takes 2 to 5 minutes.

29. Test set-up is as follows (once selected, the settings should not change):

a. Setup: Standard.

b. Results format: Linear Log CCT-HD.

c. Pass/Fail line: in the custom box type "60" and in the description box next to that type *DFR*.

d. Print Report Format: Detailed.

e. Report Customisation: Enter the name of the DFRC and UI Options: Answer tones: High/Low.

f. Tool tips: No.

30. **Conduct of Konan CCT-HD test.** The test is to be conducted in a normally lit room. The lighting in the room should not be unduly bright and there should not be reflections or other lights that might shine into the candidate's eyes and affect their performance.

a. The test is conducted seated, with the candidate's eyes 0.6 metres from the monitor. Adjust the candidate's seat so that the candidate's eyes are level with centre of the monitor.

b. The response pad has 4 direction arrow buttons. Plug the pad into the monitor and position it so it is within comfortable reach of the candidate's dominant hand. Ensure the response pad is properly orientated. The Konan Medical name and logo should be in the bottom left corner.

c. Using the Patients tab, enter the candidate's name, date of birth and identity number.

d. On the Test tab, select OU (the binocular test option). Ensure the Adaptive buttons on the screen for L-cone (P) and M-cone (D) are both selected. Note: at this stage, it is not necessary to select the S-cone (T) button. Select the green tick and move to the next screen.

e. This screen provides the test instructions for the candidate. They say: *'A letter "C" shape is shown briefly in one of four directions and may be one or more colours. Use the arrows to match the direction of the opening of the "C". A high tone indicates "correct", a low tone indicates "wrong", then the next shape/s displayed. The test calculates the limit of what you can see. When the shape fades to be difficult and then purposely impossible to see, make your best guess. The test ends after several wrong answers and the times to answer are recorded ... try to answer as quickly as practical. Start the test by selecting the tick symbol or with long press of any arrow button.*' Go through these instructions with the candidate. Before proceeding to the test screen, encourage the candidate to use the demonstration on this screen. There is a letter "C" on this screen. When the candidate presses the arrow correctly corresponding the gap in the letter, the high tone (ding) sounds, and when the candidate presses the wrong arrow, the low tone (buzzer) sounds. When the candidate is happy with this operation, the tick symbol is selected and the test starts.

f. At the end of the test, the results page will be displayed. Print the results page and save to pdf, using the pdf button on the screen.

g. For candidates who fail the PIP Test, the CP standard in relation to Konan CCT-HD scores is as per Table 2C–4.

Table 2C–3: Konan CCT-HD colour perception standard

L-cone score	M-cone score	Navy	Army and Air Force
60 or above	60 or above	CP2	CP2
60 or above	Below 60	CP3	CP2a or CP3 based on Farnsworth D-15 result
Below 60	60 or above	CP3	CP2a or CP3 based on Farnsworth D-15 result
Below 60	Below 60	CP3	CP2a or CP3 based on Farnsworth D-15 result

31. **Recording test results.** The Konan CCT-HD test results sheet includes the candidate name, date of birth, ID and results. The operator is to record the CP standard on the result sheet and add the results sheet to the candidate's medical fie. The results are to be recorded on the candidate's Form PM166.

Farnsworth D15 test

32. Candidates who do not meet CP1 or 2 require additional testing with the D15 kit. The candidate is required to arrange the 15 movable discs in natural progression of the colours, beginning with the fixed 'pilot/reference disc'. The D15 kit should be stored in a cool dry place and kept wrapped in its plastic container and protected from light.

33. **Test environment:**

a. test table surface is to be matt black and the test is to be conducted at a working distance of 50cms.

b. the candidate and test administrator (ie nurse) are required to wear non-powdered disposable gloves to prevent soiling of the test surface.

c. testing with contact lenses or tinted glasses is not permitted. Candidates are permitted to wear non-tinted glasses.

d. time allowed for testing is 2 minutes.

34. **Test procedure:**

a. testing is binocular (ie both eyes together) unless otherwise clinically indicated

b. empty removable discs onto the table and re-arrange the discs numbered 1-15 in random order on the desk coloured side facing up (disc numbered '0' remains in the case side facing up)

c. place the test case in front of the candidate with the fixed disc ('0') to the candidate's left. Instruct the candidate to start at the fixed disc and match the colour of each disc as closely as possible to the preceding disc.
The candidate proceeds disc by disc until all the discs are in the case.
Candidate is permitted to re-arrange the discs until they are satisfied that all the discs are in the correct order

d. once the candidate has completed the test close the case and turn it upside down onto the desk and record the results on Farnsworth D15 Colour Perception test score sheet (Figure 3C–2)

e. candidates are not permitted a second attempt unless specific approval is sought from CMO DFR following an appeal from the candidate.

35. **Recording and Determining Results:**

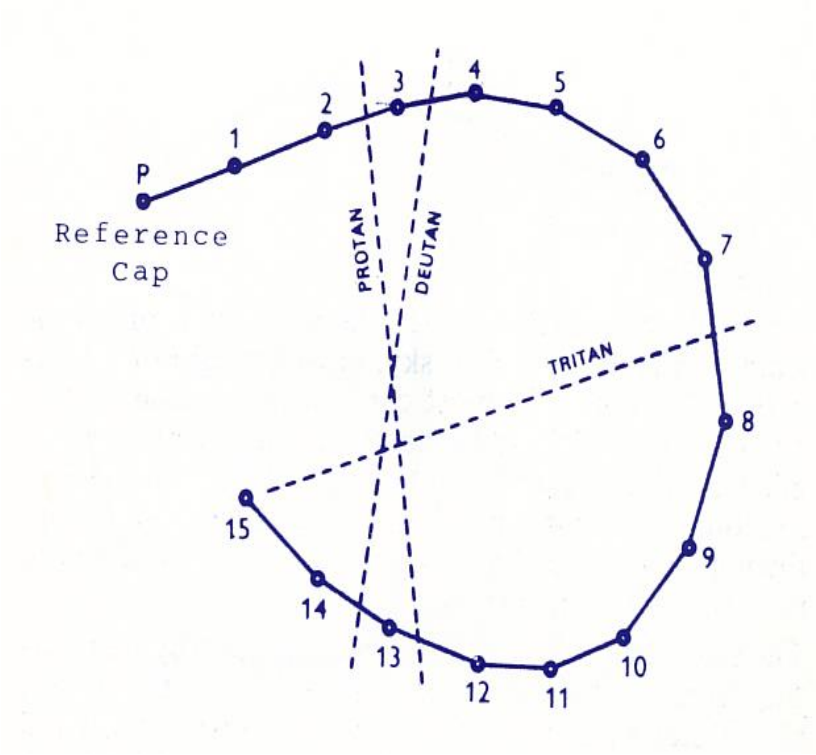
a. scoring is accomplished by reading the coloured disc number on the reverse side of the clear box and reading the sequence selected by the candidate on the score sheet

b. a line is drawn from the starting point (pilot/reference disc '0') through the sequence determined by the candidate

c. if the lines remain along the outside of the circle (ie no crossovers) then the candidate has passed the test. The Farnsworth D15 Colour Perception test score sheet (Figure 3C–2) is used to record results.

36. The following figures provides examples of results:

Figure 2C–1: Pass—normal response and no crossovers



37. The following example demonstrates minor errors which are not clinically significant and do not contain crossovers through the centre, therefore this represents a pass.

Figure 2C–2: Pass with minor errors—not clinically significant and no crossovers

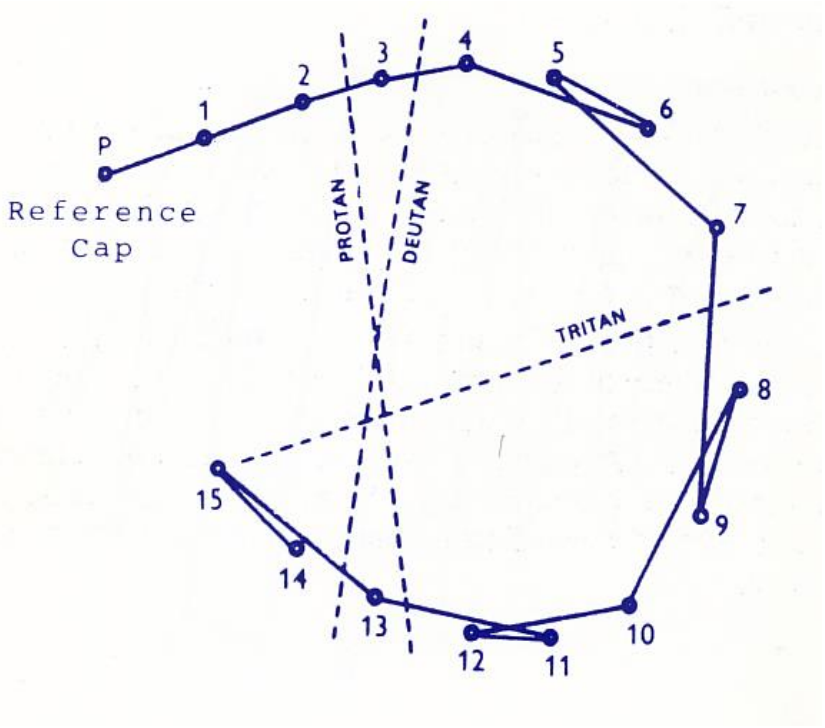


Figure 2C–3: Fail—Crossings right across the circle

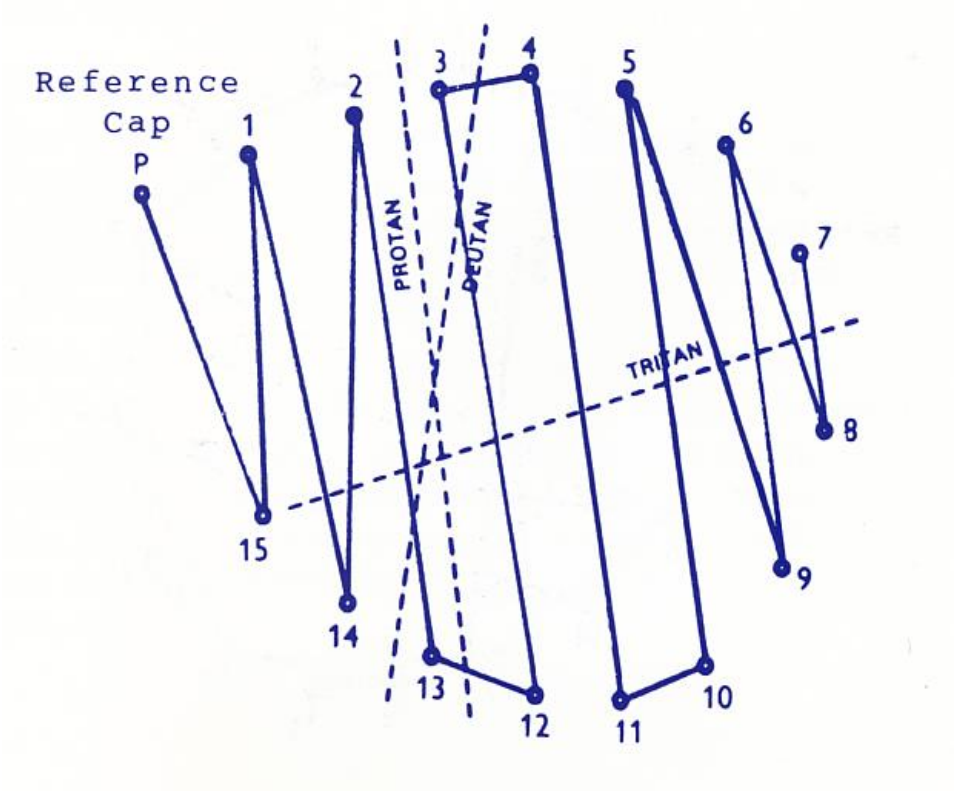


Figure 2C–4: Fail—Crossing parallel to the Tritan axis

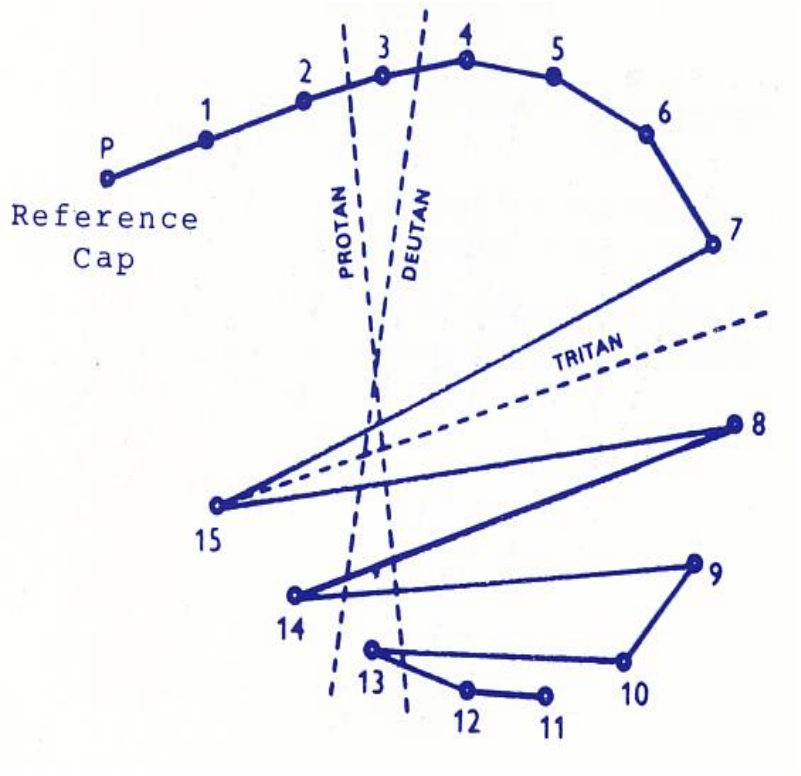
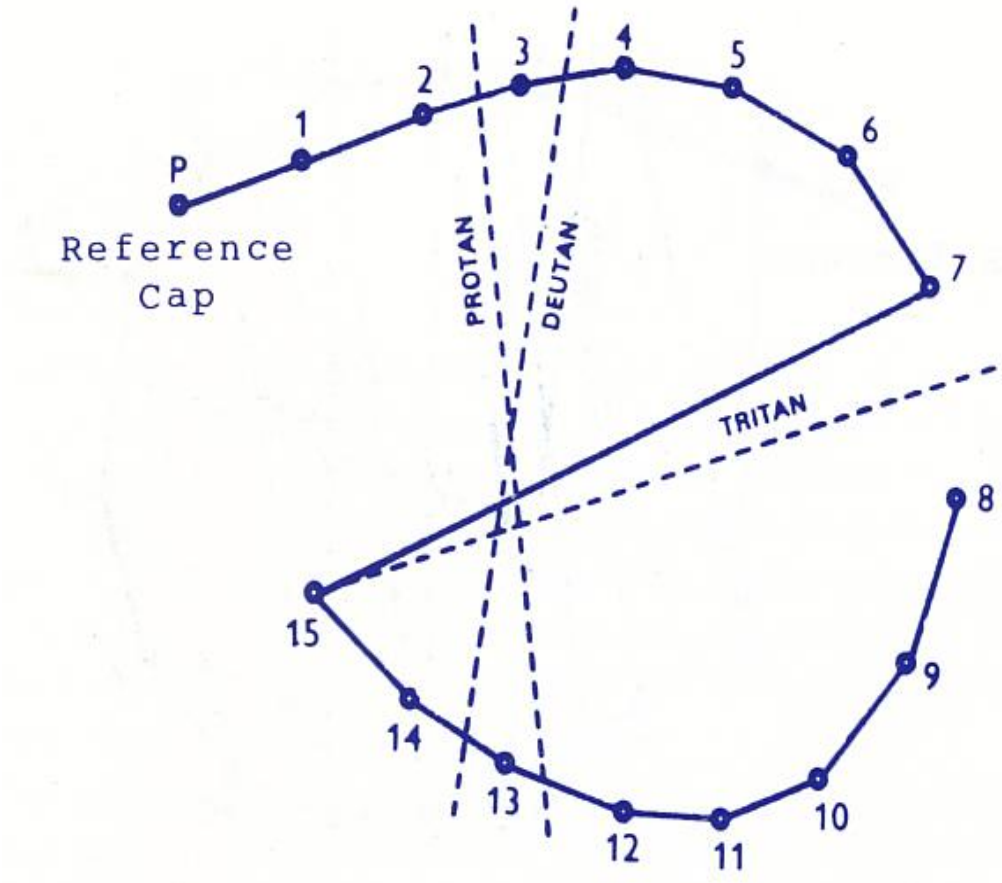


Figure 2C–5: Fail—Single crossover



38. **Management of colour perception deficient candidates.** Deficient CP will not preclude entry, per se, but will limit employment choices. Suitable occupations according to colour perception results are in DHM Level 2 Part 5 Chapter 5.

39. **Stereoscopic Test.** Candidates applying for the role of RAAF – geospatial air intelligence analyst (AIA GEOINT) are to undergo stereoscopic testing as part of the ELME preliminary test requirements. The test is to be administered using the “Circle Test” which is contained within the Random Dot Stereo Butterfly book. The animal and butterfly tests, also in the Random Dot Stereo Butterfly book, are not to be used for DFR purposes.

40. The stereoscopic test is a once only requirement and the test result does not time expire. The test however, should be repeated if the candidate sustains a significant eye injury or undergoes a significant eye operation.

41. The random dot stereo butterfly book is to be stored in a cool dry place when not in use as exposure to high heat and humidity may cause fading of the test pages. Liquid and other cleaning agents are not to be used to clean the random dot stereo butterfly book contents or the 3D stereo optical glasses. The book and glasses may only be cleaned with the use of a soft, slightly damp cloth.

42. **Test Environment.** The test is to be administered under good light conditions and book surface reflection is to be avoided.

43. **Test Procedure:**

a. only the ‘circular test’ is to be used (first test in the book)

b. the test is a binocular test (ie both eyes together)

c. the stereo optical glasses, included in the test kit, are to be worn by the candidate during the test

   (1) The stereo optical glasses are to be worn over prescription glasses

   (2) For candidates who wear bifocal glasses, the book is to be positioned for near-point viewing

   (3) Candidates who have removed contact lenses in preparation for assessment day testing are to be tested wearing prescription glasses

   (4) Candidates who fail to bring prescription glasses on assessment day will need to undergo stereoscopic testing on another day or approval will need to be sought for testing to be conducted by an optometrist for regional candidates

d. the test book should be held straight before the candidate to maintain the proper axis of polarization. The candidate may hold the book and adjust the distance to suit

e. test distance is to be at approximately 16 inches / 40 centimetres

f. there is no specified time that the test must be performed within, however, it is estimated that the test should not take any longer than 2 minutes

g. within each square are four circles, only one of the circles has a degree of crossed disparity. It should appear forward of the plane of reference for those having normal fusion (ie only one of the circles is a 3D-image that will protrude out from the other 3 circles within the square)

h. instruct the candidate to 'look at each of the four circles (within each of the squares/boxes) and identify which one of the circles "seems to come out closer to you – top, bottom, right or left"

i. record the test result on the stereoscopic test score sheet (3C-3)

j. continue the test through each of the circled sections until the candidate finishes the test (if the candidate makes two successive mistakes and accordingly fails the test; the full test is to be completed irrespective on when the two successive mistakes were made).

44. **Scoring and Recording Results:**

a. results are to be recorded on the stereoscopic test score sheet (3C-3) which should not be visible to the candidate during testing

b. record the level of stereopsis at the last one chosen correctly. If the candidate makes one mistake, and gets the next one correct, retest the incorrect one again. If the candidate answers incorrectly on the second attempt, a third attempt is not permissible

c. the candidate has failed the stereo test if they record two or more successive mistakes

d. if the candidate makes two successive mistakes they are 4J for the role of – RAAF AIA GEOINT

e. the completed stereoscopic test score sheet is to be enclosed in the candidate's medical record

f. a Pass/Fail stereoscopic test result and test date (DD MM YEAR) are is to be recorded in the general comments free text field on the medical preliminaries page in PowerForce.

Appendices:

1. Australian Defence Force minimum visual requirements
2. Farnsworth D15-colour perception test score
3. Stereoscopic test score sheet

APPENDIX 2C1

AUSTRALIAN DEFENCE FORCE MINIMUM VISUAL REQUIREMENTS

General

1. Specific visual requirements apply to Army explosive ordnance personnel employment category number (ECN) 432 and technician ammunition ECN 401.

2. Aviation Visual Requirements (AVRs) for aviation related occupations are in Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[39]—'Health requirements for aviation-related occupations' Appendix 2C3.

3. For information on specific conditions of the visual system, refer to DHM Level 2 Part 5 Chapter 5[40]—'Causes of and reasons for rejection' Annex 5K.

Table 2C1–1: Australian Defence Force minimum visual requirements

Category	Visual Acuity Unaided		Visual Acuity Aided		Refractive Error (cycloplegia)
	Right	Left	Right	Left	
MVR1	6/12	6/12	6/6	6/6	+/- 8.00 dioptres spherical in either eye
MVR2	6/120	6/120	6/9	6/9	
MVR3	6/120	6/120	6/12	6/12	
MVR4	6/120	6/120	≤ 6/12 one eye & > 6/12 other		+/- 8.00 dioptres spherical in either eye
MVR5	≤ 6/120 one eye & > 6/120 other		≤ 6/12 one eye & > 6/12 other		
MVR7	Does not achieve MVR 5				
MVR8					> +/- 8.00 dioptres spherical in either eye

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Category	Visual Acuity Unaided	Visual Acuity Aided	Refractive Error (cycloplegia)
MVR: Specific roles	• Army ECN 432 explosive ordinance disposal • Army ECN 401 technician ammunition Refer DHM Level 2 Part 5 Chapter 4[41] appendix 4B4		

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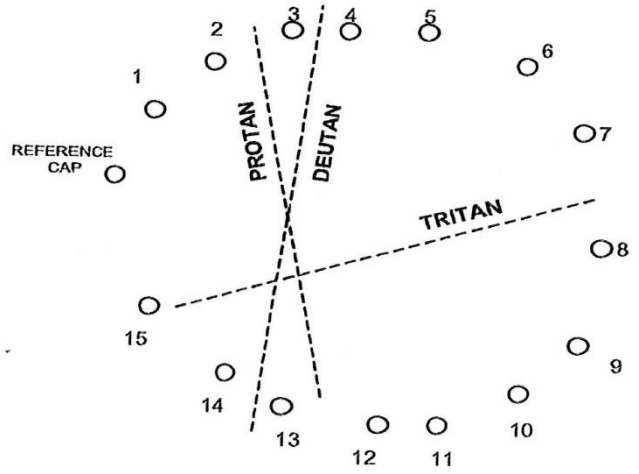
APPENDIX 2C2

FARNSWORTH D15—COLOUR PERCEPTION TEST SCORE SHEET

DRFC:	**Date of test:**	
Candidate details:		
Candidate ID:	Surname:	First name:
Test administrator details:		
First name:	Surname:	Signature:

Figure 2C2–1: Farnsworth D15 colour perception test



Passed D15 test	**Yes**	**No**	
Candidate Colour Perception Standard	Service	CPA2	CP3
	Navy		
	Army	N/A	
	RAAF	N/A	

APPENDIX 2C3

STEREOSCOPIC TEST SCORE SHEET

DFRC	
Candidate ID	
Surname	
First name	
DOB	

Stereo test – circles

Test	**Correct test answer**	**Candidate's response** (eg Top, Bottom, Right, Left) – record as T, B, R, L	**Correct response** (circle Yes or No)
1	Bottom		Yes / No
2	Left		Yes / No
3	Bottom		Yes / No
4	Top		Yes / No
5	Top		Yes / No
6	Left		Yes / No
7	Right		Yes / No
8	Left		Yes / No
9	Right		Yes / No

Test result: Candidate fails test if they record two or more successive mistakes

Test administrator details

First name	**Surname**	**Signature**	**Date**

ANNEX 2D

CLINICAL EXAMINATION AND GUIDELINES

1. **Examination of all candidates.** The importance of accurate observation and physical inspection by the examiner is stressed and should be carried out as follows:

a. the candidate will proceed with all appropriate preliminary testing in accordance with Annex 2C, and additional testing for specialist occupations in accordance with requirements articulated in either Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[42]—'Health requirements for aviation-related occupations', DHM Level 2 Part 5 Chapter 7[43]—'Health requirements for divers' or DHM Level 2 Part 5 Chapter 8[44]—'Health requirements for submariners' for the respective role(s) as applicable

b. Chaperones. Candidates of either gender need to be clearly advised of the availability of a chaperone and may request to have a chaperone of the same gender present during the medical examination. If a chaperone is requested the examination is not to commence until the chaperone is present. Entry level medical examination (ELME) is to record that a chaperone was present for the examination

c. the candidate, dressed in underwear, will be examined by the medical officer (MO). A gown is to be offered to all candidates and provided if requested. Items of underwear will only be removed as necessary in order to permit proper examination of the chest, sacral area and hernial orifices. Disposable gloves must be worn when performing visual inspection of the anal verge. Digital rectal examination is not to be performed

d. the candidate (in underwear) will be directed to stand in a good light in front of the examiner, and to turn slowly through 360 degrees

e. the MO will inspect candidates with a view to gaining a general impression of body build and physique

f. evidence of skin disease, asymmetry and abnormal vaccination marks or other marks or scars should be recorded

g. examination for cutaneous evidence of intravenous drug use is also to be conducted.

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2. **Medical examination of female candidates.** The procedure to be adopted for medical examination of female candidates is as follows:

a. modesty sheets are to be made available to all females to cover the lower abdominal area during the examination

b. DFR MOs are not authorised to perform gynaecological or breast examination. If a gynaecological or breast examination is clinically indicated, the candidate is to be referred to their treating practitioner for the examination. To determine whether a female candidate meets the gynaecological or breast entry standard, MOs are to:

(i) clarify the information provided in Form PM165—'Health questionnaire'

(ii) consider the frequency, duration, severity and management of symptoms

(iii) where additional information is required, request existing or current reports as clinically indicated.

c. Female candidates require a urinary pregnancy test during the assessment (ELME) and attestation medical examinations. The only exemption to this requirement is absent uterus. If the candidate is pregnant, allocate recruiting medical classification as per DHM Level 2 Part 5 Chapter 5[45]—'Causes of and reasons for rejection' Annex 6E.

3. **Blood pressure (BP).** BP measurements should be taken in accordance with the Guidelines for the diagnosis and management of hypertension in adults – 2016[46].This document should be available to all DFR Centre (DFRC) medical staff as a reference document.

4. **BP limits.** BP limits are defined in DHM Level 2 Part 5 Chapter 6 Annex 6A.

5. **High readings.** In cases of persistently raised BP (greater than 139 systolic and greater than 89 diastolic) the following guidelines apply:

a. initially ask the candidate if they have smoked or ingested caffeine within the last two hours. If this is the case the candidate is to be retested after they have avoided smoking and caffeine ingestion for two hours

b. recheck the BP in accordance with Guidelines for the diagnosis and management of hypertension in adults – 2016 at least twice after the candidate has been kept resting for 15 to 30 minutes

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46 https://assets.contentstack.io/v3/assets/blt8a393bb3b76c0ede/bltf610a915c0d751c5/65efd366a93acb316830f9b8/Guideline_for_the_diagnosis_and_management_of_hypertension_In_adults_-_2016.pdf

c. where the BP remains outside the high-normal range, refer the candidate to their treating medical practitioner for further assessment, in accordance with the Guideline for the diagnosis and management of hypertension in adults - 2016 and DHM Level 2 Part 5 Chapter 5 Annex 5A.

6. For further information refer to DHM Level 2 Part 5 Chapter 5 Annex 5A.

7. **Electrocardiogram examination.** Electrocardiogram examination is required for specialist occupations as detailed in DHM Level 2 Part 5 Chapter 6 Annex 6E, DHM Level 2 Part 5 Chapter 7 and DHM Level 2 Part 5 Chapter 8.

Examination of head and neck

8. Examination of the face, head and neck should include the following:

a. **Face.** The face will be examined for signs of current dermatological conditions, deformities, evidence of prior injury or surgery. In particular, any condition which may interfere with the wearing of protective personal equipment (eg masks, goggles) should be noted

b. **Head.** The head will be examined for signs of skin conditions, tumour, or old fracture of the skull, or for deformity which may interfere with wearing of face masks, helmets, etc.

c. **Neck.** The neck will be examined with particular reference to the presence of lymphadenopathy or thyroid enlargement.

Oral and dental assessment

9. Form PM165—'Health questionnaire' is also to identify candidates who are undergoing specialist dental care, or may require general dental care (refer to DHM Level 2 Part 5 Chapter 6 Annex 6J, for additional information).

10. Candidates who are about to undergo orthodontic treatment should be advised that there is no guarantee that they will be provided orthodontic treatment at public expense by Defence.

11. If specialist dental treatment is required the suitability of the candidate is to be confirmed by CMO DFR who may seek the opinion from Directorate of Defence Force Dentistry (DDFD) as appropriate.

12. A dental officer examination is required for all aircrew candidates (refer to DHM Level 2 Part 5 Chapter 6 Appendix 6B5).

13. Dental referral is NOT required for the following:

a. **Orthodontic retainers.** Candidates who are wearing passive orthodontic retainers after their orthodontic treatment has been completed. This is not a cause for temporary rejection for any candidate

b. **Impacted wisdom teeth.** Unless there is obvious, acute inflammation around impacted wisdom teeth, there is no need for referral for dental

examination. It would be unlikely that any potential candidate would require removal of third molar teeth prior to enlistment.

c. **Small number of carious teeth.** Candidates who have only a small number of carious teeth of a small size and are not in pain are usually acceptable. It is expected that a small amount of routine dental treatment may be required on entry.

d. **Dentures.** Adequate dentures are not a cause for referral for dental examination.

e. **Aesthetic problems.** For example, discoloured or slightly crowded teeth.

14. In any cases of doubt the DFRC MO is to refer the case to CMO DFR who may seek the advice of the DDFD as appropriate.

Examination of the ears, nose and throat

15. The ears, nose and throat (ENT) examination should include the following:

a. external ears and face for disease or malformations

b. nostrils, noting conditions of turbinates and position of septum, and presence of nasal obstruction. This should be tested for by asking the candidate to breathe through each nostril separately

c. mucous membrane of mouth, including the hard and soft palate and nasopharynx

d. teeth and gingival tissues for presence of disease, infections, abnormalities, or orthodontic appliances

e. jaws for presence of deformities, which interfere with the wearing of facemasks, breathing apparatus or eating

f. an inner and middle ear assessment as follows:

(1) note the results of the reference audiogram (general preliminary testing) recorded on Form PM166—‘Entry level medical examination’ refer to Annex 2C) for details of audiometric testing procedure and hearing standards (HS)

(2) an otoscopic examination must always be undertaken. If cerumen is present please refer to DHM Level 2 Part 5 Chapter 5 Annex 5I, for additional information

(3) patency of both eustachian tubes and the ability to voluntarily ventilate the middle ear on each side will be tested by means of the Valsalva manoeuvre. This is performed with the aid of an otoscope and will be conducted with the tympanic membrane in view of the examining MO. Candidates will be instructed to hold their nostrils closed with the fingers of one hand, shut their lips lightly, and expire. The manoeuvre produces

positive pressure in the nasopharynx, and if the eustachian tubes are patent, the increase in pressure will cause air to pass along the tubes into the middle ear cavity on each side. The resultant movement of the tympanic membrane under observation may be detected by the temporary alteration of the light reflex that it produces

g. The following points should be noted regarding ENT examination of candidates:

(1) the Valsalva manoeuvre is to be performed for the MO during the clinical examination for all candidates. The results need to be recorded on Form PM166 for all candidates and in the specialist occupations section (part 19) for specialist employment categories (aircrew, divers, submariners and special forces)

(2) many people are unable to Valsalva and yet have normal ears. Therefore, if the candidate is unable to Valsalva, tympanometry should be performed. If this testing demonstrates abnormal tympanic membrane movement, candidates should be referred to their treating medical practitioner for further testing to ensure an underlying condition is not present

(3) candidates who do not meet the required health standard (HS) will not be re-examined until at least 24 hours later. Where re-examination of an otherwise fit candidate is proposed, they will be instructed to avoid exposure to significant noise (including but not limited to iPod use with headphones, live music, noisy hobbies and loud workplaces without hearing protection) for at least 24-48 hours before re-examination

(4) if it is suspected that the candidate is suffering from a head cold or upper respiratory tract infection, the examination should be repeated when the candidate is free from infection or disease.

16. All candidates who fail to achieve HS2 are to be referred to their medical practitioner with a copy of the audiogram for clinical follow up as indicated.

Examination of the eyes

17. The eye examination will consist of visual acuity (VA) (including near vision and stereopsis testing where required for specified jobs), refractive error testing for candidates exceeding minimal visual requirement (MVR) 1, colour perception, presence of strabismus (squint), nystagmus, any morbid conditions of the eyes or lids, pupillary reflex to light and accommodation, fundi and visual fields. The examiner will confirm that the candidate is not wearing contact lenses.

18. Candidates must be asked specific questions to exclude night blindness or other night vision difficulties. Where a candidate indicates that there is a known family history of night blindness, or that he or she experiences difficulty with visual tasks in low light situations (even in a familiar environment, such as at home, with no lighting) the diagnosis of night blindness or a related condition needs to be excluded. In cases of doubt the candidate is to be referred to an ophthalmologist for opinion.

19. Candidates who wear contact lenses should be advised that there is no guarantee that contact lenses will be provided at public expense by the ADF.

20. VA tests and ophthalmic examination will be carried out as follows:

a. **Presence of squint or nystagmus.** Inability of the eyes to maintain binocular fixation in all directions of the gaze suggests paralytic or concomitant squint. The candidate will face the examining MO, and both will either sit or stand. A pencil or similar object will be held about 0.5 m in front of the candidate's face, and they will be directed to watch the tip closely. The pencil will then be moved from the central position to the right for about 0.6m, then up and down over a distance of about 0.6 m. It will then be moved across at the level of the candidate's eyes and to the left side of the face to a position about 0.6m from the nose and then up and down over a distance of about 0.6 m. During the movement of the pencil, the candidate's eyes will be observed closely for evidence of lagging by one or other eye, nystagmus, or actual strabismus. A cover test should then be performed. If a squint or nystagmus is discovered by performing a cover test, the candidate should be managed in accordance with DHM Level 2 Part 5 Chapter 5 Annex 5K

b. **Pupillary reflex to light and accommodation.** When testing the pupillary reflex to light and accommodation, the light should be brought in from the side of each eye

c. **Fundi.** An ophthalmoscope examination of the fundi and media should be made, with special care being taken when vision is reduced

d. **Cornea, conjunctiva, sclera.** Should be examined for gross keratoconus, significant pterygium or other obvious pathology

e. **Visual fields.** The extent of visual field in each eye will be estimated in all candidates, by means of the simple confrontation test. The test is based upon the comparison of the monocular fields of vision of the examining MO and the candidate, which should be similar. To perform the test, a simple target, such as a pencil with a white tip, or a hatpin, is the only equipment required. The examining MO should have no visual field defect. The test will be conducted as follows:

(1) the MO and the candidate, with heads erect, will face each other at a distance of 0.6m, and assume positions in which their eyes are on the same horizontal plane. The candidate will then close the left eye and the MO the right eye. Each will fix their gaze upon the other's open eye

(2) the target, in the MO's left hand, will then be positioned overhead in the vertical plane midway between them, and will be slowly lowered until it is seen by the candidate. Assuming similar brow conformation, the MO and candidate should see the target simultaneously. The procedure will be repeated at intervals of 30–40 degrees around the 360 degree periphery, and the field of vision in each of the candidate's eyes examined in the superotemporal, superonasal, nasal and inferonasal areas

(3) the candidate's temporal and inferotemporal limits of vision will be estimated by positioning the target behind the plane of each eye in turn, and then bringing it slowly forward, until it is seen by the candidate. In these meridians, the visual field on each side usually extends to at least 90 degrees

(4) the normal field form is approximately as follows: temporally 90 degrees or more; superotemporally 69 degrees or more; inferonasally 55 degrees or more; inferiorly 70 degrees or more and inferotemporally 85 degrees or more. When no diminution is detected, the result of the test will be assessed as normal. If the test is abnormal, the candidate should be referred to their medical practitioner to arrange for formal field-testing.

21. **Refractive surgery.** DFRC medical staff are to ensure that candidates who present for enlistment/appointment into the ADF and who declare a history of refractive surgery are to provide full details of:

a. their pre-operative refraction

b. two refractions performed post-surgery by an ophthalmologist at least one month apart and both at least one month post-surgery

c. details of after-care from their provider.

22. Whilst refractive surgery provides an excellent alternative to the wearing of spectacles or contact lenses, it is important to understand that it is NOT a means for candidates to overcome uncorrected refractive errors which are outside existing ADF entry standards. It is important to recognise that refractive surgery has the potential to conceal pre-operative refraction below the visual standard required for entry and will not be detectable during routine examination at the DFRC. Where doubt exists, the candidate is to be referred to an ophthalmologist for assessment. Candidates who have had refractive surgery must meet the criteria for entry in DHM Level 2 Part 5 Chapter 5 Annex 5K.

23. Candidates must NOT be advised to have refractive surgery as a means of meeting ADF entry standards.

Examination of the respiratory system

24. Examination of the respiratory system should be carried out as follows:

a. noting of any deformities, wheezing, marked flattening or impaired movement of the chest

b. examination for evidence of disease, eg clubbing, anaemia, cyanosis

c. spirometry if indicated.

25. Respiratory Function predicted values vary according to gender, age, height and ethnicity. All predicted values used should consider these variables, and most spirometers will adjust reference values based on these parameters. This should be

confirmed, or reference values should be obtained from the National Asthma Council Asthma Management Handbook[47] and its updates.

Examination of the cardiovascular system

26. Examination of the cardiovascular (CV) system should be carried out as follows:

a. the MO will examine the CV system. If any cardiac murmurs are heard over the cardiac area, the candidate should be referred to their medical practitioner for assessment and possible echocardiogram

b. sinus arrhythmia and isolated ventricular extrasystoles are not in themselves causes of rejection.

27. The heart rate and rhythm should be measured and recorded at the same time the BP is measured.

28. **CV risk assessment.** As part of the preliminary testing requirements, testing for random cholesterol, high-density lipoprotein (HDL) and glucose screening is conducted at the DFRC. Testing for random glucose is conducted for all aircrew candidates and all other candidates aged 35 years or over. All candidates with elevated glucose results are to be referred to their treating medical practitioner for further assessment.

29. Random cholesterol and HDL testing is conducted for all candidates aged 35 years or over at the DFRCeL testing is to be y or gestational diabetes mellitus) clinically indicated need to be amended to reflect 16 hour. Candidates with an elevated (≥ 5% over 5 years) overall cardiovascular risk are to be referred for further assessment. Where the overall risk is acceptable no referral is necessary. Candidates are to be referred to a cardiologist and undergo cardiac stress testing if they are assessed to be greater than five per cent five-year CV disease risk category or if clinically indicated. Guidelines for the CV risk assessment are in Appendix 2D1.

Examination of the gastrointestinal and genitourinary systems

30. Examination of the gastrointestinal (GIT) system will include the following points:

a. presence of scars, injuries, and malformations

b. evidence of GIT organ disease or enlargement, including other system manifestations of GIT disease

c. evidence of hernia in the inguinal, femoral and umbilical regions

[47] https://www.asthmahandbook.org.au/management

d. presence of haemorrhoids, rectal prolapse, fistula, fissure of anus, pilonidal sinus, coccygeal dimple or any other morbid condition (digital rectal examination is not to be performed)

e. any lymphadenopathy

f. males only: the external genitals for abnormalities; the scrotum, to ascertain if the testicles have descended and are normal, or if there is hydrocoele, varicocoele, or any other abnormal condition.

Musculoskeletal examination

31. The musculoskeletal (MSK) examination is a functional assessment. It identifies whether a candidate meets the MSK entry standard and whether there are clinical signs suggestive of an abnormality or underlying pathology.

32. **Look.** Ask the candidate to remove their shoes, socks and shirt. Assess the front, rear and both sides of the candidate's lower limb, upper limb and spinal regions. Inspect for:

a. alignment, symmetry, skin changes, scars, swelling, deformity, muscle wasting, amputation

b. defect of the toes (including ingrown toenails), feet, ankles, knees, hip joints, fingers, thumbs, limbs, wrists, elbows, shoulder joints and spine

c. pes planus, pes cavus, hallux valgus

d. orthotics , as orthotics may indicate underlying problems (inspect the soles of the candidate's shoes for indications of such problems).

33. **Feel.** Palpate the spine and limbs to check for tenderness, joint effusion, temperature, spasm, muscle bulk, ligament laxity, nodules, contractures and strength. Conduct passive range of motion tests to measure to determine joint functionality. Conduct the Lachman and pivot shift tests.

34. **Move.** Check flexion, extension, abduction and adduction to establish range of motion, ligament laxity and joint instability.

a. Lower limb region. Ask the candidate to:

(1) raise on toes

(2) do a mini-squat, one-legged squat and duckwalk

(3) spring up in the air, kick well back with both heels, and land on toes

(4) walk across the floor and back

(5) hop from side to side

(6) short hops across the floor on the toes of left foot and back on the right

b. Upper limb region. Ask the candidate to:

(1) stretch out arms in front

(2) stretch out fingers and thumbs with the palms of the hands upwards

(3) bend fingers backwards and forwards

(4) bend thumbs across the palms of hands

(5) bend wrists backwards, forwards and sideways

(6) place elbows close to sides, bend them to a right angle, show the palms of hands, turn the hands over and show the backs of the hands

(7) put arms above the head

(8) swing arms around at the shoulders

(9) pinch and then squeeze an object

c. Spinal region. Ask the candidate to:

(1) move chin to chest, then look at the ceiling

(2) look over shoulder

(3) bring ear down to shoulder

(4) touch toes or as near to the toes as you can reach (for a more accurate test of this is discussed below, see Schober's test)

(5) run arm down the side of leg in turn.

Dermatological examination

35. The dermatological examination is based on standard medical texts such as Talley & O'Connor's *Clinical Examination*. The examination seeks information to supplement that provided in Form PM165 and to confirm whether the candidate meets the Class 1 standard.

Examination of the nervous system

36. Testing of the nervous system should include the following:

a. testing of cranial nerves, and peripheral nervous system (limb power, tone and coordination, reflexes). Sensation should be assessed when clinically indicated

b. notes should be made of the presence of tics, severe biting of fingernails, stammering or restless movements indicative of a clinically significant nervous system disorder

c. **Romberg test.** Testing of balance is essential for the military and may be quickly assessed for all candidates by the Romberg test. A positive sign is when the candidate is unable to stand with their feet together and their eyes closed

d. **Sharpened Romberg test.** This test should be performed for diver candidates and forms a baseline for future testing as part of a Diving Medical Examination. Recent exposure to motion or consumption of alcohol may impair performance on the Sharpened Romberg Test. Practice can be encouraged and can improve 'normals' but not when a neurological condition exists. The procedure is as follows:

(1) the candidate should be tested barefoot or in socks and stand on an even floor surface, free of furniture and fittings

(2) the candidate must then stand heel to toe with arms crossed over chest, right palm to touch left shoulder, and left palm to touch right shoulder

(3) the candidate is then instructed to close the eyes for a period of 60 seconds. During this time, if the candidate does not lose balance, a perfect score of 60 is given

(4) if the candidate loses balance, the number of seconds that they maintained balance is noted eg 30 seconds. The test is then repeated for 60-second periods to a total of four minutes. The final score is the best of four attempts, out of 60. The pass score is 30 ie 30/60

(5) the candidate should be instructed to resume the test position immediately following any loss of balance and the 60-second test period is recommenced immediately.

37. Candidates who are doubtful cases or persistent failures should be referred to their treating medical practitioner for further neurological consultation.

Examination of mental capacity

38. A general measure of the candidate's intelligence should be formed from the way in which questions are grasped and answered and from the manner in which directions are followed. The examining MO is not expected to perform full psychological testing—this is the role of the psychologists at DFRC. However, in cases of doubt, the MO should contact the psychologist and discuss the case, regardless of whether the candidate has been formally assessed by the psychologist. This allows for forewarning the examining psychologist if the candidate has not already undergone a psychological interview, or review of the case if the interview has already been done. The psychologist is to be the final arbiter on those candidates who demonstrate behavioural or learning disorders or inadequate personality, and rejection on this basis is a non-medical rejection. Accordingly, the psychologist should confer with the MO concerning those candidates who may have a mental health issue or condition of relevance if their interview precedes the medical examination.

Examination of mental health

39. The mental health examination is based on standard medical texts such as Talley & O'Connor's *Clinical Examination*. The examination seeks information to supplement that provided in Form PM165 and to confirm whether the candidate meets the Class 1 standard.

40. Where a candidate has a mental health condition, the medical and psychological assessment of that condition should be available to both the assessing MO and assessing psychologist.

Appendix:
2D1 Assessment of cardiovascular risk

APPENDIX 2D1

ASSESSMENT OF CARDIOVASCULAR RISK

1. A cardiovascular risk assessment (CVD RA) is to be conducted on all candidates aged 35 years or over, unless they have been assessed as Class 4 for another reason. Random cholesterol and high-density lipoprotein (HDL) testing is conducted for all candidates aged 35 years or over at the Defence Force Recruiting Centre (DFRC). Candidates with lipid results outside of the normal range and the overall risk is elevated (≥ 5% over 5 years) are to be referred to their treating medical practitioner for further assessment. Where the overall risk is acceptable no referral is necessary.

2. CVD RA needs to be completed prior to pre-enlistment fitness assessment. Refer to Defence Health Manual (DHM) Level 2 Part 9 Chapter 2[48]—'Cardiovascular disease risk assessment'. The purpose of cardiovascular (CV) screening is to detect increased CV risk in asymptomatic people and to identify the subgroup who have genetic lipid disorders. A medical history indicative of a high risk of CV disease would result in a classification of Class 4. This may include a history of a previous CV event, diabetes, renal disease and genetic lipid disorders.

3. The Coronary Heart Disease Risk Factor Prediction Chart[49] (Modified American Heart Association Chart April 2002) is used by several occupational authorities in Australia including aviation, rail and maritime industries and is the preferred risk assessment tool.

4. Candidates are to be referred to a cardiologist if they are assessed to have a five per cent or greater, five-year CV disease risk category or if clinically indicated. This referral should include a request for a cardiac exercise stress test to be conducted. Where clinically indicated, a fasting blood sugar is required (ie significant family history or gestational diabetes mellitus). These assessments are to be conducted at the expense of the candidate.

5. Coronary Heart Disease Risk Factor Prediction Chart is in DHM Level 3 Part 9 Chapter 17. This has been provided with approval of Civil Aviation Safety Authority for use by DFR.

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[49] https://www.casa.gov.au/licences-and-certificates/medical-professionals/dames-clinical-practice-guidelines/coronary-artery-disease-screening

ANNEX 2E

MANDATED INVESTIGATIONS FOR ENTRY TO GENERAL AND SPECIFIC OCCUPATIONS

Table 2E–1: General entry requirements for all candidates including specialist occupations

Test	Required by	Funded by
Blood Screening for Hepatitis C, Hepatitis B and human immunodeficiency virus	All initial candidates. Serving candidates for aircrew and air traffic control officer	Defence Force Recruiting (Defence) Australian Defence Force health facility
Blood Lipid Profile	All initial candidates aged 35 years and over will have random cholesterol and high-density lipoprotein (HDL) testing conducted at the DFR Centre (DFRC). Candidates with random lipid results outside of normal range will be referred for further assessment in accordance with Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[50]—'Medical history and examination'	Random lipid testing – DFRC Further assessment - candidate
Glaucoma Screening	All initial candidates aged 45 years and over determined to be at risk in accordance with DHM Level 2 Part 5 Chapter 5[51]—'Causes of and reasons for rejection' Annex 5K	Candidate

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Table 2E–2: Mandated medical examination requirements for aviation-related occupations

Occupation	Reference
Aviation-related occupations	Refer DHM Level 2 Part 5 Chapter 6[52]—'Health requirements for aviation-related occupations' Appendix 7B1

Table 2E–3: Mandated medical examination requirements for specific occupations

Occupation	Respiratory Function	Sharpened Rombergs	Valsalva	Near vision	ECG	Chest X–ray inspiratory and expiratory, and reported	Reference
Divers	Yes	Yes	Yes	Yes	Yes	Yes	DHM Level 2 Part 5 Chapter 2 and DHM Level 2 Part 5 Chapter 7[53]—'Health requirements for divers'

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Occupation	Respiratory Function	Sharpened Rombergs	Valsalva	Near vision	ECG	Chest X–ray inspiratory and expiratory, and reported	Reference
Submariners	Yes	No	Yes	No	No	Only if clinically indicated	DHM Level 2 Part 5 Chapter 2 and DHM Level 2 Part 5 Chapter 8[54]—'Health requirements for submariners'
Special forces	No	No	Yes	Yes	No	No	DHM Level 2 Part 5 Chapter 2 and DHM Level 2 Part 5 Chapter 7

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ANNEX 2F

GUIDELINES FOR EXAMINATION BY AN OPHTHALMOLOGIST OR OPTOMETRIST

6. These guidelines relate to requirements for examination by an ophthalmologist or optometrist for candidates who apply for roles other than the aviation-related occupations. The ophthalmologist or optometrist is to record examination details required to allocate a minimum visual requirement (MVR) on Form PM529—'Eye examination'.

7. Guidelines for referral to ophthalmologist or optometrist are in Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[55]—'Medical history and examination', paragraphs 2.27–2.29, Table 2–1.

8. Serving members transferring to Army explosive ordnance personnel (Employment Category Number (ECN) 432–435), surveyor engineer (ECN 393), or technician ammunition (ECN 401) require mandatory ophthalmologist assessment, in accordance with DHM Level 2 Part 5 Chapter 5[56]—'Causes of and reasons for rejection'.

9. Ophthalmologists and optometrists should contact the Defence Force Recruiting Centre (DFRC) to ensure that they have a current copy of the Australian Defence Force (ADF) MVR standards and guidance notes. They must not perform additional testing beyond what is required in this guidance and to permit completion of Form PM529. Guidance which should be provided includes:

a. ADF MVR in DHM Level 2 Part 5 Chapter 2 Appendix 2C1 and AVR for aviation related occupations Chapter 6 Appendix 6B3 guidelines for examination by an ophthalmologist or optometrist in DHM Level 2 Part 5 Chapter 2 Annex 2F

b. Form PM529.

10. These documents may also be available on the Royal Australian and New Zealand College of Ophthalmologists' website[57] and the Australian College of Optometrists' website[58].

11. A candidate will require at least one appointment with the ophthalmologist or optometrist. Two appointments are needed if contact lenses are worn as the

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[redacted]

[57] https://ranzco.edu/

[58] http://www.optometry.org.au/

preferred method of visual correction most of the time. Contact lenses must not be worn for one week (soft contacts) or two weeks (hard contacts) prior to examination.

12. **First appointment.** At the first appointment, the candidate should present with their glasses and/or contact lenses. The examination is to include:

a. subjective refraction prior to cycloplegia which includes uncorrected vision and visual acuity (VA) with spectacle lenses

b. cycloplegic refraction using cyclopentolate HCl one per cent (waiting the usual 10–20 minutes required for effective cycloplegia). The minus cylinder form must be used for recording dioptres

c. physical examination of the eyes including identification of:

(1) squint

(2) heterophoria using a Maddox rod

(3) abnormal ocular motility

(4) abnormal convergence

(5) acute or chronic disease of the eye or eyelids

(6) visual fields to confrontation only

(7) any evidence of refractive surgery

(8) high intra-ocular pressure (mandatory check for candidates over 45 years)

(9) fundal abnormality.

d. **Near vision testing.** Candidates for special forces, non destructive inspection (NDI) technicians, ammunition technician, explosive ordnance disposal and diving candidates are required to undergo near vision testing. The recommended near vision test procedure is to use the Sussex Vision Rayner near vision testing card which displays the N series of letters (faculty approved N5 to N48):

(1) **Near test.** The near test is a small card containing a few short lines or paragraphs or text printed in high contrast and viewed at an appropriate reading distance using optimal illumination. To test near vision, the candidate will be asked to hold the card at normal reading distance. The candidate is to be tested in the range of 30–35 cm from the face and then at one metre from the face and read aloud the paragraph containing the smallest print they can comfortably read without squinting. The candidate is to be asked if they normally wear glasses or contact lenses for near vision. If visual correction is used near vision is to be tested with correction, otherwise the test is to be conducted unaided

(2) **Standard.** The standard for near vision for all ages is N5 at 30–35 cm and N14 at one metre with or without visual correction.

13. **Second appointment.** When a second appointment is required, the candidate should present in contact lenses after having worn them for at least four hours. The candidate should also be instructed to bring their spectacles to the second appointment. The ophthalmologist or optometrist should assess the following:

a. VA wearing contact lenses

b. spectacle blur, ie the vision in glasses immediately upon contact lens removal.

14. **Contact lenses.** A candidate who wears contact lenses may be acceptable if:

a. the MVR is satisfactory

b. there is no pathological condition of the eyes

c. the existing contact lenses are suitable for the proposed employment

d. the wearing of contact lenses is not obligatory and spectacles can be substituted.

Refractive surgery

15. Whilst refractive surgery provides an excellent alternative to the wearing of spectacles or contact lenses, it is important to understand that it is NOT a means for candidates to overcome uncorrected refractive errors which are outside existing ADF entry standards. Allocation of an MVR or AVR is based on the post-operative corrected refractive error and not on the pre-operative uncorrected error. For example a candidate with pre-surgery myopia of -8.00 dioptres and who corrects to 6/6 post-surgery is MVR 1. Candidates with a pre-operative error in excess of +/- 8.00 dioptres but who correct to MVR 1 after refractive surgery remain Class 4 and could only be considered for entry under a waiver, with a specialist report addressing the post-surgical outcomes, any complications, long term prognosis particularly where the corneal thickness has been reduced substantially, and the risk of retinal detachment.

16. When the DFRC medical officer (MO) or optometrist suspects that a candidate may have had refractive surgery, the candidate is to be referred to an ophthalmologist for assessment including corneal mapping.

17. Candidates who present for enlistment/appointment and who declare a history of refractive surgery, are to provide full details of their pre and post-operative refractions as well as details of after-care from their provider.

18. Any candidate who has had refractive surgery must meet the following requirements:

a. only Photo Refractive Keratotomy (PRK), Laser Epithelial Keratomileusis (LASEK) and Laser in situ keratomileusis (LASIK) are acceptable for ADF entry. Candidates who have had Radial Keratotomy, orthokeratology or the implantation of phakic intra-ocular lens are not acceptable for ADF entry

b. at least three months must have elapsed post-surgery

c. at least six months must have elapsed post-surgery for aircrew candidates who have undergone refractive surgery to correct hypermetropia

d. two refractions are to be performed post-surgery by an ophthalmologist, at least one month apart and both at least one month post-surgery, with less than 0.5 dioptres of refractive difference, and less than 10 degrees of axis deviation, between the two measurements in the same eye

e. there must be no history or evidence of unwanted symptoms or post-operative effects (including but not confined to: decrease in best corrected VA, raised intra-ocular pressure, corneal haze, reduced contrast sensitivity, corneal ulcers, pain, blurred vision, glare or flare, halos around lights or objects, night vision, aberrations, no alteration in colour perception etc.) with special note of haze and the absence of corneal aberrations

f. all topical eye drops including steroids or anti-inflammatory agents must have been discontinued but artificial tears may be used as needed

g. vision standards of the trade or specialisation must be met.

Assessment of candidates referred with a history of night vision problems

19. Good night vision is essential for all members, in particular those personnel required to operate in the field using tactical lighting or night vision devices. Poor or degraded night vision could be a major safety concern in ADF operations.

20. From time to time candidates for the ADF may be referred for an assessment of their night vision because of a history of difficulty seeing at night. As there are no readily available screening tests for true night blindness, an assessment by an ophthalmologist is considered essential to exclude known causes of night blindness; eg retinitis pigmentosa, vitamin A deficiency, prescribed medication (eg anti-malarial medications) diabetes, cataract, macular degeneration, severe myopia, etc. If the history and ophthalmological assessment supports the diagnosis of true night blindness or a related condition, where night vision is compromised the candidate will be considered unsuitable for entry.

CHAPTER 3

ENTRY OF CANDIDATES WITH PREVIOUS MILITARY SERVICE

INTRODUCTION

3.1 Candidates with previous or current experience in an Australian or foreign Defence Force, provide a valuable resource for the Australian Defence Force (ADF). It may therefore be desirable for these candidates to be accepted for entry or transfer even though they may not meet the medical standards for initial candidates.

3.2 The aim of this chapter is to document the medical examination requirements for candidates with previous or current experience in a Defence Force. These candidates include:

a. candidates with previous ADF service

b. overseas candidates with previous service in a foreign Defence Force

c. personnel transferring within and between Services in the ADF

d. appointment of serving sailors, non-commissioned officers and warrant officers who are nominees as a commissioned officer.

POLICY

CANDIDATES WITH PREVIOUS AUSTRALIAN DEFENCE FORCE SERVICE

3.3 Candidates with previous ADF service are candidates who have separated from the ADF and are not members of any component of ADF Reserve Forces. ADF health facilities are not resourced to manage the medical fitness process for candidates for ADF entry with previous ADF service, who are not members of a component of ADF Reserve Forces. Personnel who have separated from the ADF and apply for entry to the Reserve at a later date are to be managed through a Defence Force Recruiting Centre (DFRC). Candidates who are members of a component of the Reserve Forces applying for entry to Permanent or regular forces are considered to be transfers.

3.4 **Medical examination procedures.** Medical assessments of candidates with previous ADF service are to be conducted at a DFRC. The candidate is to complete Form PM165—'Health questionnaire' and Form PM166—'Entry level medical examination' is to be conducted as for initial candidates. Service medical records are to be requested from the relevant ADF Health Records (ADFHR) office. The medical records are to be thoroughly reviewed by the DFRC medical officer (MO) and candidates are to be managed as follows:

a. **Candidates who were discharged on non-medical grounds.** The medical records and current Form PM166 are to be thoroughly reviewed by the DFRC

MO and any cases of doubt are to be referred to the Chief MO DFR (CMO DFR) for consideration

b. **Candidates who were discharged on medical grounds.** Candidates who were discharged on medical grounds are to provide clear evidence that the medical problem has fully resolved and the candidate is fit for all ADF duties before further enlistment processing can occur. If following a thorough review of Service medical records, and the current Forms Form PM165 and Form PM166, the DFRC MO considers that the candidate is fit for service, the enlistment medical records and the previous Service medical records are to be forwarded to CMO DFR for confirmation

c. **Specialist occupations.** All medical documentation is to be forwarded to the relevant confirming authority as identified in Defence Health Manual (DHM) Level 2 Part 5 Chapter 1[59]—'Medical classification of candidates' paragraph 1.37.

d. Candidates who do not meet entry medical standards may be considered suitable for a waiver. The waiver process is detailed in DHM Level 2 Part 5 Chapter 1, paragraph 1.28–1.50.

3.5 A flow chart detailing the medical examination process for candidates with previous service is in Annex 3A.

CANDIDATES WITH SERVICE IN A FOREIGN DEFENCE FORCE

3.6 Candidates with either previous or current experience in a foreign Defence Force are to be assessed in accordance with this publication. Candidates for specialist occupations are to be managed as for initial candidates, refer to DHM Level 2 Part 5 Chapter 6[60]—'Health requirements for aviation–related occupations', DHM Level 2 Part 5 Chapter 7[61]—'Health requirements for divers' and DHM Level 2 Part 5 Chapter 8[62]—'Health requirements for submariner'. Candidates who are currently serving with a foreign Defence Force are known as lateral recruits. CMO DFR is the confirming authority for medical fitness of candidates other than specialist occupations. The confirming authority may apply flexibility in the allocation of a medical classification taking into consideration the candidate's military experience.

3.7 **Candidates residing in Australia.** Candidates who reside in Australia and who are not on full-time military service are to be managed by the DFRC. Copies of Service medical records are to be provided to the DFRC nursing officer on job

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options evaluation session day, if possible. Candidates are to be managed in accordance with this chapter.

3.8 **Candidates serving in Australia.** Candidates from a foreign Defence Force who are serving in Australia are to have a medical examination conducted at an ADF health facility. The candidate is to complete Form PM165. The medical examination is to be recorded on Form PM166. The MO is to review the candidate's Service medical record and take any significant medical history into consideration.

3.9 **Candidates residing in foreign countries.** Candidates applying to join the ADF from a foreign country are to have a medical examination conducted in the country of residence. If possible the medical examination should be conducted by a Defence Force MO. If a medical examination by a Defence Force MO cannot be arranged, or the candidate is no longer a serving member, the medical examination may be conducted by a local medical practitioner.

a. all candidates are required to complete Form PM165 and take this to their MO when attending for entry level medical examination (ELME). The MO may need to provide clinical details to answers provided in the medical history. This form is to be signed and dated by the candidate and signed by the MO once completed

b. Form PM166 is to be used. The medical examination is to be conducted in accordance with DHM Level 2 Part 5 Chapter 2[63]—'Medical history and examination'. Form PM166 is to be signed and dated by the examining MO. This form is valid for 12 months from the date of the medical examination

c. all current and previous serving members of a foreign Defence Force are required to provide a copy of Service medical records. For aircrew a copy of Service dental records is also to be provided.

3.10 **Provision of medical reports.** The candidate is responsible for providing medical reports related to the recruitment process. CMO DFR may review the candidate's previous medical documentation and advise the candidate if further information is required.

3.11 **Confirmation.** Candidates are to meet entry medical standards. All documentation used in the medical examination process and copies of Service medical and dental records, if necessary, are to be forwarded to CMO DFR for confirmation. If the candidate does not meet entry medical standards a request for medical waiver may be considered. Documentation for candidates for specialist occupations is to be forwarded to the relevant confirming authority.

3.12 A flow chart of the medical examination process is in Annex 3B.

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Transfers of personnel between and within Services of the Australian Defence Force and appointment of serving sailors, non-commissioned officers and warrant officers as a commissioned officer

3.13 During ADF service, permanent and reserve personnel may elect to transfer from one Service to another, from one element of a force to another or from one occupation to another. The transfer of personnel between or within a Service may be of benefit to the ADF by facilitating the retention of trained and experienced personnel.

3.14 This policy includes medical examination requirements, medical standards and notification procedures for:

a. personnel transferring from or between:

(1) different military occupations within the same Service

(2) one Service to another Service in the same military occupation

(3) one Service to another Service in a different military occupation

(4) Reserve forces to regular/permanent forces

(5) Regular/permanent forces to Reserve forces

(6) Inactive/standby Reserve to active Reserve

b. serving sailors, non-commissioned officers and warrant officers who apply for appointment as a commissioned officer.

3.15 A medical examination is not required on transfer from active Reserve Forces to the Inactive/Standby Reserve. Medical examination requirements for members transferring from Reserve Forces to continuous full-time Service (CFTS) are detailed in DHM Level 2 Part 6 Chapter 4[64]—'Health assessments Reserve members'.

Medical examination procedures

3.16 Medical examinations are to be conducted at ADF health facilities. This includes personnel who have separated from the regular or permanent ADF and have transferred to the Inactive or Standby Reserve.

3.17 An individual health assessment (IHA) is to be conducted if a IHA has not been conducted within the previous 12 months in accordance with (IAW) DHM Level 2 Part 6 Chapter 5[65]—'Individual health assessment'. For personnel transferring from Permanent/regular forces to Reserve Forces the IHA is to take the form of a

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transition health examination and is to be conducted within six months of the date of separation from the permanent/regular Force.

3.18 The aim of the medical examination is to ensure the member's military employment classification (MEC), and if appropriate, an specialist employment classification (SPEC) is applicable to the gaining Service, military occupation or officer appointment scheme (DHM Level 2 Part 6 Chapter 2[66]—'Military employment classification system'). In the case of transfer from Reserve to permanent/regular forces or permanent/regular forces to Reserve Service the medical examination will also provide a baseline to assist in the determination of possible claims for military compensation or under the *Veterans' Entitlements Act 1986*[67].

3.19 **Dental fitness.** All permanent/regular personnel are to have had a current dental assessment. The gaining Service is to be notified of the member's dental status and if they have any Dental Treatment Locality Restrictions. Reserve personnel transferring to the permanent/regular forces are to have an annual dental assessment conducted at an ADF dental facility. The member must meet the standards for general entry in DHM Level 2 Part 5 Chapter 2, Annex D, paragraphs 12–18. Members wearing orthodontic appliances can be accepted if their service will be in a single geographical location until the active treatment can be completed.

3.20 **Referral for specialist opinion.** ADF health facilities are responsible for funding specialist opinions required to determine fitness for transfer or appointment as a commissioned officer. This includes mandated specialist medical assessments for specialist occupations and seaman officers, and specialist opinions required to determine fitness of Reserve personnel applying for transfer to regular/permanent Forces.

Specialist occupations

3.21 For the purpose of this publication the term specialist occupations relates to:

a. aviation-related occupations listed in DHM Level 2 Part 5 Chapter 6, Annex 6A

b. divers

c. submariners.

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[67] https://www.legislation.gov.au/Series/C2004A03268

Specialist employment streams

3.22 Personnel applying for transfer to a specialist occupation are to meet the following requirements:

a. **Initial candidates for:**

(1) Aviation-related occupations including joint battlefield airspace controllers - refer DHM Level 2 Part 5 Chapter 7

(2) diver - refer DHM Level 2 Part 5 Chapter 7

(3) submariner - refer DHM Level 2 Part 5 Chapter 8.

b. **Qualified Permanent/regular ADF personnel or personnel currently undergoing training towards a qualification.** Qualified personnel or personnel undergoing training are to be current for IHA or SPEC as applicable, see DHM Level 2 Part 6 Chapter 5 and meet the requirements of the gaining Service. Specialist medical assessments are not required unless clinically indicated. For aviation-related occupations the IHA or SPEC is to be forwarded to the Institute of Aviation Medicine (IAM) for confirmation of medical fitness. IAM may request additional medical information to determine medical fitness for transfer. Candidates may be MEC 2 and SPEC 2

c. **Qualified reserve specialist employment classification personnel transferring to the regular or permanent Force.** An IHA is to be conducted irrespective of when the last IHA was conducted. Specialist medical assessments are not required unless clinically indicated. The IHA is to be forwarded to the confirming authority for confirmation of medical fitness as follows:

(1) for aviation-related occupations - the Commanding Officer (CO) IAM

(2) for divers and submariners - the officer in charge submarine underwater medicine unit (OIC SUMU).

3.23 Candidates may be MEC2 and/or SPEC 2.

3.24 Medical fitness requirements for parachutists are in DHM Level 2 Part 6 Chapter 3[68]—'Parachuting health standards'. Requirements for transfer to Special Forces are in Army Standing Instruction (Personnel), (ASI(P)) Part 6 Chapter 1[69]—'Selection for and service with special operations command'.

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Medical standards

3.25 If a member is transferring to the same occupation, the medical standard for transfer is MEC 1 or MEC 2 appropriate to the gaining Service. Members transferring to a different occupation or who are required to undertake recruit training or initial officer training should be MEC 1. For Army this equates to a PULHEMS medical assessment of a least 2222 8/3 8/3 22. Waiver action may apply to personnel with special qualifications who do not meet these standards. The following medical standards apply:

a. **for transfer to or within:**

(1) Navy, refer to the relevant chapters of this publication

(2) Army, refer reference ASI(P) Part 8 Chapter 3[70]—'The application of the military employment classification system and PULHEEMS employment standards in the Australian Army'

(3) Royal Australian Air Force (RAAF), refer to the relevant chapters of this publication.

b. **For serving non-commissioned officers and warrant officers applying for appointment as a commissioned officer:**

(1) **Navy.** Sailors who nominate for selection as a commissioned rank are to have an IHA and meet the medical standards of this publication prior to nomination. If the health standard of an officer candidate (OC) falls below that which permits appointment to a particular primary qualification, advice is to be forwarded to the Navy People Career Management (NPCMA) Careers Transition Advisory Cell. NPCMA is the decision-maker in relation to suitability for commission. Medical suitability for OC is to be reviewed every 12 months and a copy of the medical suitability is to be forwarded to NPCMA (see reference ANP4112[71]–'Career Management Navy')

(2) **Army.** The following medical standards apply for Army officer candidates:

(a) Personnel who require initial officer training must be MEC 1, which equates to a PULHEMS medical assessment of a least 2222 8/3 8/3 22. Waiver action may apply to Specialist Service Officers and/or entrants with special qualifications (ASI(P) Part 8 Chapter 3).

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[71] http://ibss/PublishedWebsite/Latest/{FDDE6B03-8AE1-4F8A-81E5-35191A2190DF}/Item/{E7ADD673-D93B-44AB-88D1-0611441BDE67}/Feature/id={EF8DFEF7-81DA-4118-BED4-17F0C0198981}

(b) Army senior non-commissioned officer and Warrant Officer commissioning scheme candidates are to be either MEC 1 or 2. Candidates who are MEC 4 will not be considered. MEC 3 personnel will be considered on a case-by-case basis (ASI(P) Part 6 Chapter 3—'Army senior non-commissioned office and warrant officer commissioning scheme').

(c) Specialist Service Officer pilot scheme. Candidates must meet medical standards for pilot in chapter 7 (see reference ASI(P) Part 6 Chapter 3).

(3) **Air Force.** Air Force personnel who apply for appointment as an officer are to meet the medical standards of this publication (see reference Air Force Personnel Standing Instructions[72].

(a) Members of the RAAF Reserve staff group (RSG) are not required to be deployable, therefore, there is no requirement for personnel transferring from the permanent Air Force to the RSG to be MEC1 or MEC 2.

3.26 In general, candidates should meet the medical standards as detailed, however, the determination of whether a member has an appropriate MEC for transfer, commencement of CFTS, or appointment as a commissioned officer is the responsibility of the relevant Career Management Agency based on the medical advice provided.

Military employment classification implications

3.27 An interim MEC and SPEC is to be allocated when the MEC or SPEC for the gaining Service or employment stream differs from the current MEC or SPEC. The interim MEC and SPEC is not to be entered into PMKeyS or the Defence health record (DHR) until the member has been accepted and transfer is effected. Formal MEC review (MECR) is not required to change to the MEC applicable to the new occupation.

3.28 If the member's MEC or SPEC is not valid for the member's current Service and occupation appropriate, MECR action is to be initiated in accordance with Military Personnel Policy Manual (MILPERSMAN) Part 3[73].

3.29 If a member is MEC 3 or 4 the MECR is to address whether allocation of a deployable profile in an alternate trade or Service is sustainable. For personnel confirmed as MEC 4 or who have been MEC 3 for more than 12 months central MECR documentation is to be forwarded for MECR board consideration.

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[72] http://drnet.defence.gov.au/raaf/AirForce/DPP/Pages/AFPSI.aspx

[73] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/C5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765

Notification to career managers

3.30 The IHA confirming authority will notify the Career Management Agencies (CMAs) of the losing and gaining Service by Form PM532—'Military employment classification (MEC) advice' of the:

a. current MEC and SPEC (if appropriate)

b. interim MEC and SPEC appropriate to the gaining Service and employment stream (if different to the current MEC and SPEC)

c. any restrictions applicable

d. the date the medical examination was conducted

e. the standard applied

f. whether the appropriate medical fitness standards have been met.

3.31 For Army personnel, Form PM532 is to be raised to record the PULHEMS profile and the MEC and SPEC for the current occupation.

3.32 **Privacy.** Sensitive: Personal information is not to be provided to agencies external to the Defence health service without the specific authorisation of the member. An authorisation to release medical information pro forma is in Annex 3C. All candidates for transfer who do not meet the entry medical standards are to complete the pro forma. A copy of the authorisation is to be forwarded with Form PM532 detailing medical fitness for transfer, and the original is to be retained in the member's medical record as part of the medical examination documentation. If the member authorises release of medical information, the relevant CMA may be advised in general terms of the reasons medical standards were not met. If the member does not authorise release of medical information the CMA will be informed of the implications of the medical condition only.

Waivers

3.33 A medical waiver may be initiated in circumstances where a member who does not meet the appropriate medical standards is considered to be a suitable candidate for transfer or commission. Initiation of a medical waiver is a personnel management function and not a health function. Agencies who may apply for a waiver for appointment as an Army officer are listed in reference ASI(P) Part 4 Chapter 4[74]—'Performance appraisal reporting'.

3.34 The approving authority for a waiver is the Director General of Personnel (DGPERS) or authorised delegate. In the case of transfers to a different Service, the DGPERS of the gaining Service is the approving authority. The approving authority

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may request medical opinion on the candidate's suitability for transfer from Director Defence Health Policy (DDHP) or authorised delegate. DDHP or delegate will provide a recommendation on the candidate's suitability for transfer or appointment as a commissioned officer, an MEC and SPEC, if necessary, appropriate to the gaining occupation and details of any restrictions. For aviation-related occupations sufficient information should be provided by IAM when the member's fitness is confirmed to enable personnel managers to make an informed decision on a candidate's suitability for waiver. The DDHP delegate may request medical documentation if required. DDHP is to be informed of the outcome of the waiver.

Medical appeals

3.35 A member classified as medically unfit for transfer may appeal the decision. An appeal is a written request for reconsideration of the initial medical decision. A successful appeal would require the provision of:

a. new medical evidence indicating that the condition is no longer evident and the risk of recurrence is low

b. evidence that the original assessment was based on an incorrect diagnosis

c. evidence that standards have been inappropriately applied.

Any costs incurred in providing this medical evidence will be at the candidate's expense.

3.36 DDHP or delegate is the confirming authority for medical appeals submitted by currently serving ADF personnel. Commanding officer IAM or delegate will reconsider appeals for candidates for aviation-related occupations provided the information as detailed is provided. The Director General Strategic Health Coordination (DGSHC) is the authority for consideration of second level appeals.

3.37 The member is to be informed that they have an obligation to notify the MO if there is any change in their medical status in the period between the completion of the medical examination and transfer. The MO is to advise the CMA as soon as possible if the member becomes unfit following confirmation of fitness.

Notification of new military employment classification and specialist employment classification

3.38 If the MEC and SPEC for the gaining occupation differs to the current MEC and SPEC, the following action is to be taken once written confirmation of transfer acceptance is received from the relevant Career Management Agency:

a. for Navy and RAAF personnel, the MEC and SPEC is to be formally amended by means of Form PM532. For Army personnel a corrigendum to Form PM532 is to be raised

b. the new MEC and SPEC is to be entered into PMKeyS or DHR as appropriate, by the medical facility responsible for the medical management of the member.

Currency of medical examination

3.39 An IHA for transfer or commissioning is current for 12 months.

Management of health records

3.40 When personnel transfer between the Services, medical records are to be forwarded to the ADFHR office of the Service the member is leaving, as part of the separation process. When the candidate enters the gaining Service the ADFHR office will provide Form PM004—'Unit medical record' and Form PM341—'Personal dental record—folder' for the gaining Service. When Army Reserve members transfer to Australian Regular Army, copies of the Reserve Form PM004 and Form PM341 are to be forwarded to ADFHR-Army to raise a Central Medical Record and Central Dental Record. The Reserve Form PM004 and Form PM341 will form the basis of the ongoing medical and dental record.

Medical examination procedures and standards

3.41 For ease of reference medical examination procedures and standards and relevant policies are in table format:

a. transfers in Annex 3D

b. appointment as a commissioned officer—serving personnel in Annex 3E.

3.42 A flow chart detailing the transfer process is in Annex 3F.

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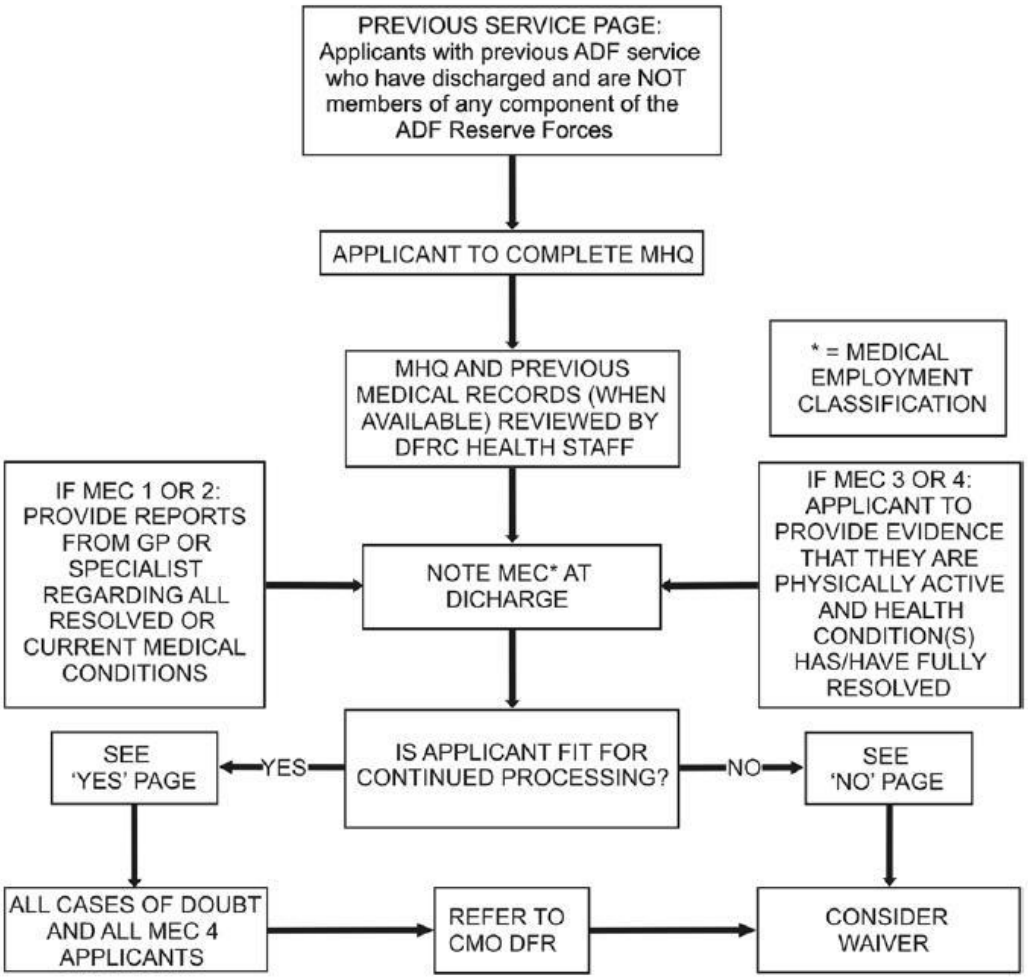
Annexes:

3A	Flow chart – candidates with previous Australian Defence Force service
3B	Flow chart – Lateral recruits
3C	Authority for release of medical information to personnel management agencies
3D	Medical examination procedures and standards for transfer
3E	Medical examination procedures and standards for appointment as a Commissioned Officer – serving personnel
3F	Flow chart – Transfers

ANNEX 3A

FLOW CHART – CANDIDATES WITH PREVIOUS AUSTRALIAN DEFENCE FORCE SERVICE

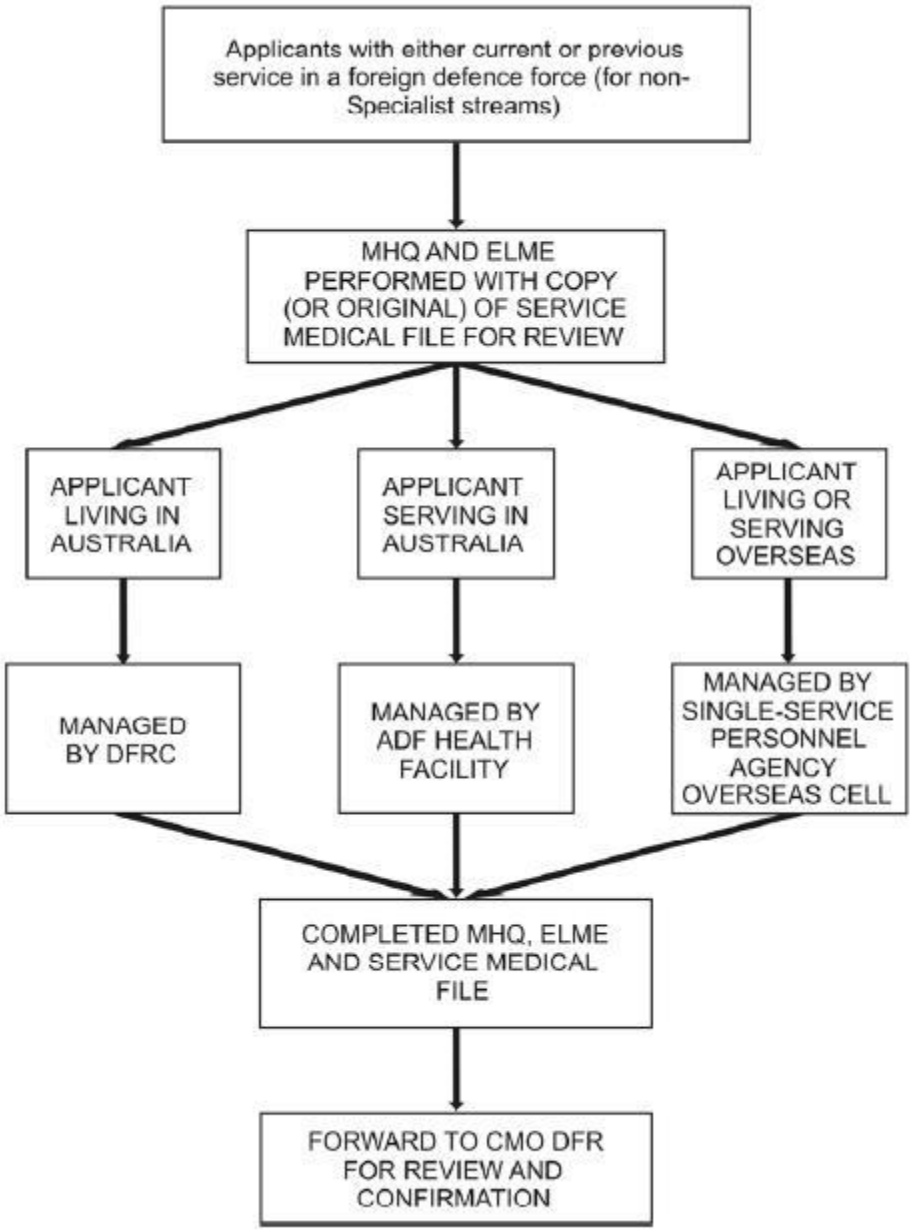
Figure 3A–1: Defence Force recruiting flow chart - medical processes



ANNEX 3B

FLOW CHART – LATERAL RECRUITS

Figure 3B–1: Lateral transfers flow chart – medical processes



ANNEX 3C

AUTHORITY FOR RELEASE OF MEDICAL INFORMATION TO PERSONNEL MANAGEMENT AGENCIES

Employee ID
Rank
Given Names
Family Names
Unit

AUTHORITY FOR RELEASE OF MEDICAL INFORMATION TO PERSONNEL MANAGEMENT AGENCIES

PRIVACY NOTICES 14 INFORMATION PRIVACY PRINCIPLE 2 [IPP2] PRIVACY ACT 1988

1. Collection, storage and use or disclosure of your personal information is subject to the Information Privacy Principles (IPP) as set out in section 14 of the *Privacy Act 1988* referred to in this document as 'the Act'.

Authority

2. I understand that I may elect to authorise release of clinical information to personnel not in the Defence Health Service (DHS) legitimately involved in determining my medical fitness for employment in the Australian Defence Force (ADF). I understand that medical information will be managed in accordance with 'the Act' and will be given a privacy marking of STAFF–IN–CONFIDENCE or MEDICAL–IN–CONFIDENCE. The 'need to know' principle will be strictly applied.

3. (Delete as appropriate)

I authorise release of medical information related to confirmation of a medical waiver to: .....

Insert ie: To: (Director General Naval Personnel and Training, Director General of Personnel—Army, Director General Personnel—Air Force, Director Army Personnel Agency or delegate, Commanding Officer, as appropriate).

OR*

I do not authorise the release of medical information held on my ADF medical records. I acknowledge that, as a consequence of my refusal to release medical information, personnel management agencies may have insufficient information to make an informed decision on my medical fitness and will make a decision based on the consequences of my condition on my ability to perform the roles of the military occupation and operational deployments.

Signature	**Name**	**Date**

ANNEX 3D

MEDICAL EXAMINATION PROCEDURES AND STANDARDS FOR TRANSFER

Table 3D–1: Transfer from Reserve to permanent/regular forces

Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
All Reserve personnel with the exception of aircrew, air traffic control officers (ATCO/JBAC) and divers/submariners	Individual health assessment (IHA) within previous 12 months	Australian Defence Force medical officer (ADF MO)	Navy: this publication Army: Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 3[75]–'The application of the military employment classification system and PULHEEMS employment standards in the Australian Army' Air Force: Physical Training and Testing Manual[76]	Military employment classification (MEC) 1 or 2	As for IHA

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[76] http://intranet.defence.gov.au/home/documents/data/RAAFPUBS/Manuals/AFPTTMAN.pdf

Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
Aircrew, ATCO, JBAC	IHA within previous 12 months	Aviation medical officer (AVMO) refer Defence Health Manual (DHM) Level 2 Part 17 Chapter 3[77]— 'Provision of aviation medicine services in the ADF'	Navy: this publication Army: ASI(P) Part 8 Chapter 3 RAAF: Air Force Physical Training and Testing Manual	MEC 1 or 2 Specialist employment classification (SPEC) 1 or 2	The Institute of Aviation Medicine (AVMED)
Divers/submariners	IHA within previous 12 months	Officer in charge submarine underwater medicine unit (OICSUMU)	Navy: this publication Army: ASI(P) Part 8 Chapter 3	MEC 1 or 2 SPEC D1 or D2	OIC SUMU

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Table 3D–2: Initial transfer to any specialisation with discrete medical examination requirements

Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
Pilot training (Including Australian Army aviation specialist service officer pilot scheme)	Form AF212—'Individual health questionnaire'	AVMO—refer DHM Level 3 Part 17 Chapter 4[78]—'Health orientation of personnel working in the Defence health environment'	DHM Level 2 Part 5 Chapter 5[79]—'Causes of and reasons for rejection' DHM Level 2 Part 5 Chapter 6[80]—'Health requirements for aviation-related occupations' ASI(P) Part 6 Chapter 1[81]—'Selection, screening, and service with special operations command'	May be provisional MEC 1 SPEC A1 for flight screening program (FSP). Specialist medical examinations may be conducted after FSP when suitability for training has been confirmed	AVMED
Initial aircrew (non-pilot) and ATCO	Form AF212	AVMO	DHM Level 2 Part 5 Chapter 5 and DHM Level 2 Part 5 Chapter 6	MEC 1 SPEC A1	AVMED

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Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
Currently serving aircrew or diver already qualified or undergoing training	Form AF212 or specialist employment stream annual health assessment within the previous 12 months	AVMO	Navy: this publication Army: ASI(P) Part 8 Chapter 3 RAAF: DHM Level 2 Part 5 Chapter 5 and DHM Level 2 Part 5 Chapter 6	May be MEC 2 SPEC 2 appropriate to the gaining Service.	AVMED for aircrew SUMU for divers
Initial Diver	Form AF212	ADF MO	DHM Level 2 Part 5 Chapter 5 and DHM Level 2 Part 5 Chapter 6	MEC 1 SPEC D1	OIC SUMU East (SUMUE)
Initial submariner	Form AF212	ADF MO	DHM Level 2 Part 5 Chapter 6 and DHM Level 2 Part 5 Chapter 8[82]—'Health requirements for submariners'	MEC 1 SPEC S1	OIC SUMUE

Table 3D–3: Service transfer non-specialist occupations

Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
Navy	Form AF212	ADF MO	Navy: this publication	May be MEC 1 or MEC 2	As for IHA

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Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
Army	Form AF212	ADF MO	ASI(P) Part 8 Chapter 3.	May be MEC 2 if initial officer or recruit training not required. If initial officer or recruit training required, must be MEC 1 PULHEMS employment standard 2222 8/3 8/3 22.	As for IHA
RAAF	Form AF212	ADF MO	DHM Level 2 Part 5 Chapter 2[83]—'Medical history and examination' Air Force Physical Training and Testing Manual.	May be MEC 1 or MEC 2	As for IHA

Table 3D–4: Transfer from permanent/regular service to a component of the Australian Defence Force Reserve

Transfer from	Medical Examination Documentation	Conducted by	Standard	MEC	Confirming Authority
Regular/permanent forces to Reserve Forces	Transition health examination (THE) recorded on Form AF212	ADF MO	DHM Level 2 Part 5 Chapter 2 Air Force Physical and Testing Manual.	May be MEC 2 SPEC 2 serving standards	As for IHA

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ANNEX 3E

MEDICAL EXAMINATION PROCEDURES AND STANDARDS FOR APPOINTMENT AS A COMMISSIONED OFFICER – SERVING PERSONNEL

Table 3E–1: Medical procedures and standards for serving personnel applying for appointment as a Commissioned Officer

Commissioning Scheme	Medical Examination Documentation	Conducted by	Reference	Military Employment Classification	Confirming authority
Navy—Warrant officer and sailors	IHA	Australian Defence Force medical officer (ADF MO)	This publication ANP4112[84]—'Career management – Navy'	Military employment classification (MEC) 1 or 2	As for IHA
Army: Australian Defence Force Academy Army: Royal Military College	IHA within last 12 months	ADF MO	Army Standing Instruction (Personnel) (ASI(P)) Part 2 Chapter 3[85]—'Waivers of entry requirements and provisional entry'	Must meet standards of Defence Health Manual (DHM) Level 2 Part 5 Chapter 4[86]—'Occupation specific – medical standards' (PULHEMS standard 2222 8/3 8/3 22)	As for IHA

[84] http://ibss/PublishedWebsite/Latest/%7bFDDE6B03-8AE1-4F8A-81E5-35191A2190DF%7d/Item/%7bE7ADD673-D93B-44AB-88D1-0611441BDE67%7d/Feature/id=%7bEF8DFEF7-81DA-4118-BED4-17F0C0198981%7d

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Commissioning Scheme	Medical Examination Documentation	Conducted by	Reference	Military Employment Classification	Confirming authority
Army Senior non-commissioned officer and warrant officer commissioning scheme	IHA within last 12 months	ADF MO	ASI(P) Part 6 Chapter 3[87]—'Army senior non-commissioned officer and warrant officer commissioning scheme'	MEC 1 or MEC 2	As for IHA
Australian Army Aviation Specialist Service Officer Pilot Scheme	IHA within last 12 months	ADF MO	ASI(P) Part 6 Chapter 1[88]—'Selection, screening, and service with special operations command'	Must meet standards of DHM Level 2 Part 5 Chapter 2[89]—'Medical history and examination'	As for IHA
Royal Australian Air Force: All candidates for commission	IHA within last 12 months	ADF MO	Air Force Personnel Standing Instructions[90]	Must meet standards of DHM Level 2 Part 5 Chapter 4	As for IHA

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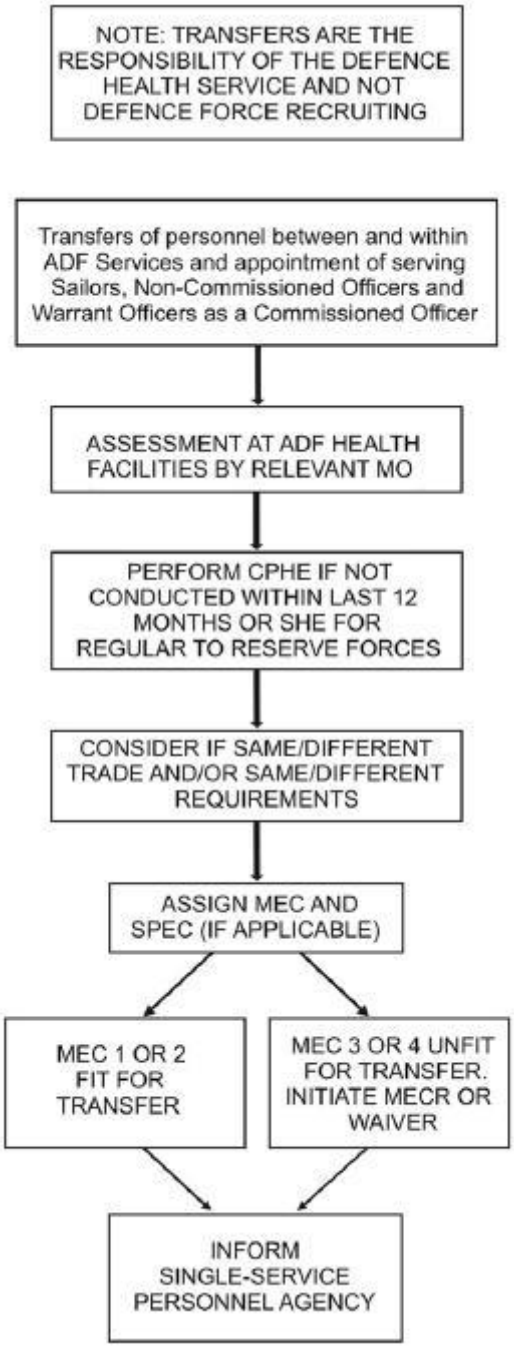
ANNEX 3F

FLOW CHART – TRANSFERS

Figure 3F–1: Australian Defence Force Service transfers



CHAPTER 4

OCCUPATION SPECIFIC – MEDICAL STANDARDS

INTRODUCTION

4.1 All initial candidates for service in the Australian Defence Force (ADF) must meet the following occupation specific health standards detailed in Defence Health Manual (DHM) Level 2 Part 5 Chapter 5[91]—'Causes of and reasons for rejection'. The standards contained within this chapter should be read in conjunction with history and examination requirements detailed in DHM Level 2 Part 5 Chapter 2[92]—'Medical history and examination'. Candidates for aviation related occupations must meet additional occupation specific requirements detailed in DHM Level 2 Part 5 Chapter 6[93]—'Health requirements for aviation-related occupations'. Divers and submariners are required to meet additional occupation specific requirements detailed in DHM Level 2 Part 5 Chapter 7[94]—'Health requirements for divers' and DHM Level 2 Part 5 Chapter 8[95]—'Health requirements for submariners'.

POLICY

ENTRY MEDICAL STANDARDS

General requirements

4.2 **Height.** The minimum height for ADF entry is 152 cm without shoes. There is no maximum height restriction for general entry into the ADF. For height limits for pilots, air combat officer, and Navy maritime aviation warfare officers refer to DHM Level 2 Part 5 Chapter 6.

4.3 **Reach.** RAAF firefighters must be able to reach to a height of 210 cm with their extended arms. There are no other reach restrictions on candidates to the ADF.

Weight limits and pre-enlistment fitness assessment

4.4 Weight standards for ADF entry are classified according to body mass index (BMI) and are detailed in DHM Level 2 Part 5 Chapter 5 Annex 5H. Weight limits for pilots are detailed in DHM Level 2 Part 5 Chapter 6.

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4.5 **Physical fitness assessment standards.** All candidates are to undertake a pre-enlistment fitness assessment (PFA) in accordance with ADF Recruiting Instruction–032—Pre-Entry Fitness Assessment[96]. The medical officer (MO) examination must have been completed prior to attempting the PFA and the candidate must have been assessed as fit to participate in PFA activities. Changes in medical status between the MO examination and conduct of the PFA may result in candidates' fitness to participate in testing being reassessed.

Occupation specific requirements

4.6 Colour perception (CP), minimum visual requirement (MVR) and hearing standard (HS) for specific occupations in the RAN, Army and RAAF are in Annex 4A, 4B and 4C respectively. Medical standards for candidates for special forces are in Appendix 4B3. Visual standards for explosive ordnance disposal and technician ammunition personnel are in Appendix 4B4.

4.7 **Royal Australian Air Force aircraft surface finisher and aeronautical life support fitter musterings.** For RAAF aircraft surface finisher and aeronautical life support fitter musterings a history of asthma disqualifies a candidate, irrespective of the asthma-free period.

4.8 Navy candidates applying for hydrographic survey officer (HSO) or combat systems operator (mine warfare) with a history of asthma requiring allocation of military employment classification (MEC) 24 are to be allocated recruiting medical classification class 4J as the appropriate level of care under MEC 24 is not available on these vessels.

SPONSOR: Deputy Surgeon General Australian Defence Force

Annexes:
4A Royal Australian Navy visual and hearing standards for entry
4B Army entry standards for officers and soldiers, excluding aircrew and divers
4C Royal Australian Air Force visual and hearing standards for entry

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ANNEX 4A

ROYAL AUSTRALIAN NAVY VISUAL AND HEARING STANDARDS FOR ENTRY

NAVY OFFICERS

Table 4A–1: Seaman officers

Branch/Category	Minimum visual requirement (MVR)	Colour perception (CP)	Hearing standard (HS)
Maritime warfare officer	3	1	1
Principal warfare officer	3	1	1
Surface warfare officer	3	1	1
Maritime and Clearance Diving officer	3	1	1
Information warfare officer	3	2	2
Maritime geospatial officer – M (Meteorology and Oceanography)	3	1	1
Maritime geospatial officer – H (Hydrography)	3	1	1
Maritime human resource officer	3	3	2

Table 4A–2: Engineering officers

Branch/Category	MVR	CP	HS
Electrical	3	2	2
Mechanical	3	2	2
Aeronautical	3	2	2

Table 4A–3: Maritime logistics

Branch/Category	MVR	CP	HS
Maritime logistics officer (MLO)	3	3	2
Legal	3	3	2
Training systems	3	3	2
Operational logistics officer (Reserve Only)	3	3	2

Table 4A–4: Health services

Branch/Category	MVR	CP	HS
Medical	3	3	2
Dental	3	3	2
Nursing	3	3	2
Psychology	3	3	2
Navy health service officer	3	3	2

Table 4A–5: Submariner officers

Branch/category	MVR	CP	HS
Maritime warfare officer submariner	3	1	1
Non-maritime warfare officer submariner	3	1	1

Table 4A–6: Miscellaneous officers

Branch/Category	MVR	CP	HS
Public relations	3	3	2
Intelligence	3	3	2
Maritime trade operations	3	3	2
Band	3	3	2
Chaplain	3	3	2

NAVY SAILORS

Table 4A–7: Aviation branch

Branch/Category	Abbreviation	MVR	CP	HS
Aviation technician aircraft	ATA	3	2	2
Aviation technician avionics	ATV	3	2	2
Aviation support	AVN	3	2	2
Navy Gap Year - aviation support technician	NGY-AST	3	2	2
Imagery specialist	IS	3	2	2

Table 4A–8: Communication branch

Branch/Category	Abbreviation	MVR	CP	HS
Communication systems	CIS-C	3	2	2
Cryptologic linguist	CTL	3	2	2
Cryptologic system	CTS	3	2	2
Cryptologic network	CT-N	3	2	2
Electronic warfare	EW	3	1	1
Information systems	CIS-I	3	2	2

Table 4A–9: Engineering and electrical

Branch/Category	Abbreviation	MVR	CP	HS
Marine technician	MT	3	2	2
Electronic technician	ET	3	2	2

Table 4A–10: Seaman branch

Branch/Category	Abbreviation	MVR	CP	HS
Boatswain mate	BM	3	1	1
Combat systems operator mine warfare	CSOMW	3	1	1
Naval police coxswain	NPC	3	1	1
Physical trainer	PT	3	1	1
Hydrographic survey	HSO	3	1	1
Combat systems operator	CSO	3	1	1

Table 4A–11: Maritime logistics branch

Branch/Category	Abbreviation	MVR	CP	HS
Maritime logistics-personnel operations	ML-P or P	3	3	2
Maritime logistics supply chain	ML-SC or SC	3	3	2
Maritime logistics chef	ML-C or C	3	3	2
Maritime logistics support operations	ML-S	3	3	2

Table 4A–12: Medical and dental

Branch/Category	Abbreviation	MVR	CP	HS
Medical	MED	3	3	2
Dental	DEN	3	3	2

Table 4A–13: Submariner sailor

Branch/Category	Abbreviation	MVR	CP	HS
Acoustic warfare analyst submarine	AWA SM	3	1	1
Cryptologic systems submarine	CTS SM	3	1	1
Electronic technician submarine	ET SM	3	2	1
Electronic warfare submarine	EW SM	3	1	1
Marine technician submarine	MT SM	3	2	1
Communication and information systems submarine	CIS SM	3	2	1
Maritime logistics support operations	ML–S SM	3	3	1
Maritime logistics chef	ML–C SM	3	3	1
Maritime logistics supply chain	ML–SC SM	3	3	1
Medical submariner (e)	MED SM	3	1	1

Table 4A–14: Miscellaneous

Branch/Category	Abbreviation	MVR	CP	HS
Musician	MUS	3	3	2
ADF gap year participants	ADF-GY	3	3	2
Non category sailor entry	NCSE	3	1	1

Notes:

(a) Aircrew standards are in Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[97]—'Health requirements for aviation-related occupations'.

(b) Diver standards are in DHM Level 2 Part 5 Chapter 7[98]—'Health requirements for divers'.

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(c) Submariner standards are in DHM Level 2 Part 5 Chapter 8[99]—'Health requirements for submariners'.

(d) Re-entry candidates who are below the entry hearing standard but comply with serving hearing standard may be acceptable. Applications for waiver of standard should be referred to Chief medical officer Defence Force Recruiting for a decision.

(e) Medical submariners have dual responsibilities, including some of the electronic warfare (EW) and acoustic warfare (AW) jobs (notably lookout) and therefore need the same CP as EW and AW.

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ANNEX 4B

ARMY ENTRY STANDARDS FOR OFFICERS AND SOLDIERS, EXCLUDING AIRCREW AND DIVERS

1. All new entrants to the Army are to have a PULHEMS medical standard which equates to Class 1 unless a medical waiver is granted. If a waiver has been approved the PULHEMS profile for entry/appointment on the Attestation Medical is to reflect the PULHEMS profile on the waiver approval Minute. PULHEMS standards required for entry are in Defence Health Manual (DHM) Level 2 Part 5 Chapter 1[100]— 'Medical classification of candidates', Annex 1B. The functional interpretation of each PULHEMS quality is in DHM Level 2 Part 5 Chapter 1, Appendix 1B1. For those candidates with mild asthma that meet J23 criteria, or where standards in DHM Level 2 Part 5 Chapter 5[101]—'Causes of and reasons for rejection' annexes require allocation of recruiting medical classification 2, approval has been granted for entry into Army as P2 or P3. Procedures for granting any other medical waiver are in DHM Level 2 Part 5 Chapter 1.

2. Occupation specific colour perception and minimum visual requirement standards for Army entry for employment category numbers for:

a. Officer Corps are in Appendix 4B1

b. Soldiers are in Appendix 4B2.

3. The minimum entry medical standard for Australian Defence Force (ADF) gap year (GY) participants is in accordance with the applicable employment classification number (ECN) being applied under the GY scheme. Medical standards for candidates for Special Forces are in Appendix 4B3. Medical standards for explosive ordnance disposal and technician ammunition personnel (Army) are in Appendix 4B4.

4. Medical standards may vary depending on whether a candidate is applying for Arms Corps or non-Arms Corps roles, particularly for musculoskeletal conditions. Arms Corps includes the following Corps:

a. Royal Australian Armoured Corps (RAAC)

b. Royal Regiment of Australian Artillery (RAA)

c. Royal Australian Engineers (RAE)

d. Royal Australian Infantry Corps (RAINF)

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e. Special forces (SF)

Reference and Related Reading

- Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 3[102]—'The application of the military employment classification system and PULHEMS employment standards in the Australian Army'

Appendices:

4B1 Minimum colour perception and minimum visual requirements standards - officers
4B2 Minimum colour perception and minimum visual requirements standards – soldiers
4B3 Minimum visual requirement standards – Special Forces direct recruiting scheme
4B4 Minimum visual requirement standards –Explosive ordnance disposal and technician ammunition personnel (Army)

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APPENDIX 4B1

MINIMUM COLOUR PERCEPTION AND MINIMUM VISUAL REQUIREMENTS STANDARDS – OFFICERS

Table 4B1–1: Minimum colour perception (CP) and minimum visual requirements (MVR) standards – officers

Corps	Abbreviation	CP	MVR
General Officers	ASC	3	3
Senior Officers	ASC	3	3
Royal Australian Armoured Corps	RAAC	2A	3
Royal Australian Artillery	RAA	2	3
Royal Australian Artillery	RAA – OPUAS Operator Uncrewed Aircraft Systems	1	Aviation visual requirements (AVR) 3 (a)
Royal Australian Engineers	RAE	2	3
Royal Australian Signal Corps	RA SIGS	3	3
Royal Australian Infantry	RA INF	2A	3
Australian Army Aviation	AA AVN	3	3
Australian Army Aviation	AA AVN - Pilots	2	AVR1A (a)
Australian Intelligence Corps	Aust Int Corps	3	3
Royal Australian Chaplains Department	RAA Ch D	3	3
Royal Australian Corps of Transport	RACT	3	3
Royal Australian Army Medical Corps	RAAMC	3	3
Royal Australian Army Dental Corps	RAADC	3	3
Royal Australian Army Ordnance Corps	RAAOC	3	3
Royal Australian Electrical & Mechanical Engineers (includes Aerospace Engineer)	RAEME	3	3
Royal Australian Army Education Corps	RAAEC	3	3
Australian Army Public Relations Service	AAPRS	3	3
Australian Army Catering Corps	AACC	3	3
Royal Australian Army Pay Corps	RAAPC	3	3
Australian Army Legal Corps	AALC	3	3
Royal Australian Corps of Military Police	RACMP	2A	3
Australian Army Psychology Corps	AA PSYCH	3	3
Australian Army Band Corps	AABC	3	3
Royal Australian Nursing Corps	RAANC	3	3
Philanthropic representatives		3	3
Officer Cadets		3	3

Corps	Abbreviation	CP	MVR
Staff Cadets		3	3
Special Force (SF) Officer	SF	2	MVR3-SF (b)

Notes:

(a) Apply in so far as consistent with aircrew MVR. Refer Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[103]—'Health requirements for aviation-related occupations' Appendix 6B3

(b) Staff need to be cognisant that MVR3-SF differs to the general MVR3 standard

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APPENDIX 4B2

MINIMUM COLOUR PERCEPTION AND MINIMUM VISUAL REQUIREMENTS STANDARDS – SOLDIERS

Table 4B2–1: Minimum colour perception (CP) and minimum visual requirements (MVR) standards – soldiers

ECN	Corps	Employment designation	Abbreviation	CP	MVR
N/A	RAA	Artillery Recruit to Segment Trainee	Artillery RTS	3	3
003	AUSTINT	Analyst Intelligence Operations	ANALYST INT OPS (AIO)	3	3
013	RAEME	Artificer Ground	ARTGND	3	3
029	RAADC	Dental Assistant	DEN ASST	3	3
034	RAEME	Technician Assistant	TECHASST	3	3
035	RACT	Operator Movements	OP MOV	3	3
060	RAAC	Armoured Cavalry	ARMD CAV	2A	3
062	RAAC	Cavalry Scout	CAVSCT	2A	3
072	RAE	Carpenter	CARPT	2	3
079	SF	Strike and Recovery Operator	S&R	2, note (c)	3, note (c)
084	AACC	Cook	COOK	3	3
096	RAE	Combat Engineer	CBT ENGR	2	3, note (e)
099	RACT	Air Dispatcher	AD	3	3
101	RAE	Draughting Technician	FTTECH	1	3

ECN	Corps	Employment designation	Abbreviation	CP	MVR
104	RAOOC	Distribution Operator	DIST OP	3	3
125	RAE	Electrician	ELECTRICIAN	1	3
141	RAE	Combat Rescue	CR	2	3
146	RAEME	Weapon Technician	WPNTECH	3	3
150	RAAOC	Command Support Clerk	COMD CLK SPT	3	3
162	RAA	Artillery Gunner	ARTYGNR	3	3
163	AAAVN	Aircrew Operator	AC OP	2A	Aviation visual requirements (AVR)2, note (a)
164	AAAVN	Aviation Groundcrew	AVN G	3	3
165	AAAVN	Aviation Operations Specialist	AO SPEC	2A	3
171	RACT	Cargo Specialist	CARGO SPEC	3	3
180	AUSTINT	Multimedia Technician	MULTIMEDIA TECH	1	3
185	RAAMC	Physical Training Instructor	PTI	3	3
190	RACMP	Australian Defence Force Investigator	ADFI	2A	3
217	RAE	Manager Works, Supervisor Works and Supervisor Construction	MNGR WKS/SPVRWKS/SPVRECON	2	3
218	RACT	Marine Specialist	MARINE SPEC	2	3
222	RAEME	Marine Technician	MARTECH	3	3
226	RAEME	Recovery Technician	RECTECH	2	3
229	RAEME	Vehicle Technician	VEHTECH	3	3
235	RAEME	Material Technician	MATTECH	3	3
237	RAA	Operator Ground Based Air Defence	OPGBAD	2A	3

ECN	Corps	Employment designation	Abbreviation	CP	MVR
240	AABC	Musician	MUSN	3	3
250-1 250-3 250-5 250-7	RAA SERCAT 6,7	Operator Uncrewed Aerial System	OPUAS	1	AVR3 , note (a), (i)
250-0 250-2 250-4 250-6 205-8	RAA SERCAT 5	Operator Uncrewed Aerial System	OPUAS	2	3, note (i)
254	RAA	Artillery Command System Operator	ACSO	3	3
255	RAA	Artillery Surveillance Reconnaissance and Targeting	ARTYSRT	2	3
269	RAAOC	Operator Petroleum	OP PETRL	3	3
270	RAE	Operator Plant	OP PLANT	2	3
274	RACT	Driver Specialist	DVR SPEC	3	3
304	RAINF	Patrolman Regional Force Surveillance Unit	PTLN RFSU	2A	3
305	RAINF	Combat Support Operator Regional Force Surveillance Unit	CSO RFSU	3	3
312	AAPRS	Army Imagery Specialist	AIS	2	3
314	RAE	Plumber	PLBR	2	3
315	RACMP	Military Police	MP	2A	3
322	RAAMC	Preventive Medicine	PVNT MED	3	3

ECN	Corps	Employment designation	Abbreviation	CP	MVR
342	AAPRS	Reporter	REPORTER	2, note (b)	3
343	RAINF	Rifleman	RFN	2A	3
345	RAAOC	Rigger Parachute	RIG PRCHT	3	3
353	SF	Special Reconnaissance Operator	SAS TPR	2, note (c)	3, note (c)
357	RAA	Manager Operations Offensive Support	MANOPS OS	3	3
368	RAAMC	Army Medic	AMED	3	3
401	RAAOC	Ammunition Technician	AMMOTECH	2	MVR, note (d)
411	RAEME	Aircraft Technician	ACFTTECH	2	3
412	RAEME	Avionics Technician	AVTECH	2	3
418	RAEME	Energy Technician	ENERGYTECH	2A	3
421	RAEME	Electronics Technician	ELECTRONTECH	2	3
423	AUSTINT	Geospatial Technician	GT	1	3
430	RAA	Manager Surveillance Target Acquisition	MNGRSTA	3	3
500		Recruit – Open Employment Category , note (f) and (g)	ROEC	3, note (f) and (g)	3, note (f) and (g)
661	RASIGS	Information Systems	INFO SYS	2A	3
662	RASIGS	Communication Systems	COMMS SYS	2A	3
663	RASIGS	Electronic Warfare	EW	3	3
664	RASIGS	Cyber Warfare Specialist	CWS	3	3
665	RASIGS	Telecommunications Network Engineering	TELS NWK ENG	2A	3
900	SF	Special Warfare Operator	SWOP	2	3, note (c)

Notes:

(a) Apply in so far as consistent with aircrew MVR. Refer Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[104]—'Health requirements for aviation-related occupations' Appendix 6B3. Candidates who meet AVR standards but fail to meet PULHEMS in accordance with Army Standing Instructions (Personnel) (ASI(P)) Part 8 Chapter 3[105]—'The application of the military employment classification system and PULHEEMS employment standards in the Australian Army' are not to be classified Class 4 until medical classification has been confirmed by the Institution of Aviation Medicine.

(b) Colour perception 3 personnel must be able to pass a trade test and must not be posted to a digital post.

(c) Refer appendix 3 for medical requirements for initial applicants for special forces.

(d) For occupational specific visual requirements for explosive ordnance personnel and technician ammunition refer DHM Level 2 Part 5 Chapter 4[106]— 'Occupation specific – medical standards' Appendix 4B4

(e) Combat engineer (Army work diver) needs to meet MVR 2 to align with diving requirements. MVR 2 is to be applied to those undertaking diving training and employment, and general Combat Engineer remains at MVR3.

(f) Candidates entering as employment category number (ECN)500 will be allocated a new employment category via a Corps Allocation Board (CAB) whilst undertaking recruit training. Noting this candidates with any history of asthma are to be informed that they will be medically unsuitable for ECN154 aircraft life support fitter in accordance with DHM Level 2 Part 5 Chapter 5[107]—'Causes of and reasons for rejection'. Defence Force Recruiting medical officer (DFR MO) is to advise the candidate that they are medically unsuitable for ECN154 and document on the entry level medical examination (ELME) and attestation medical that the candidate has been advised of the restriction.

(g) Candidates enlisting under ECN500 who are assessed as unsuitable for combat roles are to have the ELME and attestation medical clearly annotated with 'UNFIT FOR COMBAT ROLES'. DFR MO is to advise the candidate that they are medically unsuitable for combat roles and document on the ELME that the candidate has been advised of the restriction.

(h) All other roles not covered in this enclosure are to be referred to ASI (P) Part 8 Chapter 3.

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(i) Refer to DHM Level 3 Part 6 Chapter 3[108]—'In-service health requirements for aviation occupations'.

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APPENDIX 4B3

MINIMUM VISUAL REQUIREMENT STANDARDS FOR SPECIAL FORCES DIRECT RECRUITING SCHEME

1. The following table summarises the medical requirements for Special Forces direct recruiting scheme (SFDRS) applicants. The medical should confirm that the applicant is capable of withstanding the severe physical and environmental stresses associated with special forces operations in addition to any primary combat duties.

Table 4B3–1: Medical Standards for Special Forces Direct Recruiting Scheme

Factor	Requirement
Employment category number (ECN) and PULHEMS	353 Special air service (SAS) Trooper 2222 8/3 8/3 22 079 Commando 2222 8/3 8/3 22
Weight	Australian Defence Force (ADF) Recruiting Standards body mass index 18.5–32.9
Height	ADF minimum height 152 cm
Distance vision	Minimum visual requirement 3. Refraction limits are +5 dioptres/-8.00 dioptres in either axis in either eye and must correct to minimum 6/12 in both eyes with spectacles
Near vision	N5 at 30–35 cm or N14 at one metre
Colour vision	Colour perception 2 minimum
Hearing	Hearing standard 2 minimum
Dental	ADF general dental fitness recruiting standard
Surgical history	No major surgery in last 12 months
Refractive surgery	Photo refractive keratectomy, laser epithelial keratomileusis, laser assisted in situ keratomileusis—good result, stable vision—acceptable three months post-surgery in accordance with Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[109]—'Medical history and examination' Annex 2D, and DHM Level 2 Part 5 Chapter 5[110]—'Causes of and reasons for rejection' Annex 5K.

2. Fitness to attend and participate in SF selection board activities requires confirmation by Defence Force Recruiting Centre (DFRC) medical officer for candidates assessed as 3R/3T/4W.

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3. Pre-enlistment fitness assessment (PFA). All applicants are to undertake a PFA in accordance with ADF Recruiting Instructions–032—Pre-Enlistment/Appointment Fitness Assessment.

References and Related Reading

- Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 3[111]—The application of military employment classification system and PULHEMS employment standards in the Australian Army
- ASI(P) Part 5 Chapter 1[112]—Selection, screening, and service with special operations command

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APPENDIX 4B4

MINIMUM VISUAL REQUIREMENT STANDARDS FOR EXPLOSIVE ORDNANCE DISPOSAL AND TECHNICIAN AMMUNITION PERSONNEL (ARMY)

Table 4B4–1: Minimum visual requirement standards for explosive ordnance disposal and technician ammunition personnel (Army)

Factor	Explosive ordnance disposal personnel employment category number (ECN) 432	Technician ammunition ECN 401
Visual Acuity	Unaided 6/9 6/9 Aided 6/6 6/6	Unaided 6/120 6/120 (3/60 3/60) Aided 6/6 6/6
Refraction Limits with cycloplegia	Not applicable	For all refractive errors: Refraction limits are +/- 5.00 dioptres in either axis
Hypermetropia	+2.25 dioptres	Not applicable
Hypermetropic astigmatism	+1.00 dioptre	Not applicable
Myopia	-1.00 dioptre	Not applicable
Myopic astigmatism	-1.00 dioptre	Not applicable
Accommodation (Age years)	Not applicable	Not applicable
17–20	10–11 cm	Not applicable
21–25	11–12 cm	Not applicable
26–30	13–14 cm	Not applicable
31–35	14–16 cm	Not applicable
36–40	16–20 cm	Not applicable
40–45	20–30 cm	Not applicable
45–50	30–60 cm	Not applicable
Convergence	10 cm or less	Not applicable
Fields of vision	The fields of vision should be normal to confrontation, or cases of doubt to perimetry	The fields of vision should be normal to confrontation or, in cases of doubt, to perimetry

Factor	Explosive ordnance disposal personnel employment category number (ECN) 432	Technician ammunition ECN 401
Near vision	N5 at 30–35 cm and N14 at one metre or better with or without correction	N5 at 30–35 cm and N14 at one metre or better with or without correction
Refractive Surgery	Refer Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[113]— 'Medical history and examination' Annex 2D and DHM Level 2 Part 5 Chapter 5[114]—'Causes of and reasons for rejection' Annex 5K	Refer DHM Level 2 Part 5 Chapter 3 Annex 3D and DHM Level 2 Part 5 Chapter 6 Annex 6K

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ANNEX 4C

ROYAL AUSTRALIAN AIR FORCE VISUAL AND HEARING STANDARDS FOR ENTRY

Table 4C–1: Royal Australian Air Force visual (colour perception (CP) and minimum visual requirements (MVR)) standards and hearing standards (HS) for entry – Officers

Type	MVR	CP	HS untrained	HS trained(a)
Aerospace Engineer – Aeronautical	3	3	1	2
Aerospace Engineer – Armament	3	3	1	2
Airfield Engineer	3	2	2	2
Chaplain	3	3	3	3
Cyberspace Warfare Officer	3	3	2	2
Dental	3	3	2	2
Electronics Engineer - Avionics	3	3	2	2
Electronics Engineer - Networks	3	3	2	2
Environmental Health	3	3	2	2
Intelligence	3	3	1	2
Laboratory	3	3	2	2
Legal	3	3	3	3
Logistics	3	3	2	2
Medical	3	3	2	2
Nursing	3	3	2	2
Operations	3	2a	2	2
Personnel Capability Officer	3	3	2	2
Pharmacist	3	3	2	2
Physiotherapist	3	3	2	2
Psychologist	3	3	2	2
Public Affairs	3	3	3	3
Radiographer	3	3	2	2
Security Forces Officer	3	2a	2	2
Training Systems Officer	3	3	1	2

Note:

(a) Trained standards listed are for Australian Defence Force (ADF) applicants with previous experience in the military specialisation applying for re-enlistment.

MUSTERINGS

Table 4C–2: Business, administration and education musterings

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
ADF Gap Year participants	ADFGY–AF	2	2	2	N/A
ADF Gap Year - Aviation	ADFGY-AVN	2	2	1	1
Personnel Capability Specialist	PCS	3	3	2	3
Warrant Officer Disciplinary	WOD	3	2a	2	2

Table 4C–3: Combat and security musterings

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
Airbase Protection	ABP	3	2a	2	2
Airfield Defence Guard	ADG	3	2a	2	2
Air Force Police	AFPOL	3	2a	2	2
Air Force Security	AFSEC	3	2a	2	2
Firefighter	FIREFTR	2	2	2	2
Physical Training Instructor	PTI	2	3	1	2
Regional Compliance Officer	RCO	3	2a	2	2

Table 4C–4: Communications, IT and intelligence musterings

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
Advanced Communications Electronic Technician	ADCETECH	3	2	2	2
Air Force Imagery Specialist	AFIS	2	2a	2	2
Air Intelligence Analyst – Geospatial Intelligence (c)	AIAGEOINT	2	2a	2	3
Air Intelligence Analyst – Operational Intelligence	AIAOPINT	3	3	1	2
Air Intelligence Analyst – Signals Intelligence	AIASIGINT	3	3	1	2
Air Surveillance Operator	ASOP	2	2a	2	2
Communications Information Systems Controller	CISCON	3	3	1	2
Cyberspace Warfare Analyst	CWA	3	3	2	2
Network Technician	NET TECH	3	3	2	2

Table 4C–5: Healthcare and science musterings

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
Dental Assistant	DENTASST	3	3	2	2
Laboratory Technician	LABTECH	3	3	2	3
Medical Assistant	MEDASST	3	3	2	2

Table 4C–6: Logistics, hospitality and support musterings

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
ADF Gap Year - Movements	ADFGY-MOV	3	3	2	N/A
Cook	COOK	3	3	2	3
Motor Transport Driver	MTD	3	3	2	3
Movements	MOV	3	3	2	3
Musician	MUSN	3	3	1	2
Supply	SUP	3	3	2	3

Table 4C–7: Trade musterings

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
Aircraft Fitter	AFITT	3	2a	2	2
Advanced Aircraft Technician Aircraft Systems Technician	ASYTECH	3	2a	2	2
Advanced Avionics Technician	ADAVTECH	3	2a	2	2
Aeronautical Life Support Fitter(b)	ALSFITT	3	2a	2	2
Aircraft Armament Technician	ARMTECH	3	2	2	2
Aircraft Structural Technician	ASTFITT	3	2	2	2
Aircraft Surface Finisher(b) (Spray Painter)	ASURFIN	3	2a	2	3
Aircraft Technician	ATECH	3	2a	2	2
Avionics Fitter	AVFITT	3	2a	2	2
Avionics Mechanic	AVMECH	3	2	2	2
Avionics System Technician	AVSYSTECH	3	2a	2	2
Avionics Technician	AVTECH	3	2a	2	2
Carpenter	CARP	3	2a	2	2
Communications Electronic Fitter	CEFITT	3	2	2	2
Communications Electronics Systems Technician	CESYSTECH	3	2	2	2

Mustering	Abbreviation	MVR	CP	HS untrained	HS trained
Communications Electronics Technician	CETECH	3	2	2	2
Electrician	ELECN	3	2a	1	2
Fitter and Turner (Ground Mechanical Engineering Fitter)	GMEFITT	3	2	2	3
General Hand	GHAND	3	2a	2	2
(Motor Mechanic) Ground Support Engineering Technician	GSETECH	3	2	2	2
Ground Support Equipment Fitter	GSEFITT	3	2	2	2
Plant Operator	PLANTOP	3	2a	2	2
Plumber	PLUMB	3	2a	2	2

Notes:

(a) Trained standards are listed for ADF applicants with previous ADF experience applying for re-enlistment or applicants who do not require initial trade training, eg carpenters, electricians and plumbers.

(b) For aeronautical life support fitter and aircraft surface finisher musterings. A history of asthma disqualifies, irrespective of the asthma free period.

(c) All candidates for this role are to pass stereoscopic testing as outlined in Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[115]—'Medical history and examination' Annex 2C.

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CHAPTER 5

CAUSES OF AND REASONS FOR REJECTION

INTRODUCTION

5.1 It is an inherent requirement of employment in the Australian Defence Force (ADF) for all members to be operationally deployable. The enlisted member or officer is primarily a combatant and secondarily a specialist tradesperson. The many reviews that the ADF has undergone over the past few years have tested each trade/mustering/category for the need to be operationally deployable. Those jobs without operational relevance have been removed or civilianised. This means that in Defence establishments today, there may be uniformed members working alongside their civilian counterparts. The difference is that members must be able to deploy at short notice and this is reflected in specific conditions of service and health standards that must be fulfilled. Enlistees (both regular and Reserve) must be medically fit to deploy at the time they enter the ADF.

POLICY

Classification of candidates

5.2 At the medical assessment stage it is most important that candidates meet these strict health requirements. For those candidates who are rejected on medical grounds it is important, for both legal and ethical reasons, that the reasons for rejection are communicated to them fully, and in an easily understood manner. If a rejected candidate has a condition requiring further investigation or treatment they must be informed, and any relevant findings of the examining medical officer (MO) are to be referred to the medical practitioner of the candidate's choice. Therefore, MOs must critically assess Form PM165—'Health questionnaire' and Form PM166—'Entry level medical examination' to confirm the candidate's suitability for service life. Accurate recording of findings are also essential.

5.3 This chapter defines the medical conditions, which may render a candidate Class 4 permanently medically unfit for recruitment. Those candidates who do not satisfy the health standards in this chapter or are not considered suitable for waiver consideration are to be made Class 4 in the first instance, once all available clinical information has been reviewed. Recruiting officers are not to advise candidates of their unsuitability until medical administrative responsibilities have been satisfied.

5.4 **Aircrew.** For the purpose of the annexes in this chapter, the term aircrew represents aviation-related occupations listed in Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[116]—'Health requirements for aviation-related occupations' Annex 6A.

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5.5 **Doubtful cases.** Where doubt exists, expert advice should be sought from military and clinical medical specialists as appropriate. Opinions regarding the medical fitness for specialist occupations are to be referred to:

a. For divers and submariners: the officer in charge, submarine and underwater medicine unit (OIC SUMU)

b. For aviation-related occupations, the commanding officer, RAAF Institute of Aviation Medicine (CO IAM)

c. Chief medical officer Defence Force Recruiting (CMO DFR) is to be included in all correspondence to the above authorities.

5.6 It is not possible to include all conditions in this chapter. The vast majority of conditions that will affect a candidate's suitability for military service are listed. Where there is no listing for a particular condition, the case must be taken on its merits with regard to potential short and long-term impact. Military and clinical medical expert advice should be sought in this case. In allocating a classification for conditions not listed, MOs are to consider the factors addressed in paragraph 6.8. Where any doubt or uncertainty exists the case is to be discussed with CMO DFR.

5.7 The principles upon which the DHM Level 2 Part 5 Chapter 2[117]—'Medical history and examination' is based are clearly given in DHM Level 2 Part 5 Chapter 1[118]—'Medical classification of candidates', however, a brief outline of those principles is repeated here.

5.8 The following factors are to be considered when determining the operational deployability of an individual and give rise to the medical standards against which the MOs screen candidates.

a. **Function.** The ability of the individual to perform the physical and intellectual tasks required (this is often the only factor immediately obvious to the lay person)

b. **General living conditions.** The candidate must be capable of operating efficiently and effectively in all types of living and operating conditions, including occupational and domiciliary accommodation and rations

c. **Clothing and equipment.** The candidate must be able to wear and use all standard issue specific clothing and equipment, including personal protective equipment

d. **Climate.** Individuals are expected to be capable of prolonged physical activity in extremes of environmental conditions and for extended periods of time

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e. **Safety.** The ability to perform the tasks without detriment to the safety and welfare of the individual and others. Certain factors must be addressed as regards an individual's safety and this is detailed in paragraph 6.5.

5.9 **Medical reports.** When possible, candidates should be referred to a specialist with ADF experience. Medical specialists or health care providers undertaking examination of ADF candidates should not provide an opinion on fitness for ADF entry.

5.10 The report should provide advice on the diagnosis, treatment required and the prognosis (see DHM Level 2 Part 5 Chapter 2). Prior to referring a diver or submariner candidate classified as Class 3 for specialist opinion or a medical report, in complex cases or where the medical officer is of the opinion that the candidate is likely to be class 4 with the provision of further supporting evidence, the case should be discussed with OIC SUMU East for divers and OIC SUMU East or OIC SUMU West for submariners, to confirm the requirement.

5.11 **Initial entrants.** For each condition listed in the annexes a recruiting medical classification is given by Defence Force Recruiting (DFR). The examining MO is to assign a medical classification to each candidate for enlistment based on the trade/specialisation for which the candidate is applying. Where a candidate is Class 4 for some trades/specialisations, but Class 1, 2 or 3 for other trades/specialisations, that is to be noted in the medical examination. Class 2 candidates are determined following confirmation of a waiver. DFR may recommend a military employment classification (MEC) on a candidate's entry to the ADF however Joint Health Command (JHC) is the determining authority of an entrant's MEC, as specified in the Military Personnel Policy Manual[119] (MILPERSMAN).

5.12 **Australian Defence Force Academy (ADFA) scholarship.** Each year many young people apply for an ADFA scholarship. All ADFA candidates need to be assessed appropriately and have the potential for Class 1 status recognised and noted prior to making a definite decision on their ADFA scholarship. The examining MO needs to consider what Class the ADFA candidate would be when they go to ADFA in one or two years' time. If a candidate is Class 3, eg for acne, then, assuming it will be resolved by the time they leave school for ADFA they can still receive a scholarship. In some cases even Class 4 candidates may become eligible. CMO DFR is to be contacted for guidance on such cases.

5.13 **Transfers.** ADF personnel applying for transfer to a specialist occupation stream are to meet the standards of this chapter. Serving personnel transferring to or within the Royal Australian Air Force are also to meet the standards of this chapter. A MEC appropriate to the gaining occupation and/or Service is to be allocated in accordance with MILPERSMAN.

[119] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/C5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765

Definitions of classifications

5.14 Following examination by an MO all candidates are to be allocated a recruiting medical classification (DHM Level 2 Part 5 Chapter 1). Classifications addressed in this chapter are defined below.

a. **3 Temporary.** 3 Temporary (3T) denotes that the condition or clinical finding is remediable and likely to resolve within 12 months. The candidate may be made Class 1 when they provide a letter from an appropriate health care provider stating that the condition has fully resolved and that the risk of sequelae or likelihood of recurrence is small

b. **3 Report.** 3 Report (3R) denotes that a report must be obtained from a health care provider about a medical condition or clinical finding. Once the exact diagnosis has been made, and the prognosis and requirement for health care has been determined, the case is to be reviewed. This should preferably be by the examining MO who initially performed the candidate's medical examination. The candidate may then be allocated a medical classification (usually Class 1 or 4). If a condition is classified as 3R and there is no decision listed, the final class must be determined by:

(1) CMO DFR for general entry candidates

(2) CO IAM for aviation-related occupations

(3) OIC SUMU for divers and submariners

c. **3 Mandatory.** 3 Mandatory (3M) is not included in this chapter as it indicates mandatory specialist assessments required to determine fitness for a military occupation. The aim of this chapter is to identify specific medical conditions, which may cause rejection of a candidate

d. **4. Class** 4 denotes that the candidate is permanently medically unfit for military service (Class 4). Permanently, for the purposes of this classification, denotes longer than 12 months. An explanation of the reason the condition is not compatible with service in the ADF is included in the relevant annex. A candidate may decide to request a review of a decision, (DHM Level 2 Part 5 Chapter 1), but in this case all costs associated with obtaining a second or subsequent medical opinion is the responsibility of the candidate. In some cases, candidates will be Class 4 based on current or historical symptoms, but if symptoms remit, or become absent for a period of time as prescribed, the candidate may be reassessed later as suitable for recruitment.

5.15 **System specific guidelines.** Each system is dealt with in a separate annex. Each system is listed in such a way as to make location of a particular condition or finding easier.

SPONSOR: Deputy Surgeon General Australian Defence Force

Annexes:
5A Cardiovascular entry standard
5B System specific reasons for rejection – respiratory system

ANNEX 5A

CARDIOVASCULAR ENTRY STANDARD

CRITERIA FOR DECISION-MAKING

Individual cardiovascular capability

1. Military service requires cardiovascular fitness. Candidates may be required to participate in high-intensity physical activity over prolonged periods in environments with limited and time-constrained health resources. Capability requirements relevant to the cardiovascular system may include:

a. marching, running and standing for extended periods

b. strenuous physical activity in adverse conditions

c. negotiating obstacles, load carrying and manual handling

d. firefighting, damage control and casualty handling

e. self-extrication in emergency situations.

2. The nature of work and/or physical elements of the military environment render some roles more demanding and requiring of a higher degree of cardiovascular fitness. Medical officers (MOs) should consider cardiovascular health in relation to the candidate's job preference.

Class 1 criteria

3. Unless otherwise specified in this annex, a candidate should be considered Class 1 for the cardiovascular system if all of the following apply:

a. asymptomatic from the perspective of cardiovascular disease (CVD)

b. no cardiovascular limitations on physical activity

c. no identified cardiovascular condition with greater than population risk of sudden cardiac death.

Class 4 criteria

4. Candidates are medically unsuitable for Australian Defence Force (ADF) entry (Class 4) if any of the following apply to the condition:

a. cardiovascular disease symptoms despite optimal management

b. results in incapacitation, impairment of function, exercise intolerance, or restricted physical activity.

SPEC

5. For all conditions of interest, unless otherwise specified, candidates who meet the criteria for entry are to be referred the appropriate specialist employment classification (SPEC) confirming authority. The SPEC confirming authority is ultimately responsibility for determination of medical suitability.

Medical reports

6. MOs undertaking entry level medical examination (ELME) and considering suitability from the cardiovascular system perspective, should consider: aetiology and any co-existing conditions, functional impact, risk of complications or progression, physical activity limitations, requirement and frequency of cardiology review, requirement for medication, need for interventions in short, medium, and long term.

7. Where relevant, existing medical reports may inform the Defence Force Recruiting (DFR) MO decision. However, if further information is required, cardiology or other specialist opinion may be requested.

8. **Structurally normal heart:** Is defined for medical suitability assessment purposes as echocardiogram (echo) finding of: No more than trivial valvular heart disease, minor variances in atrial size eg mild atrial dilatation in the absences of a diagnosed cardiac condition, normal: biventricular size and function.

CONDITIONS OF INTEREST

Congenital heart disease

9. Congenital heart disease (CHD) represents a broad spectrum of conditions. The complexity of CHD can be classified as mild, moderate and severe[120]. Mild typically represents simple anatomical defects with good prognosis. While moderate and severe CHD has less certain prognosis and in general are not suitable for entry.

10. Mild defects have been defined as:

a. native disease:

(1) isolated congenital aortic valve disease and bicuspid aortic disease

(2) isolated congenital mitral valve disease (except parachute valve, cleft leaflet)

(3) mild isolated pulmonary stenosis (infundibular, valvular, supravalvular)

(4) isolated small Atrial Septal Defect (ASD), Ventricular Septal Defect (VSD), or Patent Ductus Arteriosus (PDA).

[120] https://academic.oup.com/eurheartj/article-pdf/42/6/563/41216858/ehaa554.pdf

b. repaired conditions:

(1) secundum ASD, sinus venosus defect, VSD, or PDA without residual shunt or sequelae, such as chamber enlargement, ventricular dysfunction or elevated pulmonary artery pressure.

11. Moderate and severe lesions are defined in the European Society of Cardiology Guidelines[121] for the management of adult congenital heart disease.

Table 5A–1: Congenital heart disease

Serial	Conditions and decision factors	Class
1.1	**Congenital heart disease – mild and uncorrected including isolated small ASD, VSD or PDA.** Existing cardiology report within last 24 months. Class 1 if all following: • meets Class 1 criteria • echo – otherwise structurally normal heart and no pulmonary artery hypertension • no haemodynamic compromise.	1
	Congenital heart disease – mild and repaired. Including ASD, VSD, PDA. Cardiology report within last 24 months. Class 1 if: • meets Class 1 criteria • echo – otherwise structurally normal heart and no pulmonary hypertension • >six months since surgery or procedure and cleared to return to normal activity • no history post-surgery of haemodynamic compromise.	1
	Congenital heart disease – moderate. • coarctation and congenital aortic valve stenosis considered in individual serials.	4
	Congenital heart disease – severe.	4
	Otherwise.	4

[121] https://academic.oup.com/eurheartj/article-pdf/42/6/563/41216858/ehaa554.pdf

Serial	Conditions and decision factors	Class
1.2	**Coarctation of Aorta – Isolated and mild (upper and lower limb SBP gradient < 20mmHg and imaging (CT or MRI) shows < 50% stenosis).** Cardiology report from within last 24 months, including appropriate imaging. Class 1 if: • meets Class 1 criteria • not associated with other cardiac conditions • no secondary complications including hypertension. • no significant aortic dilatation. **Note**. Normal exercise test and a resting SBP gradient <20 mm Hg between the upper and lower limbs and a peak SBP not exceeding the 95th percentile of predicted.	1
	Coarctation of aorta – post surgical/catheter intervention. Cardiology report within last 24 months. Class 1 if: • >six months since surgery or procedure • meets Class 1 criteria • cleared by surgeon and cardiologist to return to normal activity • meets criteria as above for unrepaired. **Note.** Consideration of military employment classification (MEC) J2 for long term follow-up. Yearly follow-up due to risk of hypertension and to monitor for complications.	1
1.3	**Dextrocardia or dextrocardia with situs inversus.** Existing report. Normal variant. No associated condition and no complications.	1
1.4	**Patent foramen ovale (PFO) – Not surgically managed.** Class 1 if isolated condition and incidentally found and all following: • meets Class 1 criteria • no history of stroke, or use of medication for prevention or management • echo – otherwise structurally normal heart.	1
	PFO – closure. Existing report. Class 1 if all following: • >six months since surgery or procedure. • no requirement for medications • meets Class 1 criteria • closure is stable with no significant complications.	1
	SPEC Candidates. SPEC confirming authority to make final determination of medical suitability. **PFO – closure.** Existing report. Class 1 if all following: • >six months since surgery or procedure. • no requirement for medications • meets Class 1 criteria • closure is stable with no significant complications.	3R
	Otherwise.	4

Rhythm disturbances

12. Rhythm disturbances may range from benign atrial or ventricular ectopic beats through to atrial and ventricular arrhythmias. Conditions associated with untreated, life-threatening arrhythmias are incompatible with military service. Arrhythmias associated with an increased risk of stroke and/or require anticoagulation are also incompatible with military service.

13. Candidates with a medical history suggestive of cardiac arrhythmia are to provide a copy of all relevant medical reports and investigations.

Table 5A–2: Rhythm disturbances

Serial	Conditions and decision factors	Class
2.1	**History of recurrent or prolonged (> 5 minutes) palpitations which are not associated with significant symptoms such as syncope or presyncope. Specialist report.** • meets Class 1 criteria • ECG within normal limits, • 24-hr Holter monitor within normal limits • echo - structurally normal heart.	1
2.2	**Sinus arrhythmia.** Normal variant.	1
2.3	**Supraventricular ectopic beats. Note: Specialist report.** infrequent, occasional premature atrial (ectopic) beats may be normal. Request cardiology assessment if more than isolated ectopic beats, or any symptoms. • meets Class 1 criteria • ECG within normal limits, • 24-hr Holter monitor within normal limits • echo - structurally normal heart.	1
2.4	**Atrial flutter/atrial fibrillation. Specialist report.** • no recurrence >12 months • no requirement for medication • meets Class 1 criteria • single episode with attribution to a precipitating factor • ECG within normal limits • echo - structurally normal heart.	1
	Recurrent or persistent atrial flutter/atrial fibrillation.	4
	SPEC Candidates.	4

Serial	Conditions and decision factors	Class
2.5	**Supraventricular tachycardia – without pre-excitation. Specialist report.** • meets Class 1 criteria • not requiring medications • infrequent in nature and non-capacitating • echo - structurally normal heart • if post-ablation, >six months following successful ablation and no complications.	1
	SPEC Candidates. SPEC confirming authority to make final determination of medical suitability.	3R
2.6	**Supraventricular tachycardia – with pre-excitation "Wolff-Parkinson-White Syndrome" or re-entrant pathway.** **Post ablation: Specialist report.** • >six months following successful ablation • no requirement for medications. • no recurrence or complications following ablation • meets Class 1 criteria • ECG – within normal limits • 24-hr Holter monitor – within normal limits.	1
	Supraventricular tachycardia – re-entrant pathway. Not treated. Specialist report. • low risk based on electro physiology (EP) study and report • no requirement for medications • no associated history of syncope or sudden incapacitation • meets Class 1 criteria.	1
	Otherwise.	4
	SPEC Candidates. SPEC confirming authority to make final determination of medical suitability.	3R
2.7.	**Premature ventricular beats (contractions).** Two or more on a resting ECG requires cardiology report. • no medication • meets Class 1 criteria • 24-hr Holter monitor – within normal limits or rare ventricular ectopics • echo – structurally normal heart	1
	Frequent ventricular ectopic beats or complex ectopy.	3R
	SPEC Candidates. SPEC confirming authority to make final determination of medical suitability.	3R
2.8.	**Ventricular tachycardia – sustained or non-sustained.**	4

Conduction disturbances

14. Conduction disturbances include atrioventricular conduction disturbance (including any degree heart block); intraventricular conduction disturbance (including left bundle branch block, right bundle branch block, incomplete right bundle branch block); and re-entry pathways. In younger people, a very small percentage of abnormal ECG findings are likely to represent actual disease. As age advances, the risk of underlying cardiac pathology increases.

15. **Group 1** conduction disturbances are low risk and usually linked to aerobic fitness. Examples are sinus bradycardia (heart rate <50 beats per minute), first-degree atrioventricular block (PR interval >200 milliseconds (ms)), incomplete right bundle branch block (QRS <120 ms), early repolarisation, and isolated QRS voltage criteria of left ventricular hypertrophy.

16. **Group 2** conduction disturbances are uncommon and not linked to aerobic fitness. Examples are T-wave inversion, ST-segment depression, pathological Q-waves, left or right atrial enlargement, left or right axis deviation, right ventricular hypertrophy, ventricular pre-excitation, second or third degree heart block (eg Mobitz or Wenckeback), left bundle branch block, complete right bundle branch block (QRS >120 ms), prolonged QTc interval (>440 ms males; >460 ms females), short QTc interval (<380 ms), and Brugada-like early repolarisation.

Table 5A–3: Conduction disturbances

Serial	Conditions and decision factors	Class
3.1	**Conduction disturbance – Group 1, age <35 years.** Class 1 if all following: • history of regular, moderate intensity physical activity • no family history of sudden cardiac death (under 50 years), unexplained drowning or epilepsy. • meets Class 1 criteria • no cardiac murmurs audible on auscultation.	1
	Conduction disturbance – Group 1, age >35 years. Cardiology report required. • history of regular, moderate intensity physical activity • no family history of sudden cardiac death (under 50 years), unexplained drowning or epilepsy. • meets Class 1 criteria. • no cardiac murmurs audible on auscultation.	1
3.2	**Conduction disturbance – Group 2,** Cardiologist review confirms: • population risk only of sudden cardiac death • 24-hr Holter monitor – within normal limits • echo – structurally normal heart. • Exercise Stress echo – within normal limits.	1
	Otherwise.	4
3.3	**Implanted pacemaker, defibrillator or cardiac monitoring device.**	4

Serial	Conditions and decision factors	Class
3.4	**ECG finding not within normal limits or covered above.** Class 1 if cardiologist review indicates no evidence of underlying cardiac disease.	1

Cardiomyopathy

17. Cardiomyopathies are progressive diseases that can cause heart failure and are associated with increased risk of sudden cardiac death. Exercise may be a trigger for sudden cardiac death and in some conditions can increase progression.

18. Cardiac chamber dilatation may be pathological in the setting of a cardiomyopathy however, balanced chamber dilatation can also occur secondary to physiological remodelling in ‘athletes heart’ and hence careful assessment by a cardiologist is warranted.

Table 5A–4: Cardiomyopathy

Serial	Conditions and decision factors	Class
4.1	**Family history of Cardiomyopathy.** If family history of cardiomyopathy, sudden cardiac death or sudden cardiac arrest. Specialist report required (with expertise in genetic cardiomyopathies). • genetic test if gene identified - within normal limits • no phenotypic features including: • ECG – within normal limits • echo – structurally normal heart • additional testing may be required in certain conditions including cardiac MRI, SAECG, holter. **Note**. if no gene identified family members may need ongoing surveillance which should be detailed by the treating specialist.	1
	SPEC Candidates.	4
4.2	**Cardiomyopathy.** Including but not limited to hypertrophic, arrythmogenic or dilated cardiomyopathy.	4
4.3	**Dilated heart chambers on echo or cardiomegaly on CXR.** May represent cardiomyopathy or athletic remodelling. Specialist report required to exclude underling cardiomyopathy or cardiac disease and support diagnosis of athlete’s heart if applicable. • meets Class 1 criteria • echo – otherwise structurally normal heart with normal systolic and diastolic function • Exercise Stress echo – within normal limits.	1
	Otherwise.	4
4.4	**Isolated mild dilatation of left or right atria:** • meets Class 1 criteria • echo – otherwise structurally normal heart with no identifiable shunts.	1

Valvular heart conditions

19. Valvular disease may be congenital or acquired. It is mostly asymptomatic in young people, even in the presence of advanced disease. Valvular heart conditions can lead to impairment of functional capacity and exercise tolerance. There is increased risk of CVD, bleeding risk associated with anticoagulant therapy and heat injury risk with diuretic medication. Complications of these conditions include progression, endocarditis and risk of heart failure.

20. All cardiac murmurs are to be investigated with a minimum of echocardiogram. Where available extant reports are acceptable unless otherwise specified.

Table 5A–5: Valvular heart conditions

Serial	Conditions and decision factors	Class
5.1	**Murmur – physiological.** echo – structurally normal heart.	1
	Murmur – pathological. Assess as per relevant serial of this annex.	n/a
5.2	**Valve regurgitation – trivial.** echo – trivial valve regurgitation with structurally normal heart.	1
5.3	**Valve regurgitation: tricuspid and pulmonary – mild.** Mild tricuspid and pulmonary valve regurgitation can be physiological. • meets Class 1 criteria • echo – structurally normal heart and pulmonary artery pressure.	1
	Valve regurgitation: mitral and aortic – mild. Note bicuspid aortic valve and mitral valve prolapse considered separately. Cardiology report from the last two years required. • no routine medications • no history of cardiac arrhythmias • echo - normal pulmonary pressures, aortic root, ascending aorta & structurally normal heart • meets Class 1 criteria.	1
	Mitral valve prolapse – mild. Mitral valve prolapse can have an increased risk of arrhythmia compared with other forms of mitral regurgitation and hence has stricter entry and surveillance requirements. Cardiology review within last 12 months. • ECG – within normal limits • 24-hr Holter monitor - within normal limits • echo – normal pulmonary artery pressure and structurally normal heart • Exercise Stress echo – within normal limits • meets Class 1 criteria. **Note.** Consideration of MEC J2 re frequency of specialist review & echo.	1
	Otherwise.	4

Serial	Conditions and decision factors	Class
	Valve regurgitation (pulmonary, tricuspid, mitral, aortic) – mild-to-moderate. Cardiology report less than 12 months required. • echo - normal pulmonary artery pressures and otherwise structurally normal heart and normal great vessels • no routine medications • no history of cardiac arrhythmia • meets Class 1 criteria • Exercise Stress test – within normal limits. **Note.** Consideration of MEC J2 re frequency of specialist review & echo.	1
	Aviation-related occupations and submariners. SPEC authority to make final recruiting medical classification decision.	3R
	Divers.	4
	Otherwise.	4
	Valve regurgitation (pulmonary, tricuspid, mitral, aortic) –moderate or severe	4
5.4	**Valve Stenosis (pulmonary, tricuspid, mitral, aortic) – mild.** Note valvular stenosis is likely congenital or rheumatic in a young population. See rheumatic heart disease (RHD) serial where appropriate. Cardiologist report within last 12 months required. • no medications • no history of cardiac arrhythmia • echo – normal pulmonary artery pressure and otherwise structurally normal heart • Exercise stress test – within normal limits • low risk of deterioration over medium term (five years). • meets Class 1 criteria. **Note.** Consideration of MEC J2 for frequency of specialist review & echo.	1
	Aviation-related occupations and submariners. SPEC authority to make final recruiting medical classification decision.	3R
	Divers.	4
	Otherwise	4
	Valve Stenosis (pulmonary, tricuspid, mitral, aortic) – moderate or severe	4
5.5	**Bicuspid aortic valve (BAV) associated with either trivial or mild aortic regurgitation or stenosis.** BAV is associated with aortopathy and coarctation of the aorta. Cardiology report required. • meets Class 1 criteria • no medications • cardiac imaging including: echo, CT or MRI – within normal limits with no evidence of aortopathy, coarctation of the aorta, normal pulmonary artery pressure and otherwise structurally normal heart. **Note.** Consideration of MEC J2 for frequency of specialist review & echo.	1

Serial	Conditions and decision factors	Class
	Aviation-related occupations. SPEC authority to make final recruiting medical classification decision.	3R
	Otherwise.	4
5.6	**Valve replacement.** Prosthetic mechanical valve or tissue valve (bioprosthetic valve).	4

Cardiovascular Risk Assessment and Coronary Heart Disease

Table 5A–6: Cardiovascular risk assessment and coronary heart disease

Serial	Conditions and decision factors	Class
6.1	**AusCVDRisk score Low (<5%) (following reclassification[122] in accordance with the AusCVDRisk guidelines)** Or **Annualised risk <1 % (following cardiologist review).**	1
	AusCVDRisk score Intermediate (≥5-9% (pending reclassification, or pending cardiologist review).	3R
	Annualised risk ≥1 % (following cardiologist review).	4
	AusCVDRisk score High (≥10%) (without reclassification).	4
	Coronary Heart Disease (eg Myocardial Infarct, Angina).	4

Inflammatory and infective cardiac conditions

21. Inflammatory and infective cardiac conditions have risk of cardiac complications and recurrence. Candidates may be medically suitable for ADF entry for mild conditions with no ongoing inflammation/infection and no complications that would place the individual at increased risk of acute deterioration.

Table 5A–7: Inflammatory and infective cardiac conditions

Serial	Conditions and decision factors	Class
7.1	**Endocarditis.** Cardiology report within the last 12 months required. • no recurrence demonstrated ≥12 months of the initial episode • meets Class 1 criteria • single episode with no associated embolic complications • no more than mild valvular heart disease (refer to relevant serial).	1

[122] https://www.cvdcheck.org.au/reclassification-factors-other-considerations

Serial	Conditions and decision factors	Class
	Endocarditis. Embolic complications or more that mild valvular heart disease.	4
7.2	**Myocarditis – single episode.** Cardiology report within the last 12 months required. • no recurrence demonstrated ≥24 months of the initial episode • meets Class 1 criteria • uncomplicated illness (ie left ventricular ejection fraction >50%, no ventricular arrhythmias) • 24-hr Holter monitor - within normal limits • inflammatory biomarkers (including CRP and troponin) – within normal limits • echo – structurally normal heart • Exercise Stress Test – within normal limits • where indicated, Cardiac MRI - no late gadolinium enhancement on cardiovascular magnetic resonance imaging at >6 months after episode.	1
	Myocarditis – recurrent.	4
7.3	**Pericarditis – idiopathic or viral.** Cardiology report within the last 12 months required. • ≥three months since diagnosis • single episode with no complications • meets Class 1 criteria • uncomplicated at presentation (no arrhythmia) • inflammatory biomarkers (including CRP and troponin) – within normal limits • echo – structurally normal heart with no evidence of residual effusion or constrictive physiology.	1
	Pericarditis – complicated or recurrent. Complicated or recurrent pericarditis.	4

Rheumatic conditions

22. Inflammatory and infective cardiac conditions have risk of cardiac complications and recurrence. Candidates may be medically suitable for ADF entry for mild conditions with no ongoing inflammation/infection and no complications that would place the individual at increased risk of acute deterioration.

23. Acute rheumatic fever (ARF) and RHD are prevalent in the Australian indigenous population. Individuals diagnosed with acute rheumatic fever may have secondary prevention measures to avoid the development of rheumatic heart disease or preclude its progression. Secondary prevention typically involves secondary prophylaxis which is the consistent and regular administration of antibiotics to people who have had ARF or RHD, to prevent future group A beta-haemolytic streptococcus (Strep A) infections and the recurrent acute rheumatic fever. This is typically an intramuscular antibiotic injection every 28 days.

24. Secondary prophylaxis is recommended for a minimum of:

a. >10 years' prophylaxis after most recent episode of acute rheumatic fever or until age 21 years (whichever is longer) or

b. Five years' prophylaxis or until age 21 (whichever is longer) if no documented history of ARF and aged <35 years or

c. Five years after most recent episode of probable ARF, or until age 21 years (whichever is longer). Follow-up echo is recommended[123] for one, three and five years after secondary prevention ends.

Table 5A–8: Rheumatic conditions

Serial	Conditions and decision factors	Class
8.1	**ARF – secondary prophylaxis complete and surveillance either complete or ongoing (up to five years).** Cardiology report from 1, 3 or 5 year review indicates: • echo – structurally normal heart • meets Class 1 criteria.	1
	ARF – secondary prophylaxis ongoing. Cardiology report. • echo – structurally normal heart • meets Class 1 criteria. **Note.** Consideration of MEC J2 for frequency of treatment, specialist review & echo.	1
	SPEC Candidates.	3R
8.2	**RHD – prophylaxis complete.** See valvular disease serial.	1/4

Vascular conditions

25. Hypertension has an increased risk of heart attack, cardiac failure, stroke, renal failure and retinopathy and may be aggravated by occupational or personal stresses on deployment. Hypotension is of concern because of the risk of falls and injuries on rising or after prolonged standing. Deep venous thrombosis (DVT) and venous thromboembolism (VTE) are of concern because of the bleeding risk associated with anticoagulation medication.

26. Chronic venous disorders are assessed using the Clinical-Aetiology-Anatomy-Pathophysiology (CEAP) classification system[124].

[123] https://rhdaustralia.org.au/arf-rhd-guidelines/

[124] https://www.ncbi.nlm.nih.gov/books/NBK557410/

27. Major vascular disease is incompatible with ADF entry because of the risk of thromboembolism or vascular rupture (especially the aorta), long-term anticoagulation, pathology testing and regular specialist review.

Table 5A–9: Vascular conditions

Serial	Conditions and decision factors	Class
9.1	**Raised blood pressure or Hypertension. Systolic Blood pressure <150 and/or Diastolic Blood Pressure <100 mmHg.** • meets Class 1 criteria. **Note.** Unless there is an identified comorbidity which is to be assessed against the relevant serial.	1
	Raised blood pressure or Hypertension. Systolic Blood pressure <160 and/or Diastolic Blood Pressure <110 mmHg. • meets Class 1 criteria • normal urine ACR • without complications including peripheral vascular disease, previous cardiovascular events or other comorbidities. **Note.** Unless there is an identified comorbidity which is to be assessed against the relevant serial	1
	SPEC. Raised blood pressure or Hypertension. Systolic Blood pressure <140 and/or Diastolic Blood Pressure <90 mmHg. • 24-hr ambulatory blood pressure monitoring. SPEC authority to make final recruiting medical classification decision.	3R
	Otherwise.	4
9.2	**DVT or VTE – genetic mutation.** No personal history of DVT but a genetic mutation associated with same (eg Factor V Leiden). Assess as per relevant serial. See Annex 5M.	n/a
	DVT or VTE – single episode provoked. • ≥two years since episode and treatment completed • no requirement for intermittent or ongoing anticoagulation prophylaxis or treatment • no post-thrombotic syndrome • no history of significant complications (eg pulmonary embolus, pulmonary hypertension, alba dolens or cerulea dolens).	1
9.3	**Thrombophlebitis.** • ≥three months since last episode • meets Class 1 criteria • no medication requirements • no evidence of post-thrombotic syndrome.	1
	Otherwise.	4

Serial	Conditions and decision factors	Class
9.4	**Varicose veins.** • >six months post-surgery, or >3 months post sclerotherapy, laser or radiofrequency ablation • meets Class 1 criteria • no evidence of active venous ulcer or liperdermatosclerotic or atrophic blanching.	1
	SPEC Candidates.	3R
	Otherwise.	4
9.5	**Raynaud's phenomenon.** • no associated conditions or complications • meets Class 1 criteria.	1
	SPEC Candidates. Raynaud's phenomenon if medication required.	4
9.6	**Major vascular trauma.** Vascular surgeon report. • meets Class 1 criteria • not graft required.	1
	Otherwise.	4
9.7	**Major vascular disease.**	4
	Aortic dilation. • dilatation of the thoracic aorta.	4
9.8	**Other vascular disease.** Aortic dilation, aneurysm, thromboangiitis obliterans, or any other progressive peripheral arterial vascular disease.	4

Other cardiovascular conditions

Table 5A–10: Other cardiovascular conditions

Serial	Conditions and decision factors	Class
10.1	**Syncope – vasovagal.** • ≤two episodes in any 12 month period • meets Class 1 criteria.	1
	Syncope – recurrent.	4
	Syncope without cause. Cardiology report. • **ECG** - within normal limits • **Holter monitor** - within normal limits. • **echo** – structurally normal heart. • ≤two episodes in any 12 month period • meets Class 1 criteria.	1

ANNEX 5B

SYSTEM SPECIFIC REASONS FOR REJECTION—RESPIRATORY SYSTEM

1. **General.** Respiratory disorders will interfere with the cardiorespiratory effort required for military training. Inadvertent exposure to fumes, smoke, excessive dust, sea-spray, or even breathing cold, dry oxygen may exacerbate or aggravate a respiratory condition. Respiratory disorders will result in the inability to function in certain military environments eg aircraft, diving or submarines. Again, if serving in a remote area where medical support is limited, a sudden exacerbation of a respiratory condition may compromise the individual and fellow personnel.

2. Asthma management has improved considerably in recent years and this has permitted a liberalisation in asthma standards. However, experience shows that on many occasions the once dormant asthma is exacerbated in an area with a high pollen count, cold climate or other respiratory irritants. This may be predicted by a borderline or mild bronchial hyper-responsiveness on challenge testing—a useful adjunct to establishing the severity of a candidates asthma. Although the opinion of respiratory physicians is sought and acknowledged, often their knowledge of military operations and field conditions and requirements is limited. A specialist with military knowledge is preferred when seeking opinion of an applicant's respiratory condition.

Conditions of the respiratory system

Table 5B–1: Congenital

Serial	Condition	Consideration	Class
1.1	**Cystic-fibrosis**	• Requires intensive and daily chest physiotherapy. • Decreased exercise tolerance. • Regular specialist review. • Increased risk of respiratory infections in military environment.	4

Table 5B–2: Functional

Serial	Condition	Consideration	Class
2.1	**Pneumothorax**	**Divers** Once pneumothorax has occurred, risks still exist for an adverse event in diving. As the outcome is possible Cerebral Arterial Gas Embolism this presents an unacceptable risk for professional diving. Any history of pneumothorax is disqualifying for divers.	4
2.1.1	**Spontaneous pneumothorax single episode** (includes aircrew)	Once one has occurred, there is a greatly increased chance of recurrence.	
	Within three years of the episode	Decision	3T/4
	More than three years symptom free	Additional information required • Respiratory physician or thoracic surgeon opinion.	3R
		Decision • If no functional abnormality.	1
		Divers (see serial 2.1)	4
2.1.2	**Recurrent pneumothorax**	The applicant should be excluded until definitive therapy is carried out.	3T
	More than six months post-surgery	**Additional information required** • Respiratory physician or thoracic surgeon opinion.	3R
		Decision • Normal spirometry. • Normal examination. • Normal hypertonic saline challenge test. • No medication.	1
	If surgical treatment declined	Decision	4
	Recurrent pneumothorax	**Aircrew/divers/submariners** (see serial 2.1)	4
2.1.3	**Pneumothorax or haemothorax due to surgery or trauma**	Within 12 months of episode	3T
		More than 12 months since the episode **Additional information required** • Specialist opinion.	3R

Serial	Condition	Consideration	Class
		Decision • Acceptance will depend on history and recovery. The lung should have no inherent weakness and healing will return the lungs to normal. • If an effusion is present, it depends what pleural abnormality persists.	1 / 4
		Aircrew/divers (see serial 2.1)	4
2.2	**Deformities of the chest**	N/A	N/A
2.2.1	**Minor pectus excavatum or carinatum**	**Decision** • If asymptomatic with physical exertion.	3R/1
2.2.2	**Moderate deformity**	**Additional information required** • Specialist opinion. • Investigate with chest X-ray (CXR) and respiratory function tests to exclude Marfan's syndrome or other conditions.	3R
		Decision • Normal investigations.	1
	If interferes with respiratory efficiency	Decreased exercise tolerance possible with symptomatic applicants.	4
2.3	**Asymptomatic bullae**	**Additional information required** • Respiratory physician assessment. • If the risk of spontaneous pneumothorax is high, manage as spontaneous pneumothorax.	3R
		Submariners • Respiratory physician assessment required • Risk must be confirmed as very low	3R
		Aircrew/divers	4

Table 5B–3: Infective

Serial	Condition	Consideration	Class
3.1	**Tuberculosis (TB)**	Generalised infection.	4
3.1.1	**Pulmonary TB**	N/A	N/A
3.1.1.1	**Active pulmonary TB**	N/A	4
	More than 12 months after completion of treatment	**Additional information required** • Assessment by a respiratory physician to confirm treatment complete.	3T/3R

Serial	Condition	Consideration	Class
		Decision • If candidate is considered cured.	1
		If treatment was incomplete or inadequate • Possible risk of spread.	4
		Aircrew • Any history of primary or treated TB.	4
		Divers/submariners • Requires respiratory physician assessment and confirmation by SMA DIVEMED/SMA SUBMED.	3R
3.1.1.2	**Latent TB infection**	**Additional information required** • Evidence of successful treatment or normal CXR eighteen months (or later) after diagnosis.	3R/1
		Aircrew/Divers • Any history of primary or treated latent TB.	3R
3.2	**Bronchiectasis**	Decision	4
3.3	**Haemoptysis**	May not be symptom of underlying respiratory illness (eg nasal infection) but should be investigated if serious illness clinically suspected. Class determined by underlying diagnosis.	3R

Table 5B–4: Inflammatory: Chronic Obstructive Pulmonary Disease (COPD), and includes asthma, chronic bronchitis and emphysema

Serial	Condition	Consideration	Class
4.1	**Asthma**	Refer appendices 5B1 and 5B2.	N/A
4.2	**Emphysema.** Characterised by abnormal permanent enlargement of the airspaces distal to the terminal bronchioles with destruction of their walls and without obvious fibrosis.	Decision	4
4.3	**Chronic bronchitis.** Characterised by chronic productive cough for at least three months in each of two successive years for which other causes have been excluded.	Decision	4

5B–5

Table 5B–5: Other

Serial	Condition	Consideration	Class
5.1	**Sarcoidosis**	A multi system disorder characterised in affected organs by an inflammation called granulomas, whose cause is unknown. It may affect almost any organ of the body, most frequently lungs, skin, and eyes.	N/A
	In complete remission for at least two years	**Additional information required** • Respiratory physician assessment including respiratory function test with normal CXR and normal electrocardiogram	3R
		Decision • May be acceptable if normal lung function and no evidence or history of extra or intra-thoracic disease.	1
	Active disease or ongoing treatment.	Risk of cardiac and other complications.	4
		Aircrew (any history)	4
		Divers/submariners • May be acceptable if no extra or intra-thoracic disease. Must discuss any history with SMA DIVEMED/SMA SUBMED.	3R
5.2	**CXR abnormality**	Address with chief medical officer Defence Force Recruiting (CMO DFR). **Additional information required.** • May require follow-up investigation, including respiratory physician assessment to exclude significant pathology, eg old tuberculous scarring.	3R
5.3	**Any other respiratory condition which is not listed in this annex. Includes active or chronic conditions**	Address with CMO DFR. **Additional information required.** • Full clinical history, specialist reports, respiratory function tests and investigations must be provided.	3R

Appendices:

5B1 Asthma

5B2 Screening process for asthma

APPENDIX 5B1

ASTHMA

1. Candidates who record ‘no’ to symptoms or history of asthma in the last three years on Form PM165—‘Health questionnaire’ are fit for entry recruiting Class 1. Occupation specific requirements are in paragraph 8.

2. Candidates who respond ‘yes’ either to the question regarding hospitalisation for asthma after the age of 15, or the question regarding significant food allergies are to be excluded as Class 4.

3. Spirometry is to be conducted on candidates who respond ‘yes’ to symptoms of asthma within the last three years. The aim is to measure respiratory function in those candidates who have a history of asthma within the last three years or current asthma. FEV1 is an indicator of asthma severity. The best of three attempts is to be recorded.

4. Candidates are to be managed as follows:

a. if FEV1 <80 per cent of predicted—exclude as Class 4 medically unfit for Australian Defence Force (ADF) entry. Refer to the candidate’s treating general practitioner (GP) for follow-up if clinically indicated, as per paragraph 6. The candidate is to be provided with guidance on the requirements for ADF entry. Mannitol and Hypertonic Saline are the preferred methods of bronchial provocation testing (BPT)

b. if FEV1 >80 per cent of predicted the candidate is to be referred to a respiratory laboratory (where possible) for BPT.

5. Class 1 candidates with intermittent and mild persistent asthma in accordance with reference A are fit for ADF entry subject to the allocation of a military employment classification (MEC), by Joint Health Command in accordance with Military Personnel Policy Manual (MILPERSMAN) Part 3 Chapter 2[125]—‘Military employment classification system’ and Defence Health Manual (DHM) Level 2 Part 6 Chapter 2[126]—‘Military employment classification system’.

a. **No symptoms or treatment of asthma in the last 12 months.** Normal BPT on no treatment. This is considered to be a low risk and the candidate is fit for entry as recruiting Class 1 and a recommended MEC 1

b. **Mild persistent and intermittent asthma.** Normal BPT on medication treated with less than 400 mcg of budesonide or equivalent, alone or in fixed

[125] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/C5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765

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dose combination with a long acting beta2 agonist. Use of short acting beta2 agonist as required or (low dose) budesonide-formoterol FDC as single maintenance and reliever therapy is acceptable. These treatments equate to steps one to three of the Australian Asthma Handbook management guidelines. This is considered to be a low risk and the candidate is fit for entry as Recruiting Class 1 subject to allocation of a MEC:

(1) **For Navy entrants.** Recommend MEC M24 – maritime environment – defined limitations and / or require—(fit for deployment or seagoing service with advanced medical assistant or military nursing officer support). The employment restriction of 4–1, requires access to pharmaceutical resupply and 4-4, requires pre-deployment medical officer review, are to be applied. Asthma will continue to be an excluding condition for service on Fleet Units or Deployable elements who do not have assured access to an advanced medical assistant

(2) **For Army and Air Force candidates.** Recommend MEC J23 – restricted deployment – defined limitations and / or required material support and defined access to health facility. (fit for deployment or seagoing service but with pharmaceutical or other medical support). Failure to provide this support for 21 days or more is not likely to result in deterioration of the member's medical condition to the point that the member's health will be compromised in the short or medium term or operational effectiveness will be impaired.

Those not fit for entry

6. Following BPT testing the following candidates are unfit for entry; those with:

a. **Positive BPT.** The candidate is to be excluded as Class 4 but may attend their treating GP for further assessment and stabilisation of their asthma either on no treatment or less than 400 mcg of budesonide daily. This is to be maintained for a minimum of three months and then confirmed with a negative BPT.

b. **Negative BPT on medication treated with more than 400 mcg of budesonide or equivalent.** Treatments equate to steps four and above of the Australian Asthma Handbook management guidelines. The candidate is to be excluded as recruiting Class 4 unfit for entry. The candidate may attend their treating GP for assessment and, if clinically appropriate, step back titration of their asthma medication to less than or equal to 400 mcg of budesonide daily. This is to be maintained for a minimum of three months and be confirmed with a negative BPT.

7. A flow chart on the recruiting medical selection process for general entry candidates diagnosed with asthma is in Appendix 5B2. Defence Force Recruiting medical officers (DFR MO) are to refer to DFR website for details of processing requirements for candidates diagnosed with asthma.

Occupation specific requirements

8. Some military occupations have specific asthma standards:

a. Surface finisher and aircraft life support fitter musterings

(1) any history of asthma is disqualifying irrespective of the asthma free period.

b. Aircrew/divers/submariners

(1) no history of asthma within the last five years. The candidate is Class 1

(2) any history of asthma, AND no symptoms or requirement for medication within the last five years. The candidate is to be referred to a respiratory laboratory (where possible) for BPT

(a) if the BPT is positive the candidate is Class 4

(b) if the BPT is negative the candidate may be fit for entry subject to confirmation by the Institute of Aviation Medicine or the Submarine Underwater Medicine Unit as appropriate

(3) any history of asthma with symptoms and/or treatment (including mild persistent or intermittent asthma) within the last five years the candidate is Class 4. Symptoms may include wheeze, chest tightness and cough with triggers

c. Special forces and joint battlefield airspace controllers

(1) no asthma symptoms and/or requirement for medication for more than three years

(a) the candidate is Class 1

(2) asthma symptoms and/or requirement for medication within the last three years. Respiratory physician assessment with diagnostic testing including spirometry and BPT required. Allergen testing may be required to confirm diagnosis

(a) if the BPT is negative the candidate is Class 1

(b) if the BPT is positive the candidate is Class 4. Joint battlefield airspace Controllers who meet the criteria in paragraph 5 may be fit for entry on a case-by-case basis subject to the granting of a medical waiver

(3) symptoms or treatment of asthma (including mild persistent or intermittent asthma) within the last twelve months. (Symptoms include wheeze, chest tightness and cough with triggers such as exercise, allergens and viral infections, whether on medication or not.)

(a) Class 4.

Prior to entry

9. Defence Force Recruiting Medical Officer (DFRMO) action. The DFRMO is responsible for:

a. referring all general entry Class 1 candidates with a confirmed diagnosis of asthma to their treating GP for:

(1) Compilation of an asthma action plan. The candidate is to be provided with a form and guidelines for completion. Action management plans and guidelines for completion are in the Asthma Cycle of Care kit available from the National Asthma Council

(2) Education in the management of their asthma. Candidates are to be educated in the use of correct use of medications and provided with the brochure Information for people with asthma in the Asthma Cycle of Care kit

(3) Prescription for sufficient asthma medication to last for one - two months from the date of entry. Entrants need to be in possession of one-month supply of asthma medication and have a repeat script

b. sighting the completed asthma management plan and the asthma medication on attestation day. If on enlistment day the candidate fails to bring in the medication then the CMO DFR should be contacted in the first instance. If the CMO DFR is unavailable the joining ADF medical facility is to be notified so that the enlistee can be supplied with medication on arrival. Should this occur a record of conversation is to be noted on the attestation medical. This course of action should be the exception not the rule as ADF health facilities do not have the resources to review all new entrants with asthma as soon as they enter the ADF. In addition there is insufficient time in the scheduling of initial ADF training for entrants to be absent for routine medical care

c. allocating an appropriate MEC classification (see paragraph 5)

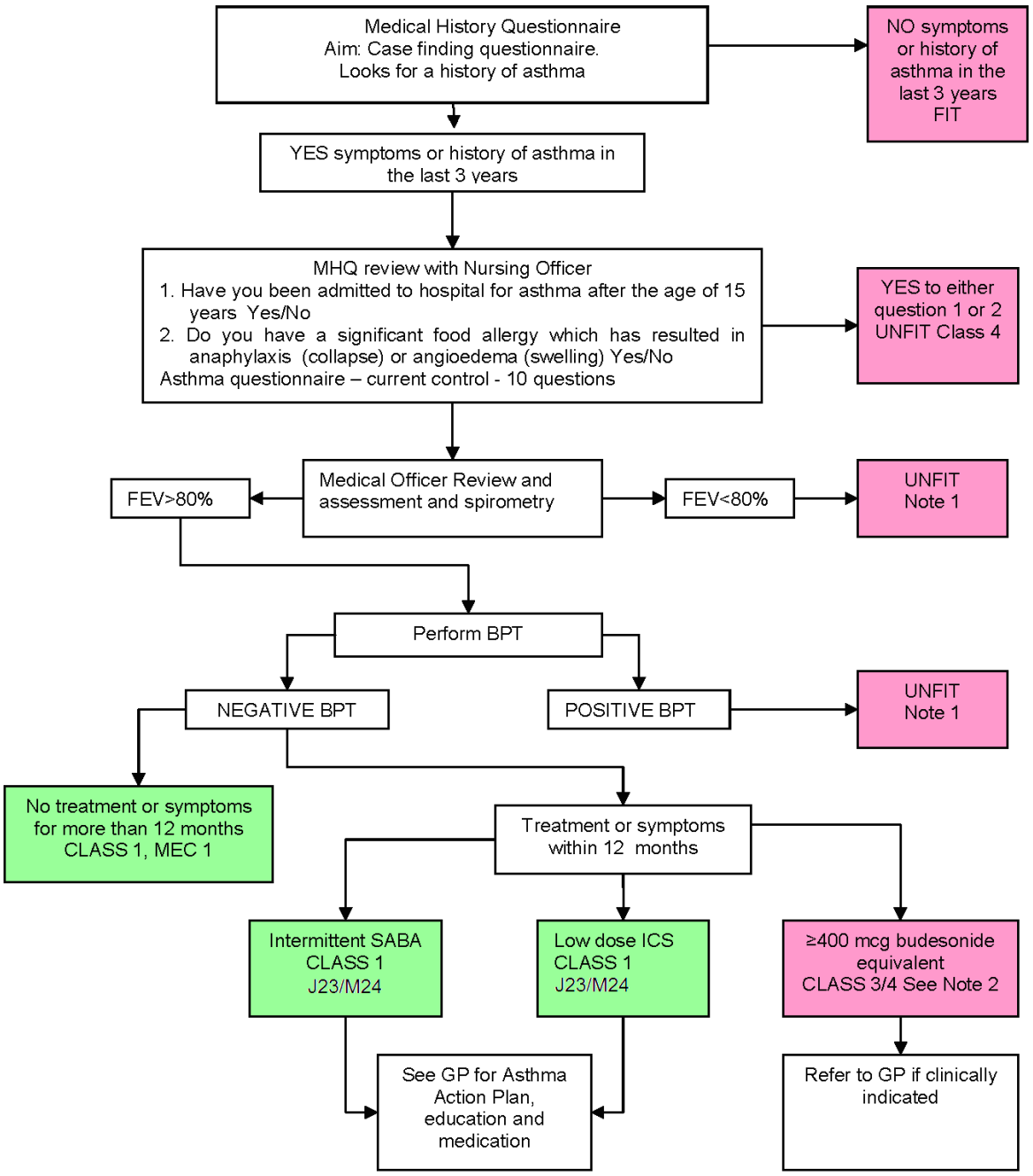
d. providing candidates with a copy of Form PM643—‘Information Sheet and acknowledgement for candidates diagnosed with intermittent or mild persistent asthma’. The signed acknowledgement is to be filed in the candidate’s medical record.

Medical records

10. All documentation related to the candidate’s asthma history is to be enclosed uppermost in the entrant’s medical record.

APPENDIX 5B2

SCREENING PROCESS FOR ASTHMA



Note 1: UNFIT but may seek review if currently on no Rx or less than low dose ICS and ICS subsequently prescribed ≤ 400mcgs daily → good control and negative repeat BPT—fit for reassessment. When control maintained for a minimum of 3 months.

Note 2: UNFIT but may seek review after ICS down-titration to ≤ 400mcgs daily and good control maintained for a minimum of 3 months. Negative repeat BPT

ANNEX 5C

SYSTEM SPECIFIC REASONS FOR REJECTION— GASTROINTESTINAL SYSTEM

This annex has been amended to align with the agreed position on waivers up to J22. The amendment is a limited review and the annex is scheduled for early review.

1. Any gastrointestinal (GIT) disease liable to cause recurrences requiring specialist care, hospitalisation or medication is not compatible with military service. Problems requiring surgical repair should generally be allowed a year for recovery and have no evidence of recurrence or likelihood of recurrence under military conditions.

2. Alternative dietary intakes are common in today's society. In an operational environment fresh rations and/or combat ration packs are provided as the circumstances permit. Combat ration packs contain high-energy foods for maximum benefit to individuals in the field. The current combat ration pack does not cater for consumers with any food allergy or special dietary requirements. The nature of the Australian Defence Force (ADF) requires that all personnel function on a diet which consists of meat, chicken, fish and eggs; dairy foods such as milk, cheese and yoghurt; grain foods such as cereals, breads, pasta and rice; and fruits and vegetables; and the food provided in combat ration packs. Therefore, candidates who are not prepared to, or who, for religious or medical reasons, cannot forgo their dietary requirements, may not be suitable for entry.

Table 5C–1: Conditions of the gastrointestinal system

Serial	Condition	Consideration	Class
1	**STOMACH / DUODENUM / OESOPHAGUS**		
1.1	**Gastro-oesophageal reflux disease (GORD)**	Symptoms can range from mild to severe. Reflux disease is common. 15–20% of adults experience heartburn at least once per week. Risk of recurrent chest and abdominal pain, bleeding and strictures/webs. Treatment may include dietary adjustment, Helicobacter pylori (H. pylori) eradication, antacids, H2 receptor antagonists (H2RA), proton pump inhibitors (PPI) or more invasive options. Endoscopy is not clinically indicated in many cases.	

Serial	Condition	Consideration	Class
1.1	‘**Alarm’ symptoms** These need duty-of-care referral to general practitioner (GP) for urgent clinical follow up.	Alarm symptoms signs include pain on swallowing, difficulty swallowing, choking on solids, unintentional weight loss or unexplained anaemia. These symptoms indicate specialist review +/- endoscopy.	3R/4
		Alarm symptoms not due to a disqualifying medical condition.	1
	Occasional symptoms	Occasional mild episodes which may be related to dietary indiscretion. Pro re nata (PRN) use (less than once a week) use of antacids, low dose PPIs or H2RAs.	1
	Intermittent or controlled symptoms	Good symptomatic control on regular H2RA or PPI. Unlikely to have functional impact if unable to obtain medication for short periods. May need regular review by GP, with infrequent specialist review.	3R/2 *eg J22 4–1, 4–3, 4–4, 4–11, P3 for Army
	Uncontrolled, resistant or severe symptoms	If requiring long-term dietary changes or multiple recurrent severe episodes, poor response to medical therapy. Risk of developing Barrett’s oesophagus (pre-malignant condition). May require anti-reflux surgery, and more frequent surveillance. May be acceptable if alternate explanation for reflux symptoms found, assess under serial of underlying condition.	4
1.2	**Non-ulcer dyspepsia.** Types: • functional type • irritable upper digestive tract (akin to irritable bowel syndrome (IBS) • ulcer-like dyspepsia • dysmotility-like dyspepsia • reflux-like dyspepsia	Non-ulcer dyspepsia causes discomfort on eating without demonstrable disease. Affects 16–25% of population but few seek treatment.	
	Occasional attacks	Symptoms not causing any significant absence from school or work.	1

Serial	Condition	Consideration	Class
1.2	**Medication required**	If ongoing medication required, but no impact on functioning.	3R/2 *eg J22 4–1, 4–4, 4–11 (GP review 3 months), P3 for Army
	Uncontrolled, resistant or severe symptoms	If diagnosis uncertain, functional impact, treatment resistant or prior abnormal endoscopy.	3R/4
1.3	**Peptic ulcer**	About 70% of patients with gastric ulcer are infected with H. pylori and eradication of the organism markedly lowers the ulcer relapse rate. Most H. pylori negative gastric ulcers are caused by non-steroidal anti-inflammatory drugs (NSAID).	3R
	H. pylori plus peptic ulcer	If cured of H. pylori and asymptomatic.	1
		Requires regular acid-lowering medication to obtain symptom control.	2 *eg J22 4–1, 4–3, 4–11 (GP review 6 monthly), P3 for Army
	NSAID peptic ulcer. Short term or intermittent use of NSAIDs only.	Peptic ulcer resulting from NSAID use is usually not serious. Must be asymptomatic following NSAID cessation.	1
		Otherwise	3R/4
	Acid hypersecretion (Zollinger-Ellison etc)	Requires long-term specialist review and medication.	4
	Perforated peptic ulcer	Disqualifying for all candidates. Risk of gastric barotrauma for divers and submariners.	4
	Any peptic ulcer	**Aircrew/ATC/divers:** Any history of peptic ulcer is disqualifying if the condition is recurrent, chronic and requires long-term dietary changes or medications.	4
	Chronic peptic ulcer	**Submariners**	4

Serial	Condition	Consideration	Class
	Recurrent peptic ulcer	**Submariners**	*eg J22S2 (if well-controlled with medicine)
1.4	**Gastritis** Chronic or recurrent gastritis	Risk of recurrent pain, nausea and vomiting; bleeding; perforation +/- peritonitis; post-healing obstruction; recurrent ulceration and malignancy.	
	Haemorrhagic or erosive (usually alcohol or NSAID)	Concerns relate to risks of above plus underlying cause. Assess alcohol-related gastritis against relevant alcohol serial.	
		Single episode, asymptomatic.	2
		Multiple episodes, diagnosis unclear, ongoing symptoms despite appropriate therapy.	3R/4
	Non-erosive chronic gastritis (associated with H. pylori)	If proven cure of H. pylori (eg negative Urease breath test) and minimal symptoms.	1
		Requires medication to obtain good symptom control.	2 *eg J22 4–1, 4–3, 4–11 (GP review 6 monthly), P3 for Army
		Multiple episodes, ongoing symptoms.	3R/4
	Gastritis	**Aircrew/ATC/divers:** Any confirmed diagnosis of gastritis.	3R/4
	Chronic or recurrent gastritis	**Submariners**	3R
1.5	**Hiatus hernia**	Hiatus hernia is common in reflux disease. Hiatus hernia increases the likelihood that reflux will occur but the presence of a hiatus hernia does not necessarily mean that reflux disease is present. Severe disease may cause disabling dyspepsia, oesophageal erosion and haemorrhage. Need for regular meals, and regular medication. Often unable to sleep flat. May require surgery.	

Serial	Condition	Consideration	Class
	Mild intermittent symptoms		1
	Severe symptoms	Severe reflux disease poorly responding to medical treatment is an indication for surgery.	4
	Post-surgery: less than one-year	Generally, long-term (10-year) control of reflux is seen in 88–93 per cent of patients.	3T
	More than one-year after surgery	Additional information required: Specialist report indicating surgery was successful and there are no symptoms or hernia present.	3R/1
		Aircrew/ATC/divers: Untreated hiatus hernia including if the symptoms are mild.	3T/4
1.6	**Bariatric surgery**		3R
1.6.1	**Gastric sleeve** Involves removing the lateral 2/3rds of the stomach with a stapling device. It leaves a stomach tube instead of a stomach sack. Has fewer late post-operative complications and requires less follow-up than alternative techniques.	Candidates should be evaluated by a surgeon who routinely performs bariatric surgery. DFR psychologist needs to be notified to ensure they ask about possible underlying eating disorders and mental health conditions associated with morbid obesity.	3R
		May be acceptable if: • 24 months post surgery. • weight loss achieved and sustained for at least 18 months, BMI acceptable • no significant post-operative complications • no current eating disorders or current mental health condition • no nutritional deficiencies (vitamin supplementation is okay) • no dumping syndrome • no associated metabolic disease • no significant aprons/loose skin • no dietary restrictions • no further surgery planned.	2

Serial	Condition	Consideration	Class
1.6.2	**Gastric bypass** **Laparoscopic assisted gastric banding** **Duodenal switch** **Biliopancreatic diversion**	Unacceptably high rates of late complications, and require medical support not available in ADF.	4
2	**SMALL AND LARGE BOWEL**		
2.1	**Abdominal adhesions—if symptomatic**	Recurrent acute abdominal pain, bowel obstruction, strangulation, perforation and haemorrhage requiring urgent surgical intervention.	4
2.2	**Chronic diarrhoea for more than one month**		
	Due to infection (eg giardiasis or secondary lactose intolerance)	Acceptable after full recovery.	3T/1
	Unknown cause		3R
2.3	**Frequent bowel actions**—more than four per day	**Additional information required:** Full investigation including exclusion of: • laxative abuse • malabsorption with weight loss, muscle wasting and anaemia • inflammatory with fever, pain, weight loss and bleeding • other infective causes such as human immunodeficiency virus, cryptosporidiosis, yersinia and non-typhoidal salmonella.	
	Treatable with no requirement for ongoing medications.		3R/1
	Untreatable, or requirement for ongoing medication.		4
2.4	**Chronic constipation**	Candidates who require strict dietary restrictions, medication or over the counter laxatives on an ongoing basis. Supply of these preparations may not be available on operational deployment. Symptoms of severe constipation can be incapacitating and could be confused with acute abdomen.	4

Serial	Condition	Consideration	Class
2.5	**Malabsorption syndromes:** Result from impaired absorption of nutrients from the small bowel. Many diseases or their consequences cause malabsorption. The commonest causes include: • carbohydrate intolerance • coeliac disease • tropical sprue; • Whipple's disease • intestinal lymphangiectasia • short bowel syndrome.	In general, any condition which leads to malabsorption including the consequences of surgery.	4
2.5.1	**Coeliac disease** (also included in annex O, serial 2.2.) Coeliac disease is also known as gluten-sensitive enteropathy, and previously as non-tropical sprue.	Obligatory dietary restrictions and inability to take some medications. Risk of abdominal pain, diarrhoea and malabsorption. Risk of dermatitis herpetiformis, insulin-dependent diabetes, splenic atrophy, osteoporosis, malignancy, alopecia, impaired fertility and neurological disease.	4
2.6	**Crohn's disease**	Crohn's disease can affect any part of the gastrointestinal tract. Inflammation is often focal and transmural. Considerations are as for coeliac disease plus: • malabsorption • bowel obstruction • abscess and fistula formation • perianal fissure or fistula • malignancy • multiple extra-intestinal complications requiring specialist care.	4

Serial	Condition	Consideration	Class
2.7	**Diverticular disease**	Risk of recurrent abdominal pain, pericolic abscess formation; fistula; perforation +/- peritonitis; bowel obstruction and bleeding.	
	Uncomplicated and asymptomatic	Majority of people are asymptomatic.	3R/1
	Bleeding and other severe symptoms	Risks as above plus need for hospitalisation with or without surgery.	4
		Aircrew/ATC/divers: Confirmed diagnosis of diverticular disease.	3R/4
2.8	**Ulcerative colitis**	Ulcerative colitis is a mucosal disease that is confined to the colon. Inflammatory changes are continuous and extend from the rectum for a variable distance towards the caecum. Risk of acute abdominal pain requiring hospital and specialist care. Risk of anorexia, vomiting, weight loss; diarrhoea +/- blood; perforation +/- peritonitis. Increased incidence of carcinoma (Ca) of colon. Multiple extra-intestinal complications requiring specialist care. Requires dietary modification and medication.	4
2.9	**Irritable bowel disease (IBS)**	Affects about 15% of the population of Western countries. Recurrent abdominal pain and alteration of bowel function may disrupt Service life, therefore, will depend on severity and ability to self-manage even on deployment. Multiple medical presentations, investigations and potential medication. Consider psychological issues.	
	If severe or complicated, requiring regular medication	Possible need for dietary manipulation not readily available in military.	4
	If symptoms minor and easily self-managed	If no requirement for regular medication or dietary restrictions, and no need for time off work or school.	3R/1
	IBS	**Aircrew/ATC:** Confirmed diagnosis of IBS or disease.	3R
		Divers: Ensure correct diagnosis and review specialist comments.	4

Serial	Condition	Consideration	Class
		Submariners	4 (if dietary restriction required) 3R otherwise
2.10	**Colonic polyps**	Colonic polyps are increasingly being found in younger people especially in those with a family history of colon cancer. Additional information required: History of any polyps of the colon and rectum requires assessment by a gastroenterologist or surgeon to determine the risk of recurrence or malignancy.	3R
2.10.1	**Hereditary (familial) polyposis**	A patient with hereditary polyposis will require either a total colectomy and ileorectal anastamosis, or a restorative proctocolectomy. These patients need regular review as they can develop tumours elsewhere in the gastrointestinal tract.	4
2.11	**Lactose intolerance**	Malabsorption of dietary lactose is common in the Australian population. This intolerance is more common in those from a non-Caucasian population, and increases with age. The amount of ingested lactose require to produce symptoms varies. The personal selection of food groups by individuals also varies and this affects the amount of lactose ingested.	
	Minor GI symptoms with ingestion of milk or milk products. Avoidance of milk and milk products is common in those on Paleo and other popular diets. Many individuals adjust their intake of milk or diary product to suit personal preference or for cultural reasons and this should not be confused with proven lactose intolerance.	Does not require a lactose tolerance test. Acceptable if: • can tolerate milk and milk product containing meals (eg pasta carbonara, cakes, ice-cream, milo, chocolate, confectionaries, flavoured milk drinks, pizza, hard cheese, yoghurt etc.) • no significant functional impact • no significant diarrhoea • no missed work/school • no chronic diarrhoea • no episodes faecal incontinence. • no suggestion of allergic cause.	2

Serial	Condition	Consideration	Class
2.11	**Major GI symptoms** on minor ingestion. May include: • significant or troublesome diarrhoea • faecal incontinence • near or complete lactose avoidance • regular, routine use of lactase medication • severe pain • missed work/school. May be unable to tolerate milk products even in processed foods such as breads, cereals or confectionary. Need for special diets cannot be met on deployment.	Requires a lactose tolerance test, as often symptoms are non-specific with significant disease overlap (eg IBD, IBS). If diagnosis confirmed suitability for entry should be determined on the results of testing and severity of symptoms.	3R/4
2.11.1	**Cows milk allergy:** Symptoms as per lactose intolerance but can also include: • urticaria or dermatitis • hives or rash • vomiting Much less common than lactose intolerance (only 4% of population).	Diagnosis requires confirmation with an allergist/immunologist. Requires complete avoidance of all cows-milk proteins, and possible medication. Incompatible with ADF service. Need for special diet not able to be met on deployment.	3R/4
2.12	**Miscellaneous colitides**, such as: • collagenous colitis • microscopic lymphocytic colitis • ischaemic colitis • clostridium difficile colitis • NSAID colitis.	Risk of recurrent abdominal pain, diarrhoea +/- blood. **Additional information required:** Specialist assessment to distinguish between severe and transient cases.	3R
		If severe, complicated, requiring chronic medications.	4

Serial	Condition	Consideration	Class
3	**GALL BLADDER**		
3.1	**Cholecystitis**	Most common cause is impaction of stones followed by inflammation. Infection is uncommon. High risk of recurrence unless gall bladder is removed (See serial 3.3 below)	3R/4
3.2	**Cholelithiasis**	Risk of biliary colic, cholecystitis, pancreatitis, other complications.	
	Asymptomatic (incidental gallstones). Discovery increasing as medical imaging becomes more common.	Most people with asymptomatic gallstones experience no attacks, with only 6% lifetime risk of cholecystectomy.	1
	Symptomatic: infrequent and minor symptoms (biliary colic)	Acceptable if: • no more than one attack per year, with last one greater than nine months ago • clear precipitant • Self-limiting, non-disabling • simple analgesia controls attacks • no complications (eg pancreatitis, infection, porcelain gallbladder).	3R/2
	Symptomatic: frequent or complications (cholecystitis or cholangitis)	High rate of recurrence (70% over two years). Likely to progress to surgery. High risk of complications.	4
	Any cholelithiasis	**Aircrew/ATC/divers/submariners:** Any evidence of cholelithiasis	4
3.3	**Cholecystectomy**	**Additional information required:** Surgical discharge letter sufficient if in last three years. If unavailable, GP report sufficient.	3R/1
		If all the following are met: • six months post-operative • no significant complications • no food intolerance • no recurrence or new symptoms • no diarrhoea.	1
		Otherwise	4

Serial	Condition	Consideration	Class
4	**LIVER**		
4.1	**Chronic liver disease**—see also Defence Health Manual DHM Level 2 Part 5 Chapter 5[127]—'Causes of and reasons for rejection' annex N	Complications often severe and progressive. Include portal hypertension, renal failure, electrolyte abnormalities and jaundice.	4
4.2	**Hepatic fibrosis**	Risk of pain, bleeding, general debility. Requires access to medical care.	4
4.3	**Hepatic cirrhosis**	Risk of pain, bleeding, general debility. Requires access to medical care.	4
4.4	**Gilbert's syndrome.** Mild unconjugated hyperbilirubinaemia with normal liver function tests.		3R/1
4.5	**Fatty liver.** Occurs when lipid accumulation exceeds the normal 5% of liver weight. Most commonly associated with alcoholism, obesity, diabetes, and pregnancy, however, other causes have been identified. There is a poor correlation between the diagnosis of fatty liver and abnormal findings on commonly used biochemical tests for liver disease. Diagnosis is usually confirmed by ultrasound/computed tomography/liver biopsy.	**Additional information required:** The history or diagnosis must be confirmed by a specialist with appropriate investigations.	3R
		Decision: In the absence of any other complications or pathology the candidate may be reviewed after six months.	3T
		If no evidence of progression, no complications and not associated with any other pathology.	1

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Serial	Condition	Consideration	Class
		If there is no current evidence of fatty liver, no other liver pathology, not associated with any other disorder and this is confirmed from investigations.	1
		If associated with hepatomegaly, other pathology (inflammation or necrosis), alcoholism, diabetes or morbid obesity.	4
5	**PANCREAS**		
5.1	**Pancreatitis**	Most episodes of acute pancreatitis are associated with gallstones (particularly bile duct stones) or with prolonged alcohol abuse. Pancreatitis may also be induced by drugs.	Nil
	Single episode	Within three years of episode.	3T/4
		A minimum of three years from the episode. More than three years from the episode If condition stable and asymptomatic. **Additional information required:** Needs full GIT work up to determine the cause of the pancreatitis.	3R
		Decision: If of a known cause which has been treated and fully recovered, no complications including diabetes, and considered by the specialist as not likely to recur.	1
	More than one episode		4
5.1.1	**Acute alcohol-related pancreatitis**	Problems of alcohol use (binge drinking or dependence). Risk of recurrent episodes requiring specialist assessment. Risk of developing chronic pancreatitis.	4
	Any alcohol-related pancreatitis	**Aircrew/ATC/divers:** Any history of alcohol induced pancreatitis.	4
5.1.2	**Acute pancreatitis secondary to biliary tract disease**	Risk of recurrent acute abdominal pain requiring hospitalisation and specialist care; renal failure, pseudocyst, abscess, peritonitis, fistula and haemorrhage; and development of chronic pancreatitis. Significant mortality rate.	
	Within one-year of cholecystectomy		3T
	More than one year after successful cholecystectomy.	No ongoing treatment requirements.	3R/1

Serial	Condition	Consideration	Class
5.1.3	**Acute traumatic pancreatitis**	Suitability depends on: • original injuries • extent of pancreatic damage • residual function • risk of sequelae.	3R
5.1.4	**Acute pancreatitis: other causes**		3R
5.1.5	**Chronic pancreatitis**	Risk of recurrent acute abdominal pain; pseudocyst formation and ascites; exocrine insufficiency (malabsorption and severe weight loss); endocrine insufficiency (diabetes); bile duct obstruction with jaundice; and malignancy Ca of the pancreas in under five per cent of cases. Requires access to medical care.	4
5.1.6	**Recurrent pancreatitis**	As for chronic pancreatitis. See serial 5.1.5.	4
6	**RECTUM AND ANUS**		
6.1	**Anal fistula, anal fissure, anal stricture or haemorrhoids**	**Additional information required:** Requires treatment and medical report.	3R
		Decision: If treatment successful and no associated serious diagnosis; eg colitis or Crohn's disease.	1
7	**GROIN AND GENERAL ABDOMEN**		
7.1	**Abdominal mass**	Enlarged liver or spleen usually equates to a serious condition. **Additional information required:** Requires full investigation for cause; decision will be based on diagnosis.	3R
7.2	**Hernia**: inguinal, femoral, epigastric or incisional/wound hernia	Risk of progression and complications from raised intra-abdominal pressure (bending, lifting, push-ups, G-forces).	
	Unrepaired		4
	Repaired	If all the following criteria are met: • more than six months post-op (three months if surgery was laparoscopic) • no complications • no recurrence • fitness has returned to normal.	3R/2
		Otherwise	4

Serial	Condition	Consideration	Class
7.3	**Hernia (umbilical)**	Risk of progression and complications from raised intra-abdominal pressure (bending, lifting, push-ups, G-forces).	
	If less than 1 cm and asymptomatic		3R
		If specialist confirms that: • hernia is small • repair is not indicated • activities that would cause raised intra-abdominal pressure such as lifting and weight bearing would not aggravate the condition.	1
	Unrepaired		4
	Repaired		3R
		If all the following criteria are met: • more than six months post-op (three months if surgery was laparoscopic) • no complications • no recurrence • fitness has returned to normal.	1
8	**OTHER**		
8.1	**Food intolerance or allergy**	See allergies Annex 5O	
8.2	**Peutz-Jegher syndrome**. Indicated by pigmentation of the skin and mucous membranes. Associated with hamartomatous polyps of stomach, small intestine and colon (the latter has a three per cent incidence of developing cancer of the colon).	Risk of abdominal pain, small bowel obstruction and haemorrhage.	4

Serial	Condition	Consideration	Class
8.3	**Amoebiasis**		
8.3.1	**Suspected or confirmed intestinal infection or asymptomatic carriage: treatment completed.**	Further information required	3R
		Acceptable if: • 12 months since treatment • now asymptomatic • normal FBC and LFT • normal CXR • no abscesses on Hepatic USS • normal dipstick urine • negative stool microscopy (x3) and PCR/antigen.	3T/2 *eg J11, P2 for Army
8.3.2	**Extra-intestinal amoebiasis: treatment completed.** Extra-intestinal manifestations include liver abscesses and more rare manifestations such as pulmonary, cardiac, and brain	A report from an infectious disease specialist or microbiologist covering likelihood of cure, risk of recurrence, risk of abscess rupture and transmission is required.	3R/4
		Otherwise	4
8.4	**Any other chronic or acute condition of the GIT tract**	Address with CMO DFR.	3R

Note:* recommendation only as per paragraph 5.11

ANNEX 5D

SYSTEM SPECIFIC REASONS FOR REJECTION—GENITO–URINARY SYSTEM

1. **General.** When performing heavy physical work, there is a risk of dehydration, which may exacerbate genito-urinary tract (GUT) conditions such as renal calculi. Postings in remote areas and/or cramped living conditions may aggravate problems such as enuresis, urinary stream problems or any condition that could suddenly deteriorate and require urgent medical support. The requirement of regular specialist reviews and blood tests may also limit an candidate's employability and deployability. Prior to examination of the GUT system, all candidates (including males) must be offered a chaperone.

2. The presence of, or history of microscopic haematuria, and or proteinuria is a common presentation by candidates. These candidates require careful assessment to determine the cause of their haematuria/proteinuria. In some cases, there will be no underlying pathology, however, in others the finding of haematuria/proteinuria may be the first indication of early renal disease. Wherever doubt exists, the candidate must be assessed by a renal physician and carefully investigated. Where renal biopsy is recommended by a specialist the candidate must make the final decision to address their health status, and not feel compelled to undertake such a procedure to maximise the chance of enlistment. Complex cases should be referred to chief medical officer Defence Force Recruiting (CMO DFR) in the first instance for consideration.

Conditions of the genito-urinary system

Table 5D–1: Congenital/developmental

Serial	Condition	Consideration	Class
1.1	**Congenital urinary obstruction with or without hydronephrosis**	Generally due to uretero-pelvic junction obstruction, vesicoureteric reflux or posterior urethral valves. Common complications include recurrent urinary tract infection (UTI), hydronephrosis and renal scarring. If uncorrected or recurrent after surgery, further risks include acute obstruction, calculi, malignancy and renal failure.	
	Current	High risk of retrograde infection and hydronephrosis. Long-term risk of malignancy and renal failure.	4

Serial	Condition	Consideration	Class
	Following corrective surgery or resolution	Further information is required, renal physician or urologist reports as appropriate and reports from time of treatment may suffice.	3R
		Acceptable if all the following are met: • Surgery if performed involved less than three procedures and was more than five years ago. • No evidence of ongoing obstruction or reflux. • No recent UTIs. • Renal function within normal limits including no hydronephrosis. • No requirement for frequent review (more than annual).	1
		Otherwise	4
1.2	**Congenital kidney disease.** (Includes polycystic kidney disease, medullary sponge kidney, noncystic renal dysplasia, renal hypoplasia)	Risks include acute and chronic renal failure; and renal malignancy. Requires regular monitoring and access to medical care.	4
1.3	**Undescended testes (cryptorchidism)**	There is an increased relative risk of testicular malignancy and torsion, which is mitigated by early surgery (pre-pubertal). Risk of reduced testosterone production and infertility. Absolute risk of malignancy remains less than 1/4000 whether surgery has been performed early or not (background population risk is between 1/10 000–1/100 000). **Additional information required:** • Current specialist report addressing the following: • Presence or absence of an underlying condition. • Ease of testicular self-examination (includes whether testes can be located and whether both present). • Risk of malignancy. • Requirement for hormonal therapy.	3R

Serial	Condition	Consideration	Class
	Unrepaired, whether testis is palpable or not	Risk for malignancy is elevated but remains low in absolute terms. **Acceptable if the following are met:** • No hormonal abnormality. • No indication for treatment. • No evidence of malignancy.	1
	Orchidopexy	**Acceptable if the following are met:** • At least 12 months since surgery. • No hormonal abnormality. • No indication for treatment. • No evidence of malignancy.	1
	Orchidectomy (unilateral or bilateral)	See related Serial 5.2	
	Evidence of hypogonadism; or requirement for hormone therapy	See related Serial 4.2	
1.4	**Enuresis** (night-time incontinence after age 5)	Significant problem in places where hygiene and laundry facilities are limited. **Additional information required for all candidates with enuresis after age 15:** • Urologist report	3R
		Acceptable if the following apply: • No episodes for at least three years. • No underlying condition. • No underlying psychological issues (DFR psychology assessment may be adequate, need to ensure DFR psych is aware of bedwetting beyond the age of 15 years).	1
		Otherwise	4
1.5	**Hypospadias or Epispadias** (Abnormal position of urinary meatus)	Surgical repair not permanently reliable; elevated risk of urethral stricture or meatal stenosis. Requires regular specialist review.	3R

Serial	Condition	Consideration	Class
	Minor	**If all the following are met:** • Original meatus was on glans or penile shaft. • No operation or only a single operation required (a single two-stage repair is acceptable), at least two years ago. • Meatus is on glans. • No stricture, spraying, reduction in flow or incontinence. • No requirement for follow-up.	1
	Moderate/Severe	**If any the following are present:** • Original meatus was on scrotum or perineum (hypospadias) or abdominal wall (epispadias). • Required two or more procedures. • Meatus not on glans. • Any stricture, spraying, reduction in flow or incontinence. • Any associated disorder of genito-urinary development.	4
1.6	**Phimosis** (congenital or acquired inability to retract the foreskin completely)	Common at birth, incidence decreases to approximately three per cent at age 17. A non- or partially retractable prepuce has an increased risk of skin irritation, infections, STDs and malignancy. A partially retractable prepuce also has increased risk of paraphimosis (see serial 1.7 below). Visual inspection and description of prepuce is mandatory. **Additional information required:** • In all cases where the foreskin is not fully retractable, refer to urologist's opinion. Treatment may be medical or surgical.	3R
	Medical treatment (steroid cream and manual stretching)	**If the following apply:** • Treatment completed three or more months ago. • Foreskin now fully retractable. • No recent infection or irritation.	1
		Otherwise	4
	Surgical treatment (circumcision)	**If the following apply:** • Surgery was three or more months ago. • Fully healed, no complications.	1
		Otherwise	4

Serial	Condition	Consideration	Class
	Untreated/relapsed	Persistent high risk of infection, irritation, paraphimosis and malignancy.	4
1.7	**Paraphimosis** (prepuce is trapped behind glans, causing constriction)	A history of paraphimosis requires assessment for possible underlying cause, likelihood of recurrence and residual damage	N/A
	Subsequently circumcised	**If the following apply:** • Surgery was 3 or more months ago. • Fully healed, no complications.	1
	Surgical or medical treatment other than circumcision	Requires assessment by urologist to determine cause and risk of recurrence, and to assess any sequelae.	3R
1.8	**Solitary kidney**	Found in 0.1 per cent of the population, usually silent.	3R
		Decision • Acceptable if functionally normal.	1

Table 5D–2: Functional

Serial	Condition	Consideration	Class
2.1	**Incontinence of urine** (males or females)	Ongoing bladder instability. Unacceptable in communal/close living quarters in the field, at sea and on deployment.	4
2.2	**Chronic genito-urinary pain** (includes interstitial cystitis, painful bladder syndrome, vulvodynia, prostatodynia and chronic non-bacterial prostatitis)	Includes anyone with symptoms or treatment for chronic genito-urinary pain in the last two years. Symptoms may include urethral, perineal and back pain, urgency, frequency and dyspareunia without infection. Significant adverse impact on function and capabilities when deployed. High risk of incontinence if access to toilet facilities is limited.	4
2.3	**Urethral stricture**	Almost always a permanent problem. Risk of recurrent lower abdominal pain due to acute urinary retention; hypertrophy of the bladder detrusor muscle with trabeculation and diverticulae formation resulting in incomplete bladder emptying; resultant urinary stasis causing further recurrent UTI; and ultimately progressive loss of kidney function. Requires regular specialist review and treatment.	4

Table 5D–3: Infective

Serial	Condition	Consideration	Class
3.1	**Balanitis and/or posthitis**	Need to exclude phimosis (see serial 1.6 above) and diabetes (see Annex 5H serial 5.2) **Additional information required:** • Report from urologist.	3R
		Single episode, resolved, no risk factors for recurrence.	1
		History of recurrent balanitis/posthitis or increased risk of recurrence.	4
3.2	**Epididymitis**	Likely to be recurrent and limit physical activities.	N/A
	Simple	Single episode, responded rapidly to antibiotics, no relapse.	1
	Relapsing, recurrent or chronic	Persistent pain and disability. Long-term antibiotics often required.	4
3.3	**Urinary tract infection**	Urethritis and cystitis are very common in females, but uncommon in males. Complications include acute or chronic pyelonephritis, renal or perinephric abscess, chronic renal failure, and acute or chronic prostatitis. Pyelonephritis in either sex should be investigated for evidence of obstruction or reflux.	N/A
3.3.1	**Urethritis or cystitis**	Common in females, uncommon in males. A letter from the treating doctor (general practitioner (GP) may be adequate) should be requested to confirm details for those who are likely to be Class 1. Candidates can be determined Class 4 on history if the criteria below are met, with no need for doctor's report. For chlamydial or gonococcal urethritis, see relevant serial.	3R
	Infrequent, uncomplicated	**Acceptable if the following are met:** • Each episode was easily treated with single course of antibiotics. • No indication of any underlying abnormality or reservoir of infection (urologic investigations are not mandated). • No spread of infection to prostate or upper urinary tract.	1
	Males with two or more episodes in the last ten years	May be associated with a urinary tract abnormality or prostatitis. Increased risk of recurrence and long-term complications.	3R

Serial	Condition	Consideration	Class
	Females with three or more episodes in the last year, or more than five in last five years	May be associated with an underlying condition. Increased risk of recurrence and long-term complications.	4
3.3.2	**Pyelonephritis or renal abscess**	**Additional information required:** • Urological investigation and urologist report required. For childhood infections secondary to congenital obstruction see relevant serial.	3R
		Acceptable if the following are met: • Single episode. • No underlying abnormality. • Renal function is normal. • Recurrence not anticipated.	1
		Otherwise	4
3.4	**Prostatitis**	Very difficult to eliminate infection once established. Likely to be recurrent and to limit physical activities. Long-term antibiotics often required. **Additional information required:** • Assessment by urologist only required if Class 1 criteria are met. Class 4 determination can be made on history.	3R
		Single episode, responded rapidly to antibiotics low risk of recurrence.	1
		Severe, relapsing or recurrent (required two or more courses of treatment or had two or more episodes).	4
3.5	**Sexually transmitted diseases**	N/A	N/A
3.5.1	**Syphilis**	See Annex 5N.	Nil
3.5.2	**Gonorrhoea**	High risk of urethral stricture, pelvic inflammatory disease and prostatitis. Many current strains of gonorrhoea are resistant to first-line antibiotics and may require repeated and prolonged treatment.	N/A
	Current infection	Requires treatment.	3T
	Past infection	**Acceptable if all the following are met:** • One or two episodes only. • Responded promptly to antibiotics. • No evidence of infectious reservoir. • No complications.	1

Serial	Condition	Consideration	Class
	Recurrent (three or more episodes) or drug-resistant (required two or more courses of antibiotics) infections	Elimination of infection is more difficult. Recurrence and complications are likely.	4
3.5.3	**Chlamydia**	High risk of urethral stricture; prostatitis and pelvic inflammatory disease. Chlamydia infection is often subtle and may be missed for months or years, leading to complications.	N/A
	Current infection	Requires treatment	3T
	Past infection	**Acceptable if all the following are met:** • One or two episodes only. • Responded to single course of antibiotics.3.5.3 • No evidence of infectious reservoir. • No complications.	1
	Recurrent: (three or more episodes)	Complete elimination is less likely; recurrence and complications are likely. Risk of exacerbation and deterioration of health.	4
3.5.4	**Genital warts (Human papillomavirus)**	Risk of irritation, secondary infection, transmission and future malignancy.	N/A
	For males:	Current warts—requires treatment.	3T
		Treatment completed at least three months ago, no relapse and low risk of recurrence.	1
		Otherwise	4
	For females:	See Annex 5E.	Nil
3.5.5	**Herpes simplex (genital)**	Infection is chronic and likely to break out in times of physical and psychological stress or with intercurrent illness. Anti-viral treatment should be started within 24 hours of the first prodromal symptoms in order to be effective. **Additional information required:** • Report from treating doctor (GP report may suffice), detailing length of infection, frequency of recurrences, severity of symptoms, and medication requirements	3R
		Acceptable if the following are met: • Attacks are infrequent (up to three per year), mild and not disabling if medication is unavailable. • No ophthalmic involvement. • No requirement for chronic suppressive therapy.	1
		Otherwise	4

Table 5D–4: Endocrine and metabolic

Serial	Condition	Consideration	Class
4.1	**Nephrolithiasis (renal calculus) or renal colic** (includes asymptomatic nephrolithiasis)	Almost always associated with an underlying metabolic disorder or structural abnormality. High symptomatic recurrence rate, even when asymptomatic. Must avoid dehydration and maintain urine output of 2.0–2.5 litres per day; may require dietary restrictions and/or medication. Long-term risk of renal failure. Renal colic may occur without a detectable stone.	4
4.2	**Hypogonadism (male)**	Multiple causes, all resulting in reduced testosterone and spermatogenesis; may affect musculo-skeletal and genito-urinary development and fertility. See also any related serials including Orchidectomy or endocrine/developmental conditions in Annex 5H. **Additional information required:** • Report from treating specialist summarising cause, treatment, current medication and follow-up requirements, and any risks to future health. Refer all cases to CMO DFR for determination.	3R
	Hypogonadism (female)	See primary conditions in annexes 5E or 5H as relevant.	N/A

Table 5D–5: Surgical

Serial	Condition	Consideration	Class
5.1	**Nephrectomy**	**Additional information required:** • Specialist report addressing reason for nephrectomy, health of remaining kidney, requirement for follow-up and any relevant future risks.	3R
	Performed for renal trauma or organ donation	Normal renal function, with no abnormality in remaining kidney and no deterioration in renal function expected in next ten years.	1
		Otherwise	4
	Performed for any other reason.	High risk of similar condition affecting the remaining kidney (see also underlying condition).	4
5.2	**Orchidectomy**	See also the following, as appropriate: cryptorchidism, hypogonadism (male), testicular cancer, gender dysphoria. **Additional information required:** • LH/FHS/testosterone levels • Reason for surgery • Ongoing treatment or surveillance requirements • Likely future health risks	3R

Serial	Condition	Consideration	Class
	Unilateral	**Acceptable if the following are met:** • At least six months since surgery. • No hormonal abnormality. • No evidence or increased risk of malignancy.	1
		Otherwise	4
	Bilateral	**Additional information required:** • Report from treating specialist or head of multidisciplinary team addressing the underlying issue, treatment, current medication and follow-up requirements (including consequences if delayed or missed), and any future health risks (CVS, bone, hormonal, malignancy, psychosocial etc). Refer all cases to CMO DFR for determination.	3R

Table 5D–6: Masses, including malignancy

Serial	Condition	Consideration	Class
6.1	**Hydrocoele**	Size and symptoms do not necessarily correlate so both must be independently considered. May be associated with other intra-scrotal pathology. Scrotal ultrasound is useful to assess volume and any associated masses.	N/A
	Small	**Acceptable if all the following are met:** • Size <50 mls. • Never symptomatic. • No history of trauma.	1
	Moderate	Size 50–80 mls OR Size <50 mls with symptoms/trauma **Additional information required:** • Urology assessment.	3R
	Large	Size >80 mls Increased risk of pain and complications.	4
	Repaired	**Additional information required:** • Surgical assessment.	3R
		Acceptable if all the following are met: • Surgery was > six months ago. • No pain, recurrence or complications.	1
6.2	**Varicocoele**	There is no clinical classification grading system based on size, therefore the MO must use clinical judgement. May be aggravated by physical activity and limit effort.	N/A

Serial	Condition	Consideration	Class
	Small and asymptomatic	May be considered by the MO without additional investigations or specialist opinion.	1
		If in doubt, refer for specialist assessment.	3R/1
	All other varicocoeles whether asymptomatic or not.	**Additional information required:** • Surgical assessment including ultrasound.	3R
		Repaired prior to enlistment.	1
	Repaired varicocoele	Six months must have elapsed following surgery. **Additional information required:** • Surgical assessment.	3R/1
6.3	**Renal mass**	Requires full investigation for cause; decision will be based on diagnosis.	3R
		Decision • Malignancy	4
		Non-malignant but requires regular specialist reviews and/or medication.	4
6.4	**Tumour or kidney, ureter, bladder or testis**	All require long-term follow-up with risk of recurrence.	4

Note:

(a) See also Malignancy Annex 5P.

Table 5D–7: Nephritis/nephropathy

Serial	Condition	Consideration	Class
7.1	**Interstitial or tubular nephritis**	Risk of relapse, pain, nephrotic syndrome, chronic kidney disease. May require prolonged antibiotic or steroid treatment.	N/A
7.1.1	**Acute interstitial nephritis**	**Additional information required:** • Renal Physician report.	3R
		May be suitable if all the following criteria are met: • Treatment ceased > 12 months ago. • Normal serum creatinine, urea and electrolytes. • Normal 24-hour urine results. • No abnormality on urine microscopy (hyaline casts acceptable). • Normal blood pressure. • Risk of relapse or recurrence is considered low.	1

Serial	Condition	Consideration	Class
		Otherwise	4
7.1.2	**Chronic nephritis** (any cause)	Requires regular monitoring and access to specialist care. High risk of progression to renal failure.	4
7.2	**Glomerulonephritis or nephropathy**	Inflammatory response involving renal tissue. Elevated risk of progressive renal disease; elevated risk of renal damage from dehydration, some medications and/or intercurrent illness. For secondary nephropathy there are also the risks associated with the underlying condition.	N/A
7.2.1	**Thin basement membrane nephropathy**	**Additional information required:** • Renal physician report. **May be suitable for entry if all the following are met:** • Normal blood pressure. • Normal haemoglobin. • Normal serum creatinine and albumin levels. • Minimal haematuria and proteinuria (less than twice the upper limit of normal)—no episodes or documented above this level. • Normal creatinine/albumin ratio on 24-hour urine. • No casts or crystals in urine (hyaline casts are acceptable). • No underlying anatomical abnormality or pathology. • Minimal surveillance required (no more than once a year). Any surveillance (eg annual urinalysis including microscopy) is to be clearly annotated on the medical record. See Defence Health Manual (DHM) Level 3 Part 5 Chapter 1[128]—'Medical records' Annex 1B.	3R /1 /4
7.2.2	**IgA nephropathy**	Elevated risk of progression to end-stage renal disease, even when symptoms and signs are minimal at time of diagnosis.	4
7.2.3	**All other causes**	Elevated risk of progression to end-stage renal disease.	4

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Table 5D–8: Urinalysis results

Serial	Condition	Consideration	Class
8.1	**Proteinuria and/or haematuria**	**Additional information required:** • Asymptomatic proteinuria or haematuria is the commonest presentation of glomerulonephritis. • Where diagnosis has been made, refer to relevant serial. Where no diagnosis has been made, and proteinuria or haematuria has been confirmed, candidates are to obtain referral to a renal physician for assessment.	3R
8.1.1	**Persistent proteinuria and/or haematuria where investigation does not provide a definitive diagnosis, including where renal biopsy is not clinically indicated, and likely source of haematuria is glomerular in origin.**	**May be suitable for entry if all the following are met:** • Normal blood pressure. • Normal haemoglobin. • Normal serum creatinine and albumin levels. • Minimal haematuria and proteinuria (less than twice the upper limit of normal)—no episodes or documented above this level. • Normal creatinine/albumin ratio on 24-hour urine. • No casts or crystals in urine (hyaline casts are acceptable). • No underlying anatomical abnormality or pathology. • Minimal surveillance required (no more than once a year). Any surveillance (eg annual urinalysis including microscopy) is to be clearly annotated on the medical record. See DHM Level 3 Part 5 Chapter 1 Annex 1B,	3R/1/4
	Persistent proteinuria and/or haematuria	Otherwise	4
8.1.2	**Orthostatic proteinuria** Uncommon over the age of 30; usually settles in three to five years.	**May be acceptable if both the following criteria are met:** • Recumbent protein excretion rate is within normal limits (50 mg/8 hours or 75 mg/12 hours) • Total protein excretion >300mg/24 hrs	1
		Otherwise	4

Serial	Condition	Consideration	Class
8.2	**Glycosuria**	Transient mild glycosuria may occur in concentrated urine. Persistent glycosuria must be fully investigated.	
8.2.1	**Impaired glucose tolerance**	See Annex 5H.	
8.2.2	**Renal tubular acidosis**	Various causes, associated with electrolyte and acid-base abnormalities. Increased risk of heat illness and adverse consequences of dehydration.	4
8.2.3	**Benign renal glycosuria**	**May be acceptable if all the following criteria are met:** • No underlying disease. • Normal plasma glucose tolerance. • Normal electrolytes and acid-base balance. • No polyuria.	1
	Glycosuria	Otherwise	4
8.3	**Pyuria**	See Serial for UTI serial 3.3.	

Table 5D–9: Other

Serial	Condition	Consideration	Class
9.1	**History of any other chronic or acute genito-urinary condition not included in this annex**	Discuss with CMO DFR.	3R

ANNEX 5E

GYNAECOLOGICAL SYSTEM ENTRY STANDARD

Individual capability

1. The inherent requirements of military service are described in Defence Health Manual (DHM) Level 2 Part 5 Chapter 1[129]–'Medical classification of candidates. These may vary depending on Service and role.

Class 1 standard

2. Candidates with a gynaecological condition may be considered Class 1 if all of the following apply:

a. minimal restriction on the ability to exercise, carry a pack/load or wear military equipment

b. condition is well controlled and stable

c. no functional impairment if therapy unavailable for up to 12 weeks

d. condition can be self-managed in the field/deployed environment.

3. Specialist employment stream candidates should be assessed in accordance with Service specialist medical guidelines.

4. Candidates for aviation-related occupations who use hormonal medication require a ground trial following Australian Defence Force (ADF) entry. The medical officer (MO) should advise candidates of this and document the discussion.

Class 4 standard

5. Candidates are medically unsuitable for ADF entry (Class 4) if any of the following apply:

a. despite optimal management, has constant or intermittent functional impairment related to their condition that affects their ability to undertake employed or deployed roles (eg recurring absence from work of two or more days per month or inability to perform the tasks of their role)

b. greater than low probability of disease progression or exacerbation as a consequence of military service (eg likelihood of sudden incapacitation, worsening of function or anatomical structures).

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Medical reports

6. Where clinically relevant, copies of existing medical reports may be requested to inform the medical suitability decision. If further information is needed, a current report may be requested (Class 3R pending report).

Physical examination

7. Examination of the genitalia, external or internal, or rectum is not required at the recruit medical examination and should not be performed. There are no indications copies of existing medical reports may be requested to inform the medical suitability decision. If further information is needed, a current report may be requested (Class 3R pending report) for such examinations during an occupational health assessment.

CONDITIONS OF INTEREST

8. This annex describes the conditions and procedures of specific interest to the ADF. If a condition is not listed, the criteria in the Class 1 and Class 4 standard apply.

9. Candidates are Class 1 if they use any form of contraception for fertility control only. If the contraception manages or treats another condition, the MO is to assess the candidate under the relevant serial of this or other annexes.

10. Active infertility treatment will usually make the candidate Class 4 because of the frequency of treatments and specialist review required.

Menstrual conditions

Table 5E–1: Menstrual conditions

Serial	Conditions and decision factors	Class
1.1	**Amenorrhoea – primary or secondary.** Assess underlying cause or co-morbidity against relevant entry standard.	N/A
1.2	**Abnormal menstruation.** Class 1 if all of the following: • managed with nonsteroidal anti-inflammatory drugs (NSAIDs), oral contraceptive pill (OCP), tranexamic acid or long acting reversible contraception (LARC) • meets Class 1 standard throughout menstrual cycle.	1
	Aviation-related occupations: If on tranexamic acid, Class 3T for trial of alternative treatment. Assess against serial 1.2 after 3 months of stable menstruation on alternative treatment. Institute of Aviation Medicine (IAM) to make final classification decision.	3T

Serial	Conditions and decision factors	Class
1.3	**Polycystic ovary syndrome (PCOS).** Existing report from last 12 months. Class 1 if meets class 1 criteria and stable >3 months on medication. Assess associated co-morbidity against relevant entry standard.	1/3T/4
1.4	**Endometriosis – mild to moderate (Grades 1–3).** Existing report. Class 1 if meets Class 1 criteria, and • no complications • if surgical treatment was required, candidate has been cleared to resume physical activity • if treated with OCP, NSAIDs, depo-medroxyprogesterone or LARC, stable >3 months.	1
	Endometriosis – severe (Grade 4). Unsuitable until definitive treatment completed and long-term stability demonstrated.	4
1.5	**Menopause.** Class 1 if meets Class 1 standard with or without therapy	1
	Note: if selective serotonin receptor inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) therapy is for a non-menopausal condition, assess against relevant entry standard.	N/A
	Aviation-related occupations. If menopause managed with SSRI or SNRI, IAM to make final classification decision.	N/A

Pelvic conditions

11. Candidates with a positive cervical screening test or a history of symptoms suggestive of a cervical abnormality require further consideration to exclude a serious underlying condition.

12. Pelvic organ prolapse is of concern to the ADF as load-bearing and high impact activity is likely to aggravate the condition.

Table 5E–2: Pelvic conditions

Serial	Conditions and decision factors	Class
2.1	**Abnormal cervical screening test.** Existing report. Class 1 if meets Class 1 standard and only requires regular screening/surveillance no more frequently than three monthly.	1
	Class 3T if treatment requirements ≤3 months.	3T
2.2	**Cervical cancer or malignancy.** See Annex 5P.	N/A

Serial	Conditions and decision factors	Class
2.3	**Pelvic inflammatory disease (PID).** Existing report. Class 1 if meets Class 1 standard, single episode and any treatment complete before ADF entry.	1
	Chronic pelvic inflammatory disease. Candidates with an established diagnosis of chronic PID are Class 4.	4
2.4	**Pelvic organ prolapse.** Existing report. Class 1 if all the following: • incidentally found during cervical screening or pelvic examination • no symptoms that affect function • no pessary required and meets Class 1 standard.	1
	Pelvic organ prolapse, surgically repaired, post-surgical review complete and meets Class 1 standards. Because of the likelihood of recurrence, a report should be sought from the treating surgeon, articulating the risk of recurrence. If the annual likelihood of recurrence is estimated as 'low' (DHM Level 3 Part 2 Chapter 9[130]-'Individual health risk assessment') over the succeeding five years, a Service waiver may be considered. Otherwise, Class 4.	3R
	Pelvic organ prolapse, with or without surgery, with ongoing pain, requirement for pessary or any history of urinary or bowel symptoms that do not meet Class 1 standard.	4
2.5	**Chronic pelvic pain syndrome.** Chronic pelvic pain has a multi-factorial aetiology and causes significant impairment.	4

Pregnancy

13. While pregnancy is not a medical condition, it is incompatible with initial military training and deployment. Exposure to environmental and workplace hazards and the in-service requirement for heavy lifting, physical exertion, vaccination and irregular sleep put at risk the wellbeing of the woman and unborn child. Breastfeeding (lactation) is compatible with ADF entry from a medical perspective.

Table 5E–3: Pregnancy

Serial	Conditions and decision factors	Class
3.1	**Current Pregnancy.**	3T

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Serial	Conditions and decision factors	Class
3.2	**Postpartum.** Any pregnancy >20 weeks' duration is to be assessed under this serial. Existing report. Class 1 if all the following: • ADF entry a minimum of >6 months postpartum • meets Class 1 standard • caesarean delivery should be assessed as per para 15.	1
3.3	**Pregnancy <20 weeks' duration.** Class 1 if all the following: • ADF entry a minimum of >3 months after end of pregnancy • meets Class 1 standard.	1

Surgical procedures

14. The underlying condition triggering surgery should be assessed against the relevant entry standard. Available records/reports should be reviewed.

15. Gynaecological procedures performed as day surgery with no more than 24 hours of post-surgical in-patient care are at low risk of complication and rapid recovery is the norm. Only procedures performed within the three months preceding application are of interest.

16. Major gynaecological surgery has higher risk of complications and longer recovery times.

Table 5E–4: Surgical procedures

Serial	Conditions and decision factors	Class
4.1	**Day Surgery.** Examples are biopsy, excisional biopsy, colposcopy, ablation, and laparoscopy with minimal treatment. The candidate is considered Class 1 (depending on the underlying condition) if there have been no complications and no further treatment is required.	1
4.2	**Major gynaecological surgery.** Examples are hysterectomy, oophorectomy, caesarean section, and laparoscopy with significant treatment of pathology. The candidate is Class 1 (depending on the underlying condition) if the Class 1 criteria are met, post-surgical review is complete and no further treatment is anticipated.	1

ANNEX 5F

MUSCULOSKELETAL ENTRY STANDARD

PRINCIPLES FOR DECISION-MAKING

Musculoskeletal capability

1. Military service is hard on the skeleton, joints and soft tissues. To withstand initial training and military service, the musculoskeletal (MSK) system must be capable of movement and weight-bearing. Pain, reduced structural integrity, bone or joint deformity, limited joint range of movement, or restricted function will affect medical suitability for Australian Defence Force (ADF) entry.

2. Military service is hard on the skeleton, joints and soft tissues. To withstand initial training and military service, the musculoskeletal (MSK) system must be capable of movement and weight-bearing. Pain, reduced structural integrity, bone or joint deformity, limited joint range of movement, or restricted function will affect medical suitability for Australian Defence Force (ADF) entry.

3. Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[131]—'Medical history and examination' describes the clinical examination. The lower extremity, upper extremity and axial skeleton need to be considered in relation to the candidate's job preference. Army combat roles[132] and specialist jobs may require a higher standard of MSK health because of the physical stressors. However, all candidates must have an MSK system capable of:

a. lifting, gripping, climbing, writing and signalling

b. marching, running and standing for extended periods

c. squatting, crawling, and negotiating obstacles and cramped spaces

d. load carrying and manual handling

e. firefighting, damage control and casualty handling

f. negotiating obstacles and confined spaces.

Class 1 standard

4. Unless otherwise specified in this annex, a candidate should be considered Class 1 if they have all of the following:

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[132] Defined by requirement to complete the Combat Arms Physical Employment Standards Assessment (CA PESA). See Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 4—'Physical training' for the other rank and officer roles required to complete CA PESA.

a. full range of movement

b. no pain

c. no symptoms

d. no instability

e. no functional impairment

f. no regular medication.

5. A history of an MSK condition is not a reason for rejection if the condition is fully resolved. For this annex, fully resolved means the candidate has all of the following:

a. full range of movement

b. no pain

c. no symptoms

d. no instability

e. no functional impairment

f. no regular medication

g. at least 6 months since surgery or 3 months since completion of non-operative management.

6. The ADF acknowledges that the natural history of MSK conditions may involve deterioration over time.

Uncertainty or doubt

7. If a candidate presents with an acute or symptomatic MSK condition that is likely to be self-limiting, they should be assigned Class 3T for up to 12 months. If the condition does not resolve in this time, the candidate should be assigned Class 4.

8. Where suitability for ADF entry is uncertain, medical officers (MOs) should consider the candidate's ability to complete job-relevant pre-entry physical fitness assessments and/or seek a functional assessment or specialist orthopaedic opinion (if necessary). A functional assessment may be from a sports physician, sports physiotherapist or podiatrist (as relevant) and should describe what the candidate is capable of doing in context of the injury/condition and the job preferences.

9. Diagnostic imaging is only required where it will support the MO's decision-making or at the request of a specialist. If doubt remains, the case is to be discussed with chief medical officer Defence Force Recruiting (CMO DFR).

Class 4 standard

10. Candidates are unsuitable for ADF entry (Class 4) if they do not meet the Class 1 standard. For example, if they have conditions causing pain or affecting function; chronic or inflammatory (rheumatological) conditions; malignant conditions; or conditions requiring regular medication, prosthesis, custom footwear, regular specialist review or clinical aids (other than orthotics).

Medical reports

11. A report from an episode of care may be a discharge from care report, operation report, treating practitioner report, functional assessment and/or specialist report (as relevant).

12. If a report(s) is not available for a historical condition and there is no clinical doubt, the medical class decision can be made without the report. If further information is needed to make the decision, a current functional assessment and/or specialist opinion may be requested.

Conditions of interest

13. Rather than provide an exhaustive list of conditions, this annex describes conditions and surgical procedures of specific interest to the ADF. It is divided into sections as follows:

a. **Musculoskeletal tissues.** This provides factors relevant to conditions of the:

   (1) bones, including fractures

   (2) joints and articular cartilage

   (3) ligaments, tendons and muscle.

b. **Lower limb region.** This provides factors relevant to hip and pelvis conditions, knee conditions, and foot and ankle conditions that are of particular relevance to the ADF.

c. **Upper limb region.** This provides factors relevant to shoulder conditions, elbow conditions, and hand and wrist conditions that are of particular relevance to the ADF.

d. **Spine region.** This provides factors relevant to spine conditions that are of particular relevance to the ADF.

MUSCULOSKELETAL TISSUES

Bone conditions and fractures

14. Initial training and military service require full function and the ability for the bony skeleton to weight bear in lower and upper extremities. Fractures must be completely united. Residual deformity is only an issue if the deformity impedes

functioning of the MSK system, impairs full function or is significant enough to increase the risk of fracture.

15. The key MSK factors affecting fitness for ADF entry are movement and weight-bearing; however, the following should be considered during the assessment process:

a. whether fractures affect the bone blood supply and may result in avascular necrosis of the bone leading to bone and joint dysfunction

b. whether a fracture or dislocation injury has caused a functional limitation

c. whether pathological lesions of bone such as large cysts, tumours, reduced mineralisation (osteopenia and osteoporosis) and infection (osteomyelitis) will reduce the strength and integrity of bone or increase the risk of fracture

d. whether conditions of bone require medical surveillance or have a risk of recurrence

e. whether bony conditions or other health conditions require regular medication or specialist review.

16. Table 5F–1 provides decision factors for specific fractures and bone conditions of interest to the ADF. If a condition is not listed, clinicians are to apply the principles for medical suitability decision-making.

Table 5F–1: Fractures and bone conditions

Serial	Conditions and decision factors	Class
1.1	**Fracture.** United, fully resolved.	1
	United with minimal deformity but otherwise meets Class 1 standard.	1
	Non-union of fracture.	4
	Aviation Class 1 and 2: if united with minimal deformity, Institute Aviation Medicine (IAM) to make final classification decision.	3
1.2	**Fracture managed with retained internal fixation.** Report from episode of care. Class 1 if all the following apply: • fully resolved 12 months • fracture united • returned to pre-surgery activity levels.	1

Serial	Conditions and decision factors	Class
	Aviation Class 1 and 2: if retained internal fixation, IAM to make final classification decision.	3
	Special forces, parachute rigger (employment category number (ECN) 345): retained internal fixation involving femur or tibia. (note: candidate with minimal internal fixation may be considered for Service waiver)	4
	Army explosive ordnance disposal recruit (ECN 432), combat engineer (ECN 096), ammunition technician (ECN 401): retained internal fixation.[(a)]	4
	Navy clearance diver: retained internal fixation.[(a)]	4
1.3	**Intra-articular fracture.** United, fully resolved (see joint and articular cartilage conditions).	1
1.4	**Spinal fracture.**	See Table 5F-8
1.5	**Stress fracture – single.** If all the following apply: • fully united • identified cause • cause and condition fully resolved • low risk of recurrence.	1
	Stress fracture – multiple fractures or episodes. Current specialist opinion. If all the following apply: • fully united • identified cause • cause and condition fully resolved 12 months • low risk of recurrence.	3R 1
	Recurrent or multiple stress fractures with undefined cause and/or not fully resolved.	4
1.6	**Avascular necrosis of bone.** Lower extremity, scaphoid or lunate bones.	4
	Avascular necrosis of bone in any other area. Report from episode of care confirms no significant bone or joint abnormality.	1
1.7	**Bone lesions, pathological bone condition and osteomyelitis.** Report from episode of care confirm all the following: • lesion benign and/or no increased risk of fracture • any infection cleared • condition fully resolved.	1
	Malignant bone tumours and chronic osteomyelitis.	4
	Aviation Class 1 and 2: if any history of bone lesions, pathological bone or osteomyelitis, IAM to make final classification decision.	3
1.8	**Amputation.** Major limb or thumb or great toe.[(b)]	4

Serial	Conditions and decision factors	Class
	Amputation of finger(s)/lesser toe(s). Requires functional assessment.	3R
	No impediment to performing the activities described paragraph 2 of this annex.	1
	Aviation Class 1 and 2: for amputated finger, IAM to make final classification decision.	3

Notes:

(a) Retained internal fixation may be an issue where a metal signature could result in an adverse outcome (eg metal could interfere with detection equipment or complete a circuit).

(b) Amputation of a major limb imposes significant limitation to functional activities such as marching and climbing. Prostheses are not adequate for members to perform the full spectrum of military duties, particularly in the deployed environment. Amputation of digits in the hand and foot impact on manual handling (especially weapons) and gait, respectively.

Joint and articular cartilage conditions

17. Functional joints are essential for movement and military tasks. Shoulder stability, range of movement and strength are important for lifting, climbing and holding. The elbow must be stable and reliable with a functional range of movement. The lower extremity joints are important for jobs involving standing, marching and running. The hip, knee and ankle must be stable and pain free.

18. The physical examination should include an assessment of all joints for deformity, active and passive range of movement, tenderness, joint effusion, and for evidence of joint instability. The following health factors should be considered in determining medical suitability for the ADF:

a. whether single or recurrent dislocations increase instability

b. whether articular cartilage changes due to aging are indicative of degenerative changes that may cause pain, restricted range of movement or functional limitation

c. whether fractures involving joint surface articular cartilage may result in early onset joint degeneration.

19. Table 5F–2 provides decision factors for the specific conditions of interest to the ADF. Any condition affecting the stability, range of movement or function of a large joint is incompatible with ADF entry. All joint conditions should be considered in conjunction with the body region (see section for lower limb, upper limb and spine). If a condition is not listed, clinicians are to apply the general principles for medical suitability decision-making.

Table 5F–2: Joint and articular cartilage conditions

Serial	Conditions and decision factors	Class
2.1	**Joint instability.** Small joints in the hand and foot with no or minimal functional impairment.	1
	Large joints with functional impairment.	4
	Aviation Class 1 and 2: if small joint instability, IAM to make final classification decision.	3
2.2	**Single or recurrent dislocation.** Treated surgically. Report from episode of care confirms fully resolved.	1
	Recurrent dislocation. Ongoing condition or not fully resolved.	4
2.3	**Joint reduced range of movement – minimal.** Minimal reduction but otherwise meets Class 1 standard. If doubt, request specialist opinion.	1
	Aviation Class 1 and 2: if minimal reduced range of movement, IAM to make final classification decision.	3
2.4	**Osteoarthritis.** Managed non-operatively. Meets Class 1 standard.	1
	Any surgical management of osteoarthritis, inclusive of joint fusion, osteotomy, joint arthroplasty	4
	Aviation Class 1 and 2: if surgically treated osteoarthritis, IAM to make final classification decision.	3

Ligament, tendon and muscle conditions

20. Soft tissue injuries affect the function of the MSK system. Ligament, tendon or muscle conditions are of concern for the ADF as full function of the MSK system is essential to military activity. Soft tissues provide for full movement and stability of joints. Tendons attach muscles to bone, ligaments provide joint stability and together these allow movement of joints.

21. The following factors should be considered in determining medical suitability for the ADF:

a. whether surgical repair or reconstruction increases risk of re-injury

b. whether recurrent ligament sprains increase the risk of joint instability

c. potential for chronic and recurrent tendinopathy

d. risk of degenerative conditions of tendons in the older candidate.

22. Table 5F–3 lists the decision factors for the specific conditions that are of interest to the ADF. Conditions may also be in the section specific to a body region. If a condition is not listed, clinicians are to apply the principles for medical suitability decision-making.

Table 5F–3: Ligament, tendon and muscle conditions

Serial	Conditions and decision factors	Class
3.1	**Active soft tissue injuries.** Recent or currently symptomatic soft tissue injuries require time to become fully resolved.	3T
3.2	**Tendon tear and/or recurrent tendinopathy.** Fully resolved.	1
	Tendon repair: if minor functional limitation but otherwise meets Class 1 standard, request current specialist opinion. If specialist opinion confirms otherwise fully resolved.	3R 1
	Aviation Class 1 and 2: for tendon repair or recurrent tendinopathy, IAM to make final classification decision.	3
3.3	**Recurrent ligament sprain.** Current specialist opinion. If fully resolved.	3R 1
	Ligament rupture or sprain – managed surgically. Report from episode of care. If all of the following: • fully resolved • 6 months since ligament repair (unless 12 months is required by a serial in this annex).	1
	Aviation Class 1 and 2: for recurrent ligament sprain, IAM to make final classification decision.	3
3.4	**Muscle injuries and conditions.** Fully resolved	1
3.5	**Exercise-induced compartment syndrome.** Report from episode of care. If all of the following: • fully resolved 6 months • returned to physical activity.	1

LOWER LIMB REGION

23. Military training and service will place repetitive loading on the lower limb region from marching, running, load carrying, climbing and extended periods of ambulation. The following factors should be considered in determining medical suitability for ADF entry:

a. whether lower limb conditions require anything other than foot orthotics

b. whether recurrent bone stress reaction to stress fracture may indicate biomechanical issues or pathological bone conditions

c. whether conditions affect the function and stability of joints, especially large joints

d. whether soft tissue injuries are related to overuse, noting they should be fully resolved prior to entry

e. risk associated with any condition requiring surgical management, especially joint replacement (arthroplasty), ligament reconstruction and tendon repair.

Hip and pelvis conditions

24. Table 5F–4 lists the decision factors for the specific conditions of the lower limb of interest to the ADF. If a condition is not listed, clinicians are to apply the principles for decision-making.

Table 5F–4: Hip and pelvis conditions

Serial	Conditions and decision factors	Class
4.1	**Femoroacetabular impingement.** Report from episode of care. If all of the following: • fully resolved • if treated surgically, no indication of hip joint surface damage.	1
4.2	**Slipped upper femoral epiphysis (SUFE).** If fully resolved 12 months, current orthopaedic opinion. Class 1 if report confirms fully resolved.	3R 1
	Aviation Class 1 and 2: if retained metalware, IAM to make final classification decision	3
	Army explosive ordnance disposal recruit (ECN 432), combat engineer (ECN 096), ammunition technician (ECN 401): if retained metalware.	4
	Navy clearance diver: if retained metalware.	4
4.3	**Avascular necrosis of the femoral head/Perthes.** If no sign of hip joint deformity, no pain and full function, request current orthopaedic opinion and plain radiography. If fully resolved, spherical shape of the femoral head maintained, no complications (eg acetabular dysplasia, labral injury, degenerative arthritis of the hip joint).	3R 1
	Hip joint deformity or pain or limited range of movement or functional impairment.	4
4.4	**Hip osteoarthritis or hip joint replacement**.	See Table 5F–2

Knee conditions

25. For all knee conditions, the MO is to check that the candidate is able to weight bear and load the knee joint without symptoms (eg weight training, running and sport).

Table 5F–5: Knee conditions

Serial	Conditions and decision factors	Class
5.1	**Anterior Cruciate Ligament (ACL) injury.** Report from episode of care confirms all the following: • 12 months since surgical management or non-operative treatment • condition fully resolved, including full range of movement; normal quadriceps strength compared to contralateral side • no instability with Lachman and pivot shift tests; stability with mini squat, one-legged squat, duck walk, and hopping side to side • returned to physical activity following injury • no intraoperative or imaging evidence of significant degenerative change.	1
5.2	**Meniscal tear.** Report from episode of care confirms all the following: • fully resolved operatively or non-operatively • no intraoperative or imaging evidence of significant degenerative change • no indication of complication (failure of repair, pain, secondary osteoarthrosis).	1
	Aviation Class 1 and 2: if meniscal tear, IAM to make final classification decision	3
5.3	**Patella dislocation.** Single episode and non-operative management. Report from episode of care confirms all of following: • fully resolved non-operatively within six months of injury • no indication of complication (recurrent dislocations, patellofemoral pain, chondral injures and/or secondary osteoarthrosis) • normal quadriceps bulk, patella movement, negative patella apprehension and stability with functional testing.	1
	Patella dislocation surgically stabilised after single or recurrent episodes. Report from episode of care confirms all of following: • fully resolved, no indication of complication (recurrent dislocations, patellofemoral pain, chondral injures and/or secondary osteoarthrosis) • normal quadriceps bulk, patella movement, negative patella apprehension and stability with functional testing.	1
	Recurrent or persistent dislocation or subluxation or evidence of apprehension or instability.	4
5.4	**Osteochondritis dissecans.** Managed non-operatively or surgically. Report from episode of care confirms fully resolved.[(a)]	1
	Osteochondritis dissecans under active treatment and/or Class 1 standard not met.	4
5.5	**Knee osteoarthritis or knee joint replacement.**	See Table 5F–2

Note:

(a) A report from the episode of care is not required if the condition was unknown, historical and fully resolved (eg discovered incidentally on xray later in life).

Foot and ankle conditions

26. Table 5F–6 lists the decision factors for specific conditions that are of interest to the ADF. If a condition is not listed, clinicians are to apply the principles for medical suitability decision-making.

Table 5F–6: Foot and ankle conditions

Serial	Conditions and decision factors	Class
6.1	**Ankle instability.** Fully resolved single or recurrent ankle sprain.	1
	Ankle instability: surgically managed. Report from episode of care confirms fully resolved.	1
	Aviation Class 1 and 2: for ankle instability, IAM to make final classification decision.	3
6.2	**Fractures of the foot.**	See Table 5F–1
6.3	**Foot deformity or biomechanical issue.** Meets Class 1 standard with or without orthotics.	1
6.4	**Achilles tendon rupture.** Treated operatively or non-operatively. Report from episode of care confirms fully resolved six months.	1

UPPER LIMB REGION

27. The upper extremity is important for carrying, lifting, climbing and manual handling. Military training and service places repetitive loading on the upper extremity with load carrying, climbing and weapons handling. Particular attention should be paid to hand function, hand movement and grip (precision and power), as hand function is critical for every task in the ADF. Full function of the upper limb region is important to all military jobs and is essential in Army combat roles.

28. The high range of movement in the shoulder joint causes it to be susceptible to instability and dislocation. MOs are to consider the following when determining suitability for ADF entry:

a. any surgical management, especially joint replacement (arthroplasty), ligament reconstruction and tendon repair

b. conditions that affect the function and stability of joints, especially large joints

c. anterior shoulder dislocation, as the injury and stabilising structures predispose to further dislocation, noting adequate repair of soft tissue structures of the capsule and labrum has a good prognosis

d. overuse injuries (eg lateral and medial epicondylitis) or ligamentous injuries that can result in joint instability, noting that overuse injuries often settle with activity modification.

29. Table 5F–7 lists the decision factors for specific conditions that are of interest to the ADF. If a condition is not listed, clinicians are to apply the principles for medical suitability decision-making.

Table 5F–7: Shoulder conditions

Serial	Conditions and decision factors	Class
7.1	**Shoulder dislocation.** Class 1 if any of the following applies: • single episode fully resolved 12 months if 25 or older at injury • single episode fully resolved five years if under 25 at injury • surgically managed and report from episode of care confirms fully resolved 12 months.	1
	Shoulder dislocation: single episode fully resolved <five years and under age 25 at injury. Current orthopaedic opinion. Fully resolved.	3R 1
	Recurrent/persistent shoulder dislocation, subluxation or instability not meeting Class 1 standard.	4
	Aviation Class 1 and 2: for any shoulder dislocation, IAM to make final classification decision.	3
7.2	**Shoulder impingement syndrome.** Report from episode of care. Fully resolved six months following operative or non-operative management.	1
	Shoulder impingement syndrome: Class 1 standard not met, or rotator cuff weakness, or signs or symptoms of impingement.	4
7.4	**Rotator cuff tear and repair – partial thickness**. Fully resolved 12 months.	1
	Rotator cuff tear managed surgically with repair – full thickness or significant partial thickness. Report from episode of care confirms fully resolved 12 months.	1
7.5	**Fractures and dislocations.**	See Table 5F–1

SPINE REGION

30. The spine is a major weight bearing structure. Military training and service will place repetitive loading on the spine from marching, running, load carrying, bending, climbing, parachuting, aircraft g-force, ejection seat, and extended periods of ambulation.

31. Spinal conditions are relatively common, often leading to pain, neurological involvement, deformity, change in structural integrity and functional impairment. Spinal pain has multiple causes: structural, biomechanical or medical (eg tumours, fractures, infections, and osteoporosis).

32. A history of back or neck pain does not require specialist review where there is no significant underlying pathologic cause identified, it resolved with minimal risk of recurrence, and the pain was well-managed with no functional impairment, medication or loss of work.

33. A history of pain is of concern where return to work and physical activity is delayed; when the pain is due to nerve root pain or specific spinal pathology; or there are recurrent episodes of pain. Positive prognostic factors are a short duration of pain, lower intensity of pain, younger patient, and activities involving back extension movements.

34. Table 5F–8 lists the decision factors for specific conditions that are of interest to the ADF. If a condition is not listed, clinicians are to apply the principles for medical suitability decision-making.

Table 5F–8: Spinal conditions

Serial	Conditions and decision factors	Class
8.1	**Back or neck pain <12 weeks.** If all the following • single episode • no significant underlying pathologic cause • fully resolved • low risk of recurrence.	1
	Back or neck pain >12 weeks. Report from episode of care. If report confirms all the following: • single episode • no significant underlying pathologic cause • fully resolved • low risk of recurrence • returned to physical activity. If doubt, seek specialist opinion.	1
	Chronic and/or recurrent back or neck pain.	4
	Aviation Class 1 and 2: back or neck pain >eight weeks. Report from episode of care. Refer to IAM for final classification decision if all the following: • single episode • no significant underlying pathologic cause • fully resolved • low risk of recurrence • returned to physical activity. Class 4 for Aviation Class 1 and 2 if criteria above not met.	3
	Special Forces: >12 weeks back or neck pain.	4
8.2	**Radiculopathy and disc prolapse.** Managed non-surgically. Report from episode of care confirms fully resolved.	1
	Aviation Class 1 and 2: If any history or presence of radiculopathy or disc prolapse.	4

Serial	Conditions and decision factors	Class
8.3	**Spine deformity.** Mild (scoliosis & kyphosis). Meets Class 1 standard. If doubt, seek specialist opinion.	1
	Moderate spine deformity. Report from episode of care confirms all the following: • Cobb angle <30º or Kyphosis angle <40º • any signs or symptoms fully resolved • spine stable • condition unlikely to progress • candidate has achieved MSK maturity. If candidate is under 25, a current specialist opinion is required.	1
	Spine deformity: Cobb angle >30º or Kyphosis angle >40º.	4
	Aviation Class 1 and 2: If all the following: • no history of back pain • spine stable • condition unlikely to progress • candidate has achieved MSK maturity • lumbar scoliosis <20°, thoracic scoliosis <25°, kyphosis or lordosis <40° by Cobb angle.	1
8.4	**Spine surgery – discectomy.** Report from episode of care. If all the following: • fully resolved • returned to pre-surgery physical activity. If doubt, seek specialist opinion.	1
	Procedures such as fracture fixation, deformity correction, spinal stabilisation, spinal fusion or disc replacement surgery.	4
	Aviation Class 1 and 2: if discectomy or other spinal surgery.	4
	Army combat roles: if discectomy or other spinal surgery.	4
8.5	**Vertebral fracture.** Managed non-surgically. Report from episode of care confirms fully resolved with no neurological injury.	1
	Aviation Class 1 and 2: if any history of vertebral fracture	4
8.6	**Intervertebral disc changes due to ageing.** Treating practitioner report indicates: • no evidence of intervertebral disc disease • no inflammation • no mechanical hypermobility • no restricted range of movement • no functional limitation • no pain in the facet joints, uncovertebral joints and ligamentous structures.	1
	Aviation Class 1 and 2: if intervertebral disc changes.	4
8.7	**Spine tumours and infection.**	See Table 5F–1

Serial	Conditions and decision factors	Class
8.8	**Spondylolisthesis.** Report from treating practitioner confirms less than 25% slip (Grade 1) with no pain and no functional limitation. If report is more than 12 months old, seek current specialist opinion.	1
	Spondylolisthesis. Slip of 25% or greater (Grades 2–4).	4
	Aviation Class 1 and 2: any history of spondylolisthesis.	4
	Army combat roles, Special Forces: any history of spondylolisthesis.	4
	Divers, submariners: any history of spondylolisthesis.	4

ANNEX 5G

SYSTEM SPECIFIC REASONS FOR REJECTION – NEUROLOGICAL SYSTEM

1. **General.** Any nervous system impairment produces a high risk of functional disability under the harsh physical and mental strain of military service. Symptoms such as headaches, muscle weakness, frequent dizziness or fainting may denote a neurological or other condition incompatible with military training and service.

Conditions of the neurological system

Table 5G–1: Functional

Serial	Condition	Consideration	Class
1.1	**Motion sickness**	Risk of dehydration and electrolyte disturbance if severe and not treated. Treatment difficult at sea or on operational deployment.	N/A
	Minor occasional episodes of seasickness	If only in small boats or in very rough seas, or occurred when less than 12 years old.	1
	Chronic and disabling after age 12 years	The presence of undue sensitivity of balance mechanisms in the ear could be detrimental to personnel, causing decreased performance and time off work.	4
1.2	**Seizure disorder**	If a seizure occurs there is an increased risk of injury from falling and/or striking the head. Weapon safety may be compromised. If the operator of any vehicle of machinery suffers a seizure; individual or collective safety will be at risk.	4

Serial	Condition	Consideration	Class
1.3	**Epilepsy**	Seizures of any kind in the field or maritime environment are an unacceptable safety risk. Risk of seizures can increase under deployed conditions and may be due to: • missed or lost medication • poor drug absorption due to gastrointestinal illness • shift work • prolonged working hours • inadequate rest • dehydration • exposure to noxious gases • stress in combat situation • sleep deprivation. Requires regular specialist review and medication; may require evacuation. Anti-epileptic medication is not routinely carried at sea.	N/A
1.3.1	**History of generalised epilepsy (excluding febrile convulsions or other specified epilepsy of childhood, see separate serial)**	With or without history of treatment with medication.	4
1.3.2	**History of benign rolandic epilepsy (benign epilepsy of childhood with centrotemporal spikes)** Off all anti-epileptic medication for five years and no seizures during that time.	**Additional information required:** Neurologist report, electroencephalogram (EEG) with no epileptic features, normal 24 hour sleep deprived EEG, normal cerebral imaging.	3R/4
1.3.3	**History of juvenile absence syndrome (petit mal)**, off all anti-epileptic medication and no seizures for five years	**Additional information required:** Neurologist report, EEG with no epileptic features, a normal 24 hour sleep deprived EEG and other provocative testing as appropriate, normal cerebral imaging.	3R/4

Serial	Condition	Consideration	Class
1.3.4	**Febrile convulsions** Uncomplicated of childhood	Usually benign	1
		Aircrew/divers/submariners • Require neurological opinion to confirm diagnosis of simple febrile convulsion.	3R
1.3.5	**All other forms or causes of epilepsy**	Any treatment or epilepsy within the last five years is incompatible with service. For those conditions where no epilepsy or treatment for epilepsy in the last five years can be demonstrated, then may be acceptable, with additional information. **Additional information required** • Neurologist report, EEG with no epileptic features, a normal 24 hour sleep deprived EEG and other provocative testing as appropriate, normal cerebral imaging.	3R/4
1.4	**Narcolepsy** Symptoms include: • hypersomnia • cataplexy • sleep paralysis and/or • hypnagogic phenomena.	Incompatible with performance of duties. Requires medication (stimulant) which may be difficult to obtain on deployment and which has unacceptable side effects.	4

Table 5G–2: Infective

Serial	Condition	Consideration	Class
2.1	**Neurosyphilis (active and/or symptomatic)**	Associated with intellectual change, spasticity and loss of balance.	4
	Past treated	May not have ongoing symptoms, but each would need to be assessed on a case by case basis. For cases where treatment has been completed over six months ago, and functional impairment is minimal or nil, then could be assessed for suitability. Specialist infectious diseases advice should be sought.	3R/4

Table 5G–3: Headaches

Serial	Condition	Consideration	Class
3	**Headaches (including migraine, cluster and tension)**	Severity of headache and functional impact are better indicators of future incapacity in a military environment than clarity around diagnosis. Frequency is also relevant although less predictive than severity. Frequency of headaches is known to increase during military training. Common trigger factors in the military environment are: • sleep deprivation • hunger • dehydration • glare • poor ventilation • heat • physical and emotional stress Differentiation between tension and vascular type headaches is not needed for occupational/functional prognosis, and there is often a mixed picture over time.	3R/1/4
3.1	**Moderate to Severe** (at any time in the last two years)	**If any of the following criteria are met:** • Neurological dysfunction other than nausea/vomiting or photophobia ie classical migraine (especially disturbance of sight, hearing, balance or motor function) • Impaired performance of academic, sporting or work activities (unable to participate) • Required time off to rest • Required more than simple analgesia to treat attacks (paracetamol and/or Non Steroidal Anti Inflammatory Drugs (NSAIDs), or combined Over The Counter (OTC) products) • Required prophylactic medication including regular (daily) use of OTC medication • Diagnosis of or history consistent with cluster headaches	4
		Aircrew/divers/submariners • Any history of confirmed or suspected migraine or moderate to severe headache in the previous three years.	4
3.2	**Mild** (None of the above criteria apply in the last two years)	Any available relevant reports should be submitted, general practitioner (GP) opinion may be helpful if poor recall of such medication use or time off (GP, specialist, imaging, other tests/opinions).	3R/1

Serial	Condition	Consideration	Class
		If all the following apply: • Frequency is less than once a month averaged over the last two years • Does not require more than simple analgesia (paracetamol or NSAIDs with OTC codeine doses) • No significant functional impairment • No relevant underlying condition	1
		Otherwise	4
		Aircrew/divers/submariners • More than three headaches per year averaged over the last three years.	4
		Aircrew/submariners If all the following apply: • Frequency is three or less headaches per year averaged over the last three years • Does not require more than OTC analgesia (paracetamol or NSAIDs only) • Does not require combination OTC analgesia • No significant functional impairment • No relevant underlying condition. • Requires neurology assessment, which must address diagnosis, severity, functional impact and prognosis. May be considered fit subject to specialist assessment and approval of confirming authority.	3R
		Divers As for aircrew and submariners above. Additionally, for diver candidates with any history of confirmed migraine. • A saline contrast study (bubble study) is required. • A neurology assessment is required prior to forwarding for confirmation.	3R

Table 5G–4: Trauma

Serial	Condition	Consideration	Class
4.1	**Head injury** Head injuries should be classified according to a presence or absence of: • loss of consciousness (LOC); • penetrating lesion; • pre and post-traumatic amnesia (PTA); • post-traumatic syndrome; • seizures; or • history of any intracranial bleeding (subdural haematoma, extradural haematoma intracerebral haemorrhage, intraventricular haemorrhage or subarachnoid haemorrhage).	**Additional information required** • Accident and Emergency and Hospital reports from the original injury must be provided and must include Glasgow Coma Scores on admission, documented history of PTA/post-traumatic epilepsy and copies of all investigations including radiology and neuropsychiatric/neuropsychological reports. In the absence of reports, all candidates with a history of head injury requiring admission to hospital (for more than overnight observation) will require neurosurgical or neurological assessment.	3R
4.1.1	**Minor head injury** (PTA and LOC less than five minutes)	Decision	1
4.1.2	**Mild head injury** (PTA and LOC more than five minutes but less than one hour)	If no seizures, normal neurological examination, no other neurological sequelae, favourable neurologists report (see serial 4.1).	3R/4
4.1.3	**Moderate head injury** (PTA and LOC more than one hour but less than 24 hours)	**Additional information required:** Neurological opinion. (see serial 4.1.) **Decision.** If: • seizures occurred but were restricted to the first 24 hours; • there was no other neurological sequelae; • seizure free for a period of at least two years; • normal computed tomography/magnetic resonance imaging of the brain; and • satisfactory neuro-psychological assessment.	3R/4
		Aircrew/JBAC/divers • Neurological opinion (see serial 4.1)	3R

Serial	Condition	Consideration	Class
4.1.4	**Major (severe) head injury** (PTA and LOC for more than 24 hours.) Major head injury includes complications such as: • Post-traumatic seizures (occurring more than five minutes after injury). • Radiographic evidence of retained metallic or bony fragments. • Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula. • Depressed skull fracture (the inner table indented by more than the thickness of the skull) with or without dural penetration. • Traumatic laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury. • Epidural, subdural, subarachnoid, or intracerebral haematoma. • Central Nervous System (CNS) infection such as abscess or meningitis within six months of head injury.	Intracranial haematoma carries 30 per cent risk of subsequent epilepsy. Past and family history of epilepsy doubles the risk of other markers for post-traumatic epilepsy. Cumulative risk of post-traumatic epilepsy is seven per cent at one year and 13.3 per cent at five years.	4
4.2	**Disturbance of consciousness eg ‘concussion**	(blow to the head not resulting in complete loss of consciousness but disorientation, headache, and cerebral impairment for up to 24 hours.)	N/A
	Single episode	Decision	1
	History of three episodes or more	Increased risk of post-traumatic complications **Additional information required:** • Neurological opinion.	3R

Table 5G–5: Demyleniation

Serial	Condition	Consideration	Class
5.1	**Progressive neurological disorder**	Affects coordination, balance and the senses, especially vision.	4

Table 5G–6: Surgery

Serial	Condition	Consideration	Class
6.1	**Ventriculoperitoneal shunt**	Increased risk of illness, injury or medical complications. Spontaneous or post-traumatic blockage of the shunt and de novo or post-traumatic infection requires emergency specialist access	4
6.2	**Craniotomy**	Increased risk of post-surgical seizure. **Decision** • If occurred before age of 12 and no sequelae or complications.	3R
		All others	4
6.3	**Other neurosurgical procedures**	Depends on procedure **Decision** • Based on neurosurgical assessment as to the risk of further complications / residual underlying pathology.	3R

Table 5G–7: Other/General

Serial	Condition	Consideration	Class
7.1	**Abnormality of cranial or other nerves**	Affects senses, muscle function, sensation, balance and coordination **Decision** • Acceptable only if there is no functional disability, eg Bell's palsy with little residual disturbance.	3R/1
		If residual functional disability	4
7.2	**Abnormality of cranial vasculature, including stroke, intracranial aneurysm, and arteriovenous malformation**	Decision	4

Serial	Condition	Consideration	Class
7.3	**Syncope—frequent** May be due to epilepsy, cerebral tumour or trauma, toxins (alcohol, drugs), or other system abnormalities such as cardiac, endocrine, psychiatric	Consequences of loss of consciousness in military environment can be serious, even life threatening: increased risk of injuries associated with falls onto equipment, vehicles, from heights, at sea, holding weapons.	N/A
	Simple explained	If due to known provocators, such as pain or the sight of blood or normal physiological syncope in response to a training event, (eg prolonged standing on parade).	1
	Unexplained	**Additional information required:** • Neurology and/or cardiology opinion to exclude pathology	3R/4
7.4	**Chronic pain and pain syndromes are divided into two broad groups: somatogenic and psychogenic**	Chronic pain can develop after injury to any level of the nervous system, peripheral or central. A variety of specific syndromes have been identified. Their pathogenesis is obscure and their incidence and prevalence are unknown. Collectively these conditions present a very poor risk for rigorous military training. Treatment is invariably multi-disciplinary, intensive, costly and with an unpredictable outcome. Refer Annex 5F serial 1.15.	N/A
7.4.1	**Somatogenic pain**—is broken into the broad divisions of neuropathic pain and reflex sympathetic dystrophy	NA	N/A
7.4.1.1	**Neuropathic pain** Neuropathic pain may involve predominantly peripheral processes (peripheral syndromes include neuroma formation and nerve compression—for example radiculopathy from discogenic disease).	Decision	4
7.4.1.2	**Reflex sympathetic dystrophy** (includes Complex Regional Pain Syndrome and Causalgia)	Decision	4

Serial	Condition	Consideration	Class
7.4.1.2.1	**Complex regional pain syndrome** is a chronic pain state induced by tissue or bone injury or nerve injury in which pain is associated with autonomic changes—eg sweating or vasomotor abnormalities, and or trophic changes (eg skin or bone atrophy, hair loss, joint contractures).	Decision	4
7.4.2	**Psychogenic pain**. Chronic pain with insufficient or no organic explanation is a common problem. Typical syndromes include: • chronic headache • continued low back pain • atypical facial pain • abdominal or pelvic pain of unknown cause.	Decision	4
7.5	**Peripheral neuropathy from any neurological injury or disorder** May result from any damage affecting the nervous system distal to the CNS. It affects movement or sensation.	Affects movement, strength, dexterity and sensation. Unlikely to be compatible with military duties unless the cause has been identified and successfully treated with no residual neuropathy or other symptoms, and the treatment is not ongoing. If the cause is treated, and the condition has resolved (for example poor diet now corrected), then could be considered for entry with appropriate specialist reports.	3R/4
7.6	**Cranial neuralgia** Includes trigeminal neuralgia and glossopharyngeal neuralgia.	Often resistant to treatment.	N/A
	Following surgery or other treatment.	Must be drug-free and asymptomatic for at least 12 months.	3R / 1
		If criteria above not met.	4
7.7	**Cerebral tumours**	History of surgical removal of benign tumour in childhood may be compatible with selection.	3R/4

ANNEX 5H

SYSTEM SPECIFIC REASONS FOR REJECTION – ENDOCRINE AND METABOLIC SYSTEMS

This annex has been amended to align with the agreed position on waivers up to J22. The amendment is a limited review and the annex is scheduled for early review.

1. Poor living conditions, limited access to fresh food and reliance on combat rations, lack of hygiene, extremes of climate and minimal transport and medical support are common in the operational area. Physical and emotional stress may also affect the endocrine system.

Table 5H–1: Conditions of the endocrine and metabolic systems

Serial	Condition	Consideration	Class
1	**WEIGHT DISORDERS**		
1.1	**Acceptable weight range: body mass index (BMI) 18.5–32.9**	Acceptable if there are no other health problems. All candidates are separately required to pass the pre-enlistment fitness assessment (PFA).	1
		Divers. Serving members who apply to transfer to diver may be considered acceptable with a BMI of up to 35 if they are able to pass the appropriate PFA.	1/4
		Pilot candidates. See Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[133]— 'Health requirements for aviation-related occupations'.	1/4
1.2	**Over acceptable weight range: BMI 33.0 or greater**	Correlation with poor aerobic fitness and risk of stress injury. Candidate must build up exercise tolerance to undergo recruit and subsequent training.	3T/4
		Weight loss to BMI 32.9 or lower has been maintained for six months and there are no complications from obesity.	1

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Serial	Condition	Consideration	Class
1.3	**Under acceptable weight range: BMI less than 18.5**	Strength is required to carry heavy packs, complete training exercises, and carry other heavy weights may be compromised. Candidate must be strong enough to undergo recruit and subsequent training.	
	If due to eating disorder	See Annex 5Q.	
	If due to developmental abnormality, or due to immaturity.	Assess on merits.	3T/3R/1
2	**ADRENAL**		
2.1	**Cushing's disease and Addison's disease**	Risk of acute deterioration requiring specialist care following minor illness or injury. Requires regular medication, regular specialist review and blood tests.	4
2.2	**Adrenal tumour with hypersecretion and sub-clinical Cushing's disease.**	Risk of acute deterioration requiring specialist care following minor illness or injury. Requires regular medication, regular specialist review and blood tests.	4
3	**REPRODUCTIVE SYSTEMS**		
3.1	**Male**	See Annex 5D.	
3.2	**Female**	See Annex 5E, serial 3.	
4	**PANCREAS**		
4.1	**Diabetes mellitus** Type I, insulinopathies, endocrinopathies with associated diabetes.	Risk of sudden deterioration with minor illness or injury, requiring hospitalisation and specialist care, bacterial and fungal infections. Late complications—neurological, retinal and renal damage. Requires strict control of diet, exercise, medication, sleep and stress; may require supply of sterile injectables and testing equipment. Even heat-stable insulin cannot survive for long in operational environment.	4
4.1.1	**Type 2 diabetes (diet controlled)**	Acceptable if: HbA1C within normal (non-diabetic) range) • normal BMI (up to 25) • normal waist–hip ratio • no regular medication • acceptable CV risk.	3R/2 *eg J22, 4–4, 4–11 (GP review annually)
		Otherwise	3R/4

Serial	Condition	Consideration	Class
4.2	**Impaired glucose regulation.** Does not meet diagnostic criteria for diabetes but 2 hour/ 75gram OGTT is abnormal. Usually discovered during targeted screening for Type 2 diabetes.	All candidates 35 years or older require an Australian absolute CV risk assessment.	3R
	Impaired fasting glucose (IFG). Meets diagnostic criteria for IFG.	**Decision:** • CVD Risk < 5% • normal BMI (up to 25)	2 *eg J11, 4–11 (3-yearly CV risk profile and assessment of glucose metabolism)
	Impaired glucose tolerance (IGT). Meets diagnostic criteria for IGT.	As for IFG above	As for IFG above
	IFG and IGT: medication required. Prescribing should be in line with Australian guidelines.	Medication required to treat IFG or IGT. Medication required to reach BP or lipid targets. See relevant serial. Infrequent review by GP.	3R/4 *eg J22, 4–1, 4–4, 4–11 (12/12)
5	**PARATHYROID**		
5.1	**Hyperparathyroidism**	Risk of hypercalcaemia, osteoporosis and/or calcium stone formation. Requires regular monitoring.	
5.1.1	**Primary or secondary hyperparathyroidism**	Requires regular specialist review and blood tests. May develop neuro-behavioural symptoms incompatible with Service life.	4
5.1.2	**Hyperparathyroidism due to parathyroid adenoma**	May be suitable if all of the following apply: • twelve months since surgery • no recurrence of tumour • normal calcium levels • no evidence of osteoporosis • no requirement for regular medication.	3R/1
		Otherwise	4
5.2	**Hypoparathyroidism (any cause)**	Risk of hypocalcaemia, hypokalaemia, hypomagnesaemia and/or osteoporosis. Most cases require long-term vitamin D and calcium supplements.	4

Serial	Condition	Consideration	Class
6	**PITUITARY**		
6.1	**Acromegaly**	Requires regular medication; regular specialist review and blood tests; hospitalisation and specialist care after infections, accidents and injuries.	4
6.2	**Pituitary tumour**	Risk of sequelae: headaches, visual field defects, and hypopituitarism. Requires regular specialist review. May require neurosurgery or multiple hormone replacement.	4
7	**THYROID** Includes: • goitre • hypothyroidism • hyperthyroidism • Graves' disease (toxic diffuse goitre) • Plummer's disease (toxic multinodular goitre) • thyroid nodules • thyroid malignancies • TSH producing pituitary tumour, • thyroiditis • thyroid eye disease.		
7.1	**Euthyroid. Condition stable, no medication**	Acceptable if: • clinical condition stable for 6 months • monitoring bloods (if indicated) not more frequent than 6 monthly • monitoring imaging (if indicated) not more than 6 monthly • no oncological concerns • no significant complications • no psychologic/psychiatric sequelae.	1/2 *egJ11 or J22 4–4, 4–11
7.2	**Euthyroid. Condition stable on medication (Thyroxine)**	Acceptable if: • clinical condition stable on thyroxine for 6 months • monitoring bloods not more frequent than 6 monthly • monitoring imaging (if indicated) not more than 6 monthly • no oncological concerns • no significant complications • no psychologic/psychiatric sequelae.	2 *eg J22 4–1, 4–4, 4–11

Serial	Condition	Consideration	Class
7.3	**Unstable thyroid function**	Thyroid performance can swing between over and under function through many thyroid illnesses. ADF entry should be deferred till the condition meets serial 8.1 or 8.2 criteria.	3T/4
7.4	**On thyroid-suppressing medication** • Carbimazole • Propothiouracil • Potassium perchlorate	All thyroid suppression medications are associated with significant sudden or subtle complications (eg bone marrow depression). Australian guidelines suggest a trial wean of suppression after a time period. Once 'burnt-out', assess as per serial 7.1 or 7.2.	3T/4
7.5	**Cancer surveillance** • nodules under surveillance • malignancies under surveillance • treated malignancies • TSH producing pituitary tumour	Some thyroid disease (eg thyroid nodules) may be suspicious for cancer, but not yet meet criteria for surgery. Biopsy is required only if clinically indicated. Acceptable if: • 12 months post surgery (if surgery indicated) • no evidence of disease recurrence • clinical condition stable for six months	3R
7.6	**Exclusion thyroid conditions**	• Current thyroid malignancy undergoing treatment • Thyroid surgery planned • Thyrotoxicosis factitia • Significant functional thoracic obstructive symptoms	4
7.7	**Iatrogenic thyroid disease**	Iatrogenic thyroid disease can occur following overdosage, amiodarone or IV contrast use (not limited to this list). Service suitability depends on causation, underlying disease and ability to avoid trigger.	3R/4
	Otherwise		3R/4

Serial	Condition	Consideration	Class
8	**METABOLIC**		
8.1	**Gout**	Gout can be associated with or lead to degenerative arthritis, renal and cardiovascular disease, diabetes and dyslipidaemia.	
	Single episode	No associated disease, prophylactic medication not required, 6 months has elapsed.	1
	In remission	No associated disease, prophylactic medication no longer required, 6 months has elapsed since last attack.	2 *eg J22, 4–4
	Current prophylactic medication	No associated disease, no attacks for at least 3 months while on prophylaxis.	2 *eg J22, 4–1, 4–4, 4–11 (GP review 6 monthly)
	Recurrent symptomatic gout or gouty tophi	Despite adequate prophylactic medication, has clinical joint changes or recurrent symptomatic gout.	4
8.2	**Haemochromatosis Homozygous and Heterozygous**	See Annex 5M, serial 7.	
8.3	**Wilson's disease** (inherited copper toxicosis). Family history or personal history.	Requires regular specialist review; lifelong treatment with chelating agents. Risk of acute psychosis, acute haemolytic anaemia, chronic hepatitis, renal failure and slow neurological degeneration.	4
8.4	**Peripheral neuropathy from any metabolic cause**		4
9	**ALLERGY/DIETARY**	See Annex 5O	
10	**URINALYSIS**		
10.1	**Glycosuria—finding on urinalysis**	**Additional information required:** requires specialist assessment to exclude underlying serious condition (diabetes, renal tubular defects).	3R
	Isolated renal glycosuria	Asymptomatic and uncomplicated.	1
	Glycosuria with diabetes	See relevant diabetes serial.	4

Serial	Condition	Consideration	Class
11	**ADVERSE DRUG INTERACTIONS**		
11.1	**Malignant hyperthermia (MH)**	High risk of muscle hypermetabolism triggered by inhalational anaesthetics or by succinylcholine. Also increased risk of heat injury and exercise-induced rhabdomyolysis.	4
	Family history of MH	Requires muscle biopsy and/or genetic assay to exclude condition in candidate.	3R
12	**OTHERS**		
12.1	**Any history of chronic or acute endocrine conditions**		4

Note:* recommendation only as per paragraph 5.11

ANNEX 5I

SYSTEM SPECIFIC REASONS FOR REJECTION – EAR, NOSE AND THROAT SYSTEMS

This annex has been amended to align with the agreed position on waivers up to J22. The amendment is a limited review and the annex is scheduled for early review.

1. The nose and throat are the first lines of defence for screening of foreign bodies such as infection and allergens. Recurrent upper respiratory tract infections may cause significant morbidity and time off work. Resultant impairment of hearing from such infections may impair job performance, particularly in combat situations where communication is paramount. In some situations masks are an essential item of personal protection equipment (PPE), eg oxygen masks for aircrew and divers, self-breathing apparatus for firefighters and chemical, biological, radiation and nuclear protection for all personnel. The requirement to travel in aircraft is essential for military personnel. Careful assessment of the ears, nose and throat (ENT) is mandatory for some occupations due to the environmental hazards of altitude or depth and the physiological challenges of those hazards.

Table 5I–1: Conditions of the ear, nose and throat

Serial	Condition	Consideration	Class
1	**EARS**		
1.1	**Radical mastoidectomy with intact tympanic membrane**	May be acceptable, provided the ear is healthy, the tympanic membrane and posterior canal wall are intact and there is no defect in the hearing.	3R/1
		If the above requirements are not met.	4
	Following cortical mastoid operation and a mastoid tympanoplasty		4
		Aircrew/ATC/divers: Any history of radical mastoidectomy	4

Serial	Condition	Consideration	Class
1.2	**Otitis Externa (OE)**		
	Severe and recurrent (ie recurring so frequently that the ears must be kept dry at all times).	Severe and recurrent OE causes pain, deafness and ear discharge requiring regular ENT management. Would exclude service in a tropical or moist area due to aggravation and worsening of the condition and requirement for long-term ENT management.	4
	Single episode with complete recovery		1
	Multiple episodes in a 12-month period	If the cause of the episodes has been identified, is self-limiting and treatment has been successful with no recurrence.	3R/1
	Recurrent eg 'swimmer's ear'		4
1.3	**Otitis media**	Usually associated with upper respiratory tract infection.	
	Acute otitis media	**Decision:** If full recovery and repeat audiogram is normal.	3T/1
	Recurrent acute otitis media	Recurrent attacks can lead to acute eardrum perforation, deafness and delayed speech. Acceptable if: • currently asymptomatic • meets hearing standards for role • no hyperacousis • normal Eustachian tube function • normal Rombergs • no significant complications (eg mastoiditis or meningitis).	2/3R/4 *eg J22,4–11 (GP review at 12 months), P2 for Army
	Chronic suppurative otitis media	Can cause chronic perforated tympanic membranes, ear discharge and deafness. Acceptable if: • currently asymptomatic • meets hearing standards for role • no hyperacousis • normal Eustachian tube function • normal Rombergs • no significant complications (eg mastoiditis or meningitis).	2/3R/4 *eg J22,4–11 (GP review at 12 months), P2 for Army

Serial	Condition	Consideration	Class
1.4	**Grommets (prior)**	And meets all other serials/requirements	1
	Grommets (current)	Acceptable if: • grommets are temporary • asymptomatic • meets hearing standard for role • can equalise effectively • no chronic ear discharge (ie ear currently dry) • no hyperacousis • no other related disqualifying condition **Mark health record:** 'caution: Aminoglycosides'	2/3T/3R/4 *eg J22, 4–2 (earplugs), 4–4, 4–11 (GP review in 12 months), P3 for Army
		Aircrew/ATC/divers	4
1.5	**Hearing loss as determined by audiogram and hearing standard (HS).** A HS is to be applied, refer paragraph 5.10. Candidates must meet the appropriate HS for the specific military occupation.	Members must respond rapidly to orders given against a high level of background noise and/or confusion. Job may require use of high tech communications devices. Impaired hearing may cause delays in response time and a requirement for repetition. Mission completion and safety may be compromised. Risk of further hearing loss due to hazardous noise exposure in Australian Defence Force operations.	
	HS1 and HS2		1
	HS below HS2	**Additional information required:** ENT surgeon assessment. If no clinical indication for specialist assessment and access to an ENT specialist is restricted due to the geographical location—the candidate may be referred to an audiologist.	3R
		Decision: If there is no clinical condition that precludes entry and the candidate meets the occupation specific HS.	1
	If entry HS for the specific occupation is not met (including if hearing aids are worn).		4
	If a clinical condition is identified refer to relevant serial in this annex.		

Serial	Condition	Consideration	Class
1.6	**Meniere's disease** Triad of vertigo, hearing loss and tinnitus may be due to Meniere's disease.	This diagnosis is to be made by an ENT surgeon only. Acute Meniere's disease is debilitating and can occur at any time in spite of medical or surgical treatment.	3R/4
1.7	**Vertigo**		
	Recurrent or chronic	Risk of falls, confusion and time off work.	4
	Single episode	Six months must have elapsed after a single, significant episode. **Additional information required:** ENT review.	3R
		If presence of underlying pathology and the need for ongoing treatment.	4
1.8	**Tinnitus**	**Additional information required:** ENT assessment required for those who meet entry HS for specific trade and are not otherwise excluded from entry with an underlying cause or other associated symptoms addressed elsewhere in this Annex.	3R/4
	Due to a reversible cause (eg drug toxicity, acoustic trauma or head trauma)	Acceptable if the cause has been identified and treated and there have been no symptoms for six months.	1
		Otherwise	3T/4
	Chronic	Acceptable if all the following apply: • no serious underlying cause • meets HS for entry • tinnitus is mild, with no functional impact, and it is not distressing • there is no need for a masker.	1
		Otherwise	4
1.9	**Otosclerosis with or without stapedectomy**	Risk of further hearing loss with unforeseen noise exposure. Risk of fistula formation with minimal pressure changes with subsequent extreme debility. Requires regular ENT reviews and eventual surgery, if not already performed. A stapedectomised ear is more likely to be adversely affected by loud noise such as firing of weapons due to the absence of the stapedius reflex.	4

Serial	Condition	Consideration	Class
1.10	**Perforations of the tympanic membranes**		
	Healed perforation. Healed perforated tympanic membranes are common in active young people, typically due to chronic childhood infections or barotrauma.	Acceptable if: • asymptomatic • meets hearing standard for role • normal balance function.	1
	Unhealed or chronic perforations	Acceptable if: • asymptomatic • unilateral lesion • not an attic or marginal perforation • meets HS for role • no chronic ear discharge (ie dry ear) • no hyperacousis • normal balance function • normal neurological examination • not associated with a skull fracture **Mark health record:** 'caution: Aminoglycosides'	2/3R/4 *eg J22, 4–2 (ear plugs), 4–3, 4–4, P3 for Army
	Otherwise		4
		Aircrew/ATC/divers/submariners: Require assessment by ENT specialist.	3R
1.11	**Any other chronic ear disease or surgical procedures of the ear including conditions of the external canal, tympanic membrane, middle ear, inner ear, eustachian tubes or mastoid.**	Likely exacerbation of symptoms from water, moisture, humidity, dust or irritation from PPE, particularly where the disease is progressive or the entrance of water is likely to cause infection.	4

Serial	Condition	Consideration	Class
2	**NOSE**		
2.1	**Allergic rhinitis**		
	Mild/occasional	Not requiring medication or well controlled on intermittent medication.	1
	Well controlled	Requires long term medications. Acceptable if: • surgery not planned • stable on intranasal steroids and oral antihistamines or desensitisation therapy underway (less than monthly) • no significant functional impairment • no significant complications (including obstructive sleep apnoea or severe polyposis)	2/3/4 *eg J22, 4–1, 4–11 (annual GP review), P3 for Army
	Following completion of desensitisation of program	If good recovery and minimal symptoms	1
	Poorly controlled	Includes: • requirement for oral steroids • unsuccessful desensitisation program	4
		Aircrew/ATC/divers: If requiring any medication.	3R

Serial	Condition	Consideration	Class
2.2	**Nasal obstruction**—due to deviated septum, hypertrophic rhinitis, polyps, or other causes, or associated with history of chronic sinusitis or acute upper respiratory tract infections.	Requires regular ENT review and possible surgery.	
	If curative treatment required.	**Additional information required:** ENT assessment aimed at determining the diagnosis.	3R
	Palliative treatment only. Severe seasonal allergic rhinitis (hay fever) requiring regular medication/topical nasal spray.		3R/3T
	If surgery required		3T/4
		May be suitable a minimum of three months after surgery, subject to a favourable ENT assessment.	3T/3R
		Decision: Must be symptom free and capable of effective valsalva.	1
		Aircrew/ATC/divers/submariners: Require ENT assessment.	3R

Serial	Condition	Consideration	Class
2.3	**Rhinosinusitis**		
	Acute episodes: maximum three per year	Mild sinusitis, resolves with short term medical treatment (intranasal steroid, neti pot and/or short course oral antibiotics).	1
	Well controlled chronic	Requires daily intranasal steroids, neti pot and occasional oral antibiotics to obtain good symptomatic control.	2 *eg J22 4–1, 4–11 (annual GP review), P3 for Army
	Chronic poorly controlled Symptoms present for at least 12 consecutive weeks, and two or more of the following: • anterior/posterior mucopurulent drainage • nasal obstruction • facial pain, pressure or fullness • presence of inflammation on examination of a decongested nose and/or CT scan showing evidence of rhinosinusitis	Risk of severe facial pain, nasal obstruction and nasal discharge	3T/3R/4
	Post-surgery Following successful intervention. If requires daily medication assess as per rhinosinusitis-medicated	May be acceptable subject to ENT review after two months. An existing operative report or a GP letter is sufficient. Acceptable if: • good symptom control obtained • no further surgery planned • no significant complications • no more missed work/school.	3T/3R/1
3	**THROAT**		
3.1	**Laryngeal disease causing dysphonia eg chronic laryngitis, vocal nodules, laryngeal papillomatosis**	Military commands depend on a good, clear voice; shouting or general voice projection causes exacerbation of laryngeal problems.	4

Serial	Condition	Consideration	Class
3.2	**Tonsillitis—severe and/or recurrent** (five or more episodes in the last year)	Attacks are debilitating and require rest and antibiotics. Requires ENT review and possible surgery.	3R
	Where surgery is not indicated	Acceptable if no recurrences for six months	3T/1
	Following tonsillectomy	Acceptable at six weeks after surgery if: • the operation was successful • recovery was uncomplicated by haemorrhage or infection • returned to full physical activity and function.	3R/1
		If surgery was complicated or have not returned to a full level of activity at six weeks, will require three months of convalescence.	3R/1
3.3	**Obstructive sleep apnoea**	Risk of daytime drowsiness, poor concentration, rapid fatigue; cardiovascular and respiratory complications; sudden death. Noisy breathing may interrupt others' sleep and compromise a combat situation. Requires Continuous Positive Airways Pressure machine which cannot be supported at sea, in the field or any operational environment. Often associated with other problems such as obesity.	3R

Note:* recommendation only as per paragraph 5.11

ANNEX 5J

SPEECH, ORAL AND DENTAL ENTRY STANDARD

1. **Speech.** Good communication skills are essential in the Australian Defence Force (ADF). Members must be able to hear, understand and relay accurate information, such as orders or reports of damage, quickly and without distortion, often against a high level of background noise. For these reasons, Defence insists on a minimum standard of English comprehension, hearing and speech. In many situations, added emotional stress may worsen a pre-existing speech difficulty, making it impossible to convey clear and precise messages.

2. Clear speech is a prerequisite to meet the medical standard for entry. In cases where speech disorders may be remediable, it is reasonable to allow the candidate to complete treatment at their own expense and be reassessed.

Conditions of the speech, oral and dental system

Table 5J–1: Speech defect

Serial	Condition	Consideration	Class
1.1	Speech defect	Ability to communicate clearly	1
		Inability to effectively communicate verbally, including the inability to pass on orders or messages in stressful situations	4

3. **Craniofacial anatomy.** Deformities and craniofacial abnormalities that compromise normal oral function, breathing or prevent the effective use of face masks and/or breathing apparatus do not meet the medical standard for entry.

Table 5J–2: Craniofacial anomaly

Serial	Condition	Consideration	Class
2.1	Deformities of the cranium and/or facial bones	If no interference with normal function, breathing, use of face masks or breathing apparatus	1
		If there is evidence that the deformity adversely affects the candidates oral function (such as the ability to eat, chew, speak or socialise); interferes with breathing; or prevents effective use of face masks/breathing apparatus	4

4. **Oral health.** Good oral health is essential for the general health of an individual. Candidates' oral structures and dentition – natural or prosthetic – should not limit their chewing function, speech and/or social wellbeing. The presence of infective and/or inflammatory oral/dental conditions amenable to dental treatment are

not a barrier to entry. Most dental conditions are remediable in the short to medium term, to the point where candidates can be expected to provide unrestricted service.

Table 5J–3: Oral health

Serial	Condition	Consideration	Class
3.1	Dental condition (eg caries, gum disease, missing teeth, wisdom teeth pathology, dentures)	If there are no adverse effects on the candidate's general health and no functional impairment (see para 4)	1
		If the oral health condition permanently impairs the candidate's general health and cannot be managed through dental treatment	4

5. **Orthodontics.** Candidates undergoing orthodontic treatment meet the medical standard for entry if their treatment plan does not require orthognathic surgery, or the surgical component of treatment has already been successfully completed. Where orthognathic surgery is part of the orthognathic treatment plan, the candidate cannot enlist until they are at least three months post-surgery. Candidates are required to acknowledge the impact entry into the ADF may have on their orthodontic treatment through Form PM646–'Information sheet and acknowledgement for ADF candidates undergoing orthodontic treatment'.

Table 5J–4: Orthodontic appliances

Serial	Condition	Consideration	Class
4.1	Orthodontic appliances (braces)	Incomplete orthodontic treatment that has no planned surgical component	1
		Orthodontic treatment that has a planned surgical component. Candidates who are three months post-surgery can be considered Class 1	3T / 1

ANNEX 5K

VISION SYSTEM ENTRY STANDARD

Individual capability requirements

1. Members need to see at a distance and discriminate between colours in order to use and interpret lights, equipment and signals. To be medically suitable for Australian Defence Force (ADF) entry, candidates need to be capable of:

a. meeting job-specific colour perception (CP) and minimum visual requirement (MVR) standards (see Defence Health Manual (DHM) Level 2 Part 5 Chapter 4[134]—'Occupation-specific medical standards')

b. performing tasks in conditions of limited visibility (able to see in low light conditions and when using vision equipment)

c. accommodating easily between distance and close vision

d. acceptable vision when fatigued

e. working and living in dry, hot, humid, windy dusty, cold, salty and sunny conditions

f. wearing role-specific helmets, goggles and headset displays.

2. Some job roles have a higher vision standard because of the nature of the work. Therefore, vision needs to be considered in the context of the candidate's job preference.

Recruiting Medical Class 1 standard

3. Candidates with a mild or transient ophthalmic condition may be considered Class 1 if all of the following apply:

a. meets CP and MVR standards for their job preference (DHM Level 2 Part 5 Chapter 2[135]—'Medical history and examination')

b. for aviation-related occupations, meets the aviation visual requirements (AVR) in DHM Level 2 Part 5 Chapter 6[136]—'Health requirements for aviation-related occupations'

c. condition has no associated vision impairment

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d. condition does not increase vulnerability of the eye to trauma or environmental exposures

e. condition is stable and its management is compatible with deployed health capability

f. condition is non-progressive and unlikely to be significantly exacerbated in the military environment

g. unless otherwise specified in this annex, at least six months since surgery or completion of non-operative treatment.

Recruiting Medical Class 4 standard

4. Candidates are medically unsuitable for ADF entry (Class 4) if any of the following apply to the condition:

a. function is impaired

b. condition causes pain or increases vulnerability of the eye to trauma and environmental exposures

c. condition is incompatible with dry, hot, humid, dusty, windy, cold, salty or sunny conditions

d. potential to deteriorate quickly or cause sudden incapacitation/loss of vision

e. condition is progressive and likely to deteriorate in the medium term (5 years)

f. treatment requirements are not compatible with deployed health capability

g. specialist review required more frequently than 12 months

h. condition is likely to be significantly exacerbated in the military environment.

Medical reports

5. Where relevant, copies of existing medical reports may be requested to inform the medical suitability decision. If further information is needed, a current general practitioner (GP), optometry or ophthalmology opinion may be requested (Class 3R pending report).

CONDITIONS AND TREATMENTS OF INTEREST

Vision aids

6. Spectacles are the preferred means of vision correction in the ADF. Candidates who prefer contact lenses must be able to achieve the MVR for the job preference without wearing contact lenses. This means their vision should be assessed while wearing spectacles or by suitable alternatives, such as a phoropter assessment.

Table 5K–1: Correction

Serial	Conditions and decision factors	Class
1.1	**Prism correction.** Existing ophthalmologist report on the eye condition (eg heterotropia or strabismus). Class 1 if all following: • meets MVR for job preference while wearing corrective lenses • any associated eye condition meets the relevant Class 1 standard.	1
1.2	**Soft contact lenses.** Vision tested with spectacles after removal of lenses >7 days. Class 1 if meets MVR for job preference.	1
1.3	**Hard or rigid gas permeable contact lenses.** Vision tested with spectacles after removal of lenses >14 days. Class 1 if meets MVR for job preference.	1
	Class 4 if hard or rigid gas permeable contact lenses are required to treat an eye condition or achieve MVR for role.	4
1.4	**Overnight corneal reshaping lenses.** These lenses (eg orthokeratology lenses) are not accepted for use in the ADF environment. Candidates who use overnight corneal reshaping lens are required to achieve MVR while using spectacles after removal of lenses >14 days.	N/A

Infective or inflammatory conditions

7. Infective and inflammatory eye conditions may be associated with frequent and troublesome symptoms (eg pain) that may cause damage to the eye (eg cysts, ulcers, scarring) or increase the risk of glaucoma.

Table 5K–2: Infective and inflammatory conditions

Serial	Conditions and decision factors	Class
2.1	**Mild infection or inflammation of the eye.** Class 1 if all following: • <2 brief acute episodes per year • no associated vision impairment • symptoms able to be managed within deployable health capability.	1
2.2	**Keratitis – single episode.** Existing report. Meets Class 1 standard and all following: • fully resolved with no sequelae • low risk of recurrence..	1
2.3	**Keratitis – herpes simplex-related.** Likely to be recurrent.	4
2.4	**Dacryocystitis.** Existing reports and surgical notes (if surgically treated). Meets Class 1 standard and all following: • >6 months post treatment • fully resolved with no sequelae • no ongoing treatment requirement.	1
2.5	**Scleritis.** Any diagnosis.	4

Serial	Conditions and decision factors	Class
2.6	**Uveitis.** Any history.	4
2.7	**Retrobulbar neuritis.**	4
2.8	**Allergic conditions.** See Annex 5O.	n/a

Cornea

8. Conditions that affect the cornea may cause pain and impair vision. Corneal conditions may be hereditary, trauma or disease-related. Some conditions are progressive with a risk of permanent loss of vision.

Table 5K–3: Cornea

Serial	Conditions and decision factors	Class
3.1	**Corneal scar.** Existing ophthalmologist report. Meets Class 1 standard and review ≥24 months.	1 *eg MEC J11
	*eg MEC J21 if meets Class 1 standard for **corneal scar and review** >12 and <24 months.	1 *eg MEC J21 4–3
	Aviation-related occupations. If any corneal scarring, Institute Aviation Medicine (IAM) to make the final classification decision.	3
3.2	**Keratoconus.** Meets Class 1 standard and all following: • hard contact lenses not required • no treatment or treated with collagen crosslinking (CXL) • <0.75D change in astigmatism in 24 months • ≥24 months review.	1 *eg MEC J11
	*eg **MEC J21 for keratoconus if all following:** • hard contact lenses not required • no treatment or treated with CXL • <0.75D change in astigmatism in 12 months • review >12 and <24 months.	1 *eg MEC J21 4–3
	Keratoconus treated with intrastromal corneal ring segments (ICRS) or keratoplasty (corneal transplant).	4
	Aviation-related occupations. Untreated keratoconus.	4
3.3	**Pterygium. Untreated.** Meets Class 1 standard, ≤3 mm on cornea and ≥24 months review.	1 *eg MEC J11

Serial	Conditions and decision factors	Class
	*eg MEC J21 if meets Class 1 standard for **untreated pterygium and review** >12 and <24 months.	1 *eg MEC J21 4–3
	Untreated pterygium ≤12 months review.	4
	Pterygium – surgically removed. Existing reports from surgery. Meets class 1 standard and all following: • >24 months since surgery • condition fully resolved, no complications, no symptoms • ≥24 months review.	1 *eg MEC J11
	*eg **MEC J21 if meets Class 1 standard for surgically removed pterygium**, but 12 months since surgery and review >12 and <24 months	1 *eg MEC J21 4–3
	Pterygium is recurrent or not stable or vision impairment or symptomatic or >3 mm on cornea.	4
	Aviation-related occupations. Untreated pterygium.	4

Notes:

(a) * recommendation only as per paragraph 5.11

Internal eye conditions

9. A candidate's vision may be affected by any condition that affects the lens, retina, vitreous humours or optic nerve. These conditions may be hereditary, trauma or disease-related. Some conditions are progressive with risk of permanent impairment of vision.

Table 5K–4: Internal eye conditions

Serial	Conditions and decision factors	Class
4.1	**Lens opacity.** Existing ophthalmologist report. Meets class 1 standard and ≥24 months review.	1 *eg MEC J11
	*eg MEC J21 if meets Class 1 standard for **lens opacity and review** >12 and <24 months.	1 *eg MEC J21 4–3
	Aviation-related occupations. If any lens opacity, IAM to make the final classification decision.	3
	Divers. Any lens opacities	4
4.2	**Dislocation of lens.**	4

Serial	Conditions and decision factors	Class
4.3	**Aphakia.**	4
4.4	**Retinal tear or detachment.** Existing ophthalmologist report. Meets Class 1 standard and all following: • no scleral buckle • any complications have been managed and are resolved • no predisposing conditions (eg high myopia).	1
	Aviation-related occupations, divers. Any history of retinal detachment.	4
4.5	**Absent pupillary light reflex.** Existing ophthalmologist report. Meets Class 1 standard and all following: • retains visual acuity on changing light levels (dark adapted within 15 minutes) • any underlying eye condition meets relevant Class 1 standard • ≥24 months review.	1 *eg MEC J11
	*eg MEC J21 if meets Class 1 standard for **absent pupillary light reflex and review** >12 and <24 months.	1 *eg MEC J21 4–3
	Aviation-related occupations, Army combat roles, diver, submariner. Absence of pupillary light reflex.	4
4.6	**Raised intraocular pressure.** Existing report. Meets Class 1 standard and all following: • normal fields on computerised perimetry • normal optic disc • no medication (oral or topical eye drops) • ≥24 months review.	1 *eg MEC J11
	*eg MEC J21 if meets Class 1 standard for **raised intraocular pressure and review** >12 and <24 months.	1 *eg MEC J21 4–3
	Aviation-related occupations. If any history of raised intraocular pressure, IAM to make final classification decision.	3
4.7	**Retained intraocular foreign body.** Existing ophthalmologist report. Meets Class 1 standard and all following: • present for >5 years • no visual impairment • non-corroding, non-magnetic metal • not organic or capable of long term degradation.	1
4.8	**Myopia.** >8.00 dioptres sphere.	4
4.9	**Glaucoma.**	4

Note: *recommendation only as per paragraph 5.11

Neurological and muscular conditions

10. Candidates may present with a history or presence of neurological or muscular conditions eye conditions. These are only of concern to the ADF if they affect vision or increase the vulnerability of the eye (eg trauma or environmental conditions).

Table 5K–5: Neurological and muscular conditions

Serial	Conditions and decision factors	Class
5.1	**Diplopia.** Existing ophthalmologist report on type, cause and treatment. Meets Class 1 standard and all following: • binocular single field when fixating objects within the central 20 degrees of the primary direction of gaze (may include use of prism correction to 20 degrees) • eye patching not required • any underlying eye condition meets relevant Class 1 standard.	1
5.2	**Binocular visual field defect.**	4
5.3	**Monocular vision.** Suitable for following if meets Class 1 standard and monocular vision at MVR1 standard: • Navy officer groupings: maritime logistics, health services, miscellaneous officers • Navy sailor groupings: maritime logistics, medical and dental • Navy sailor jobs: maritime human resource officers, musician.	1
	Class 4 for following jobs if monocular vision (vision in a single eye or one-eyed or functionally monocular): • Army and Air Force • Navy seaman and engineering officers, Navy sailors in aviation, communication, engineering and electrical, and seaman branches; Navy gap year and non-category sailor entry.	4
5.4	**Nystagmus.** Existing report confirms congenital and not progressive.	1
	Acquired nystagmus.	4
5.5	**Strabismus and Duane syndrome.** Current ophthalmology opinion. Meets Class 1 standard and all following: • no significant amblyopia • no diplopia or corrected with the use of vision aids (eg prism lenses) • does not need to tilt or turn the head to manage diplopia.	3R 1
	Aviation-related occupations, divers, submariners. IAM, senior medical adviser–diving medicine (SMA-DIVMED), SMA–submarine medicine (SMA-SUBMED) (as relevant) to make final classification decision.	3
	Air intelligence analyst – geospatial intelligence	4

Surgical procedures

11. Any surgery that weakens the globe or causes instability of the eye globe and refraction (eg radial keratotomy) is incompatible with ADF entry.

Table 5K–6: Surgical procedures

Serial	Conditions and decision factors	Class
6.1	**Refractive surgery.** Existing ophthalmologist report. Class 1 if all following: • surgery was photo refractive keratectomy (PRK), laser-assisted subepithelial keratectomy (LASEK), laser-assisted in-situ keratomileusis (LASIK), Epi-LASIK and trans-epithelial ablation, or small incision lenticule extraction (SMILE) • refraction stable 3 months • meets Class 1 standard • no unwanted symptoms or post-operative effects, such as: – decrease in best corrected visual acuity – pain or raised intra-ocular pressure – corneal aberrations, haze or ulcers – blurred vision, glare, flare or halos – reduced night vision – altered colour perception – reduced contrast sensitivity of no more than 2 lines using a 5% contrast sensitivity chart (aircrew only) • no need for topical eyedrops.	1
6.2	**Intraocular lens (IOL) implant.** Existing ophthalmologist report. Class 1 if all following: • no complications • no risk to corneal integrity • risk of late cystoid macular oedema abated • no restrictions on activity • no issues with night vision, haloes or night driving • has final spectacle prescription • meets Class 1 standard • no need for topical eye drops.	1
	Aviation-related occupations. If non-diffractive multifocal intraocular lense (IOL), IAM to make final classification decision.	3
	Aviation-related occupations. Diffractive multifocal IOL.	4
6.3	**Phakic intraocular lens (PIOL) implant.** Risk of wound dehiscence, raised intraocular pressure and cataract development.	4
6.4	**Corneal graft surgery.**	4

Other eye conditions

Table 5K–7: Other eye conditions

Serial	Conditions and decision factors	Class
7.1	**Lid abnormality.** Meets Class 1 standard and does not impair vision or protection of the eye. If doubt, request report from treating practitioner.	1
7.2	**Exophthalmos.** If familial, report from treating practitioner. Meets Class 1 standard and no ongoing treatment.	1
	Non-familial exophthalmos.	4
7.3	**Night blindness.** True night blindness is Class 4. However, if doubt about whether it is true night blindness, refer for ophthalmology opinion.	4
7.4	**Tumour or growth.** See Annex 5P—Malignancy.	n/a

ANNEX 5L

DERMATOLOGICAL SYSTEM ENTRY STANDARD

Individual capability requirements

1. Candidates need to be able to manage any dermatological condition they may experience with the exposures relevant to general military duties and their job preference. Exposure may involve:

a. working, exercising and resting in dusty, dirty, humid, hot, cold, damp, windy and sunny conditions with limited access to bathing and washing facilities

b. wearing uniforms, military footwear, webbing, packs, body armour, masks, combat equipment, personal protective equipment and job-specific equipment

c. contact with substances such as adhesives, resins, camouflage cream, chromate, clothing dyes, gun oil, metals, insect repellents, rubbers, thiomersal, industrial preservatives and rubber ingredients.

Recruiting Medical Class 1 standard

2. Candidates with a dermatological condition may be considered Class 1 if all of the following apply:

a. asymptomatic or minimal symptoms and / or localised signs

b. condition does not impair thermoregulation or skin integrity

c. condition stable and its management is compatible with deployed health capability

d. condition unlikely to impair ability to undertake general military and role-specific duties, inclusive of wearing military uniforms and equipment, such as camouflage fatigues, boots, helmets, face masks, combat body armour and personal protective equipment

e. condition unlikely to be significantly exacerbated in the military environment.

Recruiting Medical Class 4 standard

3. Candidates are medically unsuitable for Australian Defence Force (ADF) entry (Class 4) if any of the following apply:

a. function is likely to be impaired in the military environment or there is a history of impairment

b. there are chronic symptoms or signs visible (eg generalised skin involvement or impairment of skin integrity)

c. treatment requirements are not compatible with deployed health capability

d. specialist review required more frequently than 12 months

e. condition likely to be significantly exacerbated in the military environment.

Medical reports

4. Where required, copies of existing medical reports may be requested to inform the medical suitability decision. If additional information is needed, a current report and/or specialist opinion may be requested (Class 3R pending the report).

CONDITIONS OF INTEREST

Acne

5. Acne is common in adolescents and young adults and it is generally controllable or curable with medical treatment.

Table 5L–1: Acne

Serial	Conditions and decision factors	Class
1.1	**Acne.** Treatment compatible with deployed health capability.	1(a)
	Aviation-related occupations, divers, submariners. If acne poses potential impediment to wearing job-specific mask, Institute Aviation Medicine (IAM), senior medical adviser - diving medicine (SMA DIVMED) or senior medical adviser – submarine medicine (SMA SUBMED) (as relevant) to make final classification decision.	3

Note:

(a) Military employment classification (MEC) * recommend J11 if managed with over-the-counter products. If managed with prescription medicines, *recommend MEC J22 (P3 Army) with restrictions 4–1, 4–4, 4–11.

Sweating disorders

6. The ability to sweat is required for effective thermoregulation. Heat-related illness may be a risk for candidates with a sweating disorder.

Table 5L–2: Sweating disorders

Serial	Conditions and decision factors	Class
2.1	**Anhidrosis or hypohidrosis – localised.** Extant reports. No history of heat-related illness, <40% body surface area involved, no history of a related dermatologic/neurological syndrome. If doubt, refer to dermatologist for a starch-iodine test to determine the extent of body surface area involved.	1[(a)]
	Anhidrosis/hypohidrosis – generalised.	4
2.2	**Hyperhidrosis – localised.** If meets Class 1 standard.	1[(a)]
	Hyperhidrosis – generalised.	4

Notes:

(a) *recommend eg MEC J11 if managed with over-the-counter products. If managed with prescription medicines, assign MEC J22 (P3 Army) with restrictions 4–1, 4–4, 4–11.

Inflammatory conditions

7. Inflammatory conditions are of concern in the military environment as they may be associated with functional impairment, breakdown in skin integrity or significant treatment requirements.

Table 5L–3: Inflammatory conditions

Serial	Conditions and decision factors	Class
3.1	**Contact dermatitis, atopic dermatitis, eczema.** Meets Class 1 standard.	1[(a)]
	Class 4 for dermatitis/eczema if any of the following: • Class 1 standard not met • Treatment requirement not compatible with deployed health capability.	4
	Aircrew/ATC: Any eczema	4
3.2	**Palmoplantar dermatoses.** Meets Class 1 standard.	1[(a)]
	Class 4 for palmoplantar dermatoses if any of following: • Class 1 standard not met • skin integrity significantly impaired (eg hyperkeratotic, fissured, dry and/or irritable).	4
3.3	**Psoriasis.** Meets Class 1 standard.	1[(a)]
	Class 4 for psoriasis if any of following: • Class 1 standard not met • treatment requirement not compatible with deployed health capability.	4
	Divers/ submariners: Any psoriasis.	3R
	Aircrew/ATC: Any psoriasis	4
3.4	**Photosensitivity.** Meets Class 1 standard. Condition managed with routine skin protection, brimmed hat and sunscreen and normal military dress.	1
3.5	**Hidradenitis suppurativa.** May be associated with significant impairment and risk of recurrence and chronicity.	4
3.6	**Latex sensitivity.** See Annex 5O.	N/A
3.7	**Rash or reaction suggestive of allergic condition.** See Annex 5O.	N/A
3.8	**Urticaria.** See Annex 5O.	N/A

Note:

(a) * recommend MEC J11 if managed with over-the-counter products. If managed with prescription medicines, *recommend MEC J22 (P3 Army) with restrictions 4–1, 4–4, 4–11.

Other dermatology-related conditions

8. ADF service can exacerbate conditions of the skin because of periods of poor hygiene, occlusive clothing and equipment, hot/humid conditions and wearing of personal protective equipment. Heat, friction, sweating and open skin lesions can cause pain, discomfort, bleeding, discharge and secondary infection with impairment of ability to undertake military and job role duties.

Table 5L–4: Other dermatology-related conditions

Serial	Conditions and decision factors	Class
4.1	**Boils/carbuncles – recurrent, untreated or unresolved.** Class 3T until meets Class 1 standard.	3T
4.2	**Pilonidal sinus or cyst.** Asymptomatic, no history of inflammation or infection, no discharge, meets Class1 standard.	1
	Treated pilonidal sinus, cyst or disease. Existing report confirms fully resolved (eg asymptomatic with no signs of inflammation, infection or discharge) with low risk of recurrence. Treatment complete a minimum of 3 months.	1
	Chronic pilonidal sinus, cyst or disease (eg recurrent or persistent inflammation, infection or discharge).	4
4.3	**Tinea or fungal infection.** Meets Class 1 standard.	1[(a)]
4.4	**Warts and plantar warts.** Meets Class 1 standard. See Annex 5D for genital warts	1[(a)]
4.5	**Piercing.** Not disqualifying on medical grounds unless there is functional impairment. If candidate unwilling to remove piercing when on duty to comply with ADF dress code, refer to senior military recruiting officer.	N/A
4.6	**Tattoos.** Not disqualifying on health grounds. If potential incompatibility with ADF dress code, refer to senior military recruiting officer.	N/A
4.7	**Skin cancer or tumours.** See Annex 5P.	N/A

Note: *Recommendation only as per paragraph 5.11

(a) *recommend MEC J11 if managed with over-the-counter products. If managed with prescription medicines, *recommend MEC J22 (P3 Army) with restrictions 4–1, 4–4, 4–11.

ANNEX 5M

HAEMATOLOGICAL ENTRY STANDARD

CRITERIA FOR DECISION-MAKING

Individual capability

1. The demands of military service may exacerbate existing conditions of the blood and lymphatic system, and significantly reduce a member's operational performance. Extended or remote deployments may preclude members from accessing specialist clinical or material support required to manage their condition. Defence Health Manual (DHM) Level 2 Part 5 Chapter 1[137]—'Medical classification of candidates' provides an overview of the capability requirements for each Service. Critical capability requirements relevant to the haematological system are:

a. marching, running and standing for extended periods

b. strenuous physical activity in adverse conditions

c. firefighting, damage control and casualty handling.

2. When assessing haematological conditions, medical officers (MOs) should consider the following:

a. aetiology and co-existing conditions

b. functional impact

c. likelihood of complications

d. likelihood of progression

e. any physical activity restrictions

f. requirement for or frequency of review, medication, or other interventions.

Class 1 criteria

3. Unless otherwise specified, candidates should be considered Class 1 for the haematological system when all the following apply:

a. no or insignificant functional impairment

b. asymptomatic

c. specialist review required not more frequently than three monthly.

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4. Where candidates are medically suitable for Defence entry but require haematological surveillance or monitoring, requirements are to be on Form AD363—'Medical attestation declaration' using employment restriction 4–3 or 4–11 (as relevant), specifying the medical/specialist review period.

Class 4 criteria

5. Candidates are medically unsuitable for Defence entry (Class 4) if the condition:

a. has significant, intractable symptoms that are progressive in nature

b. may cause acute impairment of function, exercise intolerance, or restricted physical activity.

Medical reports

6. Where clinically relevant, copies of existing medical reports may be requested to confirm a diagnosis and inform the medical suitability decision. If further information is needed, a current report from a haematologist may be requested (Class 3R pending report).

CONDITIONS OF INTEREST

Conditions of the haematological system

7. Anaemia may impair physical performance, reduce endurance, and affect cognitive function. This may limit the operational readiness and wellbeing of members.

8. Regular screening and appropriate management (including nutritional support, targeted interventions, and strategies to minimise underlying causes of anaemia) are essential to maintaining members' optimal health and performance. In absence of secondary complications, treatment that normalises a candidate's haemoglobin will not affect recruitment.

Table 5M–1: Anaemias

Serial	Conditions and decision factors	Class
1.1	**Anaemia with or without iron deficiency**. Class 1 if: • meets all Class 1 criteria	1
	Aviation related roles. Cause must be understood and treated.	3
1.2	**Vitamin B12 deficiency anaemia (Pernicious Anaemia).** Class 1 if: • meets Class 1 criteria • normal haemoglobin • normal B12 values or existing treatment plan.	1
	Aviation related roles. Normal haemoglobin and active B12 values.	1

Serial	Conditions and decision factors	Class
1.3	**Folate deficiency**. Class 1 if: • meets Class 1 criteria • normal haemoglobin.	1
	Aviation related roles. Cause must be understood and folate value normalised.	1
1.4	**Anaemia of Chronic Disease.** Class 1 if: • meets Class 1 criteria • underlying condition meets the relevant annex • normal haemoglobin.	1
	Otherwise.	4
1.5	**Aplastic Anaemia**	4

9. Haemoglobinopathies are genetic disorders affecting structure or production of haemoglobin, and may have an increased risk of anaemia, vaso-occlusive crises, and organ damage. This can detrimentally affect health and performance of members. Where management supports a candidate's function and minimises risk of secondary complications they may be suitable for recruitment.

Table 5M–2: Haemoglobinopathies

Serial	Conditions and decision factors	Class
2.1	**Benign haemoglobinopathies: D, E, O-Arab.** Class 1 if: • meets Class 1 criteria • asymptomatic • normal haemoglobin or mild anaemia only • no associated complications • no greater than mild splenomegaly on physical examination.	1
	Otherwise	4
2.2	**Thalassaemia minor/trait (heterozygous: alpha, beta).** Existing report <24 months. Class 1 if: • meets Class 1 criteria • asymptomatic • normal haemoglobin or mild anaemia only • no associated complications • no greater than mild splenomegaly on physical examination.	1
	Otherwise	4
2.3	**Thalassaemia major (homozygous: alpha, beta).**	4
2.4	**Haemoglobin S.**	4
2.5	**Sickle cell trait (heterozygous).**	1
	Aviation, divers and submariners.	3R
2.6	**Sickle cell disease (homozygous).**	4

Serial	Conditions and decision factors	Class
2.7	**All other haemoglobinopathies.**	4

10. Members with underlying coagulopathies are at risk of exacerbation from trauma, exertion, or injury. Further, anticoagulant or antiplatelet therapies may result in excessive bleeding which poses significant risk to members.

Table 5M–3: Haemorrhagic Disorders

Serial	Conditions and decision factors	Class
3.1	**Haemophilia A (Factor VIII).**	4
3.2	**Haemophilia B (Factor IX).**	4
3.3	**Deficiency of factors II, V, VII, X, XI, XIII**	4
3.4	**von Willebrand's disease.** If diagnosed, existing haematology report within last 24 months. Class 1 if: • meets Class 1 criteria • associated complications (menorrhagia, epistaxis) meet the relevant standard • no history of haemarthrosis, or haemorrhage as a post-operative complication • no current anaemia • platelet count (>100x10^9/L) • no existing requirement to carry desmopressin.	3R/1
	Aviation related roles. If epistaxis, no recurrence for 12 months following cauterisation.	1
	Otherwise	4
3.5	**Immune thrombocytopaenia.** Current haematology report unless diagnosis was childhood (<18 years of age). Class 1 if: • meets Class 1 criteria • associated primary condition or complications meet the standard for associated condition • duration of episode <12 months • resolved ≥ 12 months prior • no ongoing therapy for ≥ 12 months • platelet count (>100x10^9/L) • spleen present.	3R/1
	Aviation related roles. Adult (≥ 18 years old) onset immune thrombocytopenia	4
	Otherwise	4
3.6	**Current anticoagulant prophylaxis or treatment.** Historical anticoagulation should be assessed to the relevant annex for the underlying condition.	3R/1/4

11. Members are at risk of exacerbation of thrombophilic disorders via prolonged exposure to risk factors such as physical inactivity, altitude, and trauma.

Table 5M–4: Hypercoagulable states

Serial	Conditions and decision factors	Class
4.1	**Inherited hypercoagulable states – Factor V Leiden.** If diagnosed, existing haematology report within last 24 months. Class 1 if: • meets Class 1 criteria • no history of thrombotic or embolic disease.	3R/1
	Aviation, divers, and submariners	4
	Inherited hypercoagulable states – other	4
4.2	**History of unprovoked thrombosis**. (ie one that occurs in the absence of identifiable risk factors).	4
4.3	**Recurrent progressive venous and arterial thromboembolism.** May occur in the following: • Antithrombin III deficiency • deficiencies of Protein S (deficiency of Protein C is asymptomatic) • fibrinolytic system deficiencies • dysfibrinogenaemia • resistance to Activated Protein C.	4

Table 5M–5: Malignancy

Serial	Conditions and decision factors	Class
5.1	**Haematological Malignancy**	See Annex 5P

12. Hyposplenism poses significant risk to members due to the potential susceptibility of severe infections, particularly from encapsulated bacteria, which may lead to higher risk of life threatening conditions such as overwhelming post-splenectomy infection.

Table 5M–6: Spleen

Serial	Conditions and decision factors	Class
6.1	**Splenectomy or history indicative of functional asplenia**	4

13. Haemochromatosis is a hereditary disorder characterised by excessive iron absorption and deposition into the body's tissues. If untreated, long-term iron accumulation may result in significant damage to organs such as the liver, heart, and pancreas. Although symptomatology may result in acute reductions of performance and wellbeing, regular screening and appropriate management are not barriers to entry.

Table 5M–7: Iron overload

Serial	Conditions and decision factors	Class
7.1	**Haemochromatosis – Heterozygous**	1

Serial	Conditions and decision factors	Class
7.2	**Haemochromatosis – Homozygous** Class 1 if: • meets Class 1 criteria • no chronic complications secondary to the condition.	1
	Aviation related roles. Normal test results for: echocardiogram, upper abdominal ultrasound, TFT, LFT, fasted BGL, HbA1c, prolactin, androgen testing; and venesection cadence of >3 months (quarterly venesections tolerated).	1
	Otherwise	4

14. Glucose-6-phosphate dehydrogenase (G6PD) deficiency is an inherited enzymatic disorder characterised by acute exacerbations in response to particular medications, infections, or oxidative stressors (which are prevalent in military environments). Acute exposure may result in haemolytic episodes that impair performance and compromise health and wellbeing. It is crucial that members are aware of their G6PD status and take precautions to avoid triggers and their resulting complications.

Table 5M–8: Other

Serial	Conditions and decision factors	Class
8.1	**G6PD deficiency**	1

ANNEX 5N

INFECTIVE CONDITIONS OF ENTRY

1. Chronic, intractable infections may be aggravated by the requirements of military service. Candidates should be assessed in accordance with the serials below, recognising the majority of infective conditions are reversible with no enduring complications that affect an individual's function.

INDIVIDUAL CAPABILITY REQUIREMENTS

2. Medical officers (MO) assessing infective conditions should consider: aetiology and any co-existing conditions, functional impact, risk of complications or progression, physical activity limitations, requirement and frequency of specialist review, requirement for medication, and the potential need for interventions in the short, medium, and long term.

3. Where relevant, existing medical reports may inform the Defence Force Recruiting (DFR) MO decision. If further information is required for progressive conditions, specialist opinion should be obtained and candidate classed 3R. Candidates experiencing any new symptoms since the existing report should be referred for review as indicated.

4. **Blood-borne Viruses (BBV).** All candidates are tested prior to enlistment to exclude active disease and check for immunity. Chief MO (CMO) DFR is to ensure each candidate is tested for bloodborne virus (BBV) infection, and inform each candidate that they may be expected to undergo testing at other times such as prior to or after deployment in accordance with Information Sheet 8-1[138]—'Bloodborne viruses'. Candidates may refuse testing.

CONDITIONS OF INTEREST

Table 5N–1: Bacterial

Serial	Conditions and decision factors	Class
1.1	**Syphilis: Treated.** Initial treatment commensurate with respective stage (Early/Latent) complete.	1
	Otherwise.	4
1.2	**Tuberculosis.** See Annex 5B, serial 3.1	N/A

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Table 5N–2: Parasitic

Serial	Conditions and decision factors	Class
2.1	**Chronic, intractable parasitic infection.** • Requires regular medication and specialist care.	4

Table 5N–3: Viral

Serial	Conditions and decision factors	Class
3.1	**Hepatitis A Virus (HAV).** Is a self-limiting disease followed by full recovery. Class 1 if: • Recovered	1
	Otherwise.	4
3.2	**Hepatitis B Virus (HBV) infection – Acute.** Class 3T for 12 months to allow for assessment and (any) treatment • Class 1 if clearance confirmed (HBsAg negative) and no complications.	3T 1
	Otherwise.	4
3.3	**HBV infection – Chronic, undergoing treatment.** Review reports from treating clinician. Class 1 if meets all the following: • HBeAg negative, or • Sustained (6 months) HBV deoxyribonucleic acid (DNA) level i.e <20 IU/ml • no significant adverse effects from treatment • no secondary complications from the infection. (no cirrhosis, normal liver function tests (LFTs)).	1 MEC J23
	HBV infection – Chronic, immune control. Review reports from treating clinician. Class 1 if meets all the following: • HBeAg negative • HBV DNA level low i.e (< 20 IU/ml) • no secondary complications from the infection. (no cirrhosis, normal LFTs).	1
	HBV infection – Chronic, do not meet criteria for treatment. • BHBsAg positive • HBeAg positive • HBV DNA level high (ie >2000 IU/ml)	4
	Otherwise.	4
3.4	**Hepatitis C Virus (HCV) infection – Acute.** Class 3T for 24 weeks post infection to allow for assessment and treatment (12 weeks), and confirmation of cure 12 weeks post treatment • Class 1 if clearance confirmed and no complications	3T 1

Serial	Conditions and decision factors	Class
	Otherwise.	4
3.5	**HCV infection - Treated.** With the advent of direct acting antivirals, chronic HCV infection is rare. Treating clinician reports should be reviewed and the candidate may be Class 1 if meets all the following: • HCV ribonucleic acid (RNA) negative • No cirrhosis • Normal LFTs.	1
	Otherwise.	4
3.6	**Hepatitis D Virus (HDV). Specialist report.** Class 1 if meets all the following: • Anti-HDV • No cirrhosis • Normal LFTs • Meet the relevant Hepatitis B serial where there is co-infection.	1
	Otherwise.	4
3.7	**Hepatitis E Virus (HEV) Infection - Acute.** Is normally a self-limiting disease followed by full recovery. Class 1 if: • Recovered • Normal LFTs.	1
	Hepatitis E Virus (HEV) Infection – Chronic. Specialist report, Class 1 if: • Specialist confirmed clearance • Recovered • Normal LFTs.	1
	Otherwise.	4
3.8	**Hepatitis G.**	4
3.9	**HIV infection.** Candidates may be Class 1 if receiving treatment in accordance with Australian Guidelines and their treating clinician (s100 prescriber) confirms all the following: • Clinically and immunologically stable (clusters of differentiation 4 (CD4) cell count >200 /mircoL for more than two years • undetectable viral load (RNA test) • normal biochemistry • no adverse effects from treatment • no identified secondary complications from infection.	3R 1 MEC J23
	Otherwise.	4

Table 5N–4: General

Serial	Conditions and decision factors	Class
4.1	**Post-viral fatigue >3 months – infective causes not otherwise stipulated, including long COVID-19.** Treating clinician report. Class 1 if: • Asymptomatic for 6 months post recovery • Any treating clinician reports confirm diagnosis and asymptomatic status.	1
	Ongoing symptoms.	4
4.2	**Chronic lethargy.**	4
4.3	**Immune deficiency.** Increased risk of infection.	4
4.4	**Any other current infectious diseases.** Seek advice from CMO DFR.	3T/3R

ANNEX 5O

SYSTEM SPECIFIC REASONS FOR REJECTION— ALLERGIC SYSTEM AND DIETARY RESTRICTIONS

1. **General.** Allergy problems have become more prominent in the last few years and doubt may exist as to whether a candidate is fit for enlistment when they give a history of allergic-type symptoms or specific conditions. Anaphylaxis is an acute, potentially life-threatening, allergic emergency resulting from precipitous allergen-induced, IgE mediated (via cross-linage of IgE molecules on the cell membrane) release of chemical mediators from mast cells and basophils. An anaphylactoid reaction is a clinical response similar to anaphylaxis but not caused by IgE mediated allergic reaction. The mechanism usually involves non-specific triggering of mast cells either by complement or an unknown mechanism. Most of the conditions below are Class 4 because regular medication and specialist care are required and render the candidate non-deployable from the outset. Recent ill-defined illnesses, attributed in part to 'allergy', without consistent criteria have been renamed Idiopathic Environmental Intolerances (IEI). This avoids the assignment of aetiologies to the symptom complexes. The potential of an adverse outcome from anaphylaxis in the deployed environment must be given serious consideration.

Conditions of the allergic system and dietary restrictions

Table 5O–1: Anaphylaxis

Serial	Condition	Consideration	Class
1	**Systemic anaphylaxis** is characterised by the presence of two or more of urticaria, angioedema, bronchospasm, gastrointestinal (GIT) symptoms and hypotension.	Common triggers include food, stings, medication. Potentially life threatening condition requiring urgent medical treatment.	N/A
1.1	**Food anaphylaxis.** Common foods include: shellfish, true nuts, peanuts (a legume), eggs, dairy products, and fish. Estimated prevalence ranges from eight per cent in young children to one per cent in adults. Peanut allergy is the most frequent cause of fatal anaphylaxis and people generally do not grow out of this allergy.	Minute quantities, including peanut oil, are enough to induce an attack. Peanut contamination of other foods is a risk.	4

Serial	Condition	Consideration	Class
1.1.1	**Food anaphylaxis** as a child with full resolution	Must be proven with specialist testing and specialist report.	3R/1
1.1.2	**Food allergy**—less severe than anaphylaxis.	Would depend on reaction time, severity and whether the foodstuff is commonly consumed, including in ration packs.	3R/1/4
1.2	**Latex sensitivity.** Three types: • Immediate allergic reactions to latex (type 1 hypersensitivity reaction (anaphylaxis). • Irritant dermatitis. • Contact allergic dermatitis. Prevalence of latex sensitivity among health care workers is 10 per cent. People with latex allergy have a higher incidence of food allergy particularly, bananas, avocado, kiwi fruit, chestnuts, pear, pineapple, grape, apricot and papaya. Latex allergy cannot be 'turned off'. The only treatment is careful avoidance.	**Additional information required:** • Wherever an candidate provides a history consistent with or suspicious of latex sensitivity of any type, the candidate will require assessment by an allergist associated with formal testing. • Investigations may include skin prick test and blood tests for latex-specific IgE antibody radioallergosorbent test.	N/A
	Past history of type 1 hypersensitivity reaction to natural rubber latex (NRL).	The ADF cannot guarantee a latex-safe environment in tactical settings. Therefore candidates with a known or proven latex allergy must be excluded from deployment to a remote area.	4
	Known clinical or occupational history of exposure to NRL including need for a job change.	Decision	4
	History of irritant dermatitis or allergic contact dermatitis to latex.	Decision	4

Serial	Condition	Consideration	Class
	Where a candidate has had a single, mild, self-limiting response to a latex product in the past.	These candidates may be considered fit for entry subject to allergist assessment and testing. Such candidates must be excluded from high risk occupational exposures including, but not limited to health care, food handling/preparation, or any trade where there is a requirement to wear protective gloves. If the candidate is enlisted or appointed to the ADF, the sensitivity is to be recorded on the attestation medical refer Defence Health Manual (DHM) Level 3 Part 5 Chapter 1[139]— 'Medical records', annex 1B paragraph 5.	3R
1.3	**Medication-induced anaphylaxis**	Where a candidate has history of severe acute reaction/anaphylaxis to medication. Risk of anaphylaxis due to inadvertent administration of medication.	4
	Less severe allergic reaction with a good history of rash/non-life-threatening reaction.	**Additional information required**: • Needs to be documented with evidence of relevant skin testing and GP or allergist report.	3R/1
	If poor/vague history or history of possible rash	Report from GP detailing where known: • time between taking drug and reaction • nature of reaction • resolution of the reaction • any other drugs at the same time • other underlying conditions.	3R/1

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Serial	Condition	Consideration	Class
1.3.1	**Aspirin anaphylaxis**	Most common cause of non-IgE-mediated anaphylaxis. Aspirin may also cause an excess leukotriene-dependent asthma with nasal polyposis. Incidence in normal population—one per cent, higher in those with asthma/hives sinus disease.	4
1.4	**Venom-induced anaphylaxis**	Most common insects that cause reactions are the Hymenoptera order: • Honeybees, bumblebees (Apidae). • Hornets and wasps (Polistae). • Fire ants and harvester ants (Formicidae). • Jumper ants (Myrmecia pilosula). • Differentiate between: • minor local swellings • large local reactions • systemic reactions.	N/A
	Less severe reactions	Minor or moderately large local reactions.	3R/1
	Severe reactions	Decision	4
1.5	**Exercise anaphylaxis**	Exercise-induced anaphylaxis typically affects young adults. May cause: itch, urticaria, angioedema, bronchospasm, sweating, or syncope. Some experience symptoms with exercise alone; others will only do so if allergenic foods are ingested around the same time.	4
1.6	**Idiopathic anaphylaxis**	In 30–40 per cent of cases of recurrent anaphylaxis no cause is identified. Syndrome features are recurrent urticaria, angioedema of upper airways, bronchospasm and hypotension. Requires specialist care and access to emergency facilities.	4
1.7	**Other drug reactions**	N/A	N/A

Serial	Condition	Consideration	Class
1.7.1	**Radiocontrast media reactions**	Use of low-osmolality contrast agents has reduced reaction rate to less than one per cent in previously high risk people (pre-treatment with steroids required).	3R
1.7.2	**Succinylcholine (scoline) sensitivity—low** pseudocholinesterase Some individuals have reduced pseudocholinesterase required to metabolise scoline. This condition affects about one in 1500 and decreases scoline inactivation. When conventional doses of scoline are given, prolonged paralysis ofthe respiratory muscles results. Persistent apnoea may require mechanical ventilation until the drug can be eliminated by alternate pathways.	During deployments with coalition forces access to emergency health support is such that a known sensitivity to scoline may not be transparent to other health care providers. If scoline was used as an emergency drug for intubation, the consequences in such circumstances would need to be anticipated.	3R
	Succinylcholine (scoline) sensitivity—low	**Additional information required:** • If any history of scoline sensitivity, the candidate must be referred to a specialist anaesthetist for assessment (including blood testing of pseudocholinesterase levels) and report. If diagnosis is confirmed the candidate may be enlisted provided there is no past history of a life threatening event associated with general anaesthesia.	3R
		If criteria above not met.	4
		If the candidate is appointed or enlisted into the ADF the history must be annotated on the attestation Medical See DHM Level 3 Part 5 Chapter 1, Annex 1B paragraph 6.	N/A

Table 5O–2: Desensitisation

Serial	Condition	Consideration	Class
2.1	**Immunotherapy**—effective for the treatment of inhalant allergies and bee or wasp stings. Effective treatment for allergic rhinitis, selected patients with asthma and the majority of patients with venom allergy. The prevalence of anaphylaxis to bee stings in Australia is high at 2.7 per cent.	Requires schedule of injections in specialist centre until maintenance dose is reached (four to six months). Continue maintenance doses, monthly with GP for three to five years. Protective in more than 80–90 per cent of individuals in preventing future severe reactions.	N/A
	Program—full and completed.	Requires specialist review.	3R
		May be acceptable following treatment if there is no requirement for medication and no geographic limitations.	1
	Still to complete full program/incomplete program in the past or requires lifelong maintenance treatment.	Requires long-term treatment if still undergoing desensitisation.	4
2.2	**Food intolerance, including coeliac disease** (proline-glutamic acid sensitised, T-lymphocyte dependent enteropathy)	See also GIT, Annex 5C, serial 8.1.	4

Table 5O–3: Urticarias and angioedemas

Serial	Condition	Consideration	Class
3.1	**Physical urticarias.** Includes: • dermatographism • pressure/vibratory urticaria • cold urticaria • solar urticaria • heat urticarial • cholinergic urticaria.	• *Dermatographism* (factitious urticaria) occurs in five per cent of population following minor trauma. • *Pressure/vibratory urticaria* may occur immediately or 24 hours later after pressure, eg enthusiastic clapping inducing painful and swollen hands. • *Cold urticaria* following wind, cold, rain, low ambient temperatures, holding cold objects, swimming in cold water. • *Solar urticaria* occurs mainly in females on exposure to blue light (wavelengths that pass through glass barriers) and ultraviolet light. May be benign or associated with serum lupus erythematosus. • *Heat urticaria* examples include wet-suit-induced urticaria and febrile urticaria. • *Cholinergic urticaria* usually due to sweating, hot showers, exercise and emotional stress.	N/A
	If severe and time off work or school, steroids required.	Decision	3R
	Minor symptoms	Decision	3R/1
	Physical urticarias	**Aircrew/divers** • Any history.	4
3.2	**Urticaria and angioedema**	Common causes: • Antibiotics, other drugs, transfusions. • Shellfish and nut ingestion. See serial 1.1. • Hymenoptera stings. See serial 1.4. • Sea urchins, Portuguese man-of war. • Jumper ants (Myrmecia pilosula) stings. • Animal dander contact. • Latex protein contact. • Viruses ie Hepatitis B Virus, Hepatitis C Virus. • Bacteria ie Streptococcus.	N/A
	Acute	Severe	4
		Infrequent and not life-threatening	3R/1
	Chronic: Severe	Requires regular medication and specialist care.	4

Serial	Condition	Consideration	Class
	Chronic: Less severe	If regular medication and specialist care is not required, or treatment is with simple antihistamines.	3R/1
3.3	**Angioedema (without urticaria):** Hereditary	Frequently inherited as autosomal dominant.	4
	Angioedema (without urticaria): Acquired (eg malignancy associated)	Less frequently an acquired defect associated with lymphoma and the chronic leukaemias.	4
3.4	**Dermatitis and other allergic skin**	See Annex 5L	N/A

Table 5O–4: IEI

Serial	Condition	Consideration	Class
4.1	**Multiple Chemical Sensitivity Syndrome**	• Symptoms on exposure to chemicals usually in the workplace, that are present in trace amounts. • Lack of objective evidence by all modes of investigation of these polysymptomatic patients. • Manifestations of anxiety, somatisation, conversion and phobias.	4
4.2	**Candidiasis Hypersensitivity Syndrome** Symptoms attributed to infection with C.Albicans or toxins thereby produced.	Rarely do people have objective evidence of candidiasis; however, yeast-free diets (free of Saccharomyces, not Candida species) sometimes produce dramatic results. However, yeast free diets cannot be accommodated in the ADF. In the deployed environment personnel may be required to consume combat ration packs, or emergency rations or have limited meal selection.	N/A
	If symptoms severe or a yeast-free diet required.	Decision	4
	If symptoms for one or two days per year.	Must have no special dietary requirements	3R/1
4.3	**Sick Building Syndrome**	Reflects a constellation of multi-system symptoms attributed to exposure to bio-aerosols in the indoor environment. Includes humidifier fevers, building-related dermatitis, and a plethora of infectious syndromes.	4

ANNEX 5P

SYSTEM SPECIFIC REASONS FOR REJECTION—MALIGNANCY

1. **General.** Anyone with a history of malignancy at any time in their lives is subject to possible recurrence or complications of their condition or its treatment. They may also be at a higher risk of a new and unrelated malignancy. The need for specialist review and possible investigations is not considered compatible with military life.

2. **Diver candidates.** No candidate who has previously been treated with Bleomycin is to be accepted as a diver in the Australian Defence Force (ADF) due to the risk of respiratory failure with hyperbaric oxygen.

Malignant conditions

Table 5P–1: Active malignant conditions

Serial	Condition	Consideration	Class
1.1	**All current malignant conditions**	• Regular medical review and investigation to assess the risk of recurrence. • Periodic review at tertiary specialist clinics which may also be required to provide treatment. • Morbidity associated with interval chemotherapy and radiotherapy modalities. • Possibility of surgical intervention. • Unresponsiveness requiring palliative care measures. • Overall prognosis, short and long term.	4

Table 5P–2: Malignant Condition now in remission

Serial	Condition	Consideration	Class
2.1	**Cervical cancer**	See also Annex 5E—‘Carcinoma in situ’.	4
	Treatment completed	The prognosis for patients is markedly affected by the extent of disease at the time of diagnosis.	4
		Additional information required: An appropriate specialist or oncologist report.	3R
		Decision. May be acceptable if: • Stage 1 • more than five years post-treatment • with no recurrence	1

Serial	Condition	Consideration	Class
2.2	**Testicular cancer** Two broad categories—seminoma and non-seminoma.	Good prognosis depends on stage, absence of tumour markers, abdominal computed tomography scan free of masses and normal respiratory function tests.	
		Additional information required: • A specialist or oncologist report.	3R
		Decision. May be acceptable if: • Stage I or II • more than five years since diagnosis • normal tests as above.	1 / 4
2.3	**Leukaemia**	NA	N/A
	Adult leukaemia chronic and acute	Decision	4
	Childhood acute lymphocitic leukaemia with no recurrence	**Additional information required:** An appropriate specialist or oncologist report.	3R
		Decision. Acceptable only if: • condition responded rapidly to treatment • treatment did not include cyclophosphamide • treatment concluded more than five years ago.	1/4
2.4	**Non Hodgkin's lymphoma**	Decision	4
2.5	**Hodgkin's disease** Diagnosis and treatment in last five years.	Decision	4
	Treatment with radiation therapy and/or chemotherapy and disease free off treatment for five years.	Note risk of toxicity related to treatment. Pulmonary and cardiac toxicity. Peripheral neuropathy. Second malignancies related to chemotherapy.	3R/1
2.6	**All other malignant conditions in remission**	Decision	4
2.7	**Chemotherapy treatment**	Any candidate who has had a condition needing any therapeutic chemotherapy agent requires specialist assessment to determine if the condition is cured, and there are no residual side effects from drug treatment.	3R/4
		Divers • Candidates who have been treated with Bleomycin are unfit for ADF diving due to the risk of respiratory failure with hyperbaric oxygen	4

Serial	Condition	Consideration	Class
		Divers • Submarine Underwater Medicine Unit is to be consulted to discuss any other chemotherapy drugs. Cardiology review may be required.	3R

Table 5P–3: Skin cancer

Note:

(a) Service personnel must work outdoors at times for long periods. Although sunscreens are provided, ultraviolet (UV) exposure generally, is greater than expected in most civilian employments. ADF duty of care precludes it from exposing personnel to excessive UV and causing further skin cancers.

Serial	Condition	Consideration	Class
3.1	**Squamous Cell Carcinoma (SCC)**	SCC has definite metastatic potential and these patients should be re-examined every three months for the first several years and then indefinitely at six-month intervals.	3R/4
3.2	**Basal Cell Carcinoma (BCC)**	BCC risk is related to sun exposure as a child and adolescent as well as cumulative UV exposure. Once one BCC has occurred there is a high risk of further BCCs. The three-year cumulative risk is estimated at 33–77 per cent. Risk is dependent on number of BCCs. Those with truncal BCCs appear to be at increased risk of developing further lesions. Also increased risk of developing other skin cancers such as SCCs and melanoma. Favourable outcome depends on prompt identification and excision/treatment.	NA
	Less than four BCCs completely excised with no recurrence	Requires dermatologist report.	3R/1
	Multiple lesions (more than four) or truncal lesions	**Additional information required:** • Dermatological opinion to verify the removal of lesions and to exclude the presence of untreated lesions.	3R
		Untreated lesions are to be removed and healed prior to entry.	3T/1
3.3	**Malignant Melanoma**—refer National Health and Medical Research Council Clinical Guidelines.	Prolonged operational exposure to sunlight in a tropical or sub-tropical environment may increase the risk of a second primary melanoma in a susceptible individual.	N/A

Serial	Condition	Consideration	Class
	Tumours less than 1 mm thick	To be assessed by a specialist dermatologist or tertiary centre specialising in malignant melanoma. Candidate may be fit for entry two years post-excision if no evidence of recurrence and if not considered susceptible to development of further primaries. Risk factors for recurrence include previous melanomas less than 1 mm, multiple dysplastic naevi or dysplastic naevus syndrome).	3T/3R/1
		Requires follow up with dermatologist at least yearly to examine the local area, in transit area, the draining lymph nodes and total skin surveillance. On appointment or enlistment to the ADF the requirement for annual review is to be annotated on the attestation medical (refer Defence Health Manual (DHM) Level 3 Part 5 Chapter 1[140]—'Medical records', Annex 1B, paragraph 6.	
		Requires regular medical review to monitor recurrence or development of a second primary melanoma.	4

Table 5P–4: Malignant tumours of bone and soft tissue

Serial	Condition	Consideration	Class
4.1	**Any malignant tumour of bone and soft tissue**	These include: • osteosarcoma and variants • chondrosarcoma • Ewing's sarcoma • fibrosarcoma • malignant fibrous histiocytoma • Kaposi's sarcoma • leiomyosarcoma • multiple myeloma • reticulum-cell sarcoma (non-Hodgkin's lymphoma) • liposarcoma.	4
4.2	**Metastatic bone disease**	Decision	4

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Serial	Condition	Consideration	Class
4.3	**Synovial tumours of the knee**	NA	N/A
4.3.1	**Pigmented villo-nodular synovitis**	Whilst not malignant the only effective treatment is synovectomy. Recurrence rate is high unless excision complete.	4
4.3.2	**Synovial sarcoma or malignant synovioma**	Decision	4
4.3.3	**Other tumours of bone associated with primary or secondary tumours**	Decision	4

ANNEX 5Q

MENTAL HEALTH ENTRY STANDARD

1. The assessment of candidate mental health occurs during both the entry medical and psychology assessments as follows:

a. **Medical assessment.** Defence Force Recruiting medical officers (DFR MOs) assess medical suitability for Australian Defence Force (ADF) service based on a review of any history of mental health illness, including symptoms, functional impairment, diagnosis, treatment(s) and outcome(s).

b. **Psychology assessment.** DFR psychologists assess psychological suitability for ADF service, which includes aptitude, trainability, resilience (including mental health function), person–environment fit and values in accordance with Defence Health Manual (DHM) Level 3 Part 10 Chapter 7[141]—'Psychology Services Manual (PSYMAN) – occupational suitability assessment'.

c. **Case discussion.** Health practitioners undertaking the medical and psychological assessment are encouraged to engage in case discussion as required to determine suitability for ADF service from the mental health perspective. Health practitioners are permitted to do so in accordance with the consent provided by candidates via their Form PM165—'Health questionnaire'.

Individual capability requirements

2. The ADF trains for and deploys on operations that may involve work in high-risk environments. Members need to be physically and mentally well to meet the day-to-day requirements of service. They need to be capable of working in diverse physical and social environments, where health resources may be limited and time constrained.

Recruiting medical class 1 standard

3. Unless otherwise specified in this annex, a candidate should be considered Class 1 if they have **recovered** from historical symptoms or behaviours suggestive of mental health illness.

4. For this annex, **recovered** means all of the following:

a. over the last 12 months (unless otherwise specified) the candidate has not had any of the following:

(1) symptoms or behaviours manifesting as a result of mental health illness

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(2) impairment (personal, social, occupational etc)

(3) treatment including medication, psychotherapy (including counselling) or rehabilitation.

b. low risk of recurrence (see DHM Level 3 Part 2 Chapter 9[142]—'Individual health risk assessment).

5. For aviation-related occupations, the Institute Aviation Medicine (IAM) will make the final recruiting medical classification decision for any candidate with a history of mental health illness or who discloses any symptoms suggestive of a mental health disorder.

Recruiting medical class 4 standard

6. Candidates are medically unsuitable for ADF entry (Class 4) if any of the following apply:

a. symptomatic with intermittent, recurrent or chronic mental health symptoms

b. ongoing need for treatment, inclusive of medication, psychological care (including counselling), rehabilitation or specialist review

c. ongoing impairment (personal, social, occupational etc).

Transient symptoms

7. Candidates may declare a brief episode of transient mental health symptoms for which they did not present to a health professional (eg general practitioner (GP) or psychologist) or did not receive a mental health diagnosis or treatment. In these circumstances, a relevant history should be taken and an assessment made in terms of the Class 1 and Class 4 standard.

Medical reports

8. Where required and available, historical medical or psychology reports (including for any periods of hospitalisation) may inform the medical suitability decision. In cases of doubt and where additional information is needed, MOs should consider a discussion with DFR psychology. If necessary, a current report and/or specialist opinion may be requested (Class 3R pending the report).

CONDITIONS OF INTEREST

Mood disorders

9. Mood disorders are common. They are prone to recurrence and may be exacerbated by the demands of military life, such as long working hours, sleep

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disruption, separation from supports and fatigue. The course of illness and recurrence are unpredictable. The severity of depression can be classified based on symptoms and functional impairment. The classifications are:

a. Mild depression (4–5 symptoms). The individual is able to continue with most everyday activities with only minor impairment in social or occupational function.

b. Moderate depression (6–7 symptoms). Significant social or occupational impairment with the individual experiencing considerable difficulty in completing everyday activities.

c. Severe depression (8–10 symptoms). Marked impairment (not able to undertake most day-to-day activities) and may include psychotic and somatic symptoms.

Table 5Q–1: Mood disorders

Serial	Conditions and decision factors	Class
1.1	**Major depressive disorder.** Review existing reports. Class 1 if meets Class 1 standard and all the following: • single episode • mild or moderate illness severity only • recovered >12 months • no symptoms or behaviour suggestive of hypomania or mania • no suicide attempt.	1
	Major depressive disorder involving any of the following: • ongoing symptoms (chronic or recurrent) • ongoing treatment (pharmacotherapy or psychotherapy) • more than a single episode • severe illness severity • suicide attempt.	4
	Aviation-related occupations. Any history or presence of any depressive disorder.	4
	Submariners • If mood disorder has resolved	3R
1.2	**Persistent depressive disorder (dysthymia).** Any diagnosis.	4
1.3	**Bipolar disorder**	4
1.4	**Cyclothymic disorder**	4

Anxiety disorders

10. An established anxiety disorder is indicated by the duration of symptoms, marked distress, and the impact on social relationships, academic progression and occupational functioning. Anxiety disorders may be exacerbated by military service.

11. Anxiety disorders are chronic and vary in intensity; however, evidence-based therapies[143] have been found to be effective treatment for anxiety disorders and relapse prevention over the long term.

Table 5Q–2: Anxiety disorders

Serial	Conditions and decision factors	Class
2.1	**Anxiety disorder.** Generalised anxiety disorder, social anxiety disorder (social phobia), panic disorder, agoraphobia etc. Review existing reports. Class 1 if meets Class 1 standard and all following: • recovered >12 months following evidence-based therapy • no suicide attempt.	1
	Anxiety disorder with any of the following: • comorbid with substance use disorder or depressive disorder • persistent or recurrent symptoms.	4
	Aviation-related occupations. Any history of anxiety disorder.	4
2.2	**Specific phobia.** If candidate has a diagnosed phobia, review existing reports. Class 1 if meets Class 1 standard and: • condition unlikely to manifest in military environment **and** • condition unlikely to cause risk for individual, others or ADF missions **or** • condition treated and recovered >12 months.	1
	Aviation-related occupations. If specific phobia, IAM to make final classification decision.	3
2.3	**Obsessive-compulsive disorder (OCD).**	4

Non-suicidal self-injury and suicidal behaviour

12. Non-suicidal self-injury is the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned or culturally congruent. It includes behaviours such as cutting, burning, biting and scratching skin. Deliberate self-harm with suicidal intent is to be regarded as a suicide attempt.

13. Suicidal planning refers to acts or preparation toward making a suicide attempt, but before potential harm has begun. It is the formulation of a specific method through which one intends to die (eg choosing location and date, buying rope

[143] https://psychology.org.au/for-the-public/psychology-topics/evidence-based-psychological-interventions

for a noose or stocking up on medications). A suicide attempt is a behaviour an individual has undertaken with some intent to die. The behaviour might or might not lead to injury or serious medical consequence.

Table 5Q–3: Non-suicidal self-injury and suicidal behaviour

Serial	Conditions and decision factors	Class
3.1	**Non-suicidal self-injury during adolescence (≤18 years of age).** Class 1 if meets Class 1 standard and all following: • single low-risk self-injury or several low risk injuries over a brief period of time • adaptive coping strategies, with no self-injury behaviour >24 months • minor injury with no medical sequelae.	1
	Non-suicidal self-injury – adult – cultural purposes. Class 1 if low-level self-injury as part of culturally appropriate behaviour, such as Sorry Business or similar.	1
	Non-suicidal self-injury – adult.	4
	Aviation-related occupations. Any history of non-suicidal self-injury.	4
3.2	**Hospitalisation.** Any admission for psychiatric care for non-suicidal self-injury, suicide planning or suicide attempt.	4
3.3	**Suicide planning or attempt.** Any history.	4

Trauma and stressor-related disorders

14. Acute stress disorder occurs shortly after trauma exposure. It involves a transient stress response that remits within one month, but some individuals may develop post-traumatic stress disorder (PTSD). If a candidate has a history of acute stress disorder or PTSD, they are more vulnerable to future trauma-related disorders.

15. Candidates who have completed evidence-based therapy for PTSD with sustained remission may be considered for entry if a recent psychiatrist opinion confirms illness remission for 24 months or more. Evidence-based therapies for PTSD include cognitive processing therapy, cognitive therapy, eye movement desensitisation and reprocessing, prolonged exposure, and trauma-focussed cognitive behaviour therapy.

Table 5Q–4: Trauma and stressor-related disorders

Serial	Conditions and decision factors	Class
4.1	**Acute stress disorder.** Review existing reports. Class 1 if meets Class 1 standard and all following: • single episode, time constrained, and limited to a specific exposure • recovered >24 months.	1
	Aviation-related occupations. IAM to make the final classification decision.	3

Serial	Conditions and decision factors	Class
4.2	**Post-traumatic stress disorder (PTSD).** Review existing reports and current psychiatric opinion. Class 1 if meets Class 1 standard and recovered >24 months.	3R 1
	Aviation-related occupations and divers. Any history of PTSD.	4
	Submariners If the following conditions apply: • 3 years symptom-free • Demonstrated ability to cope with new stressors • Supportive psychiatry and occupational psychology assessments	2
4.3	**Adjustment disorders.** Review existing reports. Class 1 if meets Class 1 standard and all following: • single episode involving mild or moderate symptoms only • recovered >12 months • no suicide attempt.	1
	Aviation-related occupations and divers. Any history of adjustment disorder with depressed mood.	4
	Submariners If the following conditions apply: • At least one year since resolution of symptoms • Demonstrated ability to cope with stress since resolution	3R

Neurodevelopmental disorders

16. Common neurodevelopmental disorders include autism spectrum disorder, intellectual disability and attention deficit hyperactivity disorder (ADHD). These conditions are lifelong.

17. DFR Psychology considers any impairment of function and adaptive strategies. The DFR MO is to consider the impact of recent or current medical treatment on suitability for ADF entry.

Table 5Q–5: Neurodevelopmental disorders

Serial	Conditions and decision factors	Class
5.1	**ADHD – no medication 3 years.**	1
	ADHD – no medication –12 months. Review existing reports. Class 1 if meets Class 1 standard and all following: • recovered >12 months • no medication, treatment or supports >12 months.	1

Serial	Conditions and decision factors	Class
	Aviation-related occupations. If any ADHD, existing reports. Class 1 if meets Class 1 standard and all following: • no medication, treatment or supports >24 months • DFR Psychology aware of condition and rates candidate as suitable • may require neuropsychological testing if <5 years of satisfactory work/study without any therapy.	1
5.2	**Other neurodevelopmental disorder – managed with medication.**	4
	Other neurodevelopmental disorder – no medication, treatment or supports for >12 months. DFR Psychology to assess.	N/A

Substance use disorders

18. Substance abuse:

a. lack of concentration, self-discipline and drive are not compatible with military training

b. risk of injury to self and others; and risk of abusing medical system and pharmaceuticals available

c. regular medical review required and may need hospitalisation and psychiatric treatment.

Table 5Q–6: Substance abuse

Serial	Condition	Consideration	Class
6.1	**Drug or alcohol dependency or non-medical use of drugs** (including neurotropic or psychotropic drug use.)	Problems arising from use of licit and illicit drugs include: • intoxication and overdose • health and social problems • criminal activity from regular use • physical dependence on the drug resulting in a withdrawal syndrome on cessation.	4
6.1.1	**History of dependency**	Any candidate with a history of drug or alcohol dependency is to be reviewed by a specialist drugs and alcohol counsellor.	3R
	Any current medical problems such as cirrhosis or depression.	Decision	4
	No clinical problems.	Administrative problem. To be referred to Senior Military Recruiting Officer and/or psychologist.	3R/1

Serial	Condition	Consideration	Class
	Any history of dependency on therapeutic substances for those applying for any health role.	Applies to candidates for all health roles including allied health professionals and medical administrative officers—for: • **Navy:** Any Health Primary Qualification or Health Category. • **Army:** Any position within medical (RAAMC), nursing (RAANC), dental (RAADC), or psychology (AAPSYCH). • **Air Force:** Any health or allied health professional.	4
6.1.2	**Currently on drug or alcohol rehabilitation treatment or program**	Decision	4
6.1.3	**Completed drug rehabilitation treatment or program and no relapse more than 18 months**	Decision	3R/1
6.1.4	**Previous failed drug rehabilitation program**	Decision	4
6.2	**Substance abuse**	**Aircrew/air traffic control/divers** • Any history of substance abuse addressed in serial 6.	4

Eating disorders

19. Eating disorders are incompatible with ADF entry because they normally affect physical and psychological wellbeing, are generally long-term, may be associated with medical complications or other mental health disorders, or require specialist management.

Table 5Q–7: Eating disorders

Serial	Conditions and decision factors	Class
7.1	**Eating disorder.** Any history or presence of an eating disorder such as anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder (ARFID), pica, rumination disorder, or other specified feeding or eating disorder (OSFED).	4

Schizophrenia spectrum or other psychotic disorders

20. Individuals with schizophrenia spectrum or other psychotic disorders are unlikely to meet the suitability requirements for ADF entry as these disorders tend to be chronic, generally associated with significant impairment of mental health function and have ongoing treatment requirements.

Table 5Q–8: Schizophrenia spectrum or other psychotic disorders

Serial	Conditions and decision factors	Class
8.1	**Psychotic disorder as consequence of another medical condition, prescribed medication or substance use.** If existing report indicates recovery >12 months, request current psychiatric opinion. Class 1 if all following: • recovered >12 months • any underlying medical condition meets Class 1 entry standard for the condition.	3R 1
	Aviation-related occupations. IAM to make the final classification decision if history of mental health disorder due to another medical condition or induced by medication.	3
8.2	**Schizophrenia spectrum or other psychotic disorders.**	4
	Specified or unspecified schizophrenia spectrum or other psychotic disorder that does not meet the full Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for diagnosis	4

Other conditions

21. Table 5Q–9 provides decision factors for other conditions.

Table 5Q–9: Other conditions

Serial	Conditions and decision factors	Class
9.1	**Sleepwalking.** Somnambulism with symptoms after the age of 15 years.	4
9.2	**Gender dysphoria – historical.** Review existing reports. Class 1 if meets all of the following: • meets Class 1 entry standard in regards to the mental health diagnosis of gender dysphoria • any co-morbid conditions meet relevant ADF entry standard.	1
	Aviation-related occupations. IAM to make the final classification decision for history of gender dysphoria.	3
9.3	**Personality disorders.** Class 4 if diagnosed personality disorder.	4
9.4	**Secondary mood/anxiety disorder.** Any mood or anxiety disorder as a consequence of another medical condition, prescribed medication or substance use. If existing reports indicate recovery > 12 months, request current psychiatric opinion. Class 1 if all following: • mental health condition recovered more than 12 months • any underlying medical condition meets Class 1 entry standard for the condition.	3R 1

CHAPTER 6

HEALTH REQUIREMENTS FOR AVIATION-RELATED OCCUPATIONS

INTRODUCTION

6.1 Members employed in aviation-related occupations are responsible for the safe conduct of flight. This includes operating or interfacing with aircraft systems during flight, controlling airspace and other tasks essential for the successful outcome of an aviation mission. Defence applies a high standard of health for personnel in aviation-related occupations because of the potential consequences of incapacitation or distraction and the potential for the aviation environment to exacerbate a health condition.

Aim

6.2 This chapter provides the minimum health requirements for:

a. any candidate for enlistment or appointment to an aviation-related occupation in the Australian Defence Force (ADF)

b. trained personnel either re-entering the ADF or with occupational experience in civil aviation or defence forces from other countries

c. serving members applying for transfer from another military occupation.

Scope

6.3 This chapter is written for health personnel who are involved in the health assessments for candidates applying for aviation-related occupations. This chapter applies to initial entry and in-Service transfers.

POLICY

AVIATION CLASSES AND MEDICAL FITNESS STANDARDS

6.4 Annex 6A lists the aviation-related occupations covered by this chapter. Annex 6B provides the medical requirements for each aviation occupation.

MEDICAL EXAMINATION

6.5 The medical examination should confirm that a candidate for employment in an aviation-related occupation is capable of:

a. withstanding the severe stresses of military flying, including prolonged flight in various aircraft types, in physiologically challenging environments, in all weather and climates, and in peace and war

b. operating in extremes such as aircraft emergencies and escape and evasion in a variety of environmental conditions

c. wearing personal protective equipment during flight operations, such as chemical, biological, radiological, and nuclear protection; body armour; G-suits; flotation devices such as immersion suits and inflatable life vests; helicopter emergency escape devices; and helmets with night vision devices.

Initial entry or re-entry candidates

6.6 Annex 6B describes the medical examination requirements, confirmation process, waiver and review of decision processes for initial entry or re-entry candidates for an aviation-related occupation.

Serving members

6.7 Annex 6C describes the medical examination requirements, confirmation process, waiver and review of decision processes for serving members who are applying to transfer to an aviation-related occupation.

AVIATION SCREENING PROGRAM

6.8 The aviation screening program (ASP) is a two-day program. Candidates applying for an officer aviation (OA) role will visit on-base training units, tour facilities, attend lectures, participate in simulator-based events (depending on availability of resources), and undergo eight hours of computer testing (broken into sessions). There are no airborne activities in the ASP and no activities that require candidates to be able to climb into an aircraft cockpit.

6.9 Candidates applying for the OA roles listed in Annex 6D are required to participate in ASP as part of the selection process. Prior to participation, each OA candidate's medical fitness to attend ASP must be assessed. The Defence or Defence Force Recruiting (DFR) medical officer (MO) is to assess medical fitness for ASP as follows:

a. for initial or re-entry candidates, in accordance with Annex 6D

b. for in-Service candidates, in accordance with Annex 6C.

6.10 For initial or re-entry candidates, following ASP, DFR will receive a list of those candidates who are to proceed, with the OA job type and Service they have been offered. Following completion of all medical assessments, the candidate's medical file is to be sent to the Royal Australian Air Force (RAAF) Institute of Aviation medicine (IAM) for confirmation of suitability for an OA role.

SPONSOR: Director General Air Force Health Services

Annexes:
6A Aviation-related occupations
6B Initial entry or re-entry medical requirements for occupation-related occupations
6C Medical requirements for in-Service transfer to aviation-related occupations
6D Minimum medical requirements for officer aviation candidates to proceed to the aviation screening program

ANNEX 6A

AVIATION-RELATED OCCUPATIONS

Aviation Class 1

1. Aviation Class 1 medical standards are for aircrew who have responsibility for the actual flight or navigation of an aircraft or who have a critical cockpit role in the event of an emergency. Medical officers (MOs) are to apply specialist employment classification (SPEC) Ax to the following:

a. Navy:

(1) pilot

(2) aviation warfare officer (AvWO)

(3) flight test engineer (FTE), see notes (a) and (d).

b. Army:

(1) pilot

(2) flight test engineer (FTE), see note (a).

c. Air Force:

(1) pilot

(2) weapons system officer (WSO)

(3) flight test engineer (FTE), see notes (a).

Aviation Class 2: Mission aircrew

2. Aviation Class 2 medical standards are for aircrew who do not have a role in the cockpit of an aircraft, but may complement the pilot handling the aircraft and be involved in the safety of the aircraft, and/or be critical to the efficiency of the mission. MO are to apply SPEC Ax to the following:

a. Navy:

(1) aircrewman

(2) flight test engineer (FTE), see notes (a) and (d)

(3) fighter controller - air, see note (a)

b. Army:

(1) Aircrewman.

c. Air Force:

(1) air mobility officer – air refuelling operator (AMO-ARO)

(2) air mobility officer – combat systems operator (AMO-CSO)

(3) maritime patrol and response officer (MPRO)

(4) airspace battle manager - air (ABM-A), see note (c)

(5) loadmaster (LOADM)

(6) airborne electronics analyst - air (AEA-A), see note (f)

(7) crew attendant (CREWATT)

(8) enlisted fighter controller Air Force – air, see note (h).

Aviation Class 3: Mission controllers

3. Aviation Class 3 medical standards apply to ground-based personnel who have a direct responsibility for the control and separation of an airborne aircraft, and have a responsibility for mission completion of a flying operation. MO are to apply SPEC Cx.

a. Navy:

(1) remote pilot warfare officer (RPWO)

(2) fighter controller – ground.

b. Army: operator uncrewed aircraft system:

(1) Service category (SERCAT) 7 operator uncrewed aircraft systems (ECN 250)

(2) any operator of a tactical uncrewed aerial system.

c. Air Force:

(1) air traffic controller (ATC)

(2) airspace battle manager - ground (ABM-G), see note (c)

(3) airborne electronics analyst – ground (AEA-G), see note (f)

(4) airborne electronics analyst – mission payload operator (AEA-MPO), see notes (f) and (g)

(5) remote pilot (RP), see note (b)

(6) enlisted Fighter Controller Air Force – ground, see note (h).

Notes:

(a) This specialisation is not open to initial candidates; however, serving members may be selected for aircrew training and will then be employed in an airborne capacity.

(b) AF RPs will enter via the Officer Aviation – Mission pathway, and will be streamed to RP through Air Mission Training School (AMTS). They will be required to meet a CASA CPL, and complete initial pilot training via RMIT (non-PC-21), before transitioning to the uncrewed aircraft system.

(c) ABM can be employed in the airborne or ground environment. Members with an Aviation Class 3 will be restricted to employment in the ground environment.

(d) Navy FTE may conduct duties that require flying in high performance aircraft. Although the entry standard for Navy FTE is Aviation Class 2, all FTE candidates are to be assessed against Aviation Class 1. Candidates confirmed as Aviation Class 1 may be considered for duties that require flying in high performance aircraft.

(e) Fighter Controller can be employed in the airborne or ground environment. Members with an Aviation Class 3 will be restricted to employment in the ground environment.

(f) Airborne Electronics Analyst can be employed in the airborne or ground environment. Members with an Aviation Class 3 will be restricted to employment in the ground environment.

(g) Airborne Electronics Analyst – Mission Payload Operator are employed with uncrewed aircraft systems.

(h) Enlisted Fighter Controller Air Force can be employed in the airborne or ground environment. Members with an Aviation Class 3 will be restricted to employment in the ground environment

ANNEX 6B

INITIAL ENTRY OR RE-ENTRY MEDICAL REQUIREMENTS FOR AVIATION-RELATED OCCUPATIONS

INTRODUCTION

1. This annex provides the medical requirements for initial entry and re-entry candidates for aviation-related occupations. Defence Force Recruiting medical officers (DFR MOs) are to pay special attention to all aspects of the medical history and examination of each individual. DFR MOs must ensure individuals meet the medical standards of this chapter and the following:

a. Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[144]—'Medical history and examination'

b. DHM Level 2 Part 5 Chapter 4[145]—'Occupation specific – medical standards'

c. DHM Level 2 Part 5 Chapter 5[146]—'Causes of and reasons for rejection'

d. for Army candidates, the appropriate PULHEMS profile in DHM Level 2 Part 5 Chapter 1[147]—'Medical classification of candidates' and Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 3[148]—'The application of the military employment classification system and PULHEMS employment standards in the Australian Army'.

Officer aviation

2. Candidates for Navy, Army and Air Force OA roles are to be assessed against the Aviation Class 1 medical standard to allow confirmation against all service and all officer aviation-related occupations.

3. The Aviation Candidate Management Centre (ACMC) will provide the outcomes of ASP for each individual for DFR and Royal Australian Air Force (RAAF) Institute Aviation Medicine (IAM) for refinement of the medical assessment.

4. If a candidate does not meet Aviation Class 1 standards, IAM is to assess the candidate against Aviation Class 2: Mission aircrew (which excludes weapon system

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[148] http://drnet.defence.gov.au/Army/EMPA/ASI/P8/Pages/ASI(P)_Part_8.aspx

officer (WSO)). If Aviation Class 2 standards are not met, the candidate is to be assessed against Aviation Class 3: Mission controllers.

5. A specialist employment classification (SPEC) is to be applied against each officer aviation-related occupation.

AVIATION CLASS 1 AND AVIATION CLASS 2: MISSION AIRCREW

Medical examination

6. When assessing candidates, MO are to:

a. conduct a medical history and examination (see DHM Level 2 Part 5 Chapter 2)

b. then apply the causes of rejection (see DHM Level 2 Part 5 Chapter 5)

c. then apply the aviation-specific requirements for the relevant aviation class in accordance with Appendix 6B1.

Anthropometric requirements

7. Due to the nature of operations, optimal eye datum, anthropometric limitations of aircraft cockpits, design of ejection seats, parachutes, and seat stroking limits, additional standards apply to pilots, flight test engineer (FTEs), aviation warfare officer (AvWOs), WSOs and Navy Aircrewman. Anthropometric requirements are in Tables 6B–1 and 6B–2. Guidelines for anthropometry measurement techniques are in Appendix 6B2. Nude body weight is measured in underwear.

8. Table 6B–1 applies only to pilot, FTE, AvWO and WSO candidates. IAM may require a cockpit assessment for candidates with a sitting height which is ≤ 0.5 cm outside of the anthropometry limits to determine cockpit compatibility. Consultation with IAM is to occur prior to approval for aviation screening program (ASP).

9. Table 6B-2 applies only to Navy aircrewman. The maximum sitting height is 95 cm. For candidates between 95.1 cm and 100 cm inclusive, the applicant is to undergo a Navy helicopter fit test, organized by IAM.

10. All other candidates are assessed against the general entry (GE) anthropometry standards in DHM Level 2 Part 5 Chapter 4.

Table 6B–1: Anthropometry: pilot, flight test engineer, aviation warfare officer and weapons system officer

Parameter	Minimum	Maximum
BMI	18.5	32.9
Weight	44 kg	105 kg
Height: Navy and Army	152 cm	Not applicable
Sitting height: Navy and Army	83	101 cm
Sitting height: Air Force	78 cm	101 cm
Buttock–knee length: Navy and Army	54 cm	67 cm
Buttock–knee length: Air Force	50 cm	67 cm
Total leg length: Navy and Army	95 cm	129 cm
Total leg length: Air Force	Not applicable	Not applicable

Table 6B–2: Anthropometry: Navy Aircrewman

Parameter	Minimum	Maximum
BMI	18.5	32.9
Weight	Not applicable	Not applicable
Height	152 cm	Not applicable
Sitting height	Not applicable	95 cm
Buttock–knee length	Not applicable	Not applicable
Total leg length	Not applicable	Not applicable

Colour perception standard

11. The colour perception (CP) standards are in Appendix 6B1. CP is only valid for two years for aviation-related occupations.

Valsalva manoeuvre

12. The valsalva manoeuvre is to be performed and confirmed by the MO. If unable to be confirmed due to cerumen, the candidate is to be referred to their treating medical practitioner for removal of the cerumen and confirmation of the valsalva. If unable to be confirmed for any other reason, the candidate is to be referred for ear, nose and throat (ENT) opinion to enable assessment and diagnosis of eustachian tube function.

Sharpened Romberg Test

13. The Sharpened Romberg Test is to be performed in accordance with the procedure in DHM Level 2 Part 5 Chapter 2. Recent exposure to motion or consumption of alcohol may impair performance on the Sharpened Romberg Test.

Practice can be encouraged and can improve ‘normals’ but not when a neurological condition exists.

14. Candidates with persistent failures should be referred to their treating medical practitioner for further neurological consultation.

Respiratory function

15. Candidates must have a forced expiratory volume in one second (FEV1) and a forced vital capacity (FVC) minimum 80 per cent of predicted values, and a FEV1/FVC ratio of 75 per cent or better.

16. In the clinical examination, the MO should give particular attention to any condition that might cause retention or trapping of expanding gas in any part of the lungs. If any result is outside the normal limits, the candidate must be reviewed by a respiratory physician for assessment, formal pulmonary function testing, bronchial provocation testing (as required), and diagnosis.

Psychological stability

17. Candidates should not have significant fear of flying, fear of water or fear of confined spaces. If an MO has any concerns, the case should be discussed with the Defence Force Recruiting Centre (DFRC) psychologist or IAM. The DFRC psychologist report is to be provided to IAM.

Specialist health assessments

18. The following specialist health assessments are required:

a. **Resting electrocardiogram examination.** All candidates are to have a 12-lead resting electrocardiogram (ECG). The ECG is to be reported on by a cardiologist and the record is to be part of the medical documentation.

b. **Visual examination.** All candidates are to be examined consistent with DHM Level 2 Part 5 Chapter 2, Table 2.1. Minimum aviation visual requirements (AVR) for specific aviation-related occupations are listed in Appendix 6B3. Guidelines for completion of the ophthalmology assessment for aviation-related occupations are in Appendix 6B4.

c. **Ear, nose and throat assessment.** Hearing standards (HS) are defined in DHM Level 2 Part 5 Chapter 3. Minimum HS for specific aviation-related occupations are in Appendix 6B1. Eustachian tubes must be patent and any nasal septal deviation or rhinitis carefully assessed. Candidates are to be referred to an ENT specialist if clinically indicated for assessment and diagnosis of eustachian tube function.

d. **Dental assessment.** Candidates are to be dentally fit as per Appendix 6B5.

Pathology screening

19. Candidates for aviation-related occupations are to undergo:

a. full blood count and film

b. random blood glucose (point of care acceptable)

c. random lipids including HDL (point of care acceptable.

20. Blood results are to be within the normal laboratory range. Candidates with blood results outside the normal range are to be managed as per the relevant serial of DHM Level 2 Part 5 Chapter 5.

Refractive surgery

21. Candidates must not be advised to have refractive surgery as a means of meeting Australian Defence Force (ADF) entry standards if they are outside of the required uncorrected minimum visual requirement limits. Candidates who have had refractive surgery are to meet the standards in Appendix 6B5 of this chapter and in Annex 6K of DHM Level 2 Part 5 Chapter 6.

AVIATION CLASS 3: MISSION CONTROLLERS

22. **Anthropometric requirements.** Candidates are to meet the GE anthropometry standards of DHM Level 2 Part 5 Chapter 4.

23. **Colour perception standard.** CP standards are in Appendix 6B1. CP is only valid for two years for aviation-related occupations.

24. **Psychological stability.** If an MO has any concerns, the case should be discussed with the DFRC psychologist or IAM. The DFRC psychologist report is to be provided to IAM.

25. **Specialist health assessments.** The following specialist health assessments are required:

a. **Resting electrocardiogram examination.** As for Aviation Class 1 and 2.

b. **Visual examination.** As for Aviation Class 1 and 2.

c. **Ear, nose and throat assessment.** HS are defined in DHM Level 2 Part 5 Chapter 2. Minimum HS for specific aviation-related occupations are listed in Appendix 6B1.

d. **Dental assessment.** Candidates are to meet dental standards for GE to the ADF.

e. **Pathology screening.** As for Aviation Class 1 and 2.

f. **Refractive surgery.** As for Aviation Class 1 and 2.

CONFIRMATION OF MEDICAL FITNESS

26. For candidates identified as Class 4 for aviation-related occupations, a DFR MO can make and confirm the Class 4 determination and inform the candidate.

27. For all other candidates applying for aviation-related occupations, the confirming authority for medical fitness is the commanding officer (CO) IAM or their appointed medical delegate. DFR medical sections are to provide all medical documentation for each candidate to IAM for confirmation.

28. Where a DFR MO is unsure whether an applicant is fit to proceed for a condition(s), the DFR medical section is to provide all relevant medical documentation for that condition(s) to IAM. IAM will provide a medical fitness determination for the condition(s).

29. IAM may request additional reports or investigations to determine the suitability of a candidate. The chief medical officer (CMO) DFR is the authority for consideration of funding approvals and subsequent provision of funding for these investigations for initial entry or re-entry candidates.

30. When a candidate is confirmed as medically fit, the confirming authority will allocate a military employment classification (MEC) and SPEC in accordance with Military Personnel Policy Manual (MILPERSMAN) Part 3 Chapter 2[149]—'Military employment classification system'. DFR MOs are responsible for allocating a recruiting medical classification to each candidate who is medically assessed for ADF entry.

31. When IAM confirms a candidate as Class 4 for an aviation-related occupation, IAM will provide written advice to the relevant DFR medical section as to the reason for the classification. The DFR medical section is to inform the candidate.

CURRENCY OF ASSESSMENTS

32. For all OA candidates, the entry level medical examination (ELME), the mandated medical tests and the IAM confirmation are valid for 12 months.

33. For all candidates (other than OA candidates), the ELME, the mandated medical tests and the IAM confirmation are valid for 24 months.

WAIVER OF MEDICAL STANDARDS

34. When a candidate does not meet entry medical standards, a DFR MO, senior military recruitment officer (SMRO) or CMO may initiate a request for medical waiver as for general candidates (see DFR website—'Recruitment procedure – medical waivers'.

[149] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/C5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765

35. Where a waiver is being considered, IAM is to inform the waiver risk assessment. IAM is to advise CMO DFR on the recommended SPEC and employment restrictions. CMO DFR will submit cases to the relevant Service (s) for consideration and waiver determination except in cases where IAM or CMO DFR has delegated authority to waiver the condition(s).

36. The Service Director General Personnel (DGPERS) or delegate is the approving authority for waiver of entry medical standards. DGPERS or delegate will forward the determination decision to CMO DFR, the DFR medical section and IAM.

37. Medical waiver approvals for all OA candidates are valid for 12 months from the date of the delegate approving the waiver. For all candidates (other than OA candidates), medical waiver approvals are valid for 24 months from the date of the delegate approving the waiver. If a candidate's medical status changes or the candidate changes their job preference, a medical waiver is to be resubmitted.

REVIEW OF DECISION

38. Requests for review of decision for initial entry and re-entry candidates are to be managed in accordance with DHM Level 2 Part 5 Chapter 9[150]—'Review of recruiting medical classification decision').

Appendices:

7B1 Medical examinations for aviation-related occupations
7B2 Anthropometry measurement technique
7B3 Aviation visual requirements
7B4 Guidelines for examination by an ophthalmologist
7B5 Dental examination for aircrew candidates

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APPENDIX 6B1

MEDICAL EXAMINATIONS FOR AVIATION-RELATED OCCUPATIONS

Table 6B1–1: Medical examinations for Aviation Class 1

Specialisation	Anthropometry	CP	Valsalva	Sharpened Romberg	Respiratory function test (spirometry)	Psychological stability	ECG (b)	AVR (c)	HS	Aviation dental	Pathology screening (d)
Pilot	Yes (a)	2	Yes	Yes	Yes	Yes	Yes	1	1	Yes	Yes
WSO	Yes (a)	2	Yes	Yes	Yes	Yes	Yes	1	1	Yes	Yes
FTE Air Force/ Army/Navy (e)	Yes (a)	2	Yes	Yes	Yes	Yes	Yes	1	1	Yes	Yes
AvWO	Yes (a)	2	Yes	Yes	Yes	Yes	Yes	1	1	Yes	Yes

Notes:

(a) See Annex 6B.

(b) ECG to be reported on by a cardiologist.

(c) The initial ophthalmology examination is valid for 12 months for officer aviation (OA) candidates. For all other aviation candidates, the initial ophthalmology examination is valid for 24 months.

(d) See Annex 6B.

(e) The entry standard for Navy FTE is Aviation Class 2; however, all candidates are to be assessed against Aviation Class 1. Candidates confirmed as Aviation Class 1 may be considered for duties that may require flying in high performance aircraft.

Table 6B1–2: Medical examinations for Aviation Class 2

Specialisation	Anthropometry	CP	Valsalva	Sharpened Romberg	Respiratory function test (spirometry)	Psychological stability	ECG (a)	AVR (b)	HS	Aviation dental	Pathology screening (c)
AMO - ARO	GE	2	Yes	Yes	Yes	Yes	Yes	1; with stereopsis </= 40 arc seconds	1	Yes	Yes
AMO – CSO	GE	2	Yes	Yes	Yes	Yes	Yes	2	1	Yes	Yes
MRPO	GE	2	Yes	Yes	Yes	Yes	Yes	2	1	Yes	Yes
ABM – Air (e)	GE	2	Yes	Yes	Yes	Yes	Yes	3	1	Yes	Yes
LOADM	GE	2	Yes	Yes	Yes	Yes	Yes	2	2	Yes	Yes
AEA – Air (f)	GE	2	Yes	Yes	Yes	Yes	Yes	2	2	Yes	Yes
CREWATT	GE	3	Yes	Yes	Yes	Yes	Yes	3	2	Yes	Yes
Aircrewman Navy	Yes (g)	2	Yes	Yes	Yes	Yes	Yes	1	1	Yes	Yes
Aircrewman Army	GE	2	Yes	Yes	Yes	Yes	Yes	2	2	Yes	Yes
FTE Navy (d)	GE	2	Yes	Yes	Yes	Yes	Yes	2	2	Yes	Yes
Fighter Controller – Air (h)	GE	2	Yes	Yes	Yes	Yes	Yes	3	2	Yes	Yes
Enlisted Fighter Controller - Air (h)	GE	2	Yes	Yes	Yes	Yes	Yes	3	1	Yes	Yes

Notes:

(a) ECG to be reported on by a cardiologist.

(b) The initial ophthalmology examination is valid for 12 months for OA candidates. For all other aviation candidates, the initial ophthalmology examination is valid for 24 months.

(c) See Annex 6B.

(d) The entry standard for Navy FTE is Aviation Class 2; however, all candidates are to be assessed against Aviation Class 1. Candidates confirmed as Aviation Class 1 may be considered for duties that may require flying in high performance aircraft.

(e) ABM can be employed in the airborne or the ground environments. Individuals with an Aviation Class 3 will be restricted to employment in the ground environment.

(f) AEA can be employed in the airborne or the ground environments. Individuals with an Aviation Class 3 will be restricted to e**mployment in the ground environment.**

(g) See Annex 6B

(h) Fighter controller and enlisted fighter controller Air Force can be employed in the airborne or the ground environments. Individuals with an Aviation Class 3 will be restricted to employment in the ground environment.

Table 6B1–3: Medical examinations for Aviation Class 3

Specialisation	Anthropometry	CP	Valsalva	Sharpened Romberg	Respiratory function test (spirometry)	Psychological stability	ECG (b)	AVR (c)	HS	Aviation dental	Pathology screening (d)
ATC	GE	2	No	No	No	Yes	Yes	3	1	GE	Yes
ABM - G (f)	GE	2	No	No	No	Yes	Yes	3	1	GE	Yes
RP	Yes (a) (e)	1	Yes	Yes	Yes	Yes	Yes	1	1	GE	Yes
AEA - MPO	GE	1	No	No	No	Yes	Yes	3	2	GE	Yes
AEA – Ground (g)	GE	2	No	No	No	Yes	Yes	2	2	GE	Yes
RPWO	GE	1	No	No	No	Yes	Yes	3	2	GE	Yes
SERCAT 7 OPUAS Army	GE	1	No	No	No	Yes	Yes	3	2	GE	Yes
Operator Tactical UAS Army	GE	1	No	No	No	Yes	Yes	3	2	GE	Yes
Fighter Controller Navy – Ground (h)	GE	2	No	No	No	Yes	Yes	3	2	GE	Yes
Enlisted Fighter Controller Air Force – Ground (h)	GE	2	No	No	No	Yes	Yes	3	1	GE	Yes

Notes:

(a) See Annex 6B.

(b) Electrocardiogram (ECG) to be reported on by a cardiologist.

(c) The initial ophthalmology examination is valid for 12 months for OA candidates. For all other aviation candidates, the initial ophthalmology examination is valid for 24 months.

(d) See Annex 6B.

(e) AF RPs will enter via the Officer Aviation – Mission pathway, and will be streamed to RP through Air Mission Training School (AMTS). They will be required to meet a CASA CPL, and complete initial pilot training via RMIT (non-PC-21), before transitioning to the uncrewed aircraft system.

(f) ABM can be employed in the airborne or the ground environments. Individuals with an Aviation Class 3 will be restricted to employment in the ground environment.

(g) AEA can be employed in the airborne or the ground environments. Individuals with an Aviation Class 3 will be restricted to employment in the ground environment.

(h) Fighter Controller can be employed in the airborne or the ground environments. Individuals with an Aviation Class 3 will be restricted to employment in the ground environment.

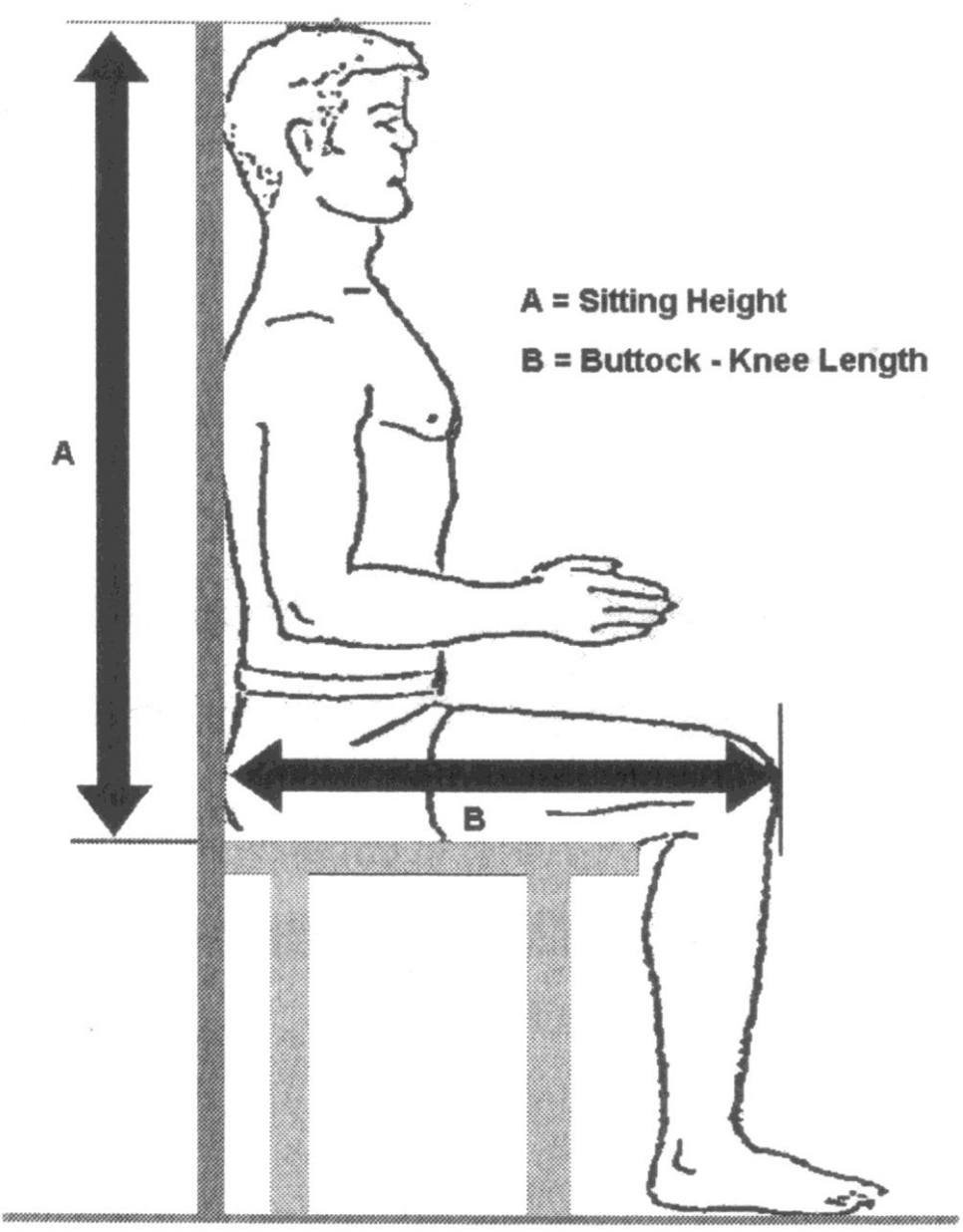
APPENDIX 6B2

ANTHROPOMETRY MEASUREMENT TECHNIQUE

1. This appendix provides the anthropometry measurement technique for pilots, weapons system officer (WSOs), flight test engineer (FTEs), and aviation warfare officer (AvWOs).

Sitting height and buttock–knee length

Figure 6B2–1: Sitting height and buttock–knee length



2. Place the candidate in the measuring position as follows:

a. seat the candidate on a stool placed against a wall

b. adjust the height of the stool so the candidate's forelegs are vertical

c. ensure the candidate's lumbo-sacral area and the back of the head are firmly touching the back wall

d. ensure the candidate's posture is erect and not slouching.

3. The measures are to be taken in in accordance with Figure 7B2–1 and the following:

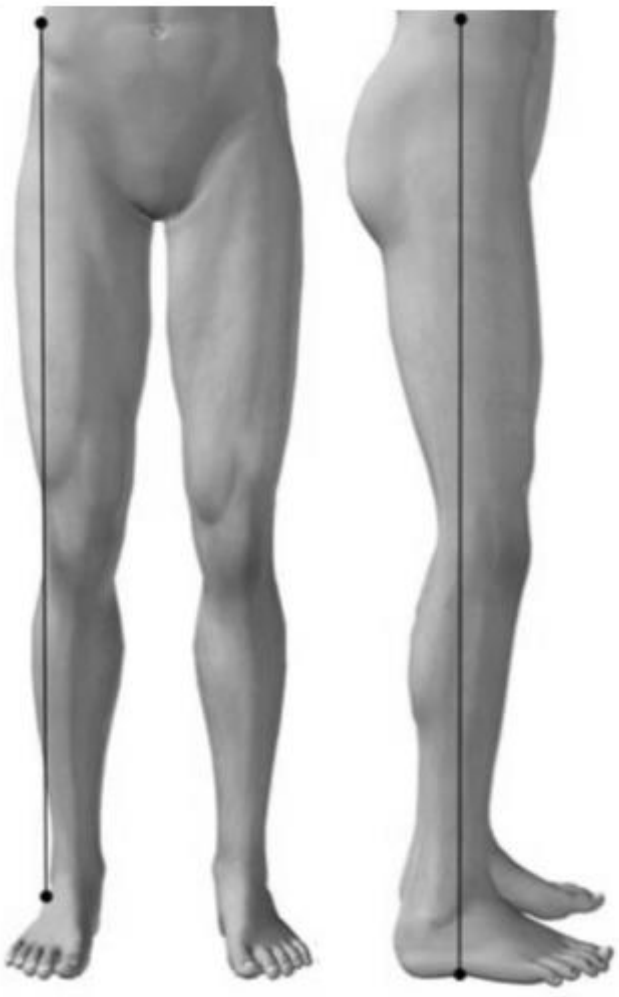
a. **Sitting height.** The vertical distance from seat surface to top of head.

b. **Buttock–knee length.** The distance from the wall to the forward most part of the knees.

Total leg length

4. Total leg length is the linear distance (parallel to the long axis of the leg) between the right iliac crest and the base of the foot when standing. Figure 7B2-1 depicts the measurement of total leg length.

Figure 6B2–2: Measuring total leg length



APPENDIX 6B3

AVIATION VISUAL REQUIREMENTS

Table 6B3–1: Aviation visual requirements

Factor (note a)	AVR1	AVR2	AVR3
Visual acuity (each eye separately)	Unaided 6/18 Corrected 6/6	Unaided 6/60 Corrected 6/6	Unaided 6/120 Corrected 6/6
Near vision (corrected)	N5 at 30–50 cms N14 at 100 cms	N5 at 30–50 cms N14 at 100 cms	N5 at 30–50 cms N14 at 100 cms
Hypermetropia	+3.00 dioptres	+4.00 dioptres	+6.00 dioptres
Hypermetropic astigmatism	+2.00 dioptres in any axis	+2.00 dioptres in any axis	N/A
Myopia	-3.00 dioptres	-4.00 dioptres	-6.00 dioptres
Myopic astigmatism	-2.00 dioptres in any axis	-2.00 dioptres in any axis	N/A
Anisometropia	2.00	2.00	2.00
Heterophoria (Eso or Exophoria)	Must not exceed 6 prism dioptres	Must not exceed 6 prism dioptres	N/A
Hyperphoria or Hypophoria	Must not exceed 1 prism dioptres	Must not exceed 1 prism dioptres	N/A
Convergence	10 cm or less	10 cm or less	N/A
Contrast Sensitivity (pre and post refractive surgery and corneal cross linking only)	Must not be ≤1.50	Must not be ≤1.50	Must not be ≤1.50

Note:

(a) Testing for refraction limits with cycloplegia using Cyclopentolate Hydrochloride 1%, two drops, 5 to 15 minutes apart. Examination performed no sooner than one hour after last drop and within two hours of the last drop of Cyclopentolate.

Table 6B3–2: Accommodation

Age	AVR1	AVR2	AVR3
17–20 years	≤10 cm	≤10 cm	N/A
21–25 years	≤12 cm	≤12 cm	N/A
26–30 years	≤14 cm	≤14 cm	N/A
31–35 years	≤16 cm	≤16 cm	N/A
36–40 years	≤20 cm	≤20 cm	N/A
40–45 years	≤30 cm	≤30 cm	N/A
45–50 years	≤60 cm	≤60 cm	N/A

Table 6B3–1 Other visual requirements for all aviation classes

Factor	Requirement
Diseases of the eye or eyelids	Acute conditions to be treated first. Chronic conditions (to include congenital conditions, eg strabismus) may result in rejection. Seek ophthalmological opinion.
Alternating strabismus	Must meet Phoria limits AND have stereopsis of ≤60 seconds of arc.
Pterygium	Class 4 if encroaches on the cornea more than 3 mm or interferes with vision, or is progressive, or causes refractive problems.
Lens	Class 4 if current aphakia, or current or history of dislocation of a lens.
Night vision	Class 4 if deficient night vision, as determined by history, of such a degree that the applicant requires assistance in travel at night.

Factor	Requirement
Glaucoma / pre-glaucoma / elevated intra-ocular pressures not meeting the diagnostic criteria for glaucoma	Class 4 if demonstrable changes in the optic disc, or changes in the visual fields, or not amenable to treatment. If no demonstrable changes in the optic disc, or changes in the visual fields, or amenable to treatment, then acceptable Class 1— requires annual ophthalmology review, with tonometry and perimetry.
Enucleated or absence of an eye	Class 4
Contact lenses	Class 4 if vision correctable only by the use of contact lenses.
Aniseikonia	Class 4 if incapacitating signs or symptoms exist that are not easily treatable with standard ophthalmic spectacle lenses.
Diplopia	Class 4 in any field of gaze, either constant or intermittent, including history of.
Hemianopsia	Class 4
Eyelids	Class 4 if any condition of the eyelids which impairs normal eyelid function or comfort or potentially threatens visual performance.
Epiphora, nasolacrimal duct obstruction, dacryostenosis	Class 4. Class 1 if treated, and symptom free.
Ptosis	Class 4. Class 1 if benign and non-progressive aetiology, which does not interfere with vision in any field of gaze or direction.
Dacryocystitis	Acute. Class 1 if treated and symptom free, without previous history. Class 4 if chronic or more than a single episode.
Conjunctivitis, chronic, allergic	Class 4.
Trachoma	Class 4. Class 1 if treated, symptom free and without visually significant scarring.

Factor	Requirement
Xerophthalmia	Class 4.
Keratoconus or any other corneal diagnoses or dystrophy including topographical patterns suggestive of keratoconus, that demonstrates progression, requires long term treatment or surgical intervention	Class 4. Class 1 if treated with collagen crosslinking (CXL) with <0.75D change in astigmatism in the subsequent 12 months.
Vascularisation or opacification of the cornea for any cause which is progressive or reduces vision below standards	Class 4.
Keratitis, chronic or recurrent, or leads to or has led to opacification or other sequelae that interferes with vision	Class 4.
Corneal ulcers/erosions, chronic or recurrent	Class 4.
History of traumatic corneal laceration	Class 4. Class 1 if nil adverse sequelae including normal intraocular pressure, nil scarring that interferes with vision in any field of gaze or direction.
Corneal refractive surgery	See Defence Health Manual (DHM) Level 2 Part 5 Chapter 5[151]— 'Causes of and reason for rejection' Annex K. Refraction is required to be stable for 3 months following correction of myopia and 6 months following correction of hypermetropia.
Episcleritis, chronic or recurrent	Class 4.
Scleritis, acute, chronic or recurrent	Class 4.
Inflammation of uveal tract, acute, chronic or recurrent	Class 4. Class 1 if healed traumatic iritis, with nil adverse sequelae.

[151] http://intranet.defence.gov.au/home/documents/data/ADFPUBS/DHM/volume2/part5/05.pdf

Factor	Requirement
History of retinal detachment – unilateral or bilateral	Class 4.
Degeneration or dystrophy of the peripheral retina that are potentially progressive, associated with visual loss or increase the risk of retinal detachment, including lattice degeneration, atrophic holes and retinoschisis	Class 4.
Degeneration or dystrophy of the macula, including retinopathies, chorioretinopathies, macular drusen, macular cysts, and macular holes	Class 4.
Retinitis, chorioretinitis, or other inflammatory conditions of the retina	Class 4.
Angiomatoses, phakomatoses, retinal cysts and other retinal / vitreous conditions which impair or may impair vision	Class 4.
Haemorrhages, exudates, or other retinal vascular disturbances	Class 4.
Vitreous opacities or disturbances	Class 4.
Congenito-hereditary conditions of the optic nerve which impair or may impair central or peripheral vision	Class 4.
Optic neuritis, of any kind, to include history	Class 4.
Papilloedema	Class 4.
Optic atrophy or pallor	Class 4.
Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2, unless proven to be physiologic after comprehensive evaluation by an ophthalmologist	Class 4. If physiologic cupping, Acceptable Class 1—requires annual ophthalmology review.
Optic neuropathy	Class 4.
Optic nerve head drusen	Class 4.
Opacities, cataracts or irregularities of the lens	Class 4.

Factor	Requirement
Pseudophakia (intraocular lens implant)	Monofocal lens only: Acceptable Class 1 if otherwise meets the visual standard. Multifocal intraocular lens – non-diffractive: IAM to make final classification decision (in consultation with aviation ophthalmologist). Multifocal intraocular lens – diffractive: Class 4.
Posterior and / or anterior capsular opacification	Class 4 until treated then Class 1 as per Pseudophakia
Intraocular contact lenses	Class 4.
Abnormal pupils or loss of normal papillary reflexes, with the exception of physiological anisocoria	Class 4. If physiologic anisocoria, Acceptable Class 1.
Extraocular muscle restriction, paralysis, or paresis with loss of ocular motility or conjugate alignment in any direction	Class 4.
Asthenopia, if not resolved with refractive correction	Class 4.
Nystagmus of any type, except on versional end points	Class 4.
Anophthalmos, microphthalmos or exophthalmos, unilateral or bilateral	Class 4.
History of extraocular muscle surgery or strabismus therapies	Class 3R.
Any traumatic, organic, or congenital disorder of the eye or adnexa, not otherwise specified, which threatens or potentially threatens to intermittently or permanently impair visual function	Class 4.
History of any ocular surgery to include lasers of any type, not otherwise specified	Class 3R.
Current or history of retained intraocular foreign body	Class 3R.

APPENDIX 6B4

GUIDELINES FOR EXAMINATION BY AN OPHTHALMOLOGIST

1. A candidate for an aviation-related occupation will require at least one appointment with an ophthalmologist. Two appointments are needed if the candidate wears contact lenses as the preferred method of visual correction most of the time.

2. The ophthalmologist or optometrist is to record examination details on Form PM086—'Eye examination – aviation'.

3. Ophthalmologists and optometrists who provide examination of Australian Defence Force (ADF) candidates are required to have a copy of this annex and Form PM086. These documents are available through Defence Force Recruiting Centre (DFRC) or the Royal Australian and New Zealand College of Ophthalmologists website[152] or the Australian Optometrist Association website[153].

Validity of assessment

4. The initial ophthalmology assessment is valid for 12 months for officer aviation (OA) candidates, and valid for 24 months for all other candidates.

FIRST APPOINTMENT

5. At the first appointment, the candidate should present with their spectacles and/or bring their contact lenses (contact lenses must not be worn for 48 hours prior to the appointment).

6. The examination is to include:

a. visual acuity (VA) uncorrected and corrected, distance and near

b. contrast sensitivity (for those who have previously had refractive surgery) and corneal cross-linking; pre and post procedure)

c. refraction with effective cycloplegia (cyclopentolate HCL 1%)

d. ocular muscle balance (phorias), both distance and near

e. abnormality of ocular motility

f. accommodation

g. convergence

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[152] https://ranzco.edu/

[153] http://www.optometry.org.au/

h. stereopsis

i. visual fields to confrontation or, in cases of doubt/clinically indicated, to perimetry

j. intra-ocular pressures

k. diseases of the eyelid

l. fundus examination.

Refraction

7. To test for refraction, the degree of hypermetropia or myopia is measured with effective cycloplegia (Cyclopentolate HCl 1%).

Contrast sensitivity

8. Contrast sensitivity is to be tested only for those who have previously had refractive surgery or corneal cross-linking. Pre and post contrast sensitivity is to be pre and post procedure.

9. To test for contrast sensitivity, a Pelli-Robson 5% Low Contrast Sensitivity Chart at 3 metres is to be used. Eyes are to be tested individually and binocularly, both uncorrected and corrected.

Accommodation

10. To test for accommodation, use Foster's Near Point Rule (Royal Air Force (RAF) Gauge) and test each eye separately.

11. The examiner holds the handle and pushes the drum containing the types away from them to a point as near to the subject as possible. They turn the N-types towards the subject, and place the shaped face piece below the infra-orbital margins.

12. The examiner instructs the subject to read out the smallest print they can see and, as the drum is moved at a steady slow speed away from the eyes, instructs the subject to say when the smallest print first becomes clear to read correctly. This distance, shown by the rear edge of the slide carrying the drum, is recorded in centimetres.

Convergence

13. To test for convergence, leave both eyes uncovered when using Foster's Near Point Rule (RAF Gauge). The test card bears a line and dot. The examiner moves this target towards the subject. At some point on the scale, the examiner will see one eye hesitate in its convergence, and then suddenly diverge. This is the objective convergence, or near point of convergence, and its distance is recorded in centimetres.

Cover test

14. The cover test indicates the presence or absence of a small angle strabismus. The test is to be conducted as follows:

a. The subject is to look steadily at the examiner's right eye. The examiner observes the subject's left eye and passes an opaque material before the subject's right eye.

b. The examiner notes whether any movement occurs at the moment of fixation of the subject's left eye. If no movement is noted, then the subject must be binocular. If a refixation movement is noted, then a small angle strabismus is present.

c. While testing the subject's right eye, the examiner observes the subject's right eye while covering the subject's left eye. On removing the cover from either eye any deviation of the observed eye is noted and the recovery to binocular fixation is noted as rapid/slow/nil.

Maddox Rod Test

15. With the Maddox Rod test, heterophoria and its degree estimated both for distance and near may be detected.

16. The present day Maddox Rod is a disc of red glass on the surface of which are cut a number of grooves. These grooves have the property of converting a spot of light into a line, the direction of which is at right angles to the direction of the grooves. The use of this disc presents dissimilar images to the eyes, thus fusional control of the extra-ocular muscles is prevented and the covered eye takes up its position of rest. In heterophoria as the eye reverses and inverts images, the red line appears to go in the opposite direction to the movement of the eye. Therefore, with the Maddox Rod before the right eye the following result would be indicated:

a. red line to candidate's right of light—Esophoria (Eso)

b. red line to candidate's left of light—Exophoria (Exo)

c. red line above—left hyperphoria (L Hyper)

d. red line below—right hyperphoria (R Hyper).

17. **Method of test.** The method of testing is as follows:

a. With the candidate looking, with both eyes open, at a spotlight at a distance of six metres, the Maddox Rod is placed in a trial frame before the right eye with the grooves horizontal. If binocular vision is present a vertical red line is seen by the right eye and the spotlight by the left eye. The candidate is asked to which side of the spotlight the red line lies. Increasing powers of prisms are placed before the right eye, with the base of the prism towards the side on which the red line lies, until the red line appears to pass through the spotlight. The power of the prism, in prism dioptres, and the type of horizontal heterophoria it has corrected are recorded.

b. The test is repeated with the grooves vertical, producing a horizontal red line, and the degree of hyperphoria recorded, if any.

c. If the red line passes through the spotlight in both subparagraphs a. and b. above, the response is orthophoric (ortho).

18. **Common errors.** The following common errors are to be avoided:

a. The candidate shuts one eye.

b. The candidate does not relax to focus on the distant spotlight. Too high a degree of esophoria is indicated, which does not match the deviation detected by the cover test.

c. Multiple red lines seen because aberrant light sources are present. If the examination room cannot be blacked out the proper red line should be indicated by flashing the spotlight on and off a few times. White Maddox Rods are available for use with a red spotlight, aberrant light leaks producing white lines and the spotlight a red line.

19. **Falsification by the candidate.** Heterophoric candidates who know the test may declare immediately that the line passes through the light. If, following the cover test, orthophoria appears unlikely, a prism should be placed in an appropriate direction before the Maddox Rod. If orthophoria is still claimed, a closer check of the candidate's responses is indicated.

Stereopsis

20. Stereopsis is to be measured and quantified using a test that can eliminate monocular cues with grading of 20 seconds of arc; for example, TNO Stereotest or Randot Stereotest, with results required in arc seconds .

21. The TNO or Randot Stereotest, the book is to be stored in a cool dry place when not in use as exposure to high heat and humidity may cause fading of the test pages. Liquid and other cleaning agents are not to be used to clean the TNO or Randot Stereotest book contents or the 3D stereo optical glasses. The book and glasses may only be cleaned with the use of a soft, slightly damp cloth.

22. **Test environment.** The test is to be administered under good light conditions and book surface reflection is to be avoided.

23. **Test procedure.** The test procedure is as follows:

a. the test is a binocular test (ie both eyes together)

b. the stereo optical glasses, included in the test kit, are to be worn by the candidate during the test

c. the stereo optical glasses are to be worn over prescription glasses

d. for candidates who wear bifocal glasses, the book is to be positioned for near-point viewing

e. candidates who have removed contact lenses in preparation for assessment day testing are to be tested wearing prescription glasses (note: candidates who fail to bring prescription glasses on assessment day will need stereoscopic testing on another day or DFRC approval for testing by an optometrist for regional candidates)

f. the test book should be held straight before the candidate to maintain the proper axis of polarization (note: the candidate may hold the book and adjust the distance to suit)

g. test distance is to be at approximately 40 centimetres

h. there is no specified time that the test must be performed within

i. candidates are asked to choose between a number of alternatives to identify and quantify disparity, with grading to 20 seconds of arc

j. results are to be recorded in arc seconds on the Form PM086.

Visual fields

24. Confrontation is generally acceptable. If clinically indicated, computerised perimetry is required.

Near vision testing

25. Candidates for aviation-related occupations require near vision testing. The recommended near vision test procedure is the Sussex Vision Rayner near vision testing card which displays the N series of letters (faculty approved N5 to N48).

History of night vision problems

26. Good night vision is essential for all members, in particular those personnel required to operate in the field using tactical lighting or night vision devices. Poor or degraded night vision could be a major safety concern in Defence operations.

27. From time to time, candidates may require an assessment of their night vision because of a history of difficulty seeing at night. As there are no readily available screening tests for true night blindness, an assessment by an ophthalmologist is considered essential to exclude known causes of night blindness, such as retinitis pigmentosa, vitamin A deficiency, prescribed medication (eg anti-malarials) diabetes, cataract, macular degeneration, severe myopia, etc.

28. If the history and ophthalmological assessment supports the diagnosis of true night blindness or a related condition where night vision is compromised, the candidate will be considered unsuitable for entry.

SECOND APPOINTMENT

29. When a second appointment is required, the candidate should present in contact lenses after having worn them for at least four hours. The candidate should be instructed to bring their spectacles to the second appointment.

30. The ophthalmologist or optometrist should assess VA wearing spectacles immediately upon contact lens removal.

31. A candidate who wears contact lenses may be accepted if all of the following apply:

a. aviation visual requirement (AVR) is satisfactory, including VA in spectacles immediately on removal of contact lens

b. there is no pathological condition of the eyes

c. existing contact lenses are suitable for the proposed employment

d. wearing contact lenses is not clinically obligatory and spectacles can be substituted.

REFRACTIVE SURGERY

32. While refractive surgery provides an excellent alternative to the wearing of spectacles or contact lenses, refractive surgery is NOT a means for candidates to overcome uncorrected refractive errors which are outside existing ADF entry standards. The ophthalmologist or optometrist must NOT advise candidates to have refractive surgery as a means of meeting ADF entry standards if refractive error exceeds AVR 3.

33. Any aircrew candidate who has had refractive surgery must meet the following requirements:

a. Candidates who have had radial keratotomy, orthokeratology, PresbyLASIK (LASIK for presbyopia) or the implantation of phakic intra-ocular lens are not acceptable for ADF entry. Note: photo refractive keratotomy, Laser Epithelial Keratomileusis (LASEK) Laser in situ Keratomileusis (LASIK), Epi-LASIK and trans-epithelial ablation, and small incision lenticule extraction (SMILE) are acceptable procedures for entry in aircrew-related occupations.

b. At least three months must have elapsed post-surgery to correct myopia.

c. At least six months must have elapsed post-surgery to correct hypermetropia.

d. Two refractions are to be performed post-surgery by an ophthalmologist, at least one-month apart, with less than 0.5 dioptres of refractive difference, and less than 10 degrees of axis deviation, between the two measurements in the same eye. These two refractions are only required if the surgery was performed within the last 12 months.

e. They must have no history or evidence of unwanted symptoms or post-operative effects including but not confined to:

(1) decrease in best corrected VA

(2) raised intra-ocular pressure

(3) reduced contrast sensitivity, as tested using the Pelli-Robson 5% contrast sensitivity chart at 3 metres used by the ophthalmologist or optometrist (note: candidates are to be tested preoperatively and postoperatively, with abnormality indicated by score less than 1.50. Contrast testing and symptom discussion should not be undertaken until three months post-surgery for myopia and 6 months post-surgery for hypermetropia)

(4) corneal ulcers

(5) pain

(6) blurred vision

(7) glare or flare

(8) halos around lights or objects

(9) night vision

(10) aberrations

(11) no alteration in colour perception (CP) etc

(12) with special note of the absence of corneal aberrations and corneal haze.

f. They must have discontinued the use of all topical eye drops including steroids or anti-inflammatory agents but artificial tears may be used as needed.

g. They must meet all vision standards of the trade or specialisation.

34. Candidates who present for enlistment or appointment into the ADF and who declare a history of refractive surgery are to provide full details of their pre- and post-operative refractions as well as details of after-care from their provider. If this information remains unavailable, advice is to be requested from Institute Aviation Medicine (IAM).

35. It is important to recognise that refractive surgery has the potential to conceal pre-operative refraction below the visual standard required for entry. Where doubt exists, the candidate is to be referred to an ophthalmological consultant for assessment including corneal mapping.

Note:

(a) Alternative methods of measuring phoria include prism, and are permitted to be used.

APPENDIX 6B5

DENTAL EXAMINATION FOR AIRCREW CANDIDATES

1. Prior to confirmation of medical status, candidates for aircrew are to have a dental assessment. The assessment is to detect significant dental defects whose treatment would interfere with training or flying duties.

Minimum dental requirements

2. As a minimum for dental fitness, aircrew candidates must possess sufficient:

a. posterior teeth to provide bilateral posterior contacts to stabilise vertical dimension

b. anterior teeth to provide functional guidance

c. teeth to adequately support and retain existing or necessary prostheses.

Dental assessment

3. A Defence dental officer (DO) or Defence-approved civilian dentist is to perform the dental examination. The examination of the oral cavity, including appropriate diagnostic aids such as radiographs and/or orthopantograms where indicated, is to include specific comment on the following aspects:

a. oral hygiene

b. gingival and periodontal condition

c. occlusion

d. restorative requirements

e. anomalies (cleft lip/palate, cranio-mandibular dysfunction, etc)

f. prosthetic requirements.

4. There will be few cases where the presence of fewer than eight serviceable teeth per arch meet minimum dental requirement. A stable implant-borne prosthesis may fulfil these functional requirements. Teeth which cannot be brought into functional occlusion, or which demonstrate marked loss of periodontal support, are to be discounted.

5. On completion of the dental examination, the DO is to record findings on Form PM599—'Aircrew application dental examination' and record whether the candidate is dentally fit, temporarily unfit or permanently unfit.

Temporarily unfit

6. A candidate who has one or more of the conditions below is to be assessed as temporarily unfit where they are likely to participate in flying training within 24 months of entry:

a. need for orthodontics, to include Invisalign

b. active carious lesions

c. missing teeth which require prosthetic replacement in the short to medium-term for functional, phonetic, or aesthetic reasons

d. defective restorations, bridges or dentures

e. periapical or periodontal infection

f. acute or chronic infections of the soft tissues of the oral cavity

g. tumours or cysts in the oral cavity

h. marked malocclusion (eg a malocclusion that may impede fitting of aircrew oxygen masks, such as a micrognathia of the mandible).

7. The examining DO is to inform an initial candidate of any condition which constitutes cause for temporary rejection. The DO is to advise initial candidates who are temporarily rejected on dental grounds of the requirement to be dentally fit for aviation-critical health standards, although dental fitness of itself will not guarantee future acceptance.

8. DO must not refer initial entry candidates for specialist dental examination without prior consultation with Institute Aviation Medicine (IAM).

Confirmation

9. The confirming authority for dental fitness is an IAM-approved senior dental officer. The confirming authority requires qualifications and experience in aviation dentistry.

10. Where there is a temporary dental condition that is easily treatable and where the candidate is unlikely to participate in flying training within 24 months of entry (such as Australian Defence Force Academy entry), a candidate can be accepted into the Australian Defence Force (ADF). Before commencing flying training, treatment must be complete and confirmation of fitness must have been provided.

ANNEX 6C

MEDICAL REQUIREMENTS FOR IN-SERVICE TRANSFER TO AVIATION-RELATED OCCUPATIONS

INTRODUCTION

1. This annex provides the medical requirements for aviation-related occupations. Aviation medical officers (AVMOs) are to pay special attention to all aspects of the medical history and examination of each individual. AVMOs must ensure individuals meet the medical standards of this chapter and the following:

a. Military Personnel Policy Manual[154] (MILPERSMAN)

b. Defence Health Manual (DHM) Level 2 Part 5 Chapter 2[155]—'Medical history and examination', DHM Level 2 Part 5 Chapter 4[156]—'Occupation specific – medical standards' and DHM Level 2 Part 5 Chapter 5[157]—'Causes of and reasons for rejection'

c. DHM Level 2 Part 6 Chapter 5[158]—'Individual health assessment'

d. for Army candidates, the appropriate PULHEMS profile in DHM Level 2 Part 5 Chapter 1[159]—'Medical classification of candidates' and Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 3[160]—'The application of the military employment classification system and PULHEEMS employment standards in the Australian Army'.

Medical fitness to apply

2. Garrison health facilities and Service career and personnel management agencies (CMA/PMA) must ensure that serving members are medically fit before they transfer to an aviation-related occupation.

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[154] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/C5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765

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[160] http://drnet.defence.gov.au/Army/EMPA/ASI/P8/Pages/ASI(P)_Part_8.aspx

Preliminary medical review

3. An AVMO is to conduct a preliminary review of the member's Defence health record (DHR) and apply any reasons for rejection (see DHM Level 2 Part 5 Chapter 5). If the AVMO is uncertain about a member's medical fitness to proceed, the AVMO should seek SAVMO advice or request a determination for the condition(s) from IAM. The AVMO is to advise the relevant CMA/PMA of the member's medical fitness to proceed with the application via Form PM101—'Medical and dental fitness advice'. A member may request a review by the relevant Service Aviation Medical Advisor or Regional SAVMO where they believe the initial review did not adequately consider fitness for aviation-related duties.

4. Members are not fit for consideration of transfer if J3x, J4x or J5x. Members assigned J41 by the military employment classification – determinations (MEC-D) are considered on a case-by-case basis, before transfer / initial employment training. An AVMO is to review the member's DHR and apply the causes of rejection (see DHM Level 2 Part 5 Chapter 5). If in doubt, AVMOs may request Institute Aviation Medicine (IAM) review of the member's DHR prior to proceeding with the transfer medical.

Approval to proceed

5. The CMA/PMA is responsible for considering the preliminary medical review and providing authorisation to proceed with the in-Service medical transfer. No further medical action is to occur until CMA/PMA provides the written authorisation to proceed.

6. The Aviation Candidate Management Centre (ACMC) will provide the outcomes of aviation screening program (ASP) for each individual to IAM for refinement of the medical assessment.

7. **Confirmation.** All candidates must be confirmed as medically fit for an aviation-related occupation by IAM and have an allocated specialised employment classification (SPEC) prior to transfer.

8. IAM are to confirm service transfers for those in aviation occupations.

Air Force only

9. Candidates for Air Force officer aviation (OA) roles are to be assessed against the Aviation Class 1 medical standard to allow confirmation against all RAAF OA related occupations.

10. For IAM, if a candidate does not meet Aviation Class 1 standards, the candidate is to be assessed against Aviation Class 2: Mission aircrew (which excludes weapons system officer (WSO)).Finally, if those standards are not met, the candidate is to be assessed against Aviation Class 3: Mission controllers. A SPEC is to be applied against each officer aviation-related-occupations.

HEALTH REQUIREMENTS FOR AVIATION CLASS 1 AND AVIATION CLASS 2: MISSION AIRCREW

Medical examination

11. When assessing candidates, an AVMO is to:

a. review the applicant's completed Form PM165—'Health questionnaire' and DHR

b. conduct an individual health assessment (IHA) in accordance with DHM Level 2 Part 6 Chapter 5

c. apply the causes of rejection (see DHM Level 2 Part 5 Chapter 5)

d. apply the aviation-specific requirements for the relevant aviation class in accordance with Appendix 6B1

e. ensure the member meets the requirements in Table 6B–1.

Anthropometric requirements

12. Due to the nature of operations, optimal eye datum, anthropometric limitations of aircraft cockpits, design of ejection seats, parachutes, and seat stroking limits, additional standards apply to pilots, flight test engineers (FTEs), aviation warfare officers (AvWOs) and WSOs. Anthropometric requirements are in Table 6B–1. Guidelines for anthropometry measurement techniques are in Appendix 6B2. Nude body weight is measured in underwear.

13. Table 6B–1 only applies to pilot, FTE, AvWO and WSO candidates. All other candidates are assessed against the general entry (GE) anthropometry standards in DHM Level 2 Part 5 Chapter 4. IAM may require a cockpit assessment for candidates with a sitting height which is ≤ 0.5 cm outside of the anthropometry limits to determine cockpit compatibility.

Colour perception standard

14. The colour perception (CP) standards are in Appendix 6B1. CP is only valid for two years for aviation-related occupations.

Valsalva manoeuvre

15. The valsalva manoeuvre is to be performed and confirmed by the MO. If unable to be confirmed due to cerumen, the candidate is to be referred to their treating medical practitioner for removal of the cerumen and confirmation of the valsalva. If unable to be confirmed for any other reason, the candidate is to be referred for ear, nose and throat (ENT) opinion to enable assessment and diagnosis of eustachian tube function.

Sharpened Romberg Test

16. The Sharpened Romberg Test is to be performed in accordance with the procedure in DHM Level 2 Part 5 Chapter 2. Recent exposure to motion or consumption of alcohol may impair performance on the Sharpened Romberg Test. Practice can be encouraged and can improve ‘normals’ but not when a neurological condition exists.

17. Candidates with persistent failures should be referred to their treating MO for further neurological consultation.

Respiratory function

18. Candidates must have a forced expiratory volume in one second (FEV1) and a forced vital capacity (FVC) minimum 80 per cent of predicted values, and a FEV1/FVC ratio of 75 per cent or better.

19. In the clinical examination, the AVMO should give particular attention to any condition that might cause retention or trapping of expanding gas in any part of the lungs. If any result is outside the normal limits, the candidate must be reviewed by a respiratory physician, to enable assessment, formal pulmonary function testing, bronchial provocation testing (as required), and diagnosis.

Psychological stability

20. Candidates should not have significant fear of flying, fear of water or fear of confined spaces. If an AVMO has any concerns, the case should be discussed with IAM.

Specialist health assessments

21. The following specialist health assessments are required:

a. **Resting electrocardiogram examination.** All candidates are to have a 12-lead resting electrocardiograph (ECG). The ECG is to be reported on by a cardiologist and the record is to be part of the medical documentation.

b. **Visual examination.** All candidates are to be examined consistent with DHM Level 2 Part 5 Chapter 3, Table 3–1. Minimum aviation visual requirements (AVR) for specific aviation-related occupations are listed in Appendix 6B3. Guidelines for completion of the ophthalmology assessment for aviation-related occupations are in Appendix 6B4.

c. **Ear, nose and throat assessment.** Hearing standards (HS) are defined in DHM Level 2 Part 5 Chapter 2. Minimum HS for specific aviation-related occupations are in Appendix 6B1. Eustachian tubes must be patent and any nasal septal deviation or rhinitis carefully assessed. Candidates are to be referred to an ENT specialist if clinically indicated, to enable assessment and diagnosis of eustachian tube function.

d. **Dental assessment.** Candidates are to be dentally fit as per Appendix 6B5.

Pathology screening

22. Candidates for aviation-related occupations are to undergo the following tests:

a. full blood count and film

b. random blood glucose (point of care acceptable)

c. random lipids including HDL (point of care acceptable).

23. Blood results are to be within the normal laboratory range. Candidates with blood results outside the normal range are to be managed as per the relevant serial of DHM Level 2 Part 5 Chapter 5.

Refractive surgery

24. Candidates must not be advised to have refractive surgery as a means of meeting entry standards if they are outside of the required uncorrected minimum aviation visual requirement limits. Candidates who have had refractive surgery are to meet the standards in Appendix 6B5 of this chapter and in Annex K of DHM Level 2 Part 5 Chapter 5.

AVIATION CLASS 3: MISSION CONTROLLERS

25. **Anthropometric requirements.** Candidates are to meet the general entry anthropometry standards of DHM Level 2 Part 5 Chapter 5.

26. **Colour perception standard.** CP standards are in Appendix 6B1. CP is only valid for two years for aviation-related occupations.

27. **Psychological stability.** If an AVMO has any concerns, the case should be discussed with IAM.

28. **Specialist health assessments.** The following specialist health assessments are required:

a. **Resting electrocardiogram examination.** As for Aviation Class 1 and 2.

b. **Visual examination.** As for Aviation Class 1 and 2.

c. **Ear, nose and throat assessment.** HS are defined in DHM Level 2 Part 5 Chapter 3. Minimum HS for specific aviation-related occupations are listed in Appendix 6B1.

d. **Dental assessment.** Candidates are to meet dental standards for general entry to the ADF.

e. **Pathology screening.** As for Aviation Class 1 and 2.

f. **Refractive surgery.** As for Aviation Class 1 and 2.

CONFIRMATION OF MEDICAL FITNESS

29. If an AVMO determines a candidate to be Class 4 for transfer to an aviation-related occupation, the determination can be made at the garrison health facility and explained to the candidate. The candidate should not proceed to the specialist medical assessments in this annex if determined Class 4 prior to that stage. IAM is to be contacted by the AVMO if there is any doubt as to the Class 4 determination made at the garrison health facility.

30. Candidates who are not Class 4 as determined by the AVMO are to complete the specialist medical assessments, and if the member meets the initial entry requirements for aviation-related occupations, the AVMO is to document recommended MEC / SPEC and restrictions in the body of the electronic health record entry only. AVMO are not to input a recommended SPEC into the MEC protocol. Garrison health facilities are to forward the medical documentation / task to IAM for confirmation.

31. The confirming authority for medical fitness is the commanding officer (CO) IAM or their appointed medical delegate. If IAM confirms a candidate as medically fit, IAM is to:

a. determine and confirm a MEC/SPEC in accordance with MILPERSMAN Part 3 Chapter 2[161]—'Military employment classification system'

b. raise Form PM532—'Military employment classification (MEC) advice' within the DHR and annotate that 'in accordance with DHM Level 2 Part 5[162], member is confirmed as medically fit for transfer. SPEC is to be allocated upon successful transfer'.

32. IAM is to notify the relevant garrison health facility of the classification / confirmed status. If the candidate is Class 3 – temporarily unfit or Class 4 – permanently unfit, IAM is to outline the reasons for classification via an entry in the DHR. If Class 4, IAM will state whether or not a waiver is supported. If a waiver is supported, IAM will complete Form PM166-2—'Confirmation of medical fitness', to allow progression to the relevant CMA/PMA.

33. The member's garrison health facility is to advise the reasons for the Class 3 or Class 4 outcome, as stated in the DHR.

[161] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/C5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765

[162] https://dpeintranet-dpg.defence.gov.au/strategy-policy/policies-manuals/defence-health-manual

CURRENCY OF ASSESSMENTS

34. A transfer medical examination is valid for 12 months; however, the following tests and assessments are valid for 24 months:

a. pathology testing (FBE, glucose, lipids-HDL)

b. dental assessment

c. ophthalmology examination

d. ECG and cardiologist report.

35. IAM confirmation is valid for 12 months. If it is 12–24 months since confirmation, the member only requires a current IHA (see DHM Level 2 Part 6 Chapter 5) for IAM confirmation. If it is more than 24 months since confirmation, and the member has not transferred to an aviation related occupation, the member will be required to complete all of the medical assessments in this Annex again. The member's garrison health facility is to remove the member's allocated SPEC from within the DHR.

WAIVER OF MEDICAL STANDARDS

36. For aviation-related occupations, IAM will provide a waiver recommendation to the gaining Service's Service aviation medicine adviser (SSAMA) or delegate. The waiver recommendation is to provide sufficient information to enable a risk assessment.

37. The SSAMA is responsible for providing the following to the relevant CMA/PMA:

a. member's consent

b. a Service recommendation on the candidate's medical suitability for transfer

c. a MEC and SPEC appropriate to the gaining occupation

d. details of any restrictions.

38. The CMA/PMA are responsible for the waiver decision, which remains valid for 24 months for the waivered condition.

39. If the waiver is approved, IAM is to be notified in writing, and will raise Form PM532 and annotate that the 'Waiver of the medical standard was approved by xxx dated xxx. In accordance with DHM Level 2 Part 5, member is confirmed as medically fit for transfer. SPEC is to be allocated upon successful transfer'.

REVIEW OF CLASSIFICATION DECISION

40. An in-Service transfer candidate who is Class 4 and does not have IAM support for waiver action may seek a review of the classification decision. In-Service transfer candidates are to progress requests for review, via Minute, to IAM for consideration by a second and independent senior AVMO within IAM.

41. A successful review of classification decision would require the provision of:

a. new medical evidence indicating that the condition is no longer evident and the risk of recurrence is low, or

b. evidence that the original assessment was based on an incorrect diagnosis, or

c. evidence that standards have been inappropriately applied.

42. Any costs incurred in providing this medical evidence will be at the member's expense.

43. IAM may request additional reports or investigations to determine the suitability of the candidate, which will be performed through the garrison health facility.

44. IAM is to notify the relevant garrison health facility of the classification / confirmed status. If the candidate is Class 3 – temporarily unfit or Class 4 – permanently unfit, IAM is to outline the reasons for classification via an entry in the DHR. If Class 4, IAM will state whether or not a waiver is supported. If a waiver is supported, IAM will complete Form PM166-2, to allow progression to the relevant CMA/PMA.

45. The member’s garrison health facility is to advise the reasons for the Class 3 or Class 4 outcome, as stated in the DHR.

46. Further review, second level appeal, is to be processed in accordance with DHM Level 2 Part 5 Chapter 3[163]—'Entry of candidates with previous military service' (paragraph 3.36).

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ANNEX 6D

MINIMUM MEDICAL REQUIREMENTS FOR OFFICER AVIATION CANDIDATES TO PROCEED TO THE AVIATION SCREENING PROGRAM

1. This chapter provides the minimum medical requirements for initial entry or re-entry candidates applying for the officer aviation (OA) role. It does not apply to in-Service candidates for OA roles.

OFFICER AVIATION ROLE

2. The OA role includes the following occupations:

a. pilot (Army, Navy and Air Force)

b. weapons system officer (WSO)

c. aviation warfare officer (AvWO)

d. maritime patrol and response officer (MPRO)

e. airspace battle manager - airborne (ABM-A)

f. airspace battle manager - ground environment (ABM-G)

g. air mobility officer - air refuelling officer (AMO-ARO)

h. air mobility officer - combat systems operator (AMO-CSO)

i. air traffic controller (ATC)

j. remote pilot (RP)

k. remote pilot warfare officer (RPWO).

MEDICAL REQUIREMENTS

3. Medical assessment for the OA role is to include the following:

a. Medical history questionnaire (MHQ) and entry level medical examination (ELME) are to be conducted in accordance with Defence Health Manual (DHM) Level 2 Part 5[164]—'Health standards and assessments – entry and

[164] https://dpeintranet-dpg.defence.gov.au/strategy-policy/policies-manuals/defence-health-manual

transfer'. DHM Level 2 Part 5 Chapter 5[165]—'Causes of and reasons for rejection' is to be applied.

b. The minimum requirements for OA candidates to proceed to aviation screening program (ASP) are in Table 6D–1.

c. Candidates who are recruiting medical class 3M, 3R or 4W for OA may proceed to ASP.

d. For candidates who are recruiting medical class 4Q, 4E or 4J for OA, a Defence Force Recruiting medical officer (DFR MO) can make and confirm the class 4 determination and inform the candidate.

e. Mandatory external assessments inclusive of ophthalmology, pathology, cardiologist report of electrocardiogram (ECG), bronchial provocation test (if required) and dental assessment are to be scheduled as soon as practicable following ELME. The applicant can proceed to ASP prior to receipt of the report(s).

f. Medical fitness determination (MFD) or waiver request should be submitted to the chief medical officer (CMO) DFR (for Institute Aviation Medicine (IAM)) as soon as practicable once sufficient relevant information is available.

Table 6D–1: Minimum requirements for OA applicants to proceed to ASP

Examination	Minimum requirement
Anthropometry	Yes (see Table 6D–2)
Valsalva	Yes
Sharpened romberg	Yes
Colour perception	2
Respiratory function test (spirometry)	Yes (see note a)
ECG (with cardiologist report)	Yes
Visual requirements	Ophthalmology report – AVR 3 (see note b)
Hearing standard	HS1
Pathology screening	Yes
Asthma screening	See note c
Aviation dental	Yes

Notes:

(a) Spirometry parameters: FEV 1 minimum 80% of predicted value; FVC minimum 80% of predicted value; FEV1/FVC ratio = or > 75% of predicted value. If a candidate fails to meet any spirometry parameter(s), DFR may progress the candidate to ASP. DFR is to request a medical

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fitness determination (MFD) as soon as practicable from IAM. IAM will determine any further investigations, and/or any further restrictions such as 'should only be considered for airspace battle manager – ground (ABM-G) or air traffic controller (ATC)'. The MFD is to include MEDFOR 211 with a copy of relevant reports, MHQ, MHQ vetting and ELME.

(b) As a minimum, candidates must meet minimum visual requirements (MVR) 3 at Defence Force Recruiting Centre (DFRC) in order to proceed to ASP. Ophthalmology assessment with Form PM086—'Eye examination - aviation' is to be completed as soon as practicable.

(c) Asthma: If > 12 months with nil symptoms or use of medications for symptoms, a negative bronchial provocation test is required as soon as practicable. If >12 months but less than 5 years with nil symptoms or use of medication for symptoms, candidates can be considered only for mission – ground roles. If >5 years with nil symptoms or use of medication for symptoms, candidates can be considered for all OA roles.

Table 6D–2: Minimum anthropometric standards for attendance at ASP

Parameter	Minimum	Maximum
Body mass index	18.5	32.9
Nude weight (note a)	44 kg	105 kg
Sitting height (note b)	78 cm (note c)	101 cm
Buttock–knee length (note d)	50 cm (note e)	67 cm
Total leg length (note f)	95 cm	129 cm
Standing height	152cm	Not applicable

4. For all OA candidates, the confirming authority for medical fitness is commanding officer (CO) IAM or their appointed medical delegate. DFR medical sections are to provide all medical documentation for each candidate to IAM for confirmation.

5. For all OA candidates, the ELME, mandated medical tests, IAM confirmation and medical waiver approvals are valid for 12 months. If a candidate's medical status changes, an MFD or medical waiver request is to be resubmitted to CMO (for IAM) as soon as practicable.

6. DFR MOs are to complete the Aviation Candidate Management Centre (ACMC) checklist for all candidates attending ASP. This checklist is to be included in the OA dossier and will allow ACMC to stream candidates into specific occupations based on their suitability.

Notes:

a. Failure to meet weight parameters: candidates can be considered only for RP, RPWO, AMO-ARO, AMO-CSO, MPRO, ABM-A, ABM-G, ATC.

b. Failure to meet sitting height parameters: candidates can be considered only for RP, RPWO, AMO-ARO, AMO-CSO, MPRO, ABM-A, ABM-G, ATC.

c. If minimum sitting height is between 78 and 82.9cm: candidates can be considered only for Air Force OA roles and RPWO.

d. Failure to meet buttock–knee parameters: candidates can be considered only for RP, RPWO, AMO-ARO, AMO-CSO, MPRO, ABM-A, ABM-G, ATC.

e. If minimum buttockknee parameters are between 50 and 53.9cm: candidates can be considered only for Air Force OA roles and RPWO.

f. Failure to meet total leg length parameters: candidates can be considered only for Air Force OA roles and RPWO.

CHAPTER 9

REVIEW OF RECRUITING MEDICAL CLASSIFICATION DECISION

INTRODUCTION

9.1 A candidate who is allocated to Class 3 or Class 4 may submit a request for review of decision following written notification of the recruiting medical classification. A request for review cannot be submitted by a third party unless the candidate provides written consent.

9.2 The review authority will consider the case and notify the candidate of the outcome of the review.

Aim

9.3 This chapter provides policy on the review of decisions for ab initio candidates for the Australian Defence Force.

Scope

9.4 This chapter is written for personnel who provide health services or health support to Defence Force Recruiting (DFR).

9.5 This chapter applies to initial entry and re-entry candidates. For in-Service or lateral transfer candidates, refer to Defence Health Manual (DHM) Level 2 Part 5 Chapter 3[186]—'Entry of candidates with previous military service'.

POLICY

Review authority

9.6 Candidates have the opportunity to have their decision reviewed once. The review authority must be objective and capable of conducting an independent review of the case. Review authorities must not review their own decisions. If a review authority is unable to undertake an independent review, the case should be referred to another review authority. If a case is complex or sensitive, the review authority should consult chief medical officer (CMO) DFR.

9.7 **Review determinations.** The following appointments have the authority to make review determinations:

a. general entry occupations: CMO DFR or delegate

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b. specialist occupations: confirming authority for the specialist occupation.

9.8 **Transferring responsibility.** If a review authority refers a review of decision to another review authority, the referring review authority is to:

a. ensure a journal comment notes the transfer of the review (DFR staff are responsible for entering journal comments for non-DFR review authorities)

b. transfer the documentation to the new review authority electronically if possible (if transferring hard-copy documentation, raise Form PM384—'Personal health records and test material transit note (issue and receipt voucher)', with a clear statement of the reason for transferring the documentation

c. ensure the appeal documentation is tracked via the normal process for receiving and transferring documents.

9.9 **Reporting.** At the end of each month, DFR review authorities are to send copies of all review determinations and notification letters to CMO DFR (irrespective of outcome) with a 'review of determination coversheet'.

Review criteria

9.10 A review of a recruiting medical classification decision assesses whether the recruiting medical classification is correct. For the candidate to achieve a 'successful' outcome and progress, the review authority must be satisfied of any one or more of the following:

a. new medical evidence indicating that the relevant condition has resolved (cured or long-term remission in the absence of ongoing treatment) and the risk of recurrence is low

b. evidence that the original classification decision was based on an incorrect diagnosis

c. evidence that medical standards have been inappropriately applied resulting in an incorrect classification.

Review process

9.11 **Processing**. For non-specialist occupations, the medical section is to send the request for review to the relevant review authority for a review determination. For specialist occupations, the medical section is to send the request for review to CMO DFR, who will request review from the relevant confirming authority.

9.12 The review authority is to consider the request and any supporting evidence to determine whether the medical standards have been correctly applied and the classification is correct. Review authorities should complete the review of decision within six weeks of DFR's receipt of the request. Delay should only occur under extenuating circumstances when additional external advice is required to assist with determining the review.

9.13 The review determination is to be recorded on the candidate's DFR medical record. Correspondence related to the determination is to be scanned into the candidate's DFR medical record.

Original decision changed

9.14 If the candidate provides evidence relating to the diagnosis that the original recruiting medical classification decision relied on, then the review authority can assess the case against the relevant annex of DHM Level 2 Part 5 Chapter 5[187]— 'Causes of and reasons for rejection'. Supporting documentation must be in accordance with the requirement of the relevant annex to DHM Level 2 Part 5 Chapter 6.

9.15 If the review authority decides to change the candidate's recruiting medical classification, the review authority is to:

a. annotate the entry level medical examination (ELME) to indicate the review has resulted in a change to the recruiting medical classification and note the new classification (if the review authority does not have access to the ELME, the review authority is to notify CMO DFR or delegate of the annotation requirement)

b. list the specialist report(s) relied on (noting specialisation and date of each report)

c. for specialist occupations, comment on the specialist employment classification

d. record a journal comment, noting location of review, outcome of review and name of review authority (ie 'reviewed at DFRC, outcome – medical classification, by Dr XXX')

e. prepare a determination letter (generated via the candidates medical record), clearly articulating the decision (note: there is no requirement to include an explanation in the letter if the candidate now meets the entry medical standards).

9.16 Defence Force Recruiting Centre (DFRC) medical staff are to counsel the candidate about the outcome of the review by providing the letter advising the candidate of the outcome of the review.

Further information required

9.17 If the review authority considers that additional information is needed (Class 3R) to support the review, the review authority is to prepare a determination – further information required letter for the candidate (generated via the candidates medical

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record). The letter is to list the information required and the reason the information is required.

Original determination upheld

9.18 If the review authority determines that the original recruiting medical classification decision is correct, the review authority is to prepare the relevant determination letter for the candidate (generated via the candidates medical record). The letter is to provide the outcome and the reasons for the determination. The letter should:

a. explain why the review found the original decision is correct

b. clearly articulate that the candidate does not meet the standards and use phrasing that is sensitive to the candidate's feelings/expectations

c. use the suggested wording provided to review authorities by CMO DFR, and discuss concerns or difficulties around phrasing with CMO DFR if necessary.

9.19 Letters that uphold the original decision must provide reasons for the decision and why the candidate's condition is not considered compatible for military duties. Any cases of doubt are to be discussed with or forwarded to CMO DFR for determination.

9.20 DFR medical section staff are to counsel the candidate about the outcome of the review by providing the letter advising the candidate of the outcome of the review. The letter is to provide DFR contact details should the candidate wish to discuss the outcome further with DFR medical staff.

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