CHAPTER 2

MILITARY EMPLOYMENT CLASSIFICATION SYSTEM

INTRODUCTION

2.1 Members are generally expected to be able to carry out their duties across various employment environments. The mechanism by which the Australian Defence Force (ADF) characterises the employment, deployment and rehabilitation support requirements of members is by the allocation of an individual military employment classification (MEC).

2.2 Allocation of MEC may have implications for members on the nature of their employment, including postings, training, transfers between employment categories, payment of specialist allowances and ultimately, retention in the ADF.

2.3 The MEC system is intended to provide the chain of command with information relating to a member's employability and deployability, including any restrictions they may have, and what health or logistic support may be required in order to mitigate risk. All information is to be managed in accordance with the Defence Privacy Policy[10]; and health information is to be managed in accordance with the Defence Health Manual (DHM) Level 2 Part 3 Chapter 1[11]—'Collection, use and disclosure of health information by Defence health personnel'.

Aim

2.4 The aim of this chapter is to support the implementation of Military Personnel Policy Manual (MILPERSMAN) Part 3 Chapter 2[12]—'Military employment classification system' by health practitioners.

POLICY

Military employment classification system

2.5 The MEC system is applied through individualised assessment of a member's medical fitness for service, as relevant to their employment area. The MEC system is a personnel management system, not a patient management tool.

2.6 The provision of accurate medical advice to individuals, commanders and Career Management Agencies (CMA) is the capstone of the MEC system and is the responsibility of all Defence health personnel.

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2.7 There are three outputs from the MEC system that summarise a member's medical fitness for service. They are:

a. **Military employment classification.** A MEC is an alphanumeric code defined as per MILPERSMAN Part 3 Chapter 2 that characterises the broad employability or deployability of that member.

b. **Specialist employment classification.** All specialist employment streams will have an additional specialist employment classification (SPEC), which characterises any broad limitations on performance of their occupational specialist duties.

c. **Employment annotations.** Employment annotations highlight specific limitations, requirements and restrictions for a member, in support of the allocated MEC/SPEC.

Responsibilities

2.8 The following organisations and appointments maintain responsibilities within the MEC system. These responsibilities are summarised as follows:

a. **Joint Health Command.** Joint Health Command (JHC) is responsible for the provision of all garrison health care in the ADF. Commanding officers of Joint Health Units (CO JHU) are to ensure all health practitioners allocating MEC within their unit are credentialed and authorised to do so.

b. **Member's chain of command.** The member's chain of command is responsible for the administrative management of the member based on the advice and information provided from health practitioners, career managers or the MEC review board (MECRB). See MILPERSMAN Part 3 Chapter 2.

c. **Military employment classification review board.** A MECRB is a personnel management function. It enables an employment review where a member's long-term medical fitness for employment or deployment is in doubt. JHUs are responsible, through the Central MEC review (CMECR) process, for undertaking an assessment of the member's health status to inform the MECRB's review. See MILPERSMAN Part 3 Chapter 5[13]—'Military employment classification review board' and Annex 2B.

d. **Career management agencies.** CMA are responsible for the presentation of information, advice and options to the MECRB for consideration regarding the member's employment. Once the MECRB has provided a decision on the member's MEC, the CMA are responsible for all career management arising from the decision. See MILPERSMAN Part 3 Chapter 2.

[13] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/%7BC5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765%7D

e. **Member.** Members are responsible for informing their chain of command of their MEC/SPEC and any implications this may have on their employment and management. Members are responsible for timely submission of paperwork in order to determine or review a MEC/SPEC, however, allocation of MEC/SPEC should not be unduly delayed due to a delay in receiving information from a member.

Military employment classification levels

2.9 The MEC system has five categories, each containing sub-classifications that summarise a member's medical fitness for deployment and employment. The levels are:

a. **MEC 1—Fully employable and deployable.** MEC 1 sub-classifications are only used in the Joint environment.

b. **MEC 2—Employable and deployable with annotations.** MEC 2 sub-classifications are applicable in the Joint, Land or Maritime environments.

c. **MEC 3—Temporarily not deployable with annotations.** Not fit for operational deployment. All MEC 3 sub-classifications are applied in the Joint environment. Designated Service medical officer (DSSMO) guidance should be sought where limited opportunities for non-operational activities arise.

d. **MEC 4—Employment at Service discretion.** All MEC 4 sub-classifications are applied in the Joint environment. J40 is the default category to be applied by health practitioners when a case is referred to the MECRB. Other MEC J4 sub-classifications can only be allocated by the MECRB.

e. **MEC 5—Not employable and not deployable, unfit for further service.** Not capable or suitable for continued employment. All MEC 5 sub-classifications are applied in the Joint environment and may only be allocated by the MECRB.

2.10 MILPERSMAN Part 3 Chapter 2 contains a detailed definition of the MECs and how they relate to health, employment and timings (including maximum periods of allocation). Additional information is located at the JHC Military Employment Classification System website[14].

Environmental classifications

2.11 While Defence operates in a variety of environments, there are three that are considered within the MEC system. These are used to indicate a member's medical fitness for service in that environment and are the basis for the 'alpha' element of the MEC code. The environments are:

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a. **Joint (J).** This is the default for members.

b. **Land (L).** This is only used for Army members with significant employment constraints.

c. **Maritime (M).** This is used for all Navy members and other members posted/attached to deployable Navy units, to reflect their ability to deploy in the maritime environment with specific health support requirements.

Specialist employment classifications (SPEC)

2.12 SPEC are additional classifications allocated to all specialist employment stream personnel using a two-digit alphanumeric code. The first part of the code refers to the following:

a. SPEC A: aircrew

b. SPEC C: aviation mission controllers

c. SPEC D: divers

d. SPEC P: military freefall parachutists

e. SPEC S: submariners.

2.13 The second element of the SPEC refers to an individual's medical fitness to undertake the specialist duties for which they are trained as follows:

a. 1—fit for unrestricted specialist duties

b. 2—fit for specialist duties but with some constraints

c. 3—unfit for specialist duties for a period up to 12 months
d. 4—unfit for specialist duties for a period longer than 12 months.

2.14 Practitioners must be specifically credentialed to assess SPEC. Guidance on the application of SPEC and the SPEC codes is in Annex 2D.

Employment annotations

2.15 A MEC and, where applicable, SPEC alone do not provide sufficient administrative guidance on the safe employment of members. Employment annotations highlight key employment requirements that must be recorded in full at each review of a member's MEC and on the Form PM532—'Military employment classification (MEC) advice'.

2.16 Annotations are grouped in the following series:

a. 1–series. Physical fitness activities

b. 2–series. Specific employment activities

c. 3–series. General duties

d. 4–series. Health support requirements

e. 5–series. Geographic and environmental limitations

f. 6–series. SPEC duties

g. 7–series. Multiple requirements and limitations during treatment or rehabilitation.

2.17 A full list of annotations and their descriptors is in Annex 2B.

Authorisation to review and allocate MEC

2.18 Defence health practitioners conducting MEC reviews must have completed Defence MEC training available on the Learn eXcel Platform[15]. All Defence-employed MOs (including contracted health staff in JHC) are authorised to conduct a MEC review and recommend a MEC on completion of this training. MOs are only authorised to allocate MEC in the following circumstances:

a. for movement between J11 and J12

b. for movement between J21 and J22

c. when there is no change to J11, J12, J21, J22, J23, M24 or M25

d. When allocating MEC J31 for up to six months

e. When allocating MEC J33 for up to 24 months.

2.19 Health practitioners other than MO may be authorised to conduct MECR, on endorsement by Surgeon General ADF (SGADF).

2.20 MEC allocation outside the circumstances in paragraph 2.18 require confirmation by an authorised MO designated as a ‘confirming authority’. Confirming authorities must be appointed by regional medical advisers or DSSMOs and registered on the Confirming authority Register[16]. All confirming authorities are required to be Medical Level three or four (or civilian equivalent) and must be deemed competent to perform MECR and/or CMECR by the regional medical advisor/DSSMO.

2.21 Confirmation of MEC allocation is required by a local confirming authority when:

a. the allocation of J23, M24, M25 or J34 is recommended

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b. the new MEC allocation involves movement between J1 and J2

c. the allocation of MEC J31 for a period greater than six months is recommended

d. the new MEC allocation involves movement from J3 to a deployable MEC.

2.22 The confirming authority is to review the documentation and confirm that the assessment is an accurate representation of the member's medical status and conforms to extant health policy.

2.23 Navy members allocated MEC J3X require either restriction 3–15 – 'fit to work in ships alongside' or 3–18 – 'unfit to work in ships alongside' to be allocated. The allocation of M26 requires Fleet MO (FMO) confirmation.

2.24 All MEC reviews requiring a CMECR must be confirmed by a regional confirming authority. The confirming authority is to review the documentation and confirm that the assessment is an accurate representation of the member's medical status and conforms to extant health policy. The role and responsibilities of the confirming authorities are in Annex 2B.

2.25 SPEC allocations require confirmation by a separate confirming authority, as detailed in Annex 2D.

MEC allocation

2.26 Health practitioners are to consider the appropriateness of a member's MEC at every clinical contact. Not all changes to a member's health status will require MEC re-classification. Short-term conditions may be managed through the use of temporary annotations to the current MEC on Form PM101—'Medical or dental fitness advice'. Where a member's health status and capacity to perform their role is not accurately reflected in the MEC allocation, and is likely to be so for more than 28 calendar days, the MEC should be amended. Where a more restrictive MEC is required this should be applied as soon as is practicable.

2.27 When reviewing a member's MEC, the examining health practitioner must take into consideration the nature of the member's employment, the requirements of a deployed setting and the tasks that an individual could be expected to perform as part of their general military duties. Member employment restrictions must be assessed against these criteria. Medical fitness standards for specific conditions are detailed in a number of policies. In addition, Service guidance is provided as follows:

a. **Navy.** DHM Level 3 Part 6 Chapter 4[17]—'The military employment classification system and the maritime environment'.

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b. **Army.** Army Standing Instruction (Personnel) (ASI(P)) Part 8 Chapter 3[18]— 'The application of the military employment classification system and PULHEMS employment standards in the Australian Army' contains information on the conduct of the assessment and the details on the employment requirements for all roles within Army.

c. **Air Force.** Air Force members are to be managed in accordance with the DHM.

2.28 Guidance on the assessment of medical suitability is in Annex 2C. If the treating health practitioner has any doubts about a member's medical fitness for employment or general service duties, the local confirming authority is to be consulted.

2.29 Where a MEC requires reclassification, the health practitioner is to recommend (or allocate, where authorised):

a. **A MEC and/or SPEC.**

b. **Annotations.** These provide greater detail about the member's capacity and limitations

c. **Expiry date.** The date that the recommended or allocated MEC is expected to be valid until. MEC expiry should not be extended any greater than 12 months beyond the due date of their next cardiovascular risk screening, up to a maximum of five years.

Central military employment classification review (CMECR)

2.30 In accordance with (IAW) MILPERSMAN Part 3 Chapter 2, a CMECR must be considered when:

a. a member is likely to be J3X for greater than 12 months. .

b. when an authorised health professional recommends MEC J29, L27, L28, or MEC J32

c. when the application of MEC M26 is sought beyond two years

d. when a member has been MEC J34 for greater than four months

e. when a member has been MEC J33 AND any of the following applies:

(1) member is reclassified to pre-pregnancy MEC J29

(2) member is reclassified to pre-pregnancy MEC J4x

[18] http://drnet.defence.gov.au/Army/EMPA/ASI/P8/Pages/ASI(P)_Part_8.aspx

(3) member was MEC J31 before pregnancy and is considered not deployable because of the status of the pre-pregnancy condition that warranted MEC J31.

f. Members undergoing ab initio training for employment as ADF officers and other ranks:

(1) Officer cadets/ Midshipmen (Australian Defence Force Academy) – if the anticipated recovery from an injury or medical condition, or the period of actual recovery, is longer than 12 months

(2) GAP year participants and all other members undergoing ab initio training (other than 2.40e(1)) – if the anticipated recovery from an injury or medical condition, or the period of actual recovery, is longer than 16 weeks

g. where the CMA or their delegate has directed MEC determination (MECD) consideration

h. when directed for further review by the MECD.

2.31 In all CMECR cases, members are to be confirmed as MEC J40 by the regional authority and a resultant Form PM532 is to be raised. The interim and final MEC will be allocated by MECD.

2.32 The case may also be considered for an extension of MEC J31 at a local level IAW MILPERSMAN Part 3 Chapter 2, Annex 2E.

2.33 If a member who is J33 extends their maternity leave, any IHA, CMECR or MECD requirement can be deferred until the member completes their maternity leave.

Members returning for periodic MECD review

2.34 For members holding a MECD-assigned deployable MEC, the member can remain at their current MEC (and not assigned J40) pending the MECRB determination, where the Regional Confirming Authority believes that this is clinically appropriate.

Special considerations

2.35 **Concurrent and consecutive conditions.** A member may experience a period where concurrent and/or consecutive medical conditions affect their MEC. As soon as it is anticipated that the total period of time that a member will be medically unfit for deployment is likely to extend beyond 12 months, the following action is to be taken:

a. **Consecutive condition.** A member has recovered from a condition resulting in MEC 3 and is awaiting MEC allocation. Prior to the MEC allocation they suffer another condition indicating recalssification of MEC 3. If the combined period of MEC 3 is greater than 12 months, a CMECR is to be conducted and

is to clearly state the MEC that would have been allocated had the second condition not presented

b. **Concurrent condition.** If a member currently confirmed as MEC 3 develops another medical condition requiring treatment or rehabilitation that renders the member non-deployable, a CMECR is to be conducted when the total period that the member is medically unfit for deployment exceeds 12 months.

2.36 Only one MEC can be allocated to a member at any one time.

Members diagnosed with a terminal illness

2.37 When a member is diagnosed with a terminal illness, the priority is to enable the member to receive appropriate support. Detail is covered in DHM Level 2 Part 2 Chapter 7[19]—'Terminal illness and end-of-life care for members'. It is essential that a CMECR is conducted as soon as practicable, to facilitate optimal support for the member and their family by their Service, the Department of Veterans Affairs (DVA) and Commonwealth Superannuation Corporation (CSC).

Medically unfit to complete a component of physical fitness assessment

2.38 Members who have medical conditions that restrict them from completing components of their Service physical fitness assessments may still be deployable as MEC J2x. MOs should consider Service policy below when allocating annotations in order that modification of components of the fitness assessment may be considered. When doing so protection of the member's medical condition is paramount, and a non-deployable MEC may be more appropriate.

a. Navy members. Australian Navy Publication (ANP) 4104-3[20]—'Conduct of the Royal Australian Navy physical fitness test' (Annex 1B)

b. Army members. ASI(P) Part 8 Chapter 4[21]—'Physical training'

c. Air Force members. Air Force Physical Training and Testing Manual[22].

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[20] http://ibss/PublishedWebsite/Latest/{FDDE6B03-8AE1-4F8A-81E5-35191A2190DF}/Item/{E7ADD673-D93B-44AB-88D1-0611441BDE67}/Feature/id={8A55C0A5-961E-412A-99DD-18648BAB6A9D}

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Risk analysis

2.39 A formal risk analysis may assist the examining authorised health practitioner reallocation or recommend a MEC. Risk assessments should be conducted in accordance with DHM Level 3 Part 2 Chapter 9[23]—'Individual health risk assessment'.

Allocation of MEC on entry and transfer

2.40 **Enlistment or appointment to the ADF.** Authorised health practitioners at point of entry garrison health facilities are to ensure that the appropriate MEC is entered into the Personnel Management Key Solution (PMKeyS) and Form PM532 is to be raised.

2.41 **Transfers of personnel between and within the Services.** Medical fitness for members transferring between or within the Services is addressed in MILPERSMAN Part 3 Chapter 2 and DHM Level 2 Part 5 Chapter 3[24]—'Entry of candidates with previous military service'. The decisions regarding standards of medical fitness for transfer remain a personnel management function.

Representation

2.42 A member or their commander/manager may contest a decision made as part of the MEC allocation process. In the first instance resolution should be sought informally through the JHU health centre manager and involved health practitioner. Formal representation is covered in MILPERSMAN Part 3 Chapter 2.

SPONSOR: Deputy Surgeon General Australian Defence Force

Annexes:
2A Assessment of medical suitability
2B Responsibilities
2C Restriction codes and their descriptors
2D Application of specialist employment classifications
2E Documentation required for CMECR

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ANNEX 2A

ASSESSMENT OF MEDICAL SUITABILITY

INTRODUCTION

1. This annex outlines the issues to be considered when assessing the medical suitability of members for deployment. Specific guidance for assessing the medical suitability of members with respect to the maritime environment is in Defence Health Manual (DHM) Level 3 Part 6 Chapter 4[25]—'The medical employment classification system and the maritime environment'. Specific guidance for assessing the medical suitability of Army members is in Army Standing Instruction (Personnel) (ASI (P)) Part 8 Chapter 3[26]—'The application of the military employment classification system and PULHEMS employment standards in the Australian Army'.

2. Authorised health practitioners have a responsibility to consider every member's medical suitability for service at each consultation. Where a change in military employment classification (MEC) is being considered, the onus is on authorised health practitioners to ensure they understand not just the nature of the member's condition, but also how this will impact on medical suitability for employment and deployment.

3. In circumstances where employment and/or deployment issues are being considered for a member who is of borderline fitness, then a formalised assessment of medical suitability is to be completed by the treating authorised health practitioner at the MEC review (MECR).

Individual health risk assessment

4. A formal assessment of medical suitability and health risk analysis, conducted in accordance with DHM Level 3 Part 2 Chapter 9[27]—'Individual health risk assessment', is mandatory under the following circumstances:

a. members being recommended as J29

b. members recommended as M26

c. members recommended as L27 or L28

d. when requested by the MECR board (MECRB) or the chain of command as part of an overarching risk assessment.

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5. The risk assessment is to be recorded on Form PM611—'Health risk assessment'.

General principles of medical suitability

6. Determining medical suitability requires:

a. a general appreciation of medical suitability for service

b. an understanding of the nature of functional capacity

c. an understanding of the environment into which a member may deploy

d. an appreciation of the limitations in health support provided on deployment

e. an assessment of risk to mission completion, and safety concerns, of employment/deployment exacerbating the condition.

7. **Medical suitability for service.** This hinges on a number of basic principles:

a. Suitability for the member's Service. Each service has inherent health and fitness requirements for service. These reflect a baseline that the member should be capable of attaining to be employed and deployed.

b. Suitability for a specific employment group. Different corps, trades, roles, categories and primary qualifications have inherently different health parameters. For specialist employment streams (SES) personnel, this will necessitate application of a specialist employment classification (SPEC) as well as a MEC.

c. Suitability for a specific environment. The environments in which the member would normally be required to operate in their employment group and Service.

8. **Functional capacity.** This is the measure of the member's ability to perform required tasks in a specific environment. In order to be fit for purpose, a member must have the functional capacity to perform the activities required in the primary employment role, as well as general military duties. Limitations in functional capacity may be brought about by any of the following:

a. biomechanical limitations in strength, range of movement or balance

b. diminished hearing or vision

c. diminished aerobic and anaerobic fitness

d. psychological illness or diminished psychological reserve

e. body habitus—extremes of overweight or underweight.

Factors to be considered—military operations

9. Military operations are categorised by extended and isolated operations where the deployed force is self-sufficient for all operational conduct and support. Military operations are conducted in a variety of single and combined environments that may consist of activities in support of:

a. training

b. peace operations

c. civil-military operations

d. special operations

e. offensive/defensive military operations.

10. The requirements on individuals throughout these activities vary widely based on the employment group and Service of the individual, the nature of the task/mission being performed and the location of the activity.

11. In general, the following factors should be considered when allocating a MEC regardless of the activity or environment:

a. **Duration.** Military operations may be short or long-term activities where members are away from home, families and support networks.

b. **Climate.** Extremes of temperature, humidity, sun exposure, reflected glare and the like, may aggravate underlying medical conditions. These may be further aggravated through personal protective equipment (PPE) use.

c. **Medical support.** Limited, or no, medical support may be available temporarily or for extended periods. Where available, health care may not meet the standards available within Australia. Health care plans for deployments are available upon request. Requirements for complex medical care must be identified and deployment restrictions enforced.

d. **Clothing and equipment.** Medical suitability for operational service may be affected by:

   (1) any requirement for special clothing, footwear or PPE. This includes prescription lenses and mask inserts, footwear and orthoses

   (2) any medical condition that prevents or interferes with the wearing of PPE such as body armour.

e. **Living conditions.** These are subject to significant variation based on the nature of employment and the tasks undertaken:

   (1) **Accommodation.** This includes physical accommodation facilities and access to ablution facilities.

(2) **Diet.** Access to set nutritional requirements in deployed environments must be considered, provisions may only be available through combat, or restricted, rations.

(3) **Hydration.** Adequate hydration may be difficult to maintain where fluid loss is exacerbated by heat, activity levels and the thermal burden of body armour and other personal protective equipment.

(4) **Work/rest cycles.** Consideration must be given to the deployed working routine, cumulative impact on the member and the inability to obtain personal time/space while deployed.

(5) **Confined spaces and ladders.** Some workplaces, particularly ships, contain 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.

f. **Physical fitness.** Access to physical training equipment and the time to conduct training is either limited or non-existent during most deployments. The impact of deteriorating fitness must be considered in relation to the employment undertaken.

Specific factors—deployed environments

12. In addition to the specific operating environment considerations, thought must be given to the impact of the deployed environment on health care for the member. These factors form part of all assessments of medical suitability and form the basis of the health risk assessment.

13. Specific issues to be considered for deployment include:

a. **Health materiel issues:**

(1) Sudden interruption to medical supplies. Continuity of medical logistic support can never be guaranteed. Cessation of health materiel may not have immediate health or performance consequences and other strategies may be available to manage the patient’s health and wellbeing.

(2) Adverse effects of treatment. Treatment protocols may or may not result in adverse side effects that impact on performance or pose secondary risks. These risks may be incompatible with deployment.

(3) Special handling of health materiel. Health materiel requirements such as refrigeration may not be available on deployment.

(4) Availability in deployed environment. Items that are not listed on the ADF Formulary or Medical Allowance List require specific procedures to obtain and may be problematic in a deployed environment.

(5) Ongoing monitoring as a result of the treatment protocol. Where a treatment protocol necessitates follow up pathology or specialist review,

consideration must be given to the deployed environment and the lack of this support.

b. **Health personnel support:**

(1) **Ongoing routine care.** A member's requirement for access to ongoing medical care must be given careful consideration. This includes whether care can be safely provided in the deployed setting and what impact the member's presence may have on health resource availability.

(2) **Sudden interruption to health care.** Sudden interruption to routine health care must considered.

(3) **Acute or adverse event related to health conditions.** The consequences for the patient, availability of emergency and definitive care and impact on available health resources need to be considered. Consequences of the loss of the member on the functionality of the deployed team should also be considered.

(4) **Medical evacuation.** Safe and timely access to medical evacuation may place both the member and the evacuation team at great risk, depending on the nature of deployed environment, locality and accessibility of definitive care and mode of evacuation. Medical evacuation may also decrease health resources available to other members.

c. **Safety considerations:**

(1) **Risk to others.** Some conditions pose a potential risk to others under adverse deployed conditions. Risks may be direct, such as including exposure to contagions or threat of physical or psychological harm; or indirect, such as imposed when having to recover a member whose condition renders them unfit to perform their duties in adverse circumstances.

(2) **Working conditions.** Where the deployed environment can reasonably be expected to directly worsen a member's condition or decrease the level of clinical stability, then deployment should be avoided.

14. **Individual readiness requirements.** Where a member's medical condition impacts on the ability to meet other individual readiness requirements, personal and team safety may be compromised. Examples include, but are not limited to, ability to comply with vaccination requirements, weapons training and combat survivability.

ANNEX 2B

RESPONSIBILITIES

1. The following are the responsibilities associated with the military employment classification (MEC), individual health assessment (IHA) and specialist (aircrew, submariner, diver, free-fall parachutist) employment classification IHA.

a. **Members.** All members are to:

(1) complete Form AF212—'Individual health questionnaire' (IHQ) prior to the IHA

(2) attend for MEC review (MECR) and IHA as per directed timeframes

(3) notify their treating health practitioner when their health status has changed to the extent that a change in MEC/SPEC may be warranted

(4) notify any medical annotations/restrictions to their chain of command

(5) complete Form AD524—'Members health statement' when requested to do so

(6) sign Form PM609—'Consent to release medical information relating to a military employment classification review board' when required for a central MECR (CMECR).

b. **Health clerks.** Health clerks are to:

(1) schedule IHA /MECR for members as required

(2) where the Defence health record (DHR) cannot be used, pre-populate applicable data fields in the relevant form, where applicable

(a) IHA: Form AF212

(b) MECR: Form PM518—'Health summary relating to military employment classification review (MECR)'.

(3) ensure all elements of MECR/IHA documentation, including MEC/SPEC and annotation recommendations, are fully completed

(4) ensure that on completion of an IHA, the member's Personnel Management Key Solution (PMKeyS) is updated to reflect medical individual readiness (IR) and expiry date as recorded by the authorised health practitioner

(5) track MECR documents

(6) package, distribute and track cases referred centrally for MEC decision (MECD)

(7) schedule follow-up appointments as directed by health practitioners

(8) ensure that Form PM101–'Medical or dental fitness advice' and supporting documentation, have been raised by the authorised health professional conducting the MEC/SPEC review and are distributed after the assessment and recommendation of MEC

(9) ensure that Form PM532–'Military employment classification (MEC) advice' and supporting documentation, is raised and distributed after the assessment and confirmation of MEC/SPEC review

(10) input MEC/SPEC outcomes, including MECD determinations, into all relevant personnel management systems

(11) where Form PM532 is raised by an external agency, such as MECD, ensure that the MEC is, or has been, entered into PMKeyS and the hard copy has been appropriately distributed

(12) process/file all MECR/IHA documentation.

c. **Nurse practitioners (NPs), registered nurses (RNs), enrolled nurses (ENs) and Australian Defence Force (ADF) medics.** Appropriately credentialed and authorised NPs, RNs, ENs and ADF medics who undertake MECR/IHA functions are responsible for the following:

(1) familiarity with the procedures in this Defence Health Manual (DHM[28]) and supporting Service policy prior to conducting MECR/IHA functions, as appropriate

(2) consideration of the member's IHQ

(3) the request of routine non-fasting screening lipids, HbA1c (where indicated as per the complete clinical guidance[29]), faecal occult blood testing (FOBT) and referral for refraction in order to support the IHA process

(4) conduct of the preliminary examination of the IHA

(5) highlighting key issues from questionnaires and preliminary examination to the health practitioner conducting any subsequent examination.

d. **Medical officers (MOs).** Appropriately credentialed and authorised MO (and NP when authorised by the Surgeon General ADF (SGADF) and Service Director of Health Services) are responsible for the following:

(1) undertaking, and compliance with, all mandatory training requirements for use of the MEC/IHA system

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(2) familiarity with Military Personnel Policy Manual (MILPERSMAN) Part 3 Chapter 2[30]–'Military employment classification system', this chapter and supporting Service policy prior to conducting MEC/SPEC review

(3) familiarity with DMH Level 2 Part 6 Chapter 5[31]–'Individual health assessment'

(4) validating the member's medical IR and expiry date as directed by DMH Level 2 Part 6 Chapter 5

(5) considering the appropriateness of the MEC and (where appropriate) SPEC of every patient, at each consultation

(6) seeking advice where doubt exists on the allocation of MEC/SPEC

(7) conduct of indicated medical examinations

(8) consideration of all elements of the MEC/SPEC review in regard to the member's employment group and environment

(9) obtaining additional specialist medical opinion to enable allocation of MEC. Where this is sought, specialist input should not include a personal judgement or opinion regarding MEC or fitness for service.

(10) allocation of recommended MEC/SPEC and employment annotations/restrictions according to:

(a) assessed levels of fitness

(b) likely roles and requirements within employment group and environment.

(11) in accordance with DHM Level 2 Part 13 Chapter 2[32]–'Health responsibilities for occupational rehabilitation', referral to rehabilitation where appropriate

(12) conducting an individual health risk assessment as required

(13) consultation with the member's chain of command as required

(14) completion, and release where authorised, of all relevant documentation

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[30] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/%7BC5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765%7D

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(15) informing members of:

(a) their recommended MEC/SPEC, the process for the management of the MEC system and the ramifications of their MEC/SPEC and any restrictions/annotations, in-person if possible

(b) the importance, and process, of submitting claims to the Department of Veterans' Affairs (DVA) for injuries and illnesses related to their ADF service

(c) the avenues for reconsideration available to them should they disagree with a MEC decision.

(16) raising Form PM101 to inform members and their supervisors of employment restrictions pending confirmation of the MECR

(17) informing members if the confirming authority has changed the recommended MEC.

e. **Confirming authorities.** All MECR/IHA for specialist employment stream personnel are to be confirmed by the authorised confirming authorities only. Confirming authorities are responsible for:

(1) being fully conversant with MILPERSMAN Part 3 Chapter 2, this DHM chapter and supporting single-Service policy prior to conducting/reviewing MECR/IHA

(2) review of the clinical content of MEC/SPEC review

(3) confirmation that recommended MEC/SPEC and employment annotations are consistent with Defence policy and requirements

(4) allocation of alternative MEC/SPEC where recommended MEC/SPEC are inconsistent with Defence policy and requirements

(5) annotating the reasons for any alteration to a recommended MEC on the MECR

(6) ensuring that CMECR documentation is complete, as per Annex 2E, prior to confirmation

(7) ensuring all post-review administration is conducted in accordance with Defence requirements. This includes:

(a) completion and distribution of all MEC/SPEC documentation

(b) recording of all MEC/IHA in Defence personnel management systems

(c) informing members of the outcome of MEC/SPEC or MECD.

(8) mentoring authorised health practitioners in the MEC process.

f. **Commanding Officer (CO) Joint Health Unit (JHU).** CO JHUs are responsible for:

(1) ensuring adherence to and consistent application of MILPERSMAN Part 3 Chapter 2, this chapter and supporting Service policy regarding MECR/IHA

(2) ensuring credentialing and authorising of health practitioners to conduct MECR/IHA

(3) appropriate training and supervision of authorised health practitioners in the unit

(4) allocating adequate resources for the timely conduct and management of IHA/MECR

(5) ensuring that chains of command and career management agencies (CMA) are engaged in the MEC/SPEC process as appropriate

(6) appointment of regional and local confirming authorities.

g. **Designated single-Service MO (DSSMO).** DSSMO are appointed by their Service to ensure medical management throughout their Service is consistent with Service policy requirements. Their responsibilities are allocated and monitored by their Service. Responsibilities relevant to MECR/IHA include:

(1) providing Service-specific advice to authorised health practitioners and confirming authorities

(2) credentialing and authorising health practitioners operating in single-service environments to conduct and confirm MECR when applicable

(3) the provision of Service guidance on MEC/SPEC allocation to authorised health practitioners

(4) liaison with chain of command for MEC/SPEC matters

(5) provision of advice to MECD where required

(6) allocation of MEC M26 (by Fleet MO only) to Navy members (whether posted to sea or otherwise).

h. **J07 Headquarters Joint Operations Command.** J07 is responsible for credentialing and authorising health practitioners to conduct and confirm MECR conducted in the area of operations.

i. **Joint Health Command (JHC).** The JHC MEC advisory and review service (MECARS) is responsible for the provision of medical practitioners and administrative staff to review all CMECR prior to MECD consideration. These practitioners and administrative staff are to:

(1) ensure timely processing of CMECR provided by health facilities

(2) ensure provision of an objective health summary of CMECR for MECD consideration

(3) ensure provision of an approved delegate for MECD proceedings to provide specialist health advice on individual cases

(4) ensure that all medical opinions expressed in the CMECR and associated documents are carefully assessed and presented objectively to MECD

(5) ensure that significant differences in medical opinion relating to a member's condition(s) are communicated and explained to MECD

(6) review all CMECR documentation, ensuring that:

(a) documentation is complete and attached

(b) content is in accordance with Defence and Service policy.

(7) provide advice to MECD on the functional impact and conditions of the member. If this differs from the content in the CMECR, the differences and the reasons for the difference are to be highlighted to MECD

(8) provide recommendations to MECD for consideration.

j. **MECD** are responsible for:

(1) allocation and confirmation of all MEC/SPEC for CMECR cases

2. ensuring personnel management actions are completed.

ANNEX 2C

RESTRICTION CODES AND THEIR DESCRIPTORS

1. Military employment classification (MEC) restriction codes and their descriptors are listed in Table 2C–1. If a treating authorised health practitioner or confirming authority considers that a change of restrictions only is required, details are to be recorded in the Defence health record (DHR). Where the DHR cannot be used, Form PM105—'Outpatient clinical record' is to be used and a new Form PM532—'Military employment classification (MEC) advice' is to be raised. If a change of MEC is required, appropriate MEC review (MECR) action is to be taken.

2. **For Army members**. To facilitate the application of the appropriate MEC, the employment restrictions have been mapped against PULHEMS. Authorised health professionals are to refer to Army Standing Instructions (Personnel) (ASI(P)) Part 8 Chapter 3[33]—'Application of the medical employment classification system and PULHEMS employment standards in the Australian Army' when allocating a MEC.

3. **For submariners**. Restriction code 6–14 is to be applied if the member does not meet standards detailed in Health Bulletin (HB) 07-24[34]—'Health Requirements – Direct Entry Nuclear Submariner Roles', or HB 09-24[35]—'Health Requirements – Direct Entry Non-Nuclear SSN Submariner Roles' or an aspect of the process described in HB 02-24[36]—'Interim Health Qualification Process – International Nuclear Training Program'.

4. Restriction code 6–15 is to be applied if the member is unfit to work with nuclear propulsion systems due to not meeting one or more requirements of 'Nuclear Field Duty' detailed in HB 02-24.

5. Restriction codes and their descriptors must be written in full on all MECR documentation.

Table 2C–1: Restriction codes and descriptors

	Code 1. Limitations on physical fitness training (the term physical fitness training is a generic term which describes tri-Service physical fitness requirements)
1–1	no running
1–2	running own pace

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	Code 1. Limitations on physical fitness training (the term physical fitness training is a generic term which describes tri-Service physical fitness requirements)
1–3	no lifting of heavy weights (additional text provided)
1–4	no physical training (additional text provided)
1–5	exempt a component of physical training (additional text provided)
1–6	no abdominal physical training
1–7	physical training at own pace (additional text provided); *this restriction may be given when members can attempt physical training, but at a slower pace, are able to slow down before symptoms or pain and distress would occur*
1–8	no contact sports
1–9	exempt physical fitness testing (additional text provided)
1–10	exempt combat fitness testing (additional text provided)
1–11	no standing at all
1–12	no standing for more than one hour
1–13	no more than four hours standing per day
1–14	avoid high impact activities
1–15	Unfit for swimming or water based activities.
	Code 2. Limitations on employment and range of duties able to be performed
2–1	avoid prolonged exposure to excessive noise without hearing protection
2–2	no working at heights or on ladders including ship’s ladders or scaffolding
2–3	not to work in confined spaces (additional text provided)
2–4	unfit repetitive bending or stooping
2–5	unfit repetitive squatting
2–6	unfit climbing
2–7	unfit pushing, lifting or throwing
2–8	unfit balancing
2–9	unfit reaching
2–10	unfit gripping
2–11	unfit for sustained concentration
2–12	unfit exposure to chemicals, solvents, fuels, corrosives, drying agents, paints, or hydrocarbons (delete as appropriate)—additional text provided to amplify specific exposure restrictions.
	Sterilising agents: for example but not limited to ethylene oxide. No work in medical and food sterilisation.
	Cytotoxic drugs. No handling of cytotoxic drugs.
	Solvents: for example but not limited to: xylene, toluene, glycol, glycol ethers, perchlorethylene, trichlorethylene. No work in the following areas nor contacts with the following agents:

	Code 1. Limitations on physical fitness training (the term physical fitness training is a generic term which describes tri-Service physical fitness requirements)
	Laboratory reagents
	Paint thinners
	Sterilising agents
	Antifreeze
	Refuelling, fuel tank entry—aircraft and vehicle maintenance
	Paper/pulp printing
	Dry cleaning/laundry
	Spray painting
	Fibre glass lay-up
	Electronics/electric assembly
	Semiconductor industry
	Fuels—no direct contact with benzene or benzene vapour. No aircraft refuelling duties. Not to be employed as fuel pump operator, no refuelling duties at POL points or on convoy.
	Hydrocarbons. No contact with hydrocarbons. Avoid inhalation of motor exhaust fumes.
	Halogenated hydrocarbons. Chemicals. No contact with chemical oils.
	No work in plastics manufacture. No work in medical and food sterilisation. No handling of cytotoxics. No duties involving the use of pesticides.
2–13	unfit exposure to toxic gases, fumes, or dust; including carbon monoxide—(additional text provided):
	(no duties in carparks which are enclosed, no transport in vehicles where exhaust fumes can accumulate, (e.g., armoured personnel carriers, Fremantle patrol boats, no firefighting), diesel exhausts, paints, organic solvent vapours or metal dusts and fumes. No exposure to CS gas. Not to be exposed to inhalation of motor exhaust fumes.
2–14	unfit for shift work
2–15	unfit to work unsupervised
2–16	unfit to work in close proximity to moving machinery or dangerous chemicals
2–17	unfit to handle food
2–18	not to work in stressful environments
2-19	not to perform physically strenuous work *(e.g. fast pace; repetitive twisting, stooping, squatting, bending and lifting; lifting heavy weights; prolonged standing/walking)*
2-20	not to work more than forty hours per week
2-21	not to participate in activities such as parachuting, hang-gliding, paragliding or abseiling
2–22	fit for sedentary office based duties in a barracks environment only
2–23	unfit grinding or sanding on metal
2–24	unfit battery, foundry or smelter work

	Code 1. Limitations on physical fitness training (the term physical fitness training is a generic term which describes tri-Service physical fitness requirements)
2–25	unfit soldering or welding.
2-26	medically unfit for aircrew, diving and pressurised submarine escape training (PSET) – (*applies to members who are **not** aircrew, divers or submariners)*
	Code 3. Restrictions on general service duties
3–1	no marching
3–2	no load carrying as defined (*eg backpacks, Open Circuit Compressed Air Breathing Apparatus etc*)
3–3	no route marches
3–4	unfit ceremonial parades
3–5	unfit weapons handling
3–6	unfit warlike operations but fit peace support operations
3–7	requires dietary control
3–8	unfit to drive Australian Defence Force (ADF) vehicles (additional text provided)
3–9	unfit to fly as a passenger
3–10	avoid exposure to significant vibration, (*including boats, off road travel in heavy military vehicles, use of fork lift trucks, use of pneumatic or electric power tools and vibrating work pieces*)
3–11	no chemical, biological, radiological, nuclear training
3–12	no fire-fighting
3–13	unfit prolonged exposure to extreme cold
3–14	avoid known electrical hazards
3–15	fit to work in ships alongside (**Note:** Members allocated restriction code 3–15 must be confirmed as MEC 3)
3–16	march activity in patrol order only
3–17	no access to live ammunition
3–18	unfit to work in ships alongside (**Note**: Members allocated restriction code 3–18 must be confirmed as MEC 3)
	Code 4. Requirements for Pharmaceutical Support or Medical Logistic Support
4–1	requires access to pharmaceutical resupply
4–2	requires access to medical logistic support; requires cold chain pharmaceutical storage; requires reliable access to power supply (delete as appropriate)
4–3	requires periodic access to specialist care
4–4	requires pre-deployment medical officer review
4–5	fit for deployment or seagoing service with minimum military level (ML) 2 medical officer, or approved equivalent, support
4–6	requires access to ML3 medical officer support

	Code 1. Limitations on physical fitness training (the term physical fitness training is a generic term which describes tri-Service physical fitness requirements)
4–7	requires procedural ML4, or equivalent, support
4–8	fit for deployment or seagoing service with advanced medical assistant (AMA) or military nursing officer (NO) support
4-9	fit for deployment or seagoing service with clinical manager or NO support
4-10	no longer active. Use restriction 5-7
4-11	requires periodic medical officer review (additional text required to specify periodicity).
4-12	refer to J07 for clearance for operational deployment
	Code 5. Geographic restrictions
5–1	fit for posting only to a specific location (additional text)
5–2	unfit for overseas postings
5–3	unfit for rapid climatic changes
5–4	unfit for cold climates
5–5	unfit tropical climates
5–6	avoid exposure to higher than 8000 feet
5–7	fit for deployment or seagoing service except to malarious areas (**Note:** *Not to be applied to MEC J2 pers unless referred to MECD for allocation and/or for MEC M2 pers – referred to the Fleet Medical Officer (FMO)*)
	Code 6. Fitness for duties in specialist branches
6–1	to wear and carry a spare pair of corrective spectacles when flying
6–2	to wear contact lenses or corrective spectacles when flying and carry a spare pair of corrective spectacles
6–3	may perform unrestricted flying duties while taking ADF authorised medication
6–4	restricted to flying duties in aircraft types as specified (must be defined in additional text)
6–5	medically fit for restricted flying duties in aircraft not equipped with an ejection system
6–6	medically fit for restricted flying duties as (additional text provided) *eg insert appropriate trade or profession), with a (additional text provided) who has no employment restrictions (for example, medically fit for restricted flying duties as pilot with a pilot who has no employment restrictions*
6–7	unfit for flying from any seaborne platform
6–8	duration of flight (to be stated both regarding the individual flight and the total flying permitted in one day)
6–9	maximum cabin altitude of 10 000 feet AMSL when flying
6–10	not to perform aerobatic flying
6–11	daylight flying only
6–12	unfit for air traffic control duties but fit for administrative duties

	Code 1. Limitations on physical fitness training (the term physical fitness training is a generic term which describes tri-Service physical fitness requirements)
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).
6–14	unfit for nuclear submarines (SSN).
6–15	unfit for nuclear submarine (SSN) nuclear field duty.
6–16	unfit for conventional powered submarines (SSG).
6–17	unfit for single person escape tower on SSG (may be fit for rush escape, rescue, or the use of larger escape towers on SSN).
6–18	fit for submarine sea duty for limited durations only (14 days minimum, to be specified by MO).
6–19	unfit for submarine deployment outside the Australian Exclusive Economic Zone.
	Code 7. Members undergoing active treatment with the expectation that they will return to MEC 1 or MEC 2 and restrictions will change during the period MEC 3 is applied. Note: Unit management are to be informed of any changes to restrictions by means of Form PM101—'Medical or dental fitness advice'.
7–1	Rehabilitation under medical officer's direction. Specific restrictions are to be detailed on Form PM 101.
7–2	Under active medical treatment. Specific restrictions are to be detailed on Form PM 101.

ANNEX 2D

APPLICATION OF SPECIALIST EMPLOYMENT CLASSIFICATIONS

INTRODUCTION

1. Specialist employment streams (SES) are occupational groups of personnel that have specific medical requirements based on the demands of their respective jobs. They require more frequent health assessments than non-specialist members to meet regulatory, safety and occupational medical requirements. These assessments take the form of a specialist employment classification (SPEC) undertaken in conjunction with an individual health assessment (IHA).

SPECIALIST EMPLOYMENT STREAMS

2. SES personnel are comprised of the five occupational groups listed below. Employment groups contained within each stream are listed in Table 2D–1.

Table 2D–1: SES employment groups

Summary	SPEC	Employment groups
Aviation Related Occupations	A/C	In accordance with (IAW) Defence Health Manual (DHM) Level 2 Part 5 Chapter 6[37]—'Health requirements for aviation-related occupations'.
Divers	D	Clearance Diver Mine Warfare and Clearance Diving Officer SCUBA Air Diver (Ship's Diver) Combat Engineer Diver Special Forces Diver Hyperbaric attendants (MO or UM)
Military parachutists	P	Paratroopers qualified in military freefall Paratroopers qualified in military tandem Paratroopers qualified in military ram air parachute static line with high altitude exposure
Submariners	S	All qualified submariners, trainees and specialist personnel required to frequently deploy in submarines

CODES

3. Medical readiness for SES personnel is indicated by military employment classification (MEC), the fitness for general employment and deployment, and SPEC,

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fitness for specialist employment duties. Examples include: J11/A1, J12/P1, M24/S3 etc.

PROCEDURES FOR SPEC A—AIRCREW AND SPEC C—CONTROLLERS

4. Members employed in aviation-related occupations are responsible for the safe conduct of aviation-related duties. This includes operating or interfacing with an aircraft's systems during flight, controlling airspace and other tasks essential for the successful outcome of an aviation mission.

5. 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. This has led to a formal aviation MECR (AMECR) process and SPEC for members in these categories.

6. SPEC A and SPEC C members listed in Table 2D–1 require an AMECR to alter MEC and/or SPEC.

7. **Allocation**. SPEC A and SPEC C members have their initial SPEC allocated by commanding officer Institute Aviation Medicine (CO IAM) (if a senior aviation medical officer (SAVMO)) or authorised delegate. Confirmation of SPEC after initial allocation is according to delegations within the Military Personnel Policy Manual (MILPERSMAN[38]) and relevant sections of the DHM[39].

Medical and dental fitness standards

8. The Service health requirements for flying or controlling duties are in:

b. Fleet Air Arm Standing Instructions (Naval Aviation) (OPS) 02–03[40]—'Aircrew competency and currency', Annex G

c. Standing Instructions (Aviation) Operations 2–121[41]—'Medical and dental fitness for aviation-related duties'

d. Air Command Standing Instructions (Operations) 01–39[42]—'Aviation medical requirements'.

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[38] http://ibss/PublishedWebsite/LatestFinal/%7B0C0A208B-0D87-4EE4-B024-48D213B0B96E%7D/Item/%7BC5D16A9A-AE96-4BE3-8CB4-F6E86A4C7765%7D

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9. This chapter does not include the health requirements for Navy non-SPEC members working in aviation-related roles. These requirements are specified in Standing Instruction (Navy Aviation) Operations 06–01[43]—'Aviation medicine'.

10. Medical fitness standards for entry into SPEC A and C are in DHM Level 2 Part 5 Chapter 6.

Management authority

11. The medical requirements for SPEC A and C are managed via the single-Service aviation medicine adviser (SSAMA) or authorised delegate of the appropriate Service. The SSAMA is appointed by the Director General of Single Service Health.

12. Authorisation to review. Only aviation medical officers (AVMO) as defined in DHM Level 2 Part 17 Chapter 3[44]—'Provision of aviation medicine services in the ADF', are to manage personnel performing aviation-related duties. Non-AVMOs are to manage personnel performing aviation-related duties within the scope defined in DHM Vol 2 Part 17 Chapter 3.

13. There are three levels of AMECR:

a. **Unit aviation military employment classification review (UAMECR).** This is conducted at a local unit level and confirmed by the SSAMA or delegate.

b. **Institute aviation military employment classification review (IAMECR).** This is conducted by IAM and confirmed by CO IAM (if a SAVMO) or delegate. IAM should consult with SSAMAs for Service specific occupational input.

c. **Central aviation military employment classification review (CAMECR).** This is conducted by IAM where long-term fitness for specialist and/or general duties is in doubt, and where a MECR board (MECRB) referral is required. The CAMECR summary is authorised by CO IAM (if a SAVMO) or delegate.

14. **Referral**. All SPEC A and C cases requiring MECRB consideration must be referred to IAM for a CAMECR. IAM must produce a detailed report, authorised by CO IAM (if a SAVMO) or delegate. The report and associated documentation is to be forwarded to the member's treating health centre, for submission to the MECRB.

15. The conduct of all three levels of AMECR are detailed in DHM Level 3 Part 6 Chapter 3[45]—'In-service health requirements for aviation-related occupations'.

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PROCEDURES FOR SPEC P MILITARY—PARACHUTISTS

16. All military parachutists who undertake high altitude parachute operations (HAPO), irrespective of mode of parachuting, are allocated SPEC P. Modes include:

d. paratroopers qualified in military freefall (MFF)

e. paratroopers qualified in military tandem (MT)

f. paratroopers qualified in military ram air parachute static line (MRAPSL) with high altitude exposure

17. Military parachute operations involve considerable physical risk and high levels of fitness are required for members undertaking these activities. All parachutists should be managed closely with respect to their physical and psychological health.

18. Modes of military parachuting and their health considerations are summarised in DHM Level 2 Part 6 Chapter 3[46]—'Parachuting health standards'. HAPO refers to all parachute operations that involve descents from altitudes of 13,000ft above mean sea level (AMSL) and higher. s47E(d)

Policy

19. Medical fitness requirements for all military parachutists are in DHM Level 2 Part 6 Chapter 3[47] , ASI(P) Part 8 Chapter 3[48]—'The application of the military employment classification system and PULHEMS employment standards in the Australian Army' and DHM Vol 2 Part 6 Chapter 3.

Management authority

20. The medical requirements for all military parachuting are managed through Director Army Health.

21. **Authorisation to review**. MECR for parachutists should be conducted by an ADF or contracted civilian MO referencing DHM Level 2 Part 6 Chapter 3. Where members fail to meet the standards, the case should be reviewed by an AVMO. Technical advice is available to all MO completing assessments on SPEC P members through:

g. Senior MO HQ SOCOMD

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h. SO1 Aviation Medicine, HQ FORCOM

22. **MEC Confirmation**. Confirmation of UMECR for SPEC P members can be done by local confirming authorities or self-confirmed by:

i. a military medical level three or four ADF MO

j. a contracted civilian MO equivalent.

k. CMECR must be confirmed by either:

l. Senior MO HQ SOCOMD, or

m. SO1 Aviation Medicine, HQ FORCOM

PROCEDURES FOR SPEC D—DIVERS

23. Diving operations within the ADF are diverse and may be undertaken by a number of occupational subgroups within each Service. Navy divers ensure that ship, and crew, safety are preserved where, within the Army, divers ensure force preservation and mobility.

Policy

24. Medical fitness requirements for divers are detailed in DHM Level 2 Part 5 Chapter 7[49]—'Health requirements for divers', and DHM Level 2 Part 5 Chapter 5[50]—'Causes of and reasons for rejection'.

Management authority

25. The Fleet MO (FMO) is the authority for determining medical fitness in the maritime environment. The senior medical adviser – diving medicine (SMA DIVMED) is the delegated authority for providing advice on ADF diving medicine.

Military diving operations

26. **Categorisation**. The following personnel groups are categorised as divers and are subjected to SPEC D requirements:

n. **Clearance divers**. Members employed within Navy who form a discrete employment branch within Navy

o. **Mine Warfare and Clearance Diving Officers**. Navy Maritime Warfare Officers who have subspecialised as diving officers, and who form a discreet employment branch

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p. **Ship divers**. Members employed primarily within Navy (but may also be Army or Air Force) whose diving function is performed in addition to their normal role

q. **Combat Engineer Divers**. Members employed within Army whose diving function is performed in addition to their normal role

r. **Special Forces Divers.** Personnel employed within Army Special Forces whose diving function is performed in addition to their normal role

s. **Hyperbaric attendants.** UM and MO who undertake hyperbaric chamber inside-attendant duties.

27. **Authorisation to review.** SPEC D medical fitness is managed by accredited and appointed medical practitioners who have completed the RAN Medical Officer Underwater Medicine Course.

MEC/SPEC FOR MILITARY DIVERS

28. **Requirement**. Divers gain competency in addition to their primary employment functions. All ADF qualified divers require allocation of a SPEC D grading.

29. **Allocation**. SPEC D members may only have SPEC allocated by SMA DIVMED or authorised delegate.

30. **Confirmation**. Confirmation of SPEC D may only be performed as follows:

a. **SPEC 1**

(1) when SPEC unchanged—not required

(2) when SPEC upgraded—SMA DIVMED or authorised delegate.

b. **SPEC 2**

(1) when MEC and SPEC are unchanged—not required

(2) when MEC or SPEC are downgraded—confirming authority with UMMO accreditation

(3) when MEC or SPEC are upgraded— SMA DIVMED or authorised delegate.

c. **SPEC 3**

(1) when MEC and SPEC are unchanged and the combined period of SPEC 3, including time between this review and the next, is less than 12 months— confirming authority with UMMO accreditation

(2) when MEC and SPEC are unchanged and the combined period of SPEC 3, including time between this review and the next, is more than 12 months—MECRB through SMA DIVMED or delegate.

d. **SPEC 4**

(1) All SPEC D members assessed as permanently unfit for diving operations are to be referred to SMA DIVMED or delegate for confirmation.

31. **Referral**. All SPEC D cases requiring MECRB consideration are to be referred to SMA DIVMED for SPEC D confirmation. When MECRB determination is required, documentation is to be forwarded to JHC MECARS for submission to the MECRB.

PROCEDURES FOR SPEC S—SUBMARINERS

32. Submarine operations are categorised by isolation, confinement and extended deployments. These operations require specialist training, selection and monitoring for each submariner.

Medical fitness

33. Medical fitness requirements for submariners are detailed in:

a. DHM Level 2 Part 5 Chapter 8[51]—'Health requirements for submariners'

b. DHM Level 2 Part 6 Chapter 7[52]—'In-service health requirements for submariners and personnel allocated SPEC S'.

Management authority

34. The FMO determines medical fitness in the maritime environments. The senior medical adviser – submarine medicine (SMA SUBMED) provides advice on submarine medicine.

Submarine operations

35. Submarine operations are conducted within the Navy only.

36. **Categorisation**. The following personnel groups are categorised as submariners and are subjected to the SPEC S requirements:

t. qualified submariners eligible for posting to submarine positions

u. trainee submariners

v. specialist personnel required to frequently deploy in submarines.

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37. **Authorisation to review**. Due to the operating environment, medical fitness is preferably managed by an accredited and appointed UMMO. However, in areas where these qualifications are not available, any MO may manage submariners with advice from SUMU-West health practitioners.

38. **Allocation**. SPEC S personnel may only have SPEC allocated or altered by SMA SUBMED or authorised delegate.

39. **Confirmation**. Confirmation of SPEC S may only be performed as follows:

a. **SPEC 1**

(1) when SPEC unchanged—not required

(2) when SPEC upgraded—SMA SUBMED or authorised delegate.

b. **SPEC 2**

(1) when MEC and SPEC are unchanged—not required

(2) when MEC or SPEC are downgraded—SMA SUBMED or authorised delegate

(3) when MEC or SPEC are upgraded—SMA SUBMED or authorised delegate.

c. **SPEC 3**

(1) when MEC and SPEC are unchanged and the combined period of SPEC 3, including time between this review and the next, is less than 12 months—SMA SUBMED or authorised delegate

(2) when MEC and SPEC are unchanged and the combined period of SPEC 3, including time between this review and the next, is more than 12 months—SMA SUBMED or authorised delegate.

d. **SPEC 4**

(1) All SPEC S members assessed as permanently unfit for diving operations are to be referred to SMA SUBMED or delegate for confirmation.

40. **Referral**. All SPEC S cases requiring MECRB consideration should be referred to SMA SUBMED for SPEC S confirmation. When MECRB determination is required, documentation is to be forwarded to JHC MECARS for submission to the MECRB.

ANNEX 2E

DOCUMENTATION REQUIRED FOR CMECR

1. The following documentation is required when completing a central military classification review (CMECR).

a. Form PM518—'Health summary relating to military employment classification review (MECR)'. This form is mandatory for the conduct of MEC allocations requiring confirmation and central MECR (CMECR). Form PM518 is also to be used to document the review of specialist employment classification (SPEC)

b. Form AD524—'Members health statement'. This form is mandatory for a CMECR. Although not a requirement for other forms of MEC allocation, a member may choose to submit a member's health statement (MHS). The re-allocation of MEC should not be delayed awaiting for the MHS

c. Form AD523—'Workplace capacity report (WCR)'. This form is mandatory for a CMECR. Although not mandatory for other forms of MEC review, it may assist in the allocation and confirmation of a MEC/specialist employment classification (SPEC)

d. Form PM609—'Consent to release medical information relating to a military employment classification review board'. This form is mandatory for a CMECR and facilitates the following outcomes:

(1) **With member consent.** The following information will be referred to MEC determination (MECD) for consideration when the member authorises release of health information:

(a) Form PM610—'Clinical advice to the military employment classification board', including all relevant clinical information

(b) Form AD524, Form AD523 and Form PM609

(c) MECR record.

(2) **Without member consent.** The member may refuse the release of their health information to MECD. It should be noted that not knowing the health circumstances of the member may limit the options available to MECD when making a determination. In these circumstances, all forms, including a Form PM518 and Form PM532, are to be sent to MEC advisory and review service (MECARS). The only information forwarded to MECD by MECARS is:

(a) Form PM610 addressing functional limitations only. Clinical details will not be provided

(b) Form AD524 and Form AD523.

e. **Form PM610**. The clinical advice to MECD is raised by Joint Health Command (JHC) MECARS and details the member's condition(s) and requirement for ongoing health care. It provides advice regarding associated risk and the functional impact of condition(s) on a member's ability to perform occupational and general service duties.

Australian Government
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SURGEON GENERAL AUSTRALIAN DEFENCE FORCE

HEALTH BULLETIN NO 8/2014

Note: Surgeon General Australian Defence Force Health Directives are produced to disseminate health policy and guidance. Health Directives are of a permanent nature and remain in force until cancelled. They are reviewed every three years and repromulgated only where a significant change of content is necessary. Publications can be accessed on the Defence Intranet
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18 NOVEMBER 2014

SEPARATION HEALTH EXAMINATIONS

References:

A. HD 278 *Health responsibilities on completion of a period of service*
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B. *Health Manual* (HLTHMAN), volume 3, chapter 2 'Australian Defence Force periodic health examinations' s47E(d)
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INTRODUCTION

1. The separation health examination (SHE) is a key component of the process of transition from military to civilian life. It is important that the health status, Medical Employment Classification (MEC) and any on going health care needs of the member at the time of separation are accurately assessed and recorded. This ensures that members are separated under the appropriate mode of separation and that their health care is handed over to the civilian health sector. Accurate recording of health conditions, illnesses and injuries also provides evidence for compensation and other claims. The SHE also provides a baseline against which future health assessments can be compared.

2. Reference A articulates what activities need to be undertaken, from a health perspective, on completion of a period of service. Reference B directs that the PHE is to be used as the basis for SHE and provides guidance for the conduct and recording of each component of the examination.

AIM

3. The aim of this Health Bulletin is to reinforce the content and procedural aspects of the SHE.

POLICY

4. The content and process for the Periodic Health Examination is to be adopted for the SHE process, with additional items as described.

5. The SHE consists of:

a. member separation health statement

b. member health questionnaire

c. preliminary examinations

d. mental health screening

e. physical examination

f. MEC.

6. The SHE may need to be completed over several appointments or sessions, particularly for those members with a long service history or complex health conditions. The SHE process should commence three to six months before separation and be finalised no later than six weeks before separation.

Member separation health statement

7. The form PM 70 *Discharge Health Statement* s47E(d) s47E(d) is to be completed by the member. This statement is being revised and adapted for completion within the eHealth system through the member portal (under development). In the interim, eHealth system users are to continue to provide form PM 70 for members to complete and to scan the completed form into the eHealth system as part of the SHE.

Member health questionnaire

8. The member health questionnaire currently in use is form AD 147 *Comprehensive Preventive Health Examination* s47E(d) s47E(d)

9. The member health questionnaire is also still in development in the Defence eHealth system. Pending its introduction, eHealth system users are to provide the member with the member health questionnaire (pages 1–3) of form AD 147 to complete and then scan into the system as part of the SHE.

Preliminary examinations

10. Preliminary examinations are conducted in accordance with Reference B and recorded on form AD 147. Defence eHealth system users are to use the corresponding templates within the system.

Mental health screening

11. **Alcohol Use Disorders Identification Test (AUDIT)**. Where the Defence eHealth system has not yet been rolled out, the AUDIT is to be completed on form AD 147. Defence eHealth system users are to administer and record the AUDIT using the AUDIT template in the system.

12. **Kessler Psychological Distress Scale—10 (K–10).** The K–10 is administered as part of the PHE and is also to be administered as part of the SHE. Defence eHealth system users are to use the template in the system. Where the eHealth system has not yet been rolled out, a paper form K–10 is available in HLTHMAN, volume 3, chapter 2, annex A, appendix 2A–4 or from the regional Mental Health and Psychology Section (MHPS). Guidance regarding interpretation of the K–10 score and follow on action is provided in HLTHMAN, volume 3 s47E(d) s47E(d) and within the eHealth system template. Advice can also be sought from the regional MHPS.

13. Assessment of mental health is also conducted through the member health questionnaire and physical examination.

Physical examination

14. A comprehensive physical examination is to be conducted in accordance with Reference B and recorded on form AD 147 or in the Defence eHealth system, using the relevant templates.

Medical employment classification

15. The member's MEC at the time of separation must accurately describe their employability and deployability.

16. If the examining Medical Officer assesses that the MEC needs to be reviewed, or that the member's health status needs further assessment, then these actions are to be done in accordance with Reference A.

17. Similarly, any new conditions or clinical concerns need to be addressed as described in Reference A.

18. **Separation on medical grounds.** There are additional requirements for those members separating on medical grounds. For medical separations, the examining medical officer is to complete form DM 42 *Invalidity Retirement from the Defence Force Medical Information* s47E(d) s47E(d) Failure to complete this in a timely fashion means that pension entitlements cannot be assessed and finalised. This may adversely affect the member's financial situation on separation.

19. The form DM 42 has very explicit instructions regarding completion and what documentation needs to accompany it to Comsuper. It is the health centre's responsibility to ensure that the completed form and supporting documentation is sent to Comsuper for receipt no later than six weeks prior to the member's separation date.

Clinical summary transfer of health care

20. It is imperative that Defence members are provided with a clinical summary of their medical history to take to their civilian health care providers. How this may be facilitated within the Defence eHealth system is still under development. In the interim, in accordance with Reference A, form PM 552 *Clinical Summary Transfer of Health Care* s47E(d) is to be completed and provided to the member together with:

a. a copy of the discharge health statement and the SHE

b. copies of any relevant reports or investigations (eg hospital or rehabilitation discharge summaries, specialist reports, pathology results, imaging reports)

c. the member's international certificate of vaccination with a copy to be retained in the health record

d. medical images.

Dental examination

21. Separating members should have a dental examination within the six months before separation. This examination is to consolidate the individual's existing dental status and make recommendations for attaining and/or maintaining a level of general dental fitness post separation, where necessary. There is no requirement for a separating member to achieve a particular dental class at separation.

22. A full dental charting is to be done during the separation dental examination and is to be recorded on form PM 344 *Dental Clinical Record* s47E(d) or in the electronic health record.

SUPPORT SERVICES

23. A variety of services are available to Defence members to assist them during their separation from the Australian Defence Force (ADF). Members can access information on the Transition Support Services website (http://www.defence.gov.au/transitions/).

SUMMARY

24. To effect a seamless transition from military to civilian life, from the health perspective, it is imperative that members' health status and ongoing health care needs are accurately assessed and recorded at the time of separation from the ADF. The SHE is the means by which this is done.

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Surgeon General Australian Defence Force
Joint Health Command

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CHAPTER 8

TRANSITION HEALTH EXAMINATIONS

INTRODUCTION

8.1 The purpose of the transition health examination (THE) and other transfer health examinations is to document the member's health status, validate the member's military employment classification (MEC), assess suitability for service, and provide handover of health care to the civilian health system as required.

8.2 The member is responsible for ensuring they allow sufficient time for a THE to be conducted. This may impact on the validation of member-generated claims for service-related compensation benefits and possible future applications for reconsideration of the modality of transition. Members should be contacted by their treating garrison health facility to make the arrangements for THE three to six months prior to their transition.

Aim

8.3 The aim of this policy is to describe the process and conduct of transfer health examinations.

Scope

8.4 This policy applies to:

a. service category (SERCAT) 6-7 and service option (SERVOP) C members who are transitioning from fulltime service

b. Reserve members transferring to SERCAT 6/7 or SERVOP C

8.5 Reserve members, other than those completing a period of SERVOP C, do not require a THE on completion of service.

8.6 This policy is to be read with Defence Health Manual (DHM) Level 2 Part 6 Chapter 6[71]—'Health responsibilities on transfer between SERCATs, SERVOP C and SERVOP D.

Accessing Defence health records (DHR)

8.7 Defence health centres do not need to provide members with a complete copy of their DHR at the time of THE. Members can request a copy of their DHR through the Defence Information Access Unit[72].

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[72] https://www.defence.gov.au/about/accessing-information

GUIDANCE

Transition from SERCAT 6/7

8.8 When a SERCAT 6/7 member requests a THE, the garrison health facility is to:

a. book the preliminary and medical appointment for the THE

b. provide the member with Information Sheet 6–1[73]—'Transition and health'

c. request the member complete and submit Form AF212–'Individual health questionnaire'

d. ask the member to provide contact details for their community general practitioner (GP) as soon as possible to enable a Joint Health Command (JHC)-funded handover appointment.

Preliminary appointment

8.9 The nurse or Australian Defence Force (ADF) medic who is conducting the THE preliminaries is to:

a. review the completed Form AF212 conduct audiometry and measurements including pulse, blood pressure, height, weight, waist circumference, near and distance vision

b. identify any post-operational deployment screens that have not been completed

c. check the member's DHR for any outstanding vaccinations, recalls, tests, referrals and follow-ups

d. flag outstanding actions for the medical officers (MO) attention as, where practicable, outstanding actions need to be completed prior to transition

e. transfer the member's vaccination information to the Australian Immunisation Register (AIR)

f. advise the member that JHC will fund a community GP appointment to support clinical handover, and provide them with Information Sheet 6-1 (see Annex 8A).

8.10 If the member has ongoing on-base health care (eg occupational rehabilitation, mental health services, physiotherapy), the nurse or ADF medic is to request closure notes/reports and flag these for MO attention and inclusion in clinical handover.

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8.11 The nurse or ADF medic is to advise the member of their responsibility to:

a. make an appointment with the Veteran's Services Officer (VSO) if the member thinks they may have compensable injuries, illnesses or conditions

b. for medical transition, complete Form DM042—'Medical transition from the Defence Force CSC certificate of capacity'

c. make a Defence dental appointment if the member is dental fitness classification 3, requires a handover of care to a civilian dentist or has reported an oral health concern via Form AF212

d. provide the name of their community GP to Defence

e. complete outstanding post-operational health assessments

8.12 The preliminary appointment is to be documented in the member's DHR.

8.13 A flowchart outlining the preliminary appointment is provided in Annex 8A.

Medical officer appointment

8.14 During the MO appointment the MO is to:

a. check the preliminaries are complete, and take action to close any outstanding tests, referrals and recalls

b. review Form AF212 and review any health concerns identified by the member

c. ensure any screens, tests or investigations that are due in the three months after the member's transition date have been arranged and completed before the transition date (if this is not possible, include in clinical handover)

d. consider any requirements for post transition health care in accordance with (IAW) DHM Level 2 Part 4 Chapter 1[74]—'Eligibility for Defence health care'. Ensure any requests for post transition health care have been forwarded to the regional medical adviser (RMA) for consideration.

e. review the items flagged during the preliminary appointment and, where practicable, complete any outstanding health actions

f. ensure any outstanding post-operational health assessments have been arranged

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g. consider whether the member's medications are accessible via the Pharmaceuticals Benefit Scheme[75] (PBS) and, if not, consider changing medication and/or advising the member to speak with their community GP about medication

h. provide the member with prescriptions to cover one month post transition for any regular medication

i. conduct a physical examination of the body systems to support handover of clinical care and document the member's health status

j. raise Form PM552—'Clinical summary transfer of health care' to summarise the member's history and status for their community GP. This includes documentation of any health actions that cannot be completed before transition or any health actions the member elects to not complete. The member's DHR vaccination record and any relevant results/reports for ongoing care are to be attached to the Form PM552.

k. for members who are transitioning for medical reasons ensure that Form DM042 has been completed and that the member is engaged in a Goal 3 ADF rehabilitation program. If not then refer the member to the ADF Rehabilitation Program.

l. raise Form PM528-8—'Handover of clinical care for member transitioning from Defence' to enable a single, JHC-funded appointment with the member's nominated community GP for handover and continuity of care.

m. raise Form PM532—'Military employment classification (MEC) advice' if there is no change to the member's MEC. The MO is to annotate that the THE is complete (tick box) and recommend if the member is fit/unfit to transfer to SERCAT 3-5. If the member is J3x, then the MO is to annotate the Yes or No options against 'anticipate deployable MEC within 12 months'. If the MO recommends a change to the member's MEC a MECR is to be conducted as described in DHM Level 2 Part 6 Chapter 2[76]—'Military employment classification system'. The resultant Form PM518—'Health summary relating to military employment classification review (MECR)' and completed THE are to be forwarded to a confirming authority for confirmation. The confirming authority will then raise Form PM532.

8.15 The MO is to document the THE in the member's DHR.

8.16 A flowchart outlining the THE appointment is provided in Annex 8A.

[75] http://www.pbs.gov.au/pbs/home

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Less than six months service

8.17 Members who have served for less than six months, are not undergoing a medical transition from service and have not deployed may undergo a modified transition health assessment (THA) in place of a complete THE. Members must complete Form AF212 which is to be reviewed by a MO during a consultation with the member. If any significant medical or psychological problems are identified on Form AF212 or the member's DHR, a complete THE is to be conducted. All other processes related to the transition process and described in the MO appointment in Annex 11A are applicable.

Post-operational health assessments

8.18 Ideally, all post-operational medical and health screening should be completed prior to transition and carried out as described in DHM Level 2 Part 7 Chapter 10[77]—'Post-deployment health requirements'. Completion of these health assessments is an occupational requirement and can carried out by on-base clinicians following the member's transition to the Reserves.

Transition from SERVOP C

8.19 The member is to complete Form AF212 and submit it to their supporting garrison health facility. Members do not need to see an MO unless there are active health concerns or a clinical handover is required. The outcome of the modified THE is to be recorded in the member's DHR and on Form PM532.

8.20 **No health concerns or conditions**. If the member has no health concerns during the SERVOP C period, there is no requirement for medical review or clinical handover to the member's community GP. A credentialed nurse/ ADF medic is to review the member's Form AF212 and DHR. If there are no concerns, the credentialed nurse/ADF medic is to document their review in the member's DHR and raise Form PM532. The THE is then considered complete. If there are any concerns, the member requires a MO review.

8.21 **Health care during service.** If the member received health care for any conditions that were not minor or self-limiting during the SERVOP C period, they require medical officer review and a clinical handover to their civilian GP related to the period of service. A desktop review is sufficient if the episode of care is closed. If the member had an illness, injury or potentially traumatic event during their service, this should be documented in the DHR and included in the clinical handover. The member should be reminded of their responsibility to submit claims for compensable injuries and illnesses to Department Veterans' Affairs (DVA). The medical officer is to raise Form PM532 following completion of the THE.

8.22 **Health concerns or outstanding health action.** If the member has ongoing health concerns or outstanding health actions, they require a THE (as described in

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paragraphs 8.8 – 8.18). If a member requires care or hospitalisation that is likely to extend beyond their transition date, the reviewing MO (or in-patient treating MO if the member is admitted to any health facility) is to contact their regional medical adviser (RMA) for consideration of post-transition care at Defence expense IAW DHM Level 2 Part 4 Chapter 1.

8.23 If consecutive periods of SERVOP C are undertaken within three months, multiple THEs are not required.

Transfer to SERCAT 6-7 and SERVOP C

8.24 On request by the Career Management Agency (CMA), the process for determining the member's health suitability for transfer is as follows:

8.25 The Reserve member is required to have an appointment with a community GP for the completion of a Reserve Health Assessment (RHA), as described in DHM Level 2 Part 6 Chapter 4[78]—'Health assessments for Reserve members', within six months prior to the proposed date of transfer to SERCAT 6 or 7 or SERVOP C. Joint Health Command (JHC) will fund the cost of the RHA.

8.26 If the Reserve member is to pay for the GP assessment at the time of the appointment they should apply for reimbursement through their local Garrison Health facility using Form AE608—'Request for reimbursement of health expenses'.

8.27 The Reserve member is to bring Form AE585-1—'Reserve health declaration (RHD) general practitioner (GP) health status certification' to their GP appointment for completion. The member sends the completed Form AE585-1 along with any other clinically relevant information to their closest ADF health facility. There is no requirement for an on-base health appointment unless advised otherwise by the reviewing MO.

8.28 **Desktop review.** Credentialed clinicians in Garrison Health are responsible for conducting a desktop review of the completed Form AE585-1 and any documentation from the member's GP, along with the member's DHR. The purpose of the review is to ensure the member's MEC and restrictions are appropriate for their health status/history. Where indicated, the clinician may seek additional information, call the member or arrange a MO appointment to support the decision regarding suitability for transfer. This may involve a MEC review if deemed appropriate by a MO (see pararagraph 11.8).The assessment is to be documented in the member's DHR.

8.29 **No change.** If MEC and restrictions are consistent with member's health status/history, the credentialed clinician is to confirm the MEC and restrictions via the DHR, ensure the MEC and restrictions on PMKeyS are updated (if required), and raise Form PM532. The completed Form PM532 is then forwarded to the member by

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garrison health staff. The member is responsible for sending their Form PM532 to their CMA.

8.30 **Change.** If the MEC and restrictions are inconsistent with the member's health status/history, the following is to occur:

8.31 MO is to conduct a MEC review (as appropriate to circumstances) within the DHR, and send the MEC review to the appropriate confirming authority. The MO should contact the member about any changes to their MEC or restrictions. The completion of the MEC review will require an appointment (telehealth or in-person) with the MO at the garrison health facility.

8.32 The confirming authority is to ensure the MEC and restrictions on PMKeyS are updated and raise Form PM532. The completed Form PM532 is forwarded to the member by garrison health staff. The member is responsible for sending their Form PM532 to their CMA.

8.33 CMAs can seek advice via their Service Health Directorate if there are concerns about medical suitability for roles (eg members are MEC J31 or below).

d. When requested by CMA, the Service Health Directorates are responsible for providing individual health risk assessments (see DHM Level 3 Part 2 Chapter 9[79]— 'Individual health risk assessment'). Send SERCAT transitions to the CMA email inbox[80] (Note: do not send include sensitive personal: health information to the CMA).

8.34 **Specialist employment classification (SPEC).** The relevant Garrison aviation MO (AVMO) or underwater MO (UWMO) is to complete the desktop review as above, and forward the assessment and recommendation to the Service confirming authority for confirmation of health suitability for transition. The confirming authority may seek additional information or request a full individual health assessment (IHA) as indicated for the member.

8.35 A Reserve member in SPEC A, C or D who is returning to an active flying/diving/controlling role is to submit a report (no more than 12 months old) from their civilian dentist along with Form AE585-1. If the member has an in-date periodic dental examination (PDE) with no identified treatment needs, there is no requirement for the civilian dental report.

8.36 If a Reserve member holds a current Civil Aviation Safety Authority (CASA) certificate, they should submit the certificate along with their completed Form AE585-1.

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Annex:

8A Transition health examinations flowchart

ANNEX 8A

TRANSITION HEALTH EXAMINATIONS FLOWCHART