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[redacted]

11 October 2022

Dear [redacted],

Thank you for your email of 3 October 2022 in which you requested the following information:

> *"British Army entry medical requirements used by medical staff examining persons wishing to join"*

I am treating your correspondence as a request for information under the Freedom of Information Act 2000 (the Act). A search for the information has now been completed within the Ministry of Defence, and I can confirm that information in scope of your request is held. A copy of Army General and Administrative Instructions Volume 2 Chapter 78 (AGAI 78), Army Medical Employment Policy PULHHEEMS Administrative Pamphlet (PAP) can be found attached.

Please be advised that redactions have been applied to some of the information under section 23(1)(d) of the Act (Information supplied by, or relating to, bodies dealing with security matters). Section 23 is an absolute exemption and there is therefore no requirement to consider the public interest in deciding whether to withhold the information.

Under section 16 of the Act, Advice and Assistance, it may be helpful if I explain that the Army's medical entry standards are derived from JSP 950 Medical Policy Leaflet 6-7-7, the Joint Service Manual of Medical Fitness.

If you have any queries regarding the content of this letter, please contact this office in the first instance. Following this, if you wish to complain about the handling of your request, or the content of this response, you can request an independent internal review by contacting the Information Rights Compliance team, Ground Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.gov.uk). Please note that any request for an internal review should be made within 40 working days of the date of this response.

If you remain dissatisfied following an internal review, you may raise your complaint directly to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not normally investigate your case until the MOD internal review process has been completed. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website at https://ico.org.uk/.

Yours sincerely,

Workforce Team 1 | Army Policy & Secretariat

February 2022
(Replaces AEL 141 dated Oct 21)

ARMY

ARMY GENERAL AND ADMINISTRATIVE INSTRUCTIONS

VOLUME 2

CHAPTER 78

ARMY MEDICAL EMPLOYMENT POLICY
PULHHEEMS ADMINISTRATIVE PAMPHLET (PAP)

This AGAI 78, formerly known as PULHHEEMS Administrative Pamphlet, is sponsored by Workforce Policy, Army Personnel Policy. It covers the employment aspects of the application of Joint Medical Policy in the Army and provides instructions for the medical administration of all Army officers and soldiers and applies to both the Regular Army and the Army Reserve.

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VOLUME 2
CHAPTER 78

ARMY MEDICAL EMPLOYMENT POLICY
PULHHEEMS ADMINISTRATIVE PAMPHLET (PAP)

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LIST OF APPENDICES

RECORD OF AMENDMENTS

Change Number	Authority	Amendment Date	Amendment
AEL 109	Pers Pol (Army)	18 Feb 19	Publication of this AGAI to replace PAP Sep 17 Edn
AEL 110	Pers Pol (Army)	29 Mar 19	Minor corrections, Appx 22 for ITT pers, Medical Assessment clarification for Officers, replacement for Appx 27 for Appx 21 Recruits
AEL 112	Pers Pol (Army)	1 May 19	Amendments relating to MND Employment in Part 10 and Appendix 22. Additional revisions to Appendix 9.
AEL 119	Pers Pol (Army)	9 Dec 19	**Introduction** Additional clarity is given regarding transferees to state that those requiring BT and ITT must meet the medical standard of MFD by entry standards. **Part 1** Additional emphasis given on the employability of SP below MFD and a new section on Occupational Medicine has been added. **Part 2** Additional clarification is given regarding the medical assessment requirement for serving candidates applying for Commission. Additional information on legislative obligations and the Executive Waiver types has also been added. **Part 3** Additional clarification is given regarding the medical assessment requirement for serving candidates applying for Commission and the assessment/standard for scheme members. There is also additional emphasis that the Appendix 8 retention process supports retention of those below the retention standard where appropriate and medically safe. There is also an amendment to clarify that recommendation for LDoS extension by FMB beyond 12 months can be made exceptionally in the Appendix 12 paragraph 2 comments. **Part 7** An amendment has been made which states where there is a rehabilitation requirement it is recommended that the FMB have details of the rehabilitation assessment prior to giving an LDoS deferral recommendation (this may require the FMB to extend the L6 Temp grade beyond the 12 month point up until the 18 months point in order to obtain this information). Additional clarification is also given to state that in the extremely rare case of an SP graded L6 E6 MND (P) at FMB who has recovered sufficiently to suggest an upgrade, the SP should be presented back to ROHT for FMB review (upgrade possible). Clarification that LDoS is calculated from receipt of discharge recommendation at APC has also been added. **Part 8** An amendment has been made regarding Bursar candidates' medical self-assessment requirement which

			removes the requirement for an annual RGMD. Additional clarification has been given regarding the re-join requirement for those discharged as TU. Additional clarification is also given to state that IMA failure in first 2 week is recorded as UNFIT 'P8', but that these individuals are not WIS SP. Additionally, clarification that there is no requirement for medical assessment between Basic training and initial Trade Training has also been made. An amendment has been made to state that Appendix 21 applies to BT and ITT SP (Appendix 22 MND Employment for trained SP only). **Part 9** Amendment added that recommends early referral for rehabilitation assessment (and rehabilitation) if appropriate for L6 Temp SP. **Part 10** Clarification added with regard to MND employment to state that there is no limit to number of applications, but that a 12 month holding period is recommended for those that do not have suitable employment identified at the first application. Clarification that Appendix 22 for trained SP is to be initiated within 28 days of the permanent medical downgrading unless an Appendix 8 application is being made. Clarification that SP in scope for MND Employment may also wish to pursue a capbadge transfer. Additional clarification that an FMed 23 must sent to Veterans UK (DBS) in APC for SP being discharged under QR(Army) para 9.385 who have served for 2 years or more. Clarification that recommendation for LDoS extension beyond 12 months can be made in exceptional circumstances by FMB, but that once the discharge is set service extensions on medical grounds can only be awarded by Pers Pol and that clinicians must be clear of this to SP and the CoC. Service extensions on medical grounds are usually authorised for no more than 6 months to enable review of transition (predominantly healthcare) planning. The amendment also states that Multi-Disciplinary Team engagement is recommended for complex WIS cases and that failure to meet JSP 950 obligations will not force a service extension. Amendment to state that additional medical scrutiny is required of the (rare) medical extension applications beyond 24 months of the FMB's recommended LDoS. Additionally, the AF B10034 extension application form has been updated. **Part 12** Additional clarification is given of the RMD process which emphasises the key medical recommendation and that RMD relates to medical condition at the time of discharge (not conditions that have been diagnosed following service). There is also a new articulation of the process for an SP (or ex-SP) to challenge Primary Invaliding Condition (PIC) code. **Part 13** Further emphasis is given that PAPMIS Appendices are still to be used (as opposed to printed copies) where the PAPMIS electronic forms have not yet been updated. Also additional clarification that Appendix 18 must be completed

			through PAPMIS annually with a hard copy retained in the SP's P File as 'refreshing' the Appendix will overwrite the previous content. Additional emphasis is also given that Appendix 26 is not required for exercise within the UK within the limitations of the SP's Appendix 9 in addition to clarification for Appendix 8 that CO is accepting the risk and that Appendix 8s can only be approved until the SP's FAD (a Unit move requires a new Appendix 8 from the receiving CO), EED or for up to 2 years (Units may specify a date within this timeframe) - whichever is the lesser. **Tables** Additional clarification of the objective tests for MFD is articulated in Table 6 to state that 'ability to pass MATTs' means physically 'fit to attempt'. **Appendices** Appendix 12 clarification is given to state that hand signed copies of Appendix 12 by clinicians are not mandated (electronic signature is accepted) but may still be used.
AEL 128	Pers Pol (A)	29 Sep 20	**Part 3** Change of terminology associated with Scheme members, deletion of the Army Undergraduate Cadetship Scheme and reference changes to Reserve policy. **Part 5** Footnote added into assignment paragraph, signposting JSP 760 when assigning pregnant SP. **Part 6** Change to Medical Retirement policy for Reserve Officers and Medical Discharge for Reserve Soldiers. **Part 7** Change to Medical Retirement policy for Reserve Officers and Medical Discharge for Reserve Soldiers. **Part 8** Reference change throughout to AGAI 40. Addition of extension of IMA, AF B204 and TJMES window due to COVID-19. **Part 9** TJMES extension requests to be sent to SO2 not SO3 Emp Pol. **Part 10** Addition of Appendix 26C reference for those deploying on op RESCRIPT. Minor changes to the Appendix 8 approvals process. Change to Reserve policy references. **Appendix 4** Change to Medical Retirement policy for Reserve Officers and Medical Discharge for Reserve Soldiers. **Appendix 12**

			Deletion of obsolete Reserve discharge references (Both Regular and Reserves now discharged/retired under the same QR(Army)/ PAW). Addition of details of where the form should be copied to. Deletion of page 3. **Appendix 21** Deleted note for Unit CO's to send QR(Army) para 9.385 to APC OH.
AEL 141	Pers Pol (A)	01 Nov 21	**Part 1** Clarification of TJMES timelines for secondary conditions. New policy on Self-certified sickness absence and Line Manager Referrals. Update to JMES table with regards to E2 markers for SCT. **Part 2** Clarification of medical requirements for serving candidates applying for commissions. A change to policy on FTRS pre-induction medicals. Clarification of the occasion for JMES reviews for Reg and Res SP and medical standards for application to join or extend membership of the Regular Reserve. Re-numbering of paragraphs. **Part 3** Confirmation of Officer entry standards for Regular, Reserve and Scheme members. Change to minimum retention standards of Regular and Army Reserve Officers. **Part 4** Retention standards for Regular soldiers and soldiers in the Army Reserve reworded. Clarification of the minimum medical standard for application to the Regular Reserve. **Part 5** Paragraphs detailing employment decisions moved to Part 10. Update to the Assignment paragraph to reflect the new process for employment decisions in part 10. Amendment to the timelines associated with IA's Appendix 9 and 26 paperwork being sent to APC. **Part 6** New Policy on the use of electronic signatures. Clarification of the discharge codes to be used for Reg and Res SP. New Policy that an App 9 is produced during the pre-lease medical for downgraded Reg SP wishing to join the Army Res. **Part 7** Confirmation of the discharge codes to be used for Reg and Res Offr and Sldrs who fail to declare medical conditions on entry or are invalided. **Part 8** Inclusion of the memorandum of understanding between LWC and ARITC with regards to OH for ITT. Clarity on the validity of RGMD/PHCR review prior to PSMA. Confirmation on the process for Army Res who do not attend BT within 12 months of PSMA. Confirmation of the Brigade or Gurkhas IMA requirements. Inclusion of DSUS alongside DTUS and

			clarity on the medical requirements for all bursar candidates and scheme members. Amendments to PQO medical requirements prior the CCS. Update to SRO, SROR policy references. Cohesion between AGAI 78 and AGIA 40 with regards to sldrs discharge TU who wish to re-join. Clarification on the management of SP who enlist via an AFB203, use of the AFB203a and the addition of a new WF Pol waiver email address. Rewording on the policy on IMA's to allow up to 4 weeks by exception. An update to the defect in enlistment process and service medical examinations. Clarification of QRs for medical discharge of SuTs and RMAS Cadets. **Part 9** Addition of line manager referrals to ROHT. Clarification on who conducts FWA(T) and FWA(P). New policy on the use of electronic signatures within Appendix 9-12 and a requirement for Appendices to be emailed to the CoC on completion. **Part 10** MND Employment process removed (including Appendix 8 and 22) and replaced with Appendix 28 Application for an Employment Offer for SP graded L5 MND(P). Changes to the minimum retention standard for OR8/9 and OF2 and above. Exceptions FTRS(HC/LC), MPGS and limited Army Reserve roles (UK only). Changes to assignments, extensions in post and promotion on retention paragraphs to reflect the new process. **Part 11** Minor changes to the AEB process to reflect changes to the board composition and the new Employment offer for SP graded L5 MND(P) (Appendix 28). All Appendix 25 applications to be initiated by the SP. **Part 12** RMD process reworded to make it clearer and to include the RMD review panel which now takes place. **Part 13** Replaced obsolete service desk details with the details for support available to units through the Army Information Front Door and via the new PAPMIS team within Regional Command. Removal of Appendix 8 and 22 and updated to reflect the new Application for an Employment Offer for SP graded L5 MND(P) (Appendix 28). **Table 2** Updated with RE trades. **Table 4a** Minimum retention standards updated. **Table 5a** Minimum retention standards updated. **Table 5b** Updated with RE trades. **Appendix 1**

			Addition of electronic signatures. **Appendix 3** Clarification of the composition of Medical Assessments. Inclusion of ratification by Con OM for all MND(P) grades. Clarification on the level of detail required on FMed 23. **Appendix 4** Removal of the requirement to post documents to APC and replaced with the email contact details. Updated with Appendix 28 process. **Appendix 8** – Replaced by Appendix 28. **Appendix 9** Update with the use of electronic signatures and direction for the completed form to be emailed to the CoC. Emphasis that the MO must inform the CO of any safety critical restrictions. **Appendix 10 & 11** Addition of electronic signatures and email addresses. Replaced GROW with prognosis unknown and possible ROHT involvement. **Appendix 12** Emphasis that the SP is to cease normal duties. Addition of requirement for a copy of the form to be emailed to the CoC. Change from MO to Unit responsibility to forward to IERO. Highlighted the Resettlement entitlements are only for Reg, FTRS (FC) or mobilised Res. **Appendix 17a** Updated to reflect use of electronic signatures **Appendix 17** Detail on electronic signatures added. Reworded and reformatted to make it clearer to the SP what they are consenting to. **Appendix 18** Box 7 updated to include specific questions on the use of weapons. **Appendix 19** Update to the level 2 appeals process. **Appendix 20** Consent form added for access to medical documents. **Appendix 21** Update to notes section providing clarity on the process and discharge codes to be used. **Appendix 22** Replaced with the CoC aide memoire. **Appendix 23** Updated with the use of electronic signatures. **Appendix 24**

			Updated to replace Appendix 8 and 22 processes with Appendix 28. Timeline and note section updated to reflect changes. **Appendix 26C** Deployable Risk Assessment for UK COVID Ops added. **Appendix 27** Updated to reflect Appendix 28 process. **Appendix 28** Replaced with a new Application for Employment Offer for SP graded L5 MND(P) (replaces old Appendix 8 and 22 processes).
AEL 145	Pers Pol (A)	09 Feb 22	Minor amendments to formatting, spelling and updating references made throughout. **Part 1** Re-worded reference if a secondary condition occurs prior to the 12 month in Temp grade, refer to Cons OM who will decide whether a Perm/Temp grade should be awarded. **Part 7** Change of wording to the aggregation of periods of absence, including changing disability to condition. **Part 10** Re-worded to make clearer that the App 28 is to be initiated within 28 days of a Perm grading and the action SP should take if not given an employment offer. Clarification on exceptional applications for SP graded MLD(P) and detail added reference the letter which SP will receive following completion of the App 28 process. **Part 11** Additional category added to allow SP to appeal Medical Discharge at the end of their App 28 Assignment if a Service need is identified and suitable role available. **Part 12** Update to paragraph detailing SP reaching EED graded L5 MND(P). Clarification on the timeline for PIC appeals. **Appendix 18** Re-word to Qu 7 to acknowledge that the Appendix may be completed by an OC. **Appendix 19** Re worded to make the appeals process for trained SP clearer and emphasise the need for evidence to support an appeal. **Appendix 26C** Minor update. **Appendix 28** Section D re-worded to make clearer the action needed by SP who have not been offered employment.

1. **Equality Analysis.** The policy in this AGAI 78 (Army Medical Employment Policy) has been considered against the Public Sector Equality Duty and an Equality Analysis Impact Assessment (EQIA) has been conducted. It is assessed that the majority of amendments to this policy will have no impact on protected groups. The Armed Forces have an exemption from the disability discrimination and the age discrimination provisions of the Equality Act, as set out in Schedule 9, paragraph 4(3). Consideration has been given to the implementation of changes to the Medical Retention standard and Medical discharge process. These have been made in order to give parity across all ranks and are based on the Army's need to consider deployability as well as employability. Management of SP is dependent on their Joint Medical Employment Standard with each case considered individually.

2. **Inclusive Language.** All new policies and services must where possible use inclusive language. For gender-neutral language, this can usually be done by rephrasing sentences, or if this is not possible, by using 'they' or 'their' rather than 'his' or 'her'. It is recognised that two multiuser email addresses referenced within this AGAI 78 contain the non-inclusive expression 'Army Manning'. These will be amended in due course. This AGAI 78 complies with the MOD's inclusive language guidelines.

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ARMY MEDICAL EMPLOYMENT POLICY
PULHHEEMS ADMINISTRATIVE PAMPHLET (PAP)

Definitions

PULHHEEMS and the JMES

1. The PULHHEEMS system of medical classification is a Tri-Service clinical system, described in JSP 950, and takes its name from the first letters of the division under which the medical examination is carried out. These are:

P	=	Physical capacity
U	=	Upper limbs
L	=	Locomotion
HH	=	Hearing
EE	=	Eyesight
M	=	Mental capacity
S	=	Emotional stability

Qualities

2. These divisions are known as 'qualities' e.g. P quality, U quality, etc, and are assessed in degrees.

Degrees

3. The standard of fitness under each quality is recorded by the figures 0 to 8; these figures are known as 'degrees'. Not all degrees are used for each quality.

Joint Medical Employment Standard (JMES)

4. The PULHHEEMS clinical information is translated into a non-clinical JMES for the employer which enables safe and appropriate employment of the subject. The JMES comprises of a number of elements which include a deployment and employment standard and associated functional restrictions (non-clinical information).

Colour Perception (CP)

5. Records the ability to discriminate red/green hues.

GLOSSARY

APC Career Manager	APC CM
Army Employment Appeals Board	AEAB
Army Employment Board	AEB
Army Health Board	AHB
Army Officer Selection Board	AOSB
Assessment Centres	AC
body mass index	BMI
Career Employment Group	CEG
Career Employment Qualifications	CEQ
Career Managers	CM
Chain of Command	CoC
Civilian Medical Practitioner	CMP
Commanding Officer	CO
Commissioning Course	CC
Department of Community Mental Health	DCMH
Defence Primary Healthcare	DPHC
Defence Medical Information Capability Programme	DMICP
Director Personnel	D Pers
Primary Healthcare	PHC
Discharge as of Right	DAOR
Delivery Duty Holder	DDH
Engagement Expiry Date	EED
Eyesight	EE
Full Medical Board	FMB
Full-Time Reserve Service	FTRS
Fitness for Work Assessment	FWA
General Practitioner	GP
Headquarters Army Recruiting and Training Division	HQ ARITC
Heads of Capability	HoCs
Hearing	HH
Individual Leave Allowance	ILA
Individual Recovery Pathway	IRP
Individual Recovery Plan	IRP
Initial Medical Assessment	IMA
Initial Training Group	ITG
Joint Medical Employment Standards	JMES
Joint Personnel Administration	JPA
Last Day of Service	LDoS
Locally Enlisted Personnel	LEP
Locomotion	L
Medical Deployment Standard	MDS
Medical Employment Policy	MEP
Medical Employment Standard	MES
Main Operating Bases	MOB
Medical Officer	MO
Medical Risk Assessment	MRA
Medically Fully Deployable	MFD
Medically Limited Deployability	MLD
Medically Not Deployable	MND
Mental Capacity	M
Military Aviation Medical Examiner	MAME
Military Provost Guard Service	MPGS
Mission Ready Training Centre	MRTC
Minimum Medical Data Set	MMDS
National Recruiting Centre	NRC
Notice to Terminate	NTT
Occupational Medicine	OM
Occupational Health Nurse	OHN
Officer Cadets	OCdts
Officers Commanding	OC
Online Medical Questionnaire	OMQ
Permanent Joint Head Quarters	PJHQ
Physical Capacity	P
Physical Selection Standards (Officer)	PSS(O)
Physical Selection Standards (Recruit Reserve)	PSS(RR)
Physical Selection Standards (Recruit)	PSS(R)
Post Graduate Medical Officer	PGMO
Pre-Commissioning Course Briefing Course	PCCBC
Premature Voluntary Release	PVR
Pre-Service Medical Assessment	PSMA
Primary Health Care Record	PHCR
Private Health Care Initiative	PHCI
Professionally Qualified Officer	PQO
Regular Army Reserve Officers	RARO
Records of Decisions	RoDs
Recruiting Branch	RB
Recruiting Group Medical Declaration	RGMD
Regional Occupational Health Team	ROHT
Resilience Margin	ReM
Royal Military Academy Sandhurst	RMAS
Senior Health Advisor (Army)	SHA(A)
Service Medical Examination	SME
Service Person	SP
Soldiers Under Training	SuT
Sponsored Reserves	SR
Stability	S
Staff & Personnel Selection Officer	SPSO
Temporarily Non-Effective	TNE
Temporary Grading Board	TGB
Terminal Leave	TL
Unit Health Conference	UHC
Unit Medical Officer	UMO
Upper Limbs	U
Unmanned Ariel System	UAS
Volunteer Reservist	VR
Wounded Injured and Sick Management Information System	WISMIS

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CHAPTER 78

ARMY MEDICAL EMPLOYMENT POLICY
PULHHEEMS ADMINISTRATIVE PAMPHLET (PAP)

Introduction

Purpose of this AGAI

78.001. This AGAI 78 contains the rules for the application of the PULHHEEMS system of medical classification in the Army and instructions for the medical administration of officers and soldiers.

Application

78.002. The instructions contained in this pamphlet are applicable to the Army and apply to all Army personnel serving in the Regular Army, Regular Reserve and Army Reserve. The general principles given in this AGAI also apply to locally enlisted personnel (LEP). Except where stated to the contrary, all the provisions of this AGAI are applicable to all soldiers/officers. The online tool PAPMIS must be used where possible for the management of personnel below the minimum medical employment standard for their Arm or Service and hard copies should only be used in extremis.

Sponsorship

78.003. The minimum medical standards in Tables 1 to 6 are the responsibility of the Regimental / Corps Colonels and E1 Workforce planners concerned, who are also responsible for supplying Workforce Policy, Army Personnel Policy with required amendments for the whole AGAI in a regular and timely system of review. Medical advice is co-ordinated by the Senior Health Advisor (Army) (SHA(A)) on behalf of Director Personnel (D Pers). Headquarters Army Recruiting and Initial Training Command (HQ ARITC) advises upon the application of entry standards for officers and soldiers and should be consulted on all matters affecting entry standards. Pers Pol (A) co-ordinates the Army's requirements and lays down the procedures for operating the PULHHEEMS system. Queries on the Parts in this AGAI 78 should normally be addressed to Pers Pol (A), although queries of a purely medical nature are best directed to SHA(A). Queries on the tables should normally be addressed to the sponsor branch concerned.

78.004. This policy has been equality and diversity impact assessed in accordance with departmental policy. This resulted in a Part 1 screening and Part 2 full equality and diversity impact assessment being undertaken.

78.005. Legal advice has been sought and incorporated throughout the development of this complex policy.

78.006. This policy is owned by Workforce Policy, Personnel Policy (Army). Observations on this policy are welcomed and should be referred to Army Pers-Pol-WFPol-Empl-SO2

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PART 1 - GENERAL PRINCIPLES OF THE PULHHEEMS SYSTEM OF MEDICAL CLASSIFICATION

General

78.101. The PULHHEEMS system is a set of medical standards designed to provide a coding for the medical assessment of the functional capacity of potential recruits and serving Army personnel from which can be derived a determination of fitness for service. Associated with the PULHHEEMS assessment is the award of a Joint Medical Employment Standard (JMES) grading in order to inform commanders and career managers of the employability and deployability of Army personnel. The allocation of a JMES grading is the responsibility of medical staff. In individual cases Army Personnel Policy has the authority (after taking appropriate medical advice) to waive or vary employment restrictions contained within the definitions of the P grade or JMES. Any application for such a waiver should be made through the Chain of Command (CoC) to the appropriate MS Branch at the Army Personnel Centre (APC) prior to submission to Pers Pol (A)[1].

78.102. Meaning of a PULHHEEMS Grading. The medical examination for a PULHHEEMS grading is an occupational medical assessment. The examination is a record of the presence or absence of a medical condition or physical limitation that may affect employment. It is not a comprehensive health review, although a PULHHEEMS review may be used by a medical officer for some health promotion activities. It does not have any useful predictive value regarding the SP's future physical performance.

78.103. Paragraphs **78.105-78.126** are intended as a guide to non-medical officers on the method used to determine and record a PULHHEEMS assessment and explain the use of JMES. JMES are explained in paragraphs **78.107-78.109**, with detailed definitions contained in the Tables.

78.104. The PULHHEEMS system of medical classification and JMES grading are designed to:

a. Provide a functional assessment of the SP's capacity for work.

b. Assist in expressing the physical and mental attributes appropriate to the SP's employment and fitness for deployment on operations with the Army.

c. Assist in assigning people to the employment for which they are most suited considering their physical, intellectual, and emotional make-up allowing efficient use of the workforce.

d. Provide a system, which is administratively simple to apply.

Method of Assessment

78.105. The allocation of a PULHHEEMS assessment is a medical responsibility. Instructions for medical officers, on the method of carrying out a medical classification under the PULHHEEMS system, are contained in JSP 950 Chapter 7 Leaflet 6-7-7.

[1] Application For Special Enlistment (AF B203), more detail at para 78.840.

The Qualities Assessed under the PULHHEEMS System

78.106. In order to record in detail the physical and mental capacity of a SP, medical classification under the PULHHEEMS system is considered and recorded under the following qualities:

a. **Physical Capacity (P).** This quality is used to indicate a SP's overall physical and mental development, their potential for physical training and suitability for employment worldwide (i.e. the overall functional capacity). The 'P' grading is affected by other qualities in the PULHHEEMS profile, namely the 'U', 'L', 'HH', 'EE' and 'S' gradings.

b. **Upper Limbs (U).** Indicates the functional use of the hands, arms, shoulder girdle and cervical and thoracic spine, and in general shows the SP's ability to handle weapons and loads. A reduced 'U' grading will affect the 'P' grading.

c. **Locomotion (L).** Indicates a SP's ability to march/run. The 'L' grading refers to the functional efficiency of the locomotor system. This quality must therefore consider assessment of the lumbar spine, pelvis, hips, legs, knees, ankles, and feet. Observation of gait and mobility are also important. Any conditions affecting the function of the locomotor system will result in a reduced 'L' grading which will in turn be reflected in the 'P' grading.

d. **Hearing (HH).** This quality assesses auditory acuity only. Diseases of the ear such as otitis externa are assessed under the 'P' quality. Severe loss of hearing will affect the 'P' grading.

e. **Eyesight (EE).** This quality assesses visual acuity only. Diseases of the eye such as glaucoma are assessed under the 'P' quality. Severe loss of visual acuity will affect the 'P' grading.

f. **Mental Capacity (M).** Indicates the SP's ability to learn military skills and duties. Mental capacity is not subject to formal medical assessment at recruitment. However, the recruit selection procedure, including interviews, and the SP's academic record will allow judgement to be made on this quality. Subject changes are only likely to occur as a result of neurological disease or head injury.

g. **Stability (S).** The S quality indicates emotional stability which grades the SP's ability to withstand the psychological stress of military life (especially operations). Amendments to the "S" grade are usually required in cases of psychiatric illness but are not restricted to these circumstances.

Joint Medical Employment Standards (JMES)

78.107. The JMES is an employment code awarded by medical staff in order to inform commanders of the employability and deployability of Service personnel. The JMES describes the functional and geographical employability of the individual along with specific medical restrictions/limitations. The JMES awarded by the medical board also contains a 'temporary' or 'permanent' marker which assists in the management of the individual. This publication reflects the harmonisation of JMES (agreed interpretation of the grading system) across all three services undertaken from 1 Aug 16.

78.108. Medical Employment Standard (MES). This relates a SP's PULHHEEMS profile to their branch/trade requirements and expresses it as numerical degrees in four functional areas, indicated by the letters A, L, M and E. These reflect medical fitness for duties in the Air (A), Land (L), and Maritime (M) environments and any requirement for medical environmental (E) support. All elements of the MES are to be allocated for each medically downgraded SP with a number from

1-5/6 awarded for each (where 1 is the least restricted and 5 or 6 is the most restricted in terms of medical limitations). Gradings A1-A3 will only be used by Army aircrew with A4 being the least restricted medical grading for the majority of Army personnel (as non-aircrew). Similarly, M1-M3 will only be used by Army personnel employed in maritime roles, for example RLC Seaman/Navigator trades and Army personnel serving within 3 Cdo Bde, with M4 being the default least restricted grading for the remainder of Army personnel.

78.109. Medical Deployment Standard. The Medical Deployment Standard (MDS) describes the medical capacity for deployment and is determined by the ALME code (see **para 78.109**). For the Army, the MDS has a specific relation to the L grade as can be seen below (the JMES table at page 1-6 gives further detail of the ALME categories).

L1	Fit for unrestricted duty	MFD
L2	Fit for high readiness roles with minor limitations.	MLD
L3	Fit for limited duties but with some restriction subject to Medical Risk Assessment.	
L4	Fit for certain deployed roles into well-established MOB locations subject to Consultant Occupational Physician Medical Risk Assessment.	
L5	Unfit deployment. Fit for branch/trade and limited UK operations.	MND
L6	Unfit for service in the land environment.	

Method Used to Record Temporary Medical Conditions – 'T' suffix

78.110. Temporary or Permanent Marker. When a medical board awards a JMES of MLD or MND, a decision will be made as to whether the JMES is temporary (Temp) or permanent (Perm). The maximum period of validity of a Temp JMES is 12 months (from day one of the TJMES) for Army personnel unless an extension to this period is authorised (**para 78.111**). As soon as it is clear that a condition is 'Perm', i.e. likely to last 12 months or more, a Fitness for Work Assessment (Permanent) (FWA(P)) should be conducted to award a permanent JMES; a Perm JMES can be awarded at any time if clinically appropriate. Permanent does not mean that the JMES can never change but is intended to assist employment decision making by distinguishing the longer-term health problems affecting a SP from the short-term. The abbreviations 'Perm' and 'Temp' are used within the JMES and the term 'not applicable (abbreviated N/A)' is the marker used with the JMES of MFD. For those graded L6E5 MND Temp, who are sick on full pay, **para 78.708** applies.

78.111. A Fitness for Work Assessment (Temporary) (FWA(T)) may award the T suffix for a maximum period of 12 months in total which starts from the day of the award of the Temporary JMES. If less than 12 months, the time awarded by the FWA(T) must reflect the estimated time to achieve a permanent grading, noting that a Perm grading may be appropriate straightaway (**78.110**). If a secondary condition occurs prior to the 12 month point, the case should be referred to ROHT for an opinion on grade and whether a Temp/Perm marker should apply. PULHHEEMS may be annotated with R against the secondary condition if it is likely to be recoverable. Where clinically appropriate, a temporary medical downgrading can be extended beyond 12 months with Cons OM authority. Extensions beyond 18 months can only be granted by Pers Pol (A), on application to SO2 Empl Pol by the Cons OM. Service personnel evacuated as a casualty from an operational theatre and admitted to a hospital for inpatient care, including the Royal Centre of Defence Medicine (RCDM) and Defence Medical Rehabilitation Centre/Defence National Rehabilitation Centre (DMRC/DNRC), should be graded L6E5 MND Temp[2] following an appropriate medical assessment (with further medical board if needed).

78.112 Self Certified Sickness Absence (SCSA)[3]. As per 2021DIN01-043 Regulars and Reservist entitled to DMS provided healthcare may self-certify sickness absence on JPA for up to 48 hours. Individuals are to notify their CoC of their illness and seek approval for subsequent JPA

[2] This is to be conducted by the UMO or equivalent.
[3] Further direction has been issued by Field Army and Home Command.

administration. SP do not have a 'right' to SCSA at all times. CO's may direct that certain individuals (e.g. on medical recommendation or those exceeding the 8-day limit) or groups (e.g. those on exceptional high readiness) are not to self-certify. CO's may also issue additional local direction and guidance on management of SCSA.

78.113. Limited Duties. Limited Duties are written advice from medical staff to the CoC about an officer or soldier's medical condition. An officer or soldier may be placed on limited duties when medical staff assess that their condition is mild and temporary in nature and is unlikely to last for longer than 28 days. On the 29th day, or before the 29th day if medical staff assess that the condition is likely to last beyond 28 days, the SP's JMES must be amended. Limited Duties should ordinarily only be given for periods of no longer than 14 days at a time, although may be given for up to 28 days where there is a clinical requirement.

78.114. Limited Duties Administration. The type and extent of limited duties are recorded on the Light Duties Proforma (LDP) recorded in the Defence Medicine Information Capability Programme (DMICP)[4] as follows:

a. **Disposal A - Attended.** SP attended a medical appointment.

b. **Disposal B - Limited duties.** SP is excused specific activities. Maximum continuous period before review 14 days (although in some cases may be up to 28 days if there is a clinical requirement).

c. **Disposal C - Unfitness for Work, Bedded Down / Admitted.** SP is bedded down at their Residence at Work Address (Home/SFA/SLA), at an MRS, or as a hospital inpatient. Maximum continuous period before review 14 days (although by exception may be up to 28 days).

d. **Disposal - Medication and Discharged.** SP was provided with medication and was discharged from medical care.

78.115. Limited Duties (Disposal B). Limited duties are ordinarily granted by the MO, although they may delegate this responsibility, with appropriate restrictions, to other members of their clinical team. SP placed on Limited Duties must be reviewed no later than the 28-day point and, if the SP's medical condition persists, a JMES assessment must be carried out. Under no circumstances can Limited Duties be extended beyond 28 days.

78.116. Limited Duties - Unfit for Work (Disposal C). Assessing a SP as Unfit for Work is not the same as granting them Sick Leave (see Part 7). The SP should be bedded down at their Residence at Work Address, at an MRS, or as a hospital inpatient. It is the SP's responsibility to inform their CoC, although Medical Staff may undertake to do this on behalf of the SP in cases of incapacity or medical emergency. MOs considering granting Sick Leave directly are to inform the SP's CoC ASAP (see JSP 760, para 21.5). If at any point during this period it is considered unlikely that a SP will return to limited or full duties by the 28-day point, then a JMES assessment must be carried out. In all cases, by the 28 day point a JMES assessment must be carried out to enable a FWA(T) to be conducted.

78.117. Medical Advice to Chain of Command. Following receipt of the Light Duties Proforma (LDP), the CO retains the authority to employ or deploy a SP contrary to medical advice. However, this must only happen in exceptional circumstances, and following a risk assessment. 'Exceptional' is defined as: In an emergency; in extremis; where there is no other choice and not using that SP would result in very serious consequences. Financial reasons or standard workforce difficulties are highly unlikely to be regarded as reasonable considerations. The CO must carefully

[4] Based around the AF I 8721 Light Duties Proforma (LDP), in extremis this may be used.

consider the situation before tasking a SP with a duty against medical advice.

78.118. Medical Limitations. In addition to the JMES grading, any JMES below MFD is accompanied by a detailed medical functionality and limitations assessment which enables continued and considered employment of the SP where there is a service need. This employment is crucial, where appropriate and medically safe, due to the high levels of employability (knowledge, skills, and experience) of many SP who are medically downgraded. For Army personnel this is articulated in the notification of functional restrictions Appendix 9 which is specific to the Army context. The Appendix 9 is for employment purposes for use by the CoC.

Pregnancy

78.119. On selection. Candidates found to be pregnant at their Pre-Service Medical Assessment (PSMA) are not to undertake any physical selection tests. They are to be given a **Defer – (Temporarily Medically UNFIT)** grading and are considered temporarily unfit (this will also apply to candidates found to be pregnant at IMA). Post-Partum candidates should be medically assessed as fit to undertake physical selection tests before any subsequent attempt as PSMA and must be at least 3 months after the end of a pregnancy (JSP 950, Lft 6-7-7, 4-J-2).

78.120. Environmental and Medical Support Grading E6. SP have no obligation to inform their CoC that they are pregnant before the notification week, (from the Sunday before the due date count backwards 15 weeks). Once a SP has formally notified their employer of pregnancy (using F Med 790) and given consent (written or a contemporaneous record within the clinical notes) for the CoC to be informed of their functional restrictions (Appendix 9), the E6 JMES grading will be used. If consent is withheld **para 78.1032** is to be enacted.

78.121. In Training. Soldiers under Training (SuT) and OCdts who are pregnant cannot be medically discharged on the grounds of pregnancy. They are to be graded A4L5M4E6 MND (T).

78.122. Postpartum Return to Work (RtW). New mothers[5] are to be graded MLD(T) A4L4M4E4 during their RtW Medical, for a period of 6 months from their RtW date. This is in order to ensure Regional Occupational Health Team (ROHT) input into Deployed Medical Risk Assessments (MRA), access to the appropriate postpartum rehabilitation and consideration at Unit Health Committee (UHC). The Return to Work (RtW) FWA will be conducted in line with JSP 760 Chapter 24 and JSP 950 Part 1 Leaflet 6-7-7 which will take account of any specialist post-natal review but will in any case be determined on an individual basis. The RtW FWA must always be conducted in the Servicewoman's presence and should be conducted having had sight of the workplace risk assessment[6] completed for the Servicewoman by the CoC, so that any Appendix 9 can be tailored specifically to the employment aspirations of both the Servicewoman and CoC.

78.123. Guidance. The Pregnancy and Maternity in the British Army Servicewomen's' and Unit Guides give direction on further considerations for the CoC.

The Role of Occupational Medicine

78.124. Definition. Occupational Medicine (OM) is an applied branch of medicine combining clinical practice with preventative and environmental medicine to deal with the interaction of work and health. It draws knowledge from epidemiology, occupational hygiene and engineering, toxicology, and law. OM assess the effects of work and the workplace on health, as well as the effects of injury and illness on a service person's ability to work. OM is concerned with the maintenance of health, and prevention of ill health and injury, with the secondary objectives of maintaining and increasing productivity and social adjustment in the workplace.

[5] Including those who have experienced perinatal death or stillborn issue.
[6] In line with JSP 375 Pt 2 Vol 1 and JSP 950 Part 1 Leaflet 6-7-7

78.125. Risk assessment. A fundamental concept in OM is risk assessment. Harm can be caused to the service person through the course of their work. A primary task of OM is to predict the degree of risk from a hazard in the work environment and to advise on the control measures required to reduce the risk to as low as reasonably practicable. This allows for the Army to comply with their general legal duty as an employer to protect their service personnel from the adverse health effects of work. In conducting a risk assessment, Occupational Medical Practitioners consider job role, health & safety at work, prevention of injury and disease, environmental factors, and Force Health Protection in the management of health, prevention of injury and disability as related to the workplace.

78.126. Training pathway. In the Army, Occupational Physicians advise the CoC to support operations and home commitments which includes the development of policy. Army Consultant Occupational Medicine (Cons OM) have usually trained as General Practitioners first and served as RMOs before embarking on a further training pathway leading to the award of Membership of the Faculty of Occupational Medicine and becoming military consultants.

78.127. Delivery of Occupational Medicine. The first tier of Occupational Health support to the CoC is in Primary Care via the UMO. These are supported by a second tier of Regional Occupational Health Teams lead by a Cons OM who provides advice to MOs and Commanders. At a tertiary level, Cons OM are embedded within Army Headquarters and Home Command.

Occupational Health Support to the Chain of Command

78.128. Policy development and Operational Support. Early involvement with OM when planning and developing policy and operational plans may assist the CoC to reduce risk and thereby safely and effectively utilise personnel in support of operational commitments.

78.129. Advice on employability. The overarching principle of Army OM is to develop means for Commanders to Employ and Deploy soldiers safely and appropriately within the bounds of injuries or medical conditions which prevent them from being fully deployable. The key is the organisational Duty of Care; this means reduction of injury in the first place to as low a risk as reasonably practicable, but also to advice on how to utilise SP in the context of their injuries or medical conditions, without worsening those conditions or impairing the chance of full recovery.

78.130. Often viewed as a system which puts barriers in place to the CoC, the opposite is true. The main effort of OM is to allow SP to do as much as possible in a safe way. In turn this allows SP to return to their maximal fitness potential, as quickly and efficiently as possible.

78.131. Line Management Referral. A Line Management Referral[7] can be submitted by the CoC to promote early engagement with the Regional Occupational Health Team (ROHT) to:

a. Assess the need to review a SP's medical grading or provide advice on medical referral.

b. Assess and advise on a SP's ability to remain effectively engaged in work and prevent avoidable prolonged absence.

c. Provide a referral process to empower the CoC to proactively manage occupational health concerns such as frequent presenteeism, absenteeism, re-occurring light duties proformas and functional issues.

[7] 2021DPHCSOP_03-04-006-Army ROHT Line Management Referrals
2021DPHCSOP_03-04-006 Annex A Line Management Referral Form - Editable Word Version

78.132 – 78.200. Reserved.

JOINT MEDICAL EMPLOYMENT STANDARDS (JMES) TABLE

MES Code	Description	Guidance	Notes
A1	Fit for flying duties without restriction.	Only for aircrew.	To be used by Army aircrew only.
A2	Fit for flying duties but has reduced hearing or eyesight.	Only for aircrew.	
A3	Fit for duties in the air within the stated employment or Appendix 9.	Only for aircrew.	
A4	Fit to be flown in a passenger aircraft.		**Default for Army personnel** less aircrew.
A5	Unfit to be taken into the air.	Will prevent aeromedical evacuation.	By exception.
A6	Unfit for any duties in the aviation environment.	Duties in the aviation environment include, but not limited to, air traffic control, baggage handling, aircraft towing, aircraft maintenance, airfield driving and duties on a flying station/base.	N/A for Army personnel.
L1	Fit for unrestricted duty		
L2	Fit for high readiness roles with minor limitations.	Must have appropriate level of musculoskeletal fitness to undertake role and all expected duties in austere environments. Must be able to undertake Pre-Employment Training (PET) and Individual Pre-Deployment Training (IPDT) to deliver the minimum personal military skills to allow a SP to carry out the requirements of their job specification while maintaining their own Force Protection (FP) and positively contributing to the FP of those around them.[8]	May undertake Operational Fitness Tests (OFTs) with appropriate build-up training. Must be fit PJHQ5 Global Low to Medium Threat environments. Deployments are subject to MRA in line with Part 5. No limitation on exposure to weapons noise. Must be E1 or E2.
L3	Fit for limited duties but with some restriction subject to Medical Risk Assessment.	Should not impose a significant and/or constant demand on the medical services if deployed, on exercise or deployments. The SP may deploy on operations or overseas exercises following completion of a deployed MRA. Have no limitations in their ability to function wearing personal equipment demanded of the environment, branch/trade, and rank.	Operational deployments require deployed MRA (App 26) to be completed by Unit CoC. ROHT input to DMRA will not be required unless annotated on App 9. Routine activities (as defined in Part 5) are covered by App 9.

[8] **2015DIN07-112** Individual Pre-deployment Training Policy. Global IPDT requirements are set against the overall risk to deployed personnel within an individual theatre. This assessment takes into account the identified risk from terrorism, armed attack, criminality and environmental factors including Road Traffic Accidents. Whilst there may be variations in IPDT requirements for personnel deployed on certain operations given their role and exposure to risk, the nature of certain Global operations require all personnel to be trained to a single standard to mitigate the expected threat. **Global Low Threat.** Environments where the identified threats or risks to deployed personnel may not require FP restrictions to be imposed. This category also includes personnel deployed within Medium and High threat environments where the nature of their deployment does not expose them to the threat**. Global Medium Threat.** Environments where there is an identified threat from terrorism, armed attack or high risk of environmental hazards to personnel operating in remote or isolated locations. Personnel deployed on Global Medium Threat deployments are required to complete enhanced training as defined by the JTRs, relevant to role or specific risks. **Global High Threat.** Environments where there is an identified high threat from terrorism, armed attacks, Insider Threat or violent criminality. Personnel deployed on Global High Threat deployments are required to complete enhanced training as defined by the JTRs, relevant to role or specific risks.

MES Code	Description	Guidance	Notes
L4	Fit for certain deployed roles into well-established MOB locations subject to Consultant Occupational Physician Medical Risk Assessment.	SPs whose medical conditions have the potential to pose a significant risk on deployment in the land environment. May be reliant on an uninterrupted supply of medication and/or a reliable cold chain. Must be able to function wearing a helmet and the minimum theatre entry standard body armour.	Operational deployments require DMRA (App 26) completed by Unit CoC. ROHT input to DMRA required in all circumstances. Routine activities (as defined in Part 5) are covered by App 9.
L5	Unfit deployment. Fit for branch/trade and limited UK operations.	SPs who are unable to deploy due to significant Appendix 9. May be fit limited UK operations. Able to provide regular and effective service in the non-deployed land environment subject to meeting the minimum requirements as specified in single-Service employment policy.	Must be fit for branch / trade subject to allowable limitations as defined in Table 6 (Functional Interpretation of JMES).
L6	Unfit for service in the land environment.	For L6 Perm (previously referred to as 'P8'): Unfit for any duties. For L6 Temp (previously referred to as 'P0'): Unfit all duties except those specifically recommended/agreed/directed by ROHT (e.g. GRoW) *Consider early referral for rehabilitation assessment/rehabilitation if appropriate* **Guidance regarding Consent**. L6 Temp is a protective JMES (enabling care and support systems) and can be used in cases in which the SP is clinically unable to give consent (VSI). This consent must then be obtained when possible. This policy is in line with GMC guidance (para 75-79): https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent/part-3-capacity-issues	L6 temp requires ROHT sanction to extend > 6 months and Pers Pol (A) sanction to extend >18 months. It is recommended that the L6 Temp grade follows discussion at UHC with ROHT involvement (or reviewed soon after the award to ensure the grade is appropriate).
M1	Fit for unrestricted duties	May be employed and deployed worldwide in the maritime environment.	Army personnel employed in the maritime environment should follow RN single-Service guidance
M2	Fit for restricted duties afloat within the limitations as stated.	Fit for duties at sea but may be restricted to specific size or type of vessel, have medical support needs or environmental limitations as indicated by the MES and Appendix 9.	
M3	Fit for restricted duties in a vessel in harbour or alongside with the limitations as stated.	Able to safely move around a ship alongside or within the confines of a harbour including the ability to evacuate from the vessel and take emergency action (e.g. firefighting and damage control) without assistance.	
M4	Fit to be carried as embarked forces in transit.	Fit to move safely around a ship at sea, in harbour or alongside including using ladders and stairs, opening heavy hatches, stepping over hatch combings and tolerating a moving/rolling platform. Not to be part of the firefighting or damage control organisation but must be able to take emergency response and evacuation actions unaided.	**Default for Army personnel** less Commando and Port and Maritime personnel should not normally be graded M4.
M5	Fit for restricted duties ashore within the limitations as stated.	Not to work on ships/submarines alongside and may not be able to complete all duties required of their branch/trade ashore.	
M6	Unfit for any duties in the maritime environment.	Long-term sick or in a MF for >28 days or given a medical board recommendation for discharge.	

MES Code	Description	Guidance	Notes
E1	Fit for worldwide service in all environments.	Fit to deploy on contingent and enduring operations with no requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent).	
E2	Fit for unrestricted duties but with a medical risk marker.	Has a specific medical condition, which does not currently affect employability or deployability but may do so in future and currently requires medical oversight. Has no climatic restriction and no requirement for medical support bar adequate supply of medication. The medical condition is stable with treatment. Should loss of medication occur for ≤ 1 week this should not lead to clinical deterioration in the condition or functional degradation during that time.	Excludes any medical condition that would require review by a MO before authorising deployment. Any restrictions or limitations advised by Cons OM/ROHT/ARITC Occ Med are to be considered permanent unless specified and can only be revoked by Cons OM[9]. E2 markers do not normally attract an App 9. However if there is an enduring limitation or advice to the CoC that accompanies that E2 Marker, then an App 9 should be issued and refreshed on an annual basis. Care should be taken to ensure that where limitations are associated with an E2 marker (e.g. in SCT) these are reflected in the App 9, particularly if a lowered JMES is awarded for another condition.
E3	Restricted employment outside UK due to medical support or environmental requirements.	Fit subject to limitations as will require access to enhanced medical support or has specific medication requirements unlikely to be compatible with contingent operations. Fit to be in areas within limitations e.g. climatic injuries, hearing loss, susceptibility to environmental exposure.	Personnel may be employed in locations with reduced health care provision. When advising on employment or deployment away from the firm base the MO must ensure that in-theatre medical provision can meet the SP's routine and emergency needs. Excluding BFG, the Low Countries, BATUS (CROWFOOT only) and Nepal for Gurkhas only.
E4	**Only** to be employed out of the UK where there is access to established, 'NHS equivalent or better' Primary and Secondary Healthcare.	Has a medical condition requiring access either routinely or as an emergency to medical care at a level available equivalent to that provided in the UK.	When advising on employment outside the UK the MO must ensure that in-theatre medical provision can meet the SP's routine and emergency needs.
E5	May be employed within the UK only.	To be employed appropriately to their Appendix 9 within the UK. 'Unfit all duties' if associated with L6 grade.	Personnel with on-going health care needs, which would be adversely affected by employment outside of the UK.
E6	Pregnancy and Maternity	Only to be used when the woman has formally informed the employer of the pregnancy (e.g. using Mat B1) **and** given consent in writing for MES to be displayed as E6 or a contemporaneous record has been made in the clinical notes confirming permission granted. E6 is to be maintained until the Service woman has successfully completed a return-to-work medical post pregnancy and/or maternity leave.	

[9] Not applicable for E2 markers added pending SCT test results if the SP subsequently test negative.

Joint Medical Employment Standards (JMES) functional matrix

The below tables demonstrate the relationship between the JMES ALME and MDS and how the JMES translates to a deployable grade. The percentage of likely deployable SP within each grade, and the risk assumed by the Chain of Command when deploying a SP.

MES	E1	E2	E3	E4	E5	E6	MDS	MRA
L1	L1E1	L1E2	N/A	N/A	N/A	N/A	MFD	N/A
L2	L2E1	L2E2	N/A	N/A	N/A	N/A	MLD	MO
L3	N/A	N/A	L3E3	L3E4	N/A	N/A	MLD	MO
L4	N/A	N/A	L4E3	L4E4	N/A	N/A	MLD	OM Cons
L5	N/A	N/A	L5E3	L5E4	L5E5	L5E6	MND	N/A
L6	L6E1	N/A	N/A	N/A	L6E5	L6E6	MND	N/A

MDS	ASSUMED RISK
MFD	0
MLD	1
MLD	2
MLD	3
MND	4
NK	Consent witheld
E6	Pregnant

L Grade	Estimated deployability
L1	100%
L2	>98%
L3	70%
L4	30%
L5	<0.5%

Intentionally blank

PART 2 - INSTRUCTIONS FOR CLASSIFICATION

PULHHEEMS Assessments

78.201. Responsibility. The allocation of a PULHHEEMS assessment is a medical responsibility, but officers commanding units are responsible for ensuring that all ranks are referred to a medical officer in accordance with the instructions contained in **para 78.202-78.209** and Appendix 6. The PULHHEEMS reviews detailed in **para 78.206-78.207** are to be carried out by a medical officer, who may arrange a medical board if a change of JMES is indicated. Where PULHHEEMS reviews are required for different reasons over a short period (six months), a further PULHHEEMS review need not be completed unless there has been a change in the SP's medical condition.

78.202. Non-Serving Candidates for Commission and Enlistment. The process for these candidates is defined in Part 8.

78.203. Serving Candidates Applying for Commission.

a. Regular serving candidates (of all three Services) who are to undertake AOSB events (Briefing or Main Board) for the Regular Commissioning Course are required to provide the National Recruiting Centre (NRC) with CoC confirmation that their extant JMES on JPA is no lower than MFD A4 L1 M4 E2. Confirmation is to be provided in the form of Annex B to JSP 950 Part 1 Lft 1-2-12 – Commander's Certificate of Medical Suitability, accompanied by a JPA screenshot of their MDS.

b. Reservist candidates (of all three Services and including UOTC cadets) who are to undertake AOSB events are required to provide the NRC with confirmation that their extant JMES on JPA is no lower than MFD A4 L1 M4 E2. When Reservist candidates are loaded to the Regular Commissioning Course they are required to provide the NRC with confirmation that they have undertaken a DPHC Army Reserves medical within 12 months of the Commissioning Course, which should include review of an up to date NHS PHCR (full record or Summary Care Record (SCR)) [10] (iaw 2019DIN-01-080). Confirmation is to be provided in the form of Annex B to JSP 950 Part 1 Lft 1-2-12 – Commander's Certificate of Medical Suitability, accompanied by a JPA screenshot of their MDS, and the date of their Army Reserves medical.

Reserves

78.204. Mobilised Service. Mobilised personnel are to be examined prior to acceptance into service at the mobilisation centre. Reserves called out for permanent service[11] will be treated in the same way as Regular SPs and be offered the same level of access to Defence Primary Healthcare (DPHC). However, the Army has a responsibility to release a Reservist called out for permanent service at the earliest opportunity as these SP are likely to have suspended a civilian career when called out. The ability of the SP to resume their civilian career on release from service must be taken into consideration when retaining the Reservist in permanent service to continue treatment of any medical condition. Reservists who cannot be medically treated and are below an acceptable retention standard will be provided with clear advice and support and demobilised, including referral to Veterans UK as necessary.

78.205. Full-Time Reserve Service (FTRS). Following selection for an FTRS post, APC FTRS Section will write to the candidate informing the SP of suitability and informing them of the requirement to confirm their JMES grading depending on which category they fall into:

[10] 2019DIN-07-080
[11] JSP 753.

a. Candidates currently Serving in the Regular Army, Army Reserve or on a current FTRS Commitment must have an in date JMES. The CoC is to confirm that their extant JMES on JPA is correct. If an individual is below MFD an in date Appendix 9 must be sent to APC FTRS desk. Where the CoC is in doubt of the validity of an individual's current JMES they should request a medical review.

b. Candidates who have left Regular Service within 12 months and have an in date JMES are to complete a self-declaration of any changes in circumstances since leaving the Army. If a candidate declares a change in medical condition or is overdue a JMES review, they are to complete the application process as per those who have been out of service for over 12 months. Candidates who declare no change and are in date will not need to undertake a medical but should present for a new patient check at the DPHC MTF on arrival at their new unit.

c. Candidates who left Regular Service over 12 months ago are to be invited to approach the Mission Ready Training Centre (MRTC) or a local Medical centre by APC FTRS Section following selection for an FTRS post to arrange a medical. Individuals are to complete a Recruiting Group Medical Declaration (RGMD) as part of this medical in order that a confirmed JMES grade can be given.

d. All FTRS candidates must have a JMES recorded prior to commencing their FTRS commitment. Candidates who are graded below MFD must forward a copy of their Appendix 9 to APC FTRS Section and if graded below medical retention standards may have their commitment offer withdrawn. Once in service medical care will be provided as follows:

(1) **FTRS (Full Commitment) (FC).** Reserves serving on FTRS(FC) will be treated in the same way as Regular SPs and be offered the same level of access to Defence Primary Healthcare (DPHC). These SP may be held on the REM when under treatment. Reserves serving on an FTRS(FC) have a specific term of employment with a clearly defined start and end date and therefore must not be retained beyond the commitment date without Pers Pol (A) authority (see **para 78.1035**). Any extension of service should be merely to facilitate immediate medical treatment and its transfer and the Reservist has no entitlement to alternative employment.

(2) **FTRS (Limited Commitment) (LC) and (Home Commitment) (HC).** Reserves serving on FTRS (LC) and (HC) should register for routine healthcare with a GP under normal NHS arrangements. They are entitled to Occupational Healthcare from DPHC (related to, for example, pre-course requirements where applicable) and must attend an annual medical review with a military doctor if they are below MFD. If the CoC believe that a SP does not have the functional capability to complete their role for medical reasons, DPHC should be consulted and will conduct a FWA. If the SP is certified as unfit for any form of Army Service and are discharged or retired[12] from the Army Reserve or Regular Reserve via FMB, this will also have the effect of terminating their FTRS commitment if it is still in effect. SP graded L5 MND(P) may be retained in the Army Reserve if employed on an FTRS commitment.

78.206. Part-Time Reserves. All Reserves serving less than full time, including on ADC, should register for routine healthcare with a GP under normal NHS arrangements. They are entitled to Occupational Healthcare from DPHC (related to, for example, pre-course requirements where applicable) and are entitled to attend an annual medical review with a military doctor if they

[12] AGAI 49, Annex C for soldiers and ACR Pat 2 para 6.1029 for officers

are below MFD. If the CoC believe that a SP does not have the functional capability to complete their role for medical reasons, DPHC should be consulted and will conduct a FWA. If the SP is subsequently downgraded the CoC should follow the processes in **78.1014-78.1024**. SP failing to meet the minimum retention standard who are not offered employment or choose not to accept an offer of employment will be medically discharged/retired[13].

78.207. The Regular Reserve.

a. A JMES is mandatory for SP in the Regular Reserve.

b. Mobilised personnel are to be medically assessed prior to acceptance into service at the mobilisation centre.

c. The minimum acceptable standard for application to join or extend membership of the Regular Reserve is L5 MND(P). However, a JMES of L5 MND(P) will limit a SP's membership to this cohort.

d. The JMES assessment at the time a SP leaves the Regular Army or Army Reserve remains valid (under normal circumstances) throughout the time they remain liable for call-out or recall for full-time service. A medical examination, however, will be arranged by the APC whenever a significant disability comes to their notice.

Occasions for Review of JMES Grading

78.208. All Ranks.

a. Conducted annually for all SP when deployability standard is other than MFD. If sufficiently familiar with the clinical history, this review will not always require a consultation and may be based on a review of the medical records with supporting input from the employer, as needed. Any changes to the assessment will require the SP's consent for the release of the Appendix 9 (therefore requiring a consultation).

b. Prior to substantive promotion or confirmation of the appropriate authority for a SP to move from one career stage to another and the change conversion of engagement or commission.

c. Before termination of service, in accordance with **para 78.605**.

d. Additionally, when required by regulations (an example is annual aircrew medicals).

e. Before proceeding overseas if required after checking medical documents against medical standard required.

f. On the 29th day of a period of Limited Duties (including civilian issued medical note).

78.209. Soldiers. On the application for change of engagement, extension, or continuance in the Service, the PULHHEEMS and JMES assessment is to be verified by a check of medical and Service documents and a personal interview. A medical examination is to be carried out if considered necessary.

78.210. Alterations to PULHHEEMS Assessments. Alterations to PULHHEEMS/JMES assessments are to be notified using Appendix 9 and via DMICP/JPA.

[13] AGAI 49, Annex C for soldiers and ACR Part 2 para 6.1029 for officers

78.211. Documentation. Documentation as laid down in Part 6 is to be completed whenever:

a. An initial or Service assessment is allotted (see also Appendix 6).

b. Any alteration is made to an assessment.

c. An automatic review is carried out in accordance with **para 78.208 – 78.0209**.

d. On termination of full time service.

Legislative Obligations and the Executive Waiver

78.212. Medical Employment Policy link to Primary Legislation. The enactment of medical employment policy (specifically the use of the PULHHEEMS classification system to award a JMES which details an SP's functionality in relation to employment) relates to obligations articulated in primary legislation. The MOD has a disability waiver in relation to the disability provisions articulated in the Equality Act 2010 which enables the services to maintain medical fitness standards. Any deviation from these standards must be carefully managed to both protect the individual and the organisation, providing a safe system of work in accordance with the Health and Safety at Work Act 1974. AGAI 78 provides the process mechanisms (enacted through the Appendices to AGAI 78) that ensure these legislative obligations are met so that medical risk assessment is properly conducted (and recorded). In addition to retention below full medical fitness, there are exceptional circumstances in which SP may be enlisted below the medical standards. To ensure the legislative obligations outlined in this paragraph are met in such enlistments, an Executive Waiver policy is in place.

78.213. The Executive Waiver. There are three Executive waiver types defined in medical employment policy. Whilst the Individual Medical Waiver ('Special Enlistment') has been enacted for many years (and is also articulated in AGAI 40 Recruiting Policy), the Conditions Based Exemption has been enacted for the first time in 2019 and the Capability Waiver has not yet been enacted.

a. **Individual Medical Waiver ('Special Enlistment').** The Individual Medical Waiver is enacted through the AF B203 process (detail at **para 78.825**) and enables exceptional enlistment of those who would otherwise be considered UNFIT by entry standards. Such enlistment is made on a case-by-case basis and relates to 'exceptional circumstances' in terms of the candidate's Knowledge, Skills and/or Experience (KSE) and the service need.

b. **Conditions Based Exemption**. The Conditions Based Exemption enables the service to take additional risk within specific clinical areas following clear clinical recommendation. This does not relate to a candidate's KSE and enables candidates to be assessed as FIT out with the Tri-Service clinical policy where the recommended Single Service clinical parameters are met.

c. **Capability Waiver**. The Capability Waiver is a workforce lever that enables the recruitment of capability grouped cohorts (such as Career Employment Groups and rank within CEG for re-join applications) who would otherwise be considered UNFIT by entry standards. The enactment of the Capability Waiver has not yet occurred but becomes more likely when there is a mature Physical Employment Standard (PES) model, which defines PES across CEGs and ranks (and therefore gives a scientific basis to stratified medical standards which could be adopted incrementally through use of the Capability Waiver).

78.214 – 78.300. Reserved.

PART 3 - STANDARDS FOR OFFICERS

Entry Standards

78.301. Commissions in the Regular Army. The normal entry medical standards required for those wishing to be commissioned into the Regular Army are as follows:

a. **As a civilian.** The common Army entry standard[14] of:

P	U	L	H	H	E	E	M	S	CP
2	2	2	2	2	8	8	2	2	4
					3	6			

Note: Arms and Services variations can be found at Table 1.

b. **From the Ranks (Regular or Reserve) or from another Officer Service**.

(1) Regular serving candidates [of all three Services] who are to undertake AOSB (Briefing or Main Board) or the Regular Commissioning Course, require CoC confirmation that their extant JMES on JPA is no lower than MFD A4 L1 M4 E2 within 12-months prior to Commissioning Course start date. A candidate self-declaration is required prior to AOSB Briefing and Main Board. Details in both cases should be passed to the NRC using JSP 950 Part 1 Lft 1-2-12.

(2) Reservist candidates [of all three Services] (including UOTC) who are to undertake AOSB (Briefing or Main Board) or the Regular Commissioning Course require a DPHC Army Reserves medical within 12 months of the Commissioning Course, which should include review of an up to date NHS PHCR (full record or Summary Care Record (SRC))[15]. To attend AOSB Briefing and Main Board, candidates require CoC confirmation that their extant JMES on JPA is no lower than MFD A4 L1 M4 E2. If this is dated more than 12-months prior to the AOSB event, candidates must submit a self-declaration to the NRC using JSP 950 Part 1 Lft 1-2-12[16]. This is to confirm they meet the required standard (this includes Reservists attending the Commissioning Course (Short) Module C and Module D). The routine standard requires is a JMES of MFD (A4L1M4E2) by in-service standards[17], as shown in Table 4.

(3) **Scheme members**. Candidates must meet the Army Medical Employment entry Standard on acceptance to the following courses/schemes and, where necessary, within 12-months prior to their enlistment date. Once enlisted, candidates who go on to seek a Commission must have a JMES of MFD by in-service standards to commence the Commissioning Course. All Scheme Members require a DPHC Army Reserves medical within 12 months of the Commissioning Course, which should include review of an up to date NHS PHCR (full record or Summary Care Record (SRC)).

a. The Defence Technical Undergraduate Scheme/ The Defence STEM Undergraduate Scheme (DTUS/DSUS)

b. The Army Sixth Form Scholarship Scheme

[14] In accordance with Section 4 of JSP 950 Part 1 Lft 6-7-7 (V1.1 2 Sep 16).
[15] GN 19/15 Access and Entitlement to Occ Health services and rehab for Reservists
[16] In accordance with JSP 950 Part 1 Lft 1-2-12 (V2.0 May 19)

c. The Army Undergraduate Bursary Scheme

d. Pre-RMAS courses

e. Army Internship

f. University Officer Training Corps

c. **Other forces**. Candidates who are serving personnel of the Regular or Reserve Forces of the Crown, including those from Commonwealth states, must meet the normal standard MFD as shown in Table 4.

d. **All candidates listed above who are below the medical standards**. Corps Colonels or Commanding Officers[18] wishing to commission a SP who is below the normal entry standard may apply to Hd Pers Pol (A) for special enlistment authority outlining the exceptional circumstances of the case[19].

78.302. Commissions into the Army Reserve. For those already serving and eligible to apply for an Army Reserve Group A Senior Soldier Entry Commission (SSE)[20], the minimum medical standard is normally MFD however, SP who are Below Normal Medical Standards (BNMS) will be considered by the Army Employment Board[21] (AEB) post selection and their commissioning is subject to AEB approval. For direct entry, the standards for candidates wishing to be commissioned into the Army Reserve are the same as in **para 78.301** above. Selection boards may consider candidates below these standards with special enlistment authority (AFB203 which must be added to the DMICP record) from Hd Pers Pol (A) provided that:

a. On enlistment, they are provided with an official medical grading and protected from further harm by an appropriate Appendix 9.

b. Specific guidance from ARITC Occ Med[22] and Pers Pol (A) is complied with.

c. Each candidate has been identified as being of particular value to the Army Reserve.

Minimum Standards for Retention of Regular and Army Reserve Officers

78.303. Officers are to be retained provided their medical assessment does not fall below the minimum standard for their respective Arm or Service as laid down in Table 4. If an officer is below the medical retention standard and does not receive or accept an employment offer following an Appendix 28 application, they will be retired on medical grounds or may apply for their case to be referred to the Army Employment Board (see Part 11).

78.304. Officers with a JMES assessment below that required of their own Arm or Service but not graded *medically unfit for service in the Land environment* (L6 MND Perm[23]), may be considered for transfer to the Regular Army Reserve of Officers (RARO) and offered employment within medical restrictions.

Medical Standards for Conversion of Commission, Promotion and Appointment Boards

[18] Minimum rank of OF4.
[19] Application for Special Enlistment (AF B203), more detail at Para 78.839.
[20] Army Commissioning Regulations 2019, Part 2 Ch 1
[21] Formerly known as the Army Commissions Board
[22] ARITC Cons OM and ARITC Spec Nurses within ARITC Occ Med are authorised to give guidance.
[23] Unless employment is approved by the AEB.

78.305. Normally, JMES will not be considered at boards for changes of engagement (which includes conversion of commission) or for promotion but will be considered following a provisional board decision in relation to future employment on a case by case basis. For Soldiers who are commissioning and Officers the final authority for all changes of engagement will be the Army Employment Board (AEB). For appointment boards, including command boards, JMES will be considered as the medical status will have a direct effect on employability. OH and employment advice will be required to accompany any applications in order to inform any board decision.

Medical Standards for the Regular Army Reserve of Officers

78.306. The JMES assessment awarded at the time of retirement remains valid throughout the time the officer remains liable for callout for full-time service. However, a callout re-entry medical will be conducted prior to any RARO officer being called-out to the Service.

Medical Standards for Officers Applying to Re-Instate

78.307. The re-instatement standards for trained officers, including those joining from FTRS, RARO and mobilised service, are as laid down in Table 4. Submissions for officers falling below those standards and considered desirable to the interests of the service for re-employment, are to be submitted to Pers Pol (A) for approval.

Medical Standards for those Transferring into the Service

78.308. As the medical employment standard on entry accounts for the rigours of the early years of service (JSP 950 leaflet 6-7-7) of which Basic Training and Initial Trade Training form a key part, any transferee (regardless of where the individual is transferring from) that the AOSB Transfer Board states requires Basic Training and Initial Trade Training must be judged by Medical Employment Standards on Entry (as opposed to the in-service standard).

78.309 – 78.400. Reserved.

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PART 4 - STANDARDS FOR SOLDIERS

Entry Standards

78.401. Common Army Entry Standard.

a. The common medical standard for entry into the Army is a minimum of:

P	U	L	H	H	E	E	M	S	CP
2	2	2	2	2	8	8	2	2	4
					3	6			

Note. *Certain Career Employment Groups/Qualifications (CEG/CEQ) within some Arms/Services may require different standards due to role specific requirements. In these cases, written justification has been provided by Regimental / Corps Colonels to Pers Pol (A) in support. Variations from the Common Army Entry Standard are shown in Table 2.*

b. Candidates for entry who are below the normal entry standard may be considered for special enlistment authority by Pers Pol (A)[24].

c. **Scheme members.** Assuming they have already met the common Army entry standard on acceptance, soldier candidates who undertake any form of bursary, scholarship, or higher educational training as part of, or prior to the completion of initial Trade Training must have a JMES of MFD by in-service standards on the completion of their training.

78.402. Regular Soldiers. The minimum medical standards by Arms and Services and employment are given in Table 2.

78.403. Volunteers for the Army Reserve. The minimum medical standards acceptable by Arms and Services are given in Table 2. Soldiers below the standard required for a particular employment may be accepted on the submission of an application for special enlistment authority from the Commanding Officer to Pers Pol (A) via ARITC Occ Med, provided that:

a. On enlistment, they are provided with an official medical grading and safeguard by an appropriate Appendix 9.

b. Specific guidance from ARITC Occ Med[25] and Pers Pol (A) is complied with.

78.404. Regular Reserve. Soldiers with a JMES assessment below that required of their own Arm or Service but not graded *medically unfit for service in the Land environment* (L6 MND Perm[26]), may be considered for transfer to the Regular Reserves and offered employment within medical restrictions.

Retention Standards during Basic and Initial Trade Training in the Army

78.405. From completion of Initial Medical Assessment (IMA), the Joint Medical Employment Standard (JMES) of Medically Fully Deployable (MFD) must be maintained throughout basic and Initial Trade Training. When a SP falls below MFD (see Part 8) and is unlikely to recover in a reasonable time, discharge action is to be considered in accordance with the appropriate paragraph of The Queen's Regulations for the Army 1975 (QR(Army)). Prior to completion of Initial Trade Training and assignment, a medical assessment is to be carried out (**para 78.828**).

[24] Application for Special Enlistment (AF B203), more details at **Para 78.839**.
[25] ARITC Cons OM and ARITC Spec Nurses within ARITC Occ Med are authorised to give guidance.
[26] Unless employment is approved by the AEB.

Where this assessment identifies a JMES which is lower than the minimum entry standard for the Arm or Corps, as shown in Table 2, the following action is to be taken:

a. **In Peace.** SP may be offered the option of a voluntary transfer to another Corps for which they are suitable. If the SP does not wish to transfer or there are no available transfer opportunities, the SP will be discharge under **QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements**. The Unit can also apply for authority for the SP to move into the Field Army below the medical standard[27].

b. **In War or During an Emergency (on Instructions from the Ministry of Defence).** Service personnel are to be compulsorily transferred to another Corps or discharged in accordance with the then current instructions for reallocation.

c. SPs accepted for entry as special cases under **para 78.401b**. must maintain their entry PULHHEEMS medical standard throughout training.

Retention Standards after Basic and Initial Trade Training in the Army, or for Retention in the Army Reserve

78.406. Retention standard after Basic and Initial Training, or for retention in the Army Reserve, differs from those still under training.

a. **Regular soldiers.** Soldiers are to be retained provided their medical assessment does not fall below the minimum standard for their respective Arm or Service as laid down in Table 5. If a soldier is below the medical retention standard and does not receive or accept an employment offer following an Appendix 28 application, they will be discharged on medical grounds or may apply for their case to be referred to the Army Employment Board (see Part 11).

b. **Army Reserve.** Ex-Regular soldiers enlisting into the Army Reserve within 12 months of discharge or Army Reserve personnel currently serving in the Army Reserve are to comply with the standards laid down in Table 5. Audiometric tests must be undertaken in accordance with the AGAI Volume 2, Chapter 77 - Army Hearing Conservation Policy. Provided a volunteer is up to the retention standard of MLD(P) L4[28] for their Arm or Service, and suitable employment is available, they are eligible to complete their current engagement.

Standards for Re-Joining for Trained Soldiers and from the Regular Reserve

78.407. The re-entry standards for trained soldiers, including those joining on, or from, FTRS and mobilised service, are laid down in Table 5. Candidates who are below a deployable standard of MLD or do not meet the standards in Table 5, but whose enlistment is thought to be desirable, can only be accepted subject to Pers Pol (A) approval via the special enlistment waiver process.

78.408. The PULHHEEMS assessment allotted by the medical authorities at the time application is made to re-join the Colours is to be regarded as a provisional assessment. The Officer Commanding the unit to which the SP first reports is to arrange for their medical examination within six days of reporting. The SP should be assessed and a PULHHEEMS grade and JMES grading allocated. Further guidance is at Part 8.

Medical Standards for Change of Engagement (QR(Army) 9.078), Promotion and Appointment Boards

[27] Using the AF B203A Application for Special Enlistment Authority.
[28] The retention of SP serving in Non warfighting PIDs may be considered in accordance with table 4.

78.409. Normally, medical employment standards will not be considered at boards for changes of engagement (which includes VEng Transfer) or for promotion but will be considered following a provisional board decision in relation to future employment on a case by case basis. For soldiers, the final authority for all changes of engagement will be the parent MS Branch Colonel. For appointment boards, medical employment standards will be considered as the medical status will have a direct effect on employability. OH and employment advice will be required to accompany any applications in order to inform any board decision.

a. The minimum medical standards normally acceptable are those given by Arms and Services in Table 5.

b. Soldiers who do not meet the Table 5 standards for MFD or MLD should only be accepted if:

(1) Suitable approved employment compatible with their assessment is likely to remain available for the duration of the extension or new engagement.

(2) The candidate is aware that should suitable employment compatible with the PULHHEEMS assessment cease to be available an Appendix 28 will be initiated.

(3) The candidate acknowledges in writing the special conditions applied to the extension or change of engagement.

Standards for Continuance (QR(Army) 9.098 - 9.107)

78.410. Provided a soldier meets the standard of MLD (see Table 5) for their Arm and suitable employment is available, they may be considered for an initial period of continuance in the Service. The same will apply to any further periods of continuance.

Standards for Compulsory Transfer (QR(Army) 9.229) or Reallocation (QR(Army) 9.232)

78.411. The reallocation or retransfer of a soldier is not to be considered unless their JMES is within the standards contained in Soldier Terms of Service (SToS).

78.412 – 78.500. Reserved.

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PART 5 - RULES FOR THE ASSIGNMENT AND EMPLOYMENT OF OFFICERS AND SOLDIERS

General

78.501. The normal minimum PULHHEEMS assessments for each Joint Medical Employment Standards (JMES) for all employments are given in Table 4 for officers and Table 5 for soldiers.

78.502. The JMES shows the medical limitations on employment, operational deployment, and assignment.

Assignment of Officers and Soldiers

78.503. Assignments. Personnel may be assigned to any unit provided they are up to the minimum standard for retention in their Arm or Service and are not restricted by the limitations of their JMES. Personnel below the minimum standard[29] who are retained on an Appendix 28 will be assigned to another unit on the prior approval of their Career Manager and new Commanding Officer (CO) or as directed by the Army Employment Board. Regimental / Corps Colonels and E1 Workforce planners and the CoC are to assist APC Career Managers (CMs) in ensuring that any requirements for a specific post to deploy is clearly annotated against the post to ensure that someone with employment limitations which fall below these requirements is not assigned to that post.

78.504. Specialist Employment. Personnel employed on [redacted]/flying duties must be up to the minimum PULHHEEMS assessment for the appropriate JMES for flying duties as given in Appendix 6, or [redacted]. Personnel employed in flying duties may have assignments restricted because of their suitability for certain types of aircraft even though they meet the JMES for flying duties as per Appendix 6. The medical standards for Unmanned Arial Systems (UAS) operators are defined in Appendix 13 (taken from MAA Regulations which is the authority).

Minimum Medical Deployment Standard (MDS) for Deployments

78.505. General. Deployment Medical Risk Assessments (DMRA) are mandatory for all SP graded Medically Limited Deployability (MLD). The responsibility for the medical advice used in completing the risk assessment of L2 and L3 MLD SP rests with the UMO and for L4 MLD SP with the Regional Operational Health Team (ROHTs) Cons OM. In all cases the Appendix 26 DMRA must be completed by the CO of the deploying/losing unit[30]. A copy of Appendices 9 and 26 must be held by the deployed OF4 Comd for the duration of the deployment to ensure the individual is not employed outside of their authorised remit.[31]

78.506. It should be noted that as the nature of a conflict and the medical facilities available in Theatre (Th) evolve, the minimum permissible JMES for a deployment may also change. Comds must be continuously cognisant of the JMES of those under their Comd.

78.507. Unit and Formation Deployments. COs are to determine whether SP with MDS of MLD are fit to deploy. The CO will need to consider the standards laid down in the operational mounting instructions and take advice from the Unit Medical Officer (UMO), and if appropriate, the ROHTs using the Appendix 9 and Unit Health Committee (UHC). An Appendix 26 must be completed by the unit and authorised by the CO, following the below process, before an MLD SP can be deployed:

[29] Except where the reduced medical category relates to pregnancy. Pregnant Service Personnel are to be treated at all times in accordance with JSP 760 and not treated less favourably.
[30] even if the deployment is on assignment.
[31] This should be reviewed during G/J1 Assurance visits of deployed HQs.

a. When an SP enters a period of elevated readiness or likely deployability[32], Section 1 – Role Specific Assessment of the Appendix 26 should be completed by the owning unit (on behalf of the Force Generating HQ, if different).

b. Upon confirmation of a deployment location, Sections 2 – 4 must be completed and endorsed by the CO.

78.508. Individual Augmentees (IA). OCE selection letters or LOC FGensOs will provide the detail and timelines that emphasise responsibilities in providing the appropriate documents, and guidance to the IAs current CoC in the deployment process.

a. **Losing Chain of Command.** The losing unit has the responsibility to ensure that any MLD SP to be deployed as an IA has an up to date Appendix 9, which will cover the duration of their deployment and a completed Appendix 26. The completed Appendices 9 and 26 must be received by APC and MRTC NLT 1 month prior to the deployment.

(1) Details of the deployed role and environmental conditions can be obtained through APC CM Op Cts cell, or through formation G3/5 to ADOC in the event of a trawl.

(2) Details of medical infrastructure for the deployment can be obtained through PJHQ J4 Med. Those in an L4 grade must also receive input from DPHC ROHTs OH.

b. **APC/LOC.** Having reviewed the documents to ensure suitability for deploy in the identified role, APC/LOC will forward them to PJHQ J3/J4 Med for endorsement.

c. **PJHQ.** J4 Med will consider the Appendix 26 in consultation with J3. If PJHQ J3 accept the SP for deployment to the Th they will ratify Comd endorsement and forward the Appendix 26 to the appropriate Comd in Th. A copy of Appendices 9 and 26 should be given to the IA to deploy with.

78.509. If an IA becomes MLD after attending MRTC but prior to deployment and remains liable to deploy in their new grade, the MRTC MO should provide a current Appendix 9 and the MRTC CoC will become responsible for completion of Appendix 26. In this instance, or if the IA is a Reserve without the opportunity to be discussed at a UHC, OH advice can be sought from APC OH. The IA must provide explicit consent for their DMICP records to be reviewed by APC OH on an Appendix 17.

78.510. Reservists. Regardless of the mechanism for deployment, as part of a Unit and Formation deployment or as an Individual Augmentee, when a Reservist is warned for operations their CoC must submit a copy of both Appendices 9 and 26 to APC CM Ops Mob and MRTC Ops. Without a clear understanding that the DMRA has been completed, no call out notice would be issued.

78.511. Deployment of MND Service Personnel. In exceptional circumstances, MND (P) SP may be deployed subject to an Appendix 26 completed with ROHTs input. The CoC should engage PJHQ J3/4 and where appropriate APC/MRTC[33] at the outset, as soon as the SP is aligned to the deployment. Once the deployment has been agreed in principle, the SP may deploy, subject to confirmation that:

a. The agreement of the deploying and Theatre Headquarters that their employment is

[32] As part of any task force or ORBAT held at readiness.
[33] For IAs.

consistent with their JMES and accompanying functional restrictions.

b. UMO and ROHTs OM Con is content the SP's medical condition is not likely to deteriorate as a result of a deployment to that theatre.

c. Suitable medical facilities exist in Th for management of the condition for which the SP has been graded.

d. An appropriate risk assessment is conducted (in accordance with Appendix 26) outlining the risks and mitigating considerations.

Medical Risk Assessment for Routine Activities

78.512. The principles for medical risk assessments for deployments outlined in paragraph **78.505-78.511** may also apply to more routine activities, including ranges, exercises, and courses, for all personnel who are graded MLD or Medically Not Deployable (MND). Normally routine activity including domestic (UK) deployments, ranges and other such activity conducted at unit's barracks or which are included on an enduring basis on the Units' static Risk to Life (RtL) Register, will not require an Appendix 26. Conversely, activities which are required to be included on a Units' dynamic RtL Register normally will require an Appendix 26. Any activity reliant on a reverse CASEVAC chain will normally fit into this category. The Appendix 9 and appropriate risk assessment is to be used by the unit for all such personnel to plan activities anticipated in the 12 months following a downgrade. Where ambiguity arises regarding the requirement for an Appendix 26, or a specific risk is identified, an Appendix 26 should be completed.

78.513 – 78.600. Reserved.

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PART 6 - DOCUMENTATION

78.601. Responsibility. Commanding Officers (COs) are responsible for ensuring that personnel are referred to medical authorities for assessment or reassessment as required on entering the Army, on completion of Initial Trade Training, during service and before termination of service (see Part 2).

a. Medical authorities are responsible for:

(1) FWAs and notification of results to COs.

(2) Recording results in the medical record.

b. COs are responsible for:

(1) Publishing the results.

(2) Recording the results in Service records.

c. All concerned are responsible for ensuring that **JMES and PULHHEEMS assessments are treated as OFFICIAL SENSITIVE – PERSONAL** and that they are not disclosed to any unauthorised person.

78.602. Notification. Assessments and reassessments, including those showing no change, are to be notified to Officers Commanding (OC) on the form at Appendix 9,10 or 11[34]. If a Full Medical Board (FMB) recommends discharge on medical grounds, the decision is notified on the form at Appendix 12.

78.603. Recording. Details of all assessments and reassessments, even when no change is notified are to be recorded on at least one of the following as appropriate:

a. **Electronic Personnel Record.** All PULHHEEMS assessments are to be entered onto the electronic medical record. Joint Medical Employment Standard (JMES) assessments are to be recorded onto the electronic medical record and will automatically transfer to JPA and PAPMIS. Where electronic systems are not available the appropriate medical and personal documents are to be completed.

b. **Pre-Service and During Training.** The Recruiting Group Medical Declaration (RGMD) is to be completed and held by the training unit until completion of Initial Trade Training. They are then retained in the SP's medical record along with the PHCR check. See Part 8.

c. **FMed 1.** This is now only routinely used for the Initial Medical Assessment (IMA) upon commencing Basic Training. The pre-release and final PULHHEEMS and JMES assessments are recorded on the electronic medical record using the appropriate templates. FMed 1 is only used at release when the electronic record is unavailable.

d. **FMed 23.** This is used to record all FWA(P) proceedings (for guidance on completion, see the notes at Appendices 1,3 and 4).

e. **Electronic Medical Record.** Where electronic medical records are held, assessment, reassessments and JMES are to be recorded using extant medical board and run-ups

[34] Appendix 9 is used for a working grade. Appendices 10 and 11 are used to notify temporary unfitness for duty by primary care and ROHTs respectively.

templates.

f. **FMed 143.** Used to record details of routine career related PULHHEEMS, JMES, Army Reserve Re-Engagement, etc. The electronic template is to be used where available.

g. **AF B193.** Held by Command/Theatre headquarters, JMES entered.

h. **FMed 133.** This is to be issued at the final medical along with a Defence Medical Information Capability Programme (DMICP) summary printout for onward transmission to the service leaver's civilian general practitioner.

78.604. **Electronic signatures.** Electronic signatures are acceptable as an alternative to a 'wet' signature and are admissible on documents in legal proceedings. Relevant appendices may be signed electronically by both the clinician and patient inserting their details and 'signed electronically' in the relevant boxes during the consultation or via email following a consultation.

78.605. **Assessment on Termination of Service.** Before termination of service all Regular and Reserve personnel, including all scheme members (**para 78.301**) are to be reassessed as follows and the assessment notified, published, and recorded as in **para 78.603**.

a. **Termination of Service on Medical Grounds.** The President of the Medical Board will complete an FMed 23 in line with the following for both Regular and Reserve SP:

(1) Officers unfit for Service on medical grounds/medically unfit for Service under existing standards will be retired under **The Promotions and Appointments Warrant 2020 (PAW 20), Article 199**.

(2) Soldiers unfit for service on medical grounds will be discharged under **QR(Army) para 9.386 or 9.387.**

(3) Soldiers medically unfit for service under existing standards will be discharged under **QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements**.

Note: In all cases the SP is to be informed as soon as the decision to invalid them is made.

b. **Termination of Service other than on medical grounds.** COs are to refer personnel to a Medical Officer for assessment:

(1) **On Normal Termination of Service.**

(a) **Pre-Release Medical.** This is to be completed no later than eight weeks prior to the date the SP is due to leave the unit, in order to allow newly declared medical conditions to be investigated and/or treated. For units in the UK this is eight weeks before the date on which terminal leave begins, if such leave has been authorised, or discharge. For units overseas, this is eight weeks before returning to a UK unit for commencement of release procedures (e.g. start of resettlement course and/or terminal leave). The Medical Officer will complete the DMICP FMed 143 template using Read Code "Release Medical" and the resultant PULHHEEMS and JMES assessment is to be recorded on the electronic medical record. If the SP has enduring healthcare needs the Medical Officer is to commence transitional planning immediately in writing to the relevant NHS Clinical Commissioning Group for NHS England or Health Board for NHS Scotland, Wales, and Northern Ireland. Copies of correspondence are to be retained in the Service Healthcare Record. This medical is to be carried out in theatre for personnel in units overseas. This is the last opportunity for referral to

FMB in Service. Regular SP graded below MFD who are considering Reserve service should inform the medical chain in order that where appropriate an Appendix 9 is produced prior to discharge.

(b) **Final Medical.** To take place immediately prior to departure on terminal leave, if such leave has been authorised, or discharge.

(c) **Release Overseas.** If being released overseas the Pre-Release Medical is to be completed at least eight weeks prior to the date the SP is due to leave the unit. The Final Medical is to take place immediately prior to departure on terminal leave, if such leave has been authorised, or discharge.

(2) **On Premature Termination of Service.** Following receipt of the authority for termination:

(a) Where there is no alteration to an assessment, the MO is to complete the FMed 1, recording, in appropriate cases, the SP's fitness for Reserve Service. This information is then forwarded to the officer commanding.

(b) Where an alteration to the assessment is necessary, a Medical Board is to be convened. The proceedings are to be endorsed 'Termination of Full Time Service' and disposed of in the usual manner.

(3) **On Premature Termination of Service During Training.** See Appendix 21.

78.606. Hospitalisation at the Termination of Service Date. When a SP, who is entitled to full pay and allowances, including under the provisions of **para 78.711**, is admitted to hospital, the Unit of the SP is responsible for arranging the medical board that is to be convened in the following circumstances:

a. If in-patient treatment is likely to exceed 28 days (four weeks) duration at the end of the eight-week period.

b. A final medical board will be held four months after admission if in-patient treatment is still required at that date.

c. In other cases, if at the end of in-patient treatment:

(1) An alteration to the PULHHEEMS assessment shown on the medical record is required.

(2) The period of in-patient treatment has exceeded eight weeks.

78.607. Boards held under **para 78.605** are to recommend whether the SP should be retired/discharged on medical grounds or by normal administrative procedure.

78.608 – **78.700.** Reserved.

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PART 7 - MANAGEMENT OF PERSONNEL WHO ARE ABSENT FROM WORK THROUGH SICKNESS

General

78.701. Application. The provisions of this Part 7 apply to all Service Personnel (SP) of the Regular Army and all members of the Reserve Land Forces.

78.702. Command and Care of the Wounded Injured and Sick. AGAI Volume 3 Chapter 99 gives the policy for the management of SP who are absent from work through sickness. The Wounded Injured and Sick Management Information System (WISMIS) is to be used for recording all events, such as visits or the granting of sick leave, during the period that a SP is sick-absent. Medical in Confidence information must not be recorded on WISMIS or PAPMIS. All WIS SP are deemed to be on Recovery Duty unless they are specifically exempt recovery activity on sick leave, on annual leave, Graduated Resettlement Time (GRT), terminal or invaliding leave.

78.703. Any reference in this Part to absence from duty will be assumed to have resulted from sickness or injury and from no other cause.

Applicable Categories

78.704. The following categories will be considered:

a. SP who are not likely to become fit for duty by reason of a disability incurred before entry into the Service.

b. SP who are temporarily unfit.

c. SP who are permanently unfit.

d. SP becoming unfit during terminal leave or otherwise shortly before date of termination of service.

e. SP becoming unexpectedly unfit following Notice To Terminate (NTT) or application for Premature Voluntary Release (PVR).

78.705. Notwithstanding anything stated hereafter, in exceptional cases a SP may have their service terminated prematurely on medical grounds at any time before their due date for termination of service.

Disabilities Incurred Before Entry into the Service

78.706. A SP who, as a result of a disability incurred before entry (regardless if identified following the PSMA), is deemed unlikely to become fit for Service is to have their Service terminated at once following:

a. Examination by a Medical Board or specialist, or admission to hospital or as the immediate result of the initial medical examination held within six days of joining for duty, or.

b. The lowering of medical category for a pre-existing condition, the history of which was denied or not disclosed on the Recruiting Group Medical Declaration (RGMD) Part 1-3 at the pre-service medical examination.

The following provisions are to be used:

Engagement	Provision
Regular and Reserve Officer	PAW 20 Article 191
Regular and Reserve Soldier	QR(Army) Para 9.381d

Temporarily Non-Effective

78.707. A SP who is, or is likely to be, unfit all duties for more than 28 days is to be assessed by a medical board, graded L6E5 Temp, and an Appendix 10[35] issued. Sick Leave recommended by the Appendix 10 following the L6E5 Temp grading should be based around the Residence at Work address (unless there is a clear clinical recommendation for an exception – a discussion which should occur at the UHC), enabling the clinical and command chains to support the medically downgraded SP. If the SP is a member of the Regular Army or a Reserve on FTRS(FC) or on mobilised service, the unit must apply via WISMIS to APC Glasgow for the SP to be granted Temporarily Non-Effective (TNE) status. Only a SP who is selected at the Army Recovery Capability Assessment Board (ARCAB) and assigned to a Personnel Recovery Unit (PRU) will be assigned to the Resilience Margin (ReM). A SP may be retained exceptionally in Service beyond a period of 12 months TNE on the authority of Cons OM and beyond 18 months on the authority of Pers Pol (A) provided that, in the opinion of the approved medical authority (FWA(P) or FMB), there is a reasonable prospect that the SP has a clear outcome (either returning to duty or being invalided out of the Regular Army, Army Reserve or Regular Reserve on medical grounds) and also provided that the SP's Regular Army or Army Reserve Expiry Date (EED) does not occur within that period (in which case it must normally be put into effect unless covered by **paras 78.0711 to 78.0716**[36]).

78.708. For the purpose of calculating the above mentioned 12-month TNE period all periods of absence from duty due to the same condition will be aggregated. Where a SP develops a new unrelated condition or has recovered back to a working grade following a period of TNE or TEMP downgrading, a new period of TEMP downgrading may be considered, but only with authorisation from Cons OM.

Permanently Unfit

78.709. If at any stage it becomes clear that there is no reasonable prospect of the SP becoming fit for duty invaliding action, which is likely to result in a shortening of their Regular Army or Reserve Service, must be recommended immediately and a FMB convened. The following provisions for invaliding are to be used:

Engagement	Provision
Regular and Reserve Officer	PAW 20 Article 199
Regular and Reserve Soldier	QR(Army) Para 9.385-7

78.710. Where the FMB has graded a SP L6E5 MND(P) medically unfit for service, the FMB may recommend a deferral to the Last Day of Service (LDoS) which in the majority of cases will be earlier than their pre-medical retirement/discharge EED. Where there is a rehabilitation requirement, it is recommended that the FMB have details of the rehabilitation assessment prior to giving an LDoS deferral recommendation (this may require the FMB to extend the L6 Temp grade beyond the 12 month point up until the 18 months point in order to obtain this information). Once recommended, the LDoS deferral is calculated from the date that the FMB recommendation arrives and is actioned at OH APC. Where the SP requires access to DMS Healthcare facilities and treatment and no comparable treatment can be achieved on the NHS, APC SO1 OH is

[35] The SP is under the authority of their parent unit and the leave is granted on CoC authority.
[36] In extremis, with the agreement of Pers Pol (A) discretion may be shown to allow the TNE period to run to the SPs normal retirement date or end of engagement.

authorised[37] to award a later EED providing it is not later than their pre-medical retirement/discharge EED and does not exceed the recommendation of the Appendix 12 (routinely up to 12 months, but up to 24 months in exceptional circumstances). In rare cases there may the requirement for a medical extension in service (see Part 10) if the factors articulated from **para 78.1034** are met. In the extremely rare case that an SP has been graded L6 E5 MND(P) and has recovered sufficiently to suggest an upgrade may be possible then the case should be presented back to the ROHT for an FMB review and may lead to a JMES upgrade (with cancellation of the medical discharge LDoS).

Becoming UNFIT Shortly Before Termination of Service

78.711. Leave. JSP 760 Chapter 19 does not allow Service to be extended to take unused Annual Leave. This must include Annual Leave lost through sickness (or other reasons) prior to the start of Terminal Leave. SP on Terminal Leave can no longer take Sick Leave (see **para 78.716g**).

78.712. In-Patients.

a. For the purposes of this Part, 'inpatient treatment' is defined as:

(1) SP undergoing treatment, including courses of intensive rehabilitation[38], which necessitate retention in hospital.

(2) SP granted periods of sick leave between successive stages of in-patient treatment or courses of intensive rehabilitation, for example two-stage surgical operations or DMRC care.

(3) It will not include SP who may eventually require further in-hospital treatment, but for whom such treatment cannot be immediately and affirmatively diagnosed as necessary.

b. SP who are in-patients immediately prior to or during their entitled Terminal Leave (some types of Reserve Service do not have an entitlement for Terminal Leave) shall have their Terminal Leave suspended and resumed on the day they cease to be an in-patient. If they are an in-patient for 5 months from their last day at duty, noting that GRT counts as duty, their EED will be set at the 12-month point. SP who are being invalided out of the Regular Army, Army Reserve or Regular Reserve, or a SP whose service is being ended for special reasons[39], will not have their Terminal Leave suspended if they are an in-patient.

78.713. Graduated Resettlement Time (GRT). If a SP has GRT which has not been taken at their EED, and they are fit to take it, an application can be made for their service to be extended by the number of working days of GRT that were lost through sickness. If at their EED they are not fit to take this GRT or they wish to use all or some of it at a later date rather than have their Service extended, they may apply through resettlement channels for Post Discharge Resettlement (PDR) in accordance with JSP 534. If the SP's disability endures, PDR in some cases can be transferred to a spouse or dependant.

[37] In consultation with the appropriate Pers Pol (A) Policy desk.
[38] Exclusive of RRU treatment courses.
[39] Special reasons include retirement/discharge on administrative and disciplinary grounds, which may take precedence over medical retirements/discharges, QR(Army) Para 9.379g refers for Regular Army soldiers.

Definition of Medical Absence Categories

78.714. Absence on Medical Grounds includes three types of absence, all of which are Recovery Duties and defined in JSP 760 Part 1: Sick Leave**,** Hospital Inpatient Leave and Hospital Sick Leave. Sick leave is notably distinct from Light Duties – Unfit for Work, see **para 78.115**.

Sick Leave Criteria

78.715. Sick Leave on Medical Grounds (a medical absence and recovery duty) is an authorised period of absence in addition to the Individual Leave Allowance (ILA) to allow Service personnel the opportunity to rest or receive treatment for an illness or injury. Sick Leave does not excuse a SP from clinical, medical, rehabilitation appointments or other recovery activities, which should continue to be conducted during a period of convalescence, in line with clinical direction and the Individual Recovery Pathway (IRP).

78.716. Sick leave is permissible only when the following conditions are fulfilled:

a. The SP is unfit for military duty.

b. The SP is in or attending hospital or is under the care of a medical officer or specialist[40] and requires sick leave before return to military duty.

c. The disability is unlikely to be aggravated and direct medical supervision is not necessary.

d. The SP can continue to conduct directed recovery activity.

e. The SP can attend clinical and medical appointments scheduled over their period of sick leave.

f. The SP is not assessed as unfit for further service; and

g. It is not additional to normal terminal leave.

78.717. Sick leave is not to be granted to a SP who:

a. Has been assessed as *medically unfit for service*.

b. Has been assessed temporarily unfit, when no further in-patient treatment is required, and they are due a routine termination of service (not medical discharge).

78.718. Granting Sick Leave. In addition to the personnel listed at JSP 760 Part 1, the authority to grant absence on medical grounds also extends to Unit COs (inc PRU COs) after liaison with the SP's unit medical staff, on the recommendation of a civilian clinician. JSP 760 Part 1 details the process that must be undertaken when granting Sick Leave, in all instances the CoC is to be informed by all parties as soon as possible.

Leave Allowances

78.719. General. A SP who is being medically retired or discharged[41] is to be granted 20 working days Invaliding Leave (IL) plus the appropriate Terminal Leave (TL) as defined by JSP

[41] QR(Army), paragraph 9.385-9.387.

760[42], both are to be recorded on JPA. Additionally, a SP is to be granted the balance of any outstanding Individual Leave Allowance (ILA) in accordance with their JPA record if it does not extend beyond their medical retirement/discharge EED. ILA is still to be recorded on JPA, accounting for Unit Stand-down periods and leave from recovery activity.

78.720. Medical Discharge leave entitlements. Leave is to be reckoned from the date on which the SP is officially notified of the decision that they are to be invalided, the first day of leave being fixed by the APC. The date of medical retirement/discharge is as notified by the APC and is calculated having considered the balance of any entitlement to GRT, IL and TL. Whilst these entitlements form part of the APC calculation (when setting the Last Day or Service (LDoS), they do not run sequentially.

78.721. Terminal Leave. A SP may be granted five working days TL if their service is to be terminated on medical grounds, because of a disability incurred before entry and which becomes evident during in-service medical examination. The SP will not be entitled to TL if the disability incurred before entry and was not disclosed at the time at which it lowers the SP's medical grading.

78.722. Personnel whose Repatriation Overseas has been Approved. A SP who is to be invalided and whose repatriation to their home country has been approved is to be retained on full pay until the date of disembarkation in their home country (provided that embarkation to that country takes place at the first available opportunity) and for the periods of IL and TL admissible thereafter. This may involve the continuance of pay beyond the appropriate period specified in **para 78.707**, or beyond the normal date for termination of service. If, however, the SP is currently residing in their country of domicile or has elected to remain in the country in which they are located at the date when the decision to invalid is taken, pay is not issuable beyond the appropriate period specified in **paras 78.711** and **78.723e**.

78.723. Service Personnel sentenced to a period of detention at MCTC. In cases where a SP has been sentenced to, or is likely to be sentenced to, a period of detention at MCTC the following factors need to be taken into consideration:

a. All SP must have an in date medical grade.

b. SP graded *medically unfit for Service L6E5* can be admitted to MCTC.

c. If a SP who is graded *medically unfit for duty and under medical care L6E5* or *medically unfit for Service L6E5* is being charged with an offence that could lead to a period of detention, then the unit MO is to liaise with the MCTC medical centre in advance of the case being considered to ensure that continuity of care can be provided should a sentence of detention be awarded.

d. All SP must be seen on arrival by the health team at MCTC who will provide medical advice to the CoC to ensure that the SP is managed and risk assessed in accordance with their limitations.

e. IL and TL are not admissible in the case of a SP discharged on medical grounds while serving a sentence of imprisonment.

78.724. Service Personnel sentenced to a period of detention in a civilian prison. In cases where a SP has been sentenced to, or is likely to be sentenced to, a period of detention at a civilian prison the following factors need to be taken into consideration:

a. Where the SP is released on bail every attempt should be made to confirm an in date

[42] Normally 20 working days, at the rate of 1 day for each month of reckonable service to a maximum of 20 days, provided they have completed a minimum of 6 months service.

medical grade, prior to sentencing.

b. Where the SP has been held on remand until their court date, the CoC and UMO are to contact the HMP medical chain to establish a retrospective medical grade for administrative discharge and ensure the continuation of appropriate medical care.

78.725 – 78.800. Reserved.

PART 8 - THE MEDICAL ASSESSMENT STANDARDS OF ARMY CANDIDATES FOR RECRUITMENT AND TRAINING

Introduction

78.801. Headquarters Army Recruiting and Initial Training Command (HQ ARITC) is responsible for the pre-employment medical assessment of candidates for enlistment and commissioning and the award of an initial Joint Medical Employment Standards (JMES), as well as the management of individuals through their Basic Training (BT)[43]. Although Land Warfare Centre (LWC) is responsible for individuals in Initial Trade Training (ITT), Occupation Health support is provided by HQ ARITC through a Memorandum of Understanding[44]. Occupational Health HQ ARITC (HQ ARITC Occ Health) provides medical advice regarding the implementation of standards at all stages of selection and throughout training. The National Recruiting Centre (NRC), through Recruiting Branch (RB), is responsible for the administration and assurance of the Assessment Centres (AC) and ARITC for administration of the Army Officer Selection Board (AOSB).

78.802. This Part 8 describes the procedures to be used for the medical assessment of candidates prior to enlistment or commission and during Basic Training and subsequent Initial Trade Training.

General

78.803. The Medical Employment Standards on Entry are common for all *ab initio* (external from the beginning) candidates, (officers and soldiers [Junior Entry and Standard Entry], Regular and Reserve).

Medical Administrative Process for Pre-Employment Assessment

78.804. **Online Medical Questionnaire (OMQ).** In all *ab initio* cases, applications are initiated by the candidates online. The candidate is required to complete the OMQ, to confirm that they do not have any of the major disqualifying medical conditions listed. This list is not exhaustive but acts as a useful preliminary filter.

78.805. Recruiting Group Medical Declaration (RGMD). This is a health declaration which includes optometrist, dentist and General Practitioner's (GP) reports intended for pre-employment screening for Regular officers, Reserve officers and soldiers, including UOTC[45]. RGMDs for re-joins are to be submitted to NRC Chief Medical Officer.

78.806. Copy of Primary Healthcare Record (PHCR). Successful candidates will be asked to consent to their GP providing a copy of their entire PHCR to inform the medical screening processes up to and including the Initial Medical Assessment (IMA), to ensure continuity of primary care on joining. Candidates applications will be unable to progress without this consent. Candidates will also be requested to compete a dental and eye-sight proforma to ensure they meet the published standards.

78.807. RGMD/PHCR Review. The completed RGMDs and PHCRs (including any specialist reports and/or previous service medical records) are reviewed by medical examiners for pre-service medical screening purposes. Successful candidates are to be called forward for Pre-Service Medical Assessment (PSMA). Other candidates may be deferred or rejected at this stage. In cases of deferral, medical examiners may seek clarification from the candidate, the candidate's

[43] Including Combined Infantry Course.
[44] ARITC – LWC MOU.
[45] For OFs the RGMD is known as the RMAS Form 01.

GP or other agencies. Liaison with HQ ARITC Occupational Medicine (OM) may be required. The RGMD must have been completed in the 12 months preceding the PSMA (from the date of GP signature) and this time line applies if the PSMA is repeated – the AC assessment must have access to up-to-date (within 12 months) GP information (whether this is a repeat RGMD or just a summary sheet of the relevant GP information in the period since the previous RGMD was submitted).

78.808. Pre-Service Medical Assessment (PSMA). The PSMA will be conducted in accordance with JSP 950 Medical Policy Part 1 Leaflet 6-7-7 Joint Service Manual of Medical Fitness. The result is recorded in the candidate's medical record and the employer informed of the outcome. The PULHHEEMS award is not to be disclosed but, with the candidate's consent, qualities for hearing (HH), visual acuity (EE) and Colour Perception (CP) may be disclosed to the employer to ensure eligibility for their chosen CEG. The medical examiner must determine whether candidates may undertake the physical components of the military selection tests that follow the PSMA. Pregnant candidates are not to undertake the physical selection tests. The validity of the PSMA is 12 months prior to commencing BT[46]. After this period, the candidate is to be re-examined by an AC medical examiner and the RGMD updated/repeated. For Reserves who have attested and not attended BT within 12 months, fitness to attend BT is to be confirmed through a Commanders certification confirming that their extant JMES on JPA is no lower than MFD A4L1M4E2, supported by MO confirmation through a DPHC facility as required (JSP 950 Part 1 Lft 1-2-12 refers). Reserves must have a JMES recorded on DMICP prior to commencing BT. Candidates are graded as follows:

a. **Pass – (FIT).** The JMES normally[47] necessary for an untrained individual to enter the Army. Certain categories of candidate who fall below entry standards but who recruiters wish to be considered as special cases by Pers Pol (A) must be applied for on an AFB 203 (see **para 78.825**).

b. **Probationary Pass – (Temporarily Medically UNFIT).** Only to be used for candidates and Scheme Members[48] considered to be temporarily unfit but likely to meet entry standards in time to commence Basic Training (see **para 78.812**) where a permanent decision on fitness has not been established. These may be graded MND (Temporary) with the annotation that they are considered fit for the award of a scholarship / bursary subject to annual medical review. Current restrictions, conditions of employment and proposed timeline of treatment / recovery can be articulated in a format akin to the waiver paperwork, but the candidate must be FIT at the time of BTS.

c. **Defer – (Temporarily Medically UNFIT).** Candidates considered temporarily unfit (for example those who require a specialist opinion or time to recover fitness from illness or injury, or pregnancy) are to be graded MND (Temp) until a final decision is made. The examining MO must determine whether candidates graded MND may undertake the physical components of military selection tests that follow the pre-employment medical examination. Candidates discovered to be pregnant at selection are not to undertake physical tests.

d. **Fail – (Permanently Medically UNFIT).** Candidates found to be medically UNFIT for service in accordance with the standards laid down in JSP 950 Medical Policy Part 1 Leaflet 6-7-7 Joint Service Manual of Medical Fitness are graded MND Permanent. They do not require a further assessment by a second medical examiner.

[46] The validity of the RGMD/PHCR and PSMA can be extended to 24 months to support AF B203 Special Enlistment Applications due to the subsequent additional medical scrutiny applied to these cases (see **Para 78.825**). Where the time period has been extended, additional scrutiny is required at IMA.
[47] E1 Workforce planners / Regimental / Corps Colonels Entry standard may vary as either a temporary measure or for individual cases. In all circumstances, specific authority from Pers Pol (A) is required. See para 0825.
[48] See 0301c.

e. **Pass – MFD/MLD/MND (FIT to retention standards).** This grading should be used for re-joiners only. Retention standards must be met.

78.809. Soldier Candidates for the Regular Army. Candidates graded MFD are fit for attestation and may be allocated a place on a Basic Training course. The AC military selection staff are to ensure that the candidate meets the standards required of their chosen CEG/CEQ. Selection medical staff send pre-employment screening records to the NRC for forwarding to the SMO of the Basic Training unit at least ten working days prior to the Candidate's start date.

78.810. Candidates for the Brigade of Gurkhas. The PSMA for Gurkha recruits is conducted in Nepal. Candidates must be declared fit to perform the Gurkha Role Fitness Test (Entry) (RFT(E)) assessment. Candidates graded PASS are fit for attestation (which itself is conducted in Nepal) and may start Basic Training on arrival in the UK. Gurkha recruits do not require an IMA for fitness to serve provided they enter the Infantry Training Centre within three months of their PSMA but they do require the rest of the new patient medical process such as the creation of a medical record on DMICP and recording of PMH and vaccination status.

78.811. Officer Candidates for Direct Entry to RMAS. Candidates for direct entry[49] to the Commissioning Course (CC) are normally administered by Recruiting Group (RG) who initiate the pre-employment medical assessment process:

a. **Army Officers Selection Board (AOSB).** For successful Candidates, following PSMA and AOSB, RG will forward the RGMD, PSMA record and PHCR to SMO RMAS at least ten working days prior to Pre-Commissioning Course Briefing Course (PCCBC). The successful Candidate is called forward to PCCBC.

b. **Pre-Commissioning Course Briefing Course (PCCBC) Medical.** Candidates successful at AOSB will undergo a second pre-employment examination at RMAS (around three months before the start of the CC). Candidates are to be graded in accordance with **78.808** and must be declared FIT to proceed. SMO RMAS has responsibility for all aspects of the administration of the PCCBC medical with the exception of referrals and appeals which are directed back to SMO AC Westbury. The PCCBC medical is accepted as the IMA, with the caveat that the candidate completes a self-declaration to confirm no change in their medical status at the commencement of the CC. Where the candidate has not attended PCCBC, the IMA is undertaken on arrival for the CC, prior to attestation.

c. **Serving Candidates**. Serving (Regular and Reserve) candidates applying for Commission are to refer to paras 78.203 and 78.301.

78.812. Bursars (including DTUS/DSUS). The PSMA procedure for Bursar candidates is as described in para 78.803 to 78.809. When medical fitness at the time of the CC cannot be accurately predicted, but an eventual grade of MFD is expected, candidates may be graded Probationary Pass – MND (Temporarily Medically UNFIT) (as per para 78.808b). To ensure on-going fitness, all Bursar candidates are required to have completed an annual medical self-declaration. Completed self-declarations are to be submitted to AC (Westbury) who will assess against two categories; those candidates who remain FIT (with no further action to be taken) and those who have a declared condition or illness which requires further clinical assessment against future employability. When Bursars join UOTC or DTUS Sqn they will be subsequently treated as in-service reserve candidates. These Bursars who require further action will have their self-declaration forms sent to their Unit CoC (UOTC or DTUS/DSUS Sqn) with the direction that a DPHC Army Reserves appointment for assessment of JMES is then conducted. This should include an opinion as to whether the SP could be MFD by in-service standards prior to their RMAS

[49] In this context, the term "direct entry" refers to candidates who are selected at AOSB to attend the Commissioning Course in contrast to scholars (see para 78.814).

CC or confirmation of MLD/MND Perm and not FIT for RMAS CC. The Unit CoC are to communicate with C (Westbury) any confirmed change in JMES circumstances for their Scheme Member. All Bursar candidates (except PQO) and Scheme Members require a DPHC Army Reserves medical within 12 months of the Commissioning Course, which should include review of an up to date NHS PHCR (full record or Summary Care Record (SRC))[50].

78.813. Professionally Qualified Officers (PQOs). Regular PQOs are recruited by procedures determined by their Corps or Department, typically commissioned on 'probation' and administered by their Corps during this period. Those who undertake military service during this time (e.g. Army Reserves or UOTC) and who continue to do so at the time of the PQO BC require an in-service medical assessment within 12 months of the Commissioning Course Short (CCS), which should include review of an up to date NHS PHCR (full record or Summary Care Record (SRC)). Those who undertake no military service during their bursarship undergo further RGMD screening via Capita in the 12 months prior to attendance on the CCS, conducted in accordance with **para 78.803-78.808** above. Regardless of whether they choose to undertake military service at university, AMS PQO MO bursars are enlisted into the Regular Army when they commence their Foundation Years training[51] and therefore require an in-Service DPHC Army medical within 12 months of the Commissioning Course, which should include review of an up to date NHS PHCR (full record or Summary Care Record (SRC))[52] if they have been accessing PHC from a NHS GP during this period. This OH assessment should be arranged in conjunction with the AMS SU. Medical officers who are recruited after completion of Foundation Years and are not bursars, attend RMAS as Direct Entrant PQO civilian candidates following the full RG medical process **para 78.803-78.808**. Prior to the start of the RMAS PQO CCS, all PQOs are to undergo an IMA, normally at PQOBC[53].

78.814. Specialist Reserve Officers (SROs) and Specialist Reserve Other Ranks (SRORs/SRSs). Procedures for the enlistment of **SRO** are published in **The Army Commissioning Regulations 2019 (ACRs)** and for SROR can be found in **SToS**.

78.815. Officer Reinstatements. Procedures for the medical assessment of officers wishing to reinstate their commission are found in **ACRs** and **AGAI 40** Part 4. Only OFs reinstate, ORs re-join.

78.816. Re-joiners to the Regular Army. The terms 're-join' or 're-joiner' means the re-enlistment or re-joining of trained ex-Regular personnel[54] who have left Regular service and wish to return to the Regular Army. The terms replace previous terminology used; 're-employment' and 'trained re-enlister'. Procedures for re-enlisters and re-joiners to the Regular Army are published in Part 4 of **AGAI 40**. The process and requirement vary according to length of time since prior Service, rank and Medical Deployment Standard (MDS) on exiting the Service[55].

78.817. Re-joiners to the Army Reserve and Army Reserve Re-Engagement. Procedures for re-joiners to the Army Reserve are published in Part 4 of **AGAI 40**. The process and requirement vary according to length of time since prior Service, rank and Medical Deployment Standard (MDS) on exiting the Service.

a. Serving Soldiers and Candidates who left Regular Service less than 12 months prior to application into the Army Reserve. Current or discharge grading of Medically Fully

[50] 2019DIN-07-080
[51] Army Commissioning Regulations **2.9.003**. …potential medical, dental officers will undertake Ministry of Defence provided foundation period employment as officer cadets serving in the Regular Army.
[52] 2019DIN-07-080
[53] For further details of the PQO recruitment pipeline see The Army Commissioning Regulations.
[54] As announced by CGS on 28 Jun 16, personnel who have successfully completed Regular Army Basic (Phase 1) training are to be considered 'trained strength' (ACIN 25/16).
[55] The NRC will, where possible, confirm the medical grade on their Prior Service Check. If any concern is raised during the interview and selection stage of the process, regarding an individual's medical suitability, they will require additional medical scrutiny.

Deployable (MFD) or Medically Limited Deployable (Permanent) (MLD(P)) is acceptable. Candidates will not need to undertake a medical but should present for a new patient check at the DPHC MTF on arrival at their new unit.

b. Candidates who left Regular Service more than 12 months and less than 6 years prior to application in the Army Reserve. Discharge grading MFD or MLD(P) is acceptable. The candidate will complete the National Recruiting Centre (NRC) online medical questionnaire[16] which seeks to identify whether the candidate meets the Army medical eligibility criteria[17] and will request civilian GP records (PHCR or RGMD)[18]. The NRC will arrange a physical medical examination (PSMA) for the candidate at one of the Assessment Centres around the UK[19]. Cost for travel by public transport will be met by the NRC. Candidates who left with a discharge grade of MND will be initially rejected by NRC and directed to ARITC Occ Health to complete a Medical Eligibility Check (MEC) to confirm that they may now be within employment standards, prior to conducting the NRC medical process. All candidates, regardless of JMES should attend an DPHC Reserves OH assessment for an Initial Medical Assessment (IMA) at the on arrival at their new unit.

c. Candidates who left more than 6 years ago at any grade are required to complete the full application process through NRC. MND candidates will also require ARITC Occ Health Medical Eligibility Check (MEC) before their NRC application can proceed.

78.818. Transfer from Regular Service to Reserve Service. Procedures for Regulars Officers to join the Army Reserve are published in **ACRs**. Policy for Regular soldiers to the Army Reserve are published in **SToS**. Policy on transfer to the Army Reserve Reinforcement Group (ARRG) can be found in **Reserve Land Forces Regulations (RLFRs).**

78.819. Transfer from Reserve Service to Regular Service. Procedures for Reservists to join to the Regular Army are published in **AGAI 40**

78.820. Soldiers Discharged from the Army as Temperamentally Unsuitable for Army Service under QR(Army) 9.414 Services No Longer Required wishing to re-join may apply to rejoin after a period of over 2 years since date of discharge, subject to their conduct and efficiency prior to discharge but above all the needs of the service. Where an applicant's conduct on discharge was less than 'Exemplary' RG must consult WF Pol SO2 Discharges for advice. In less straight forward cases both Pers Pol (Army) and OH final approval may be required, in particular if parallel medical concerns were raised on discharge/PTSD etc. In these cases, the Applicant must be seen at a face to face interview with an SPSO and JMES assessed by a Single Service Occupational Physician (SSOP). If temperamental suitability is confirmed the candidate must still undergo the full PSMA as described in **Paras 78.803-78.809**.

78.821. AGC Military Provost Guard Service (MPGS). MPGS candidates are normally either serving personnel or those who will have left the Service. In exceptional circumstances where there is a specific Service requirement, recruits may be sought who have no prior military experience. Further information can be found in AGAI 40 – Recruitment Policy and **SToS.**

78.822. Ab Initio Soldier candidates to the Army Reserve. Candidates are to undergo the full PSMA as described in **para 78.803-78.808**. Candidates must be declared fit to perform the Role Fit Assessment – Entry (RFT-E)[56]. Candidates graded PASS are fit for attestation but may not commence training until the medical screening process is complete. Basic Training must commence within one year of the medical screening process. The AC selection staff are to ensure that the candidate meets the standards required of the chosen CEG/CEQ.

[56] All candidates graded MFD A4L1M4E1 by entry standards may attempt RFT-E (formerly Physical Selection Standards (Recruit Reserve) (PSS(RR)). Those that do not meet this standard (prior to referral or deferral) may undertake RFT-E at the discretion of the examining MO.

78.823. Serving Army Reserve soldiers applying for a Commission in the Army Reserve. Army Reserve officer candidates who have spent a period of time in the ranks will have been subject to the procedures outlined in **para 78.819**. Upon commissioning the validity of their recorded JMES is to be confirmed (see **para 78.301**). Candidates for commission directly into the Army Reserve are to undergo the full pre-employment medical assessment as described in **Paras 78.803-78.809** and **78.203**.

78.824. Appeals. The Appeals process is detailed in Appendix 19. ARITC is responsible for all appeals concerning selection and training. SHA(A) is the final authority for any appeals against published medical standards. Where practicable, appeals should be considered in the first instance by the Medical Officer or Board that made the original decision.

Application for Special Enlistment

78.825. AF B203 Application for Special Enlistment. Candidates will require medical assessment to consider fitness to undertake physical selection tasks or be waived of this requirement. Where a candidate does not meet the pre-employment standards of A4L1M4E2 MFD but, their Arm or Corps wishes to sponsor the candidate's employment on an executive waiver due to exceptional qualities (Knowledge, Skills and/or Experience), an application for special enlistment can be submitted[57]. The process for special enlistment is directed by AGAI 40 – Recruitment Policy. At IMA, the MedLim 1302 'Enlisted Below Entry Standards' **MUST** be recorded on the candidates DMICP record along with a copy of the AF B203 by the conducting physician. An approved AF B203 will only remain valid for 12 months from the date of approval, candidates must be enlisted or attested by this time. Once enlisted the candidate is then subject to the normal medical assessment process and must remain fit within the caveats of the waiver for **role** and stage of training / employment. Wf PoI will review all waiver candidates after 12 months to ensure that they remain fit for service.

Medical Administrative Processes for Assessment During Training

78.826. General. Throughout BT and ITT, both Regular and Army Reserve soldiers and Officer Cadets (OCdts)[58] must retain the in-service standard[59] of A4L1M4E2 MFD as a minimum. Personnel may not remain in training if they fall below this standard and their prognosis indicates that recovery within 84 days is very unlikely, preventing completion of all training objectives and pass out of training at the in-service standard[60] of MFD A4L1M4E2.

78.827. Initial Medical Assessment (IMA). This assessment is to be conducted as soon as practical to confirm the individual's fitness to commence training, ideally within the first 2 weeks (usually in the first week) of starting Basic Training, not to exceed 4 weeks. The minimum medical data set (MMDS) that must be available in all cases is the RGMD, an in-date PSMA and a copy of the full PHCR (not required for AR). Without this MMDS, the IMA cannot be conducted and must be deferred until such times as it is available. 10/13 DPHC Guidance on MMDS for conduct of IMA at ARITCs provides specific guidance on circumstances where PHCR and RGMD may not be available, such as Foreign and Commonwealth candidates.

a. **Soldiers under Training (SuT) and RMAS OCdts.** All candidates are to undergo an IMA to ensure they meet the entry standard. Potential Officers will usually undergo IMA at PCCBC. Repeat physical examination may be required at the discretion of the examining

[57] AFB 203 applications for Group D specialist applicants require that the RGMD/PHCR and PSMA is in-date by 24 months as these specialists are enlisted on a 12 month probationary period which facilitates the opportunity for any new medical or exacerbation of previous medical conditions to be declared/assessed and if required, medically managed out of Service. ARITC Occupational Health will assess on a case by case basis and may still request either an updated RGMD or PSMA if there is a clinical requirement prior to submission of an AFB 203 section 5 (medical) to Pers PoI.
[58] OCdts include those undertaking academic training, e.g. under DTUS/DSUS.
[59] JSP 950 Part 1 Leaflet 6-7-7 Section 5
[60] JSP 950 Part 1 Leaflet 6-7-7 Section 5

MO. The pre-employment PULHHEEMS grade is confirmed and the MO's assessment (FIT TO TRAIN) entered into the DMICP medical records. At the discretion of the Training Unit CO, individuals who are not fit to start training[61] may be retained for further investigation, remedial treatment[62] or discharged. The PHCR is to be summarised on DMICP and all other pre-service medical screening documentation is to be retained in the electronic healthcare record in accordance with DPHC medical records management policy; DPHC Handbook Guidance Number 16: Summarisation and Scrutiny of Medical Records.

b. Defect in Enlistment Procedure. If during the Initial Medical Assessment (IMA) or at a subsequent time during BT, the Recruit is found to be medically UNFIT for training due to a condition or illness prior to enlistment which was previously not known, not declared, missed or underestimated, which is considered to be incompatible with enlistment into the Army, discharge is authorised under QR(Army) para 9.381 - Defect in Enlistment. The discharge is completed using the AF B204 process described in para 78. 826 – 78.834. The AF B204 is initiated on DMICP by the UMO and sent to ARITC Occ Med for ratification with an electronic copy sent to the CoC to initiate discharge administration and ensure duty of care. Once ratified, ARITC Occ Med return the AF B204 to the Unit and final completion of the AF B204 by the Unit CO is sufficient authorisation for the SP's administrative discharge, the AF B130 is not required. The DiE is recorded in DMICP as 'UNFIT' P8 (A6L6M6E5), however these candidates are not L6 Perm in terms of their functional restrictions and are, therefore, not WIS SP (and do not require a WISMIS account).

c. **Army Reserve Recruits and Officers.** Army Reserve recruits and officers undertake modular BT and ITT. After BT, it is not logistically possible to medically examine SP at the start of each element. Training organisations therefore provide personnel with a form, as part of course joining instructions, outlining the nature of activities to be undertaken during each course together with a self-declaration of fitness to be signed and returned to the course administrators.

78.828. Service Medical Examination (SME) and award of JMES.

a. **SuT and OCdts.** There is no requirement for medical assessment between Basic Training and Initial Trade Training. Prior to completion of ITT[63], a 'Commander certificate of Medical Suitability' is required to confirm JMES Medical Assessment (JSP 950 lft 1-2-12 Para 8.c). This must confirm that SuT and 2Lts completing their Young Officers' courses meet the minimum medical standards for entry to the Field Army contained in Tables 1 / 2[64] as assessed by in-service standards. Where there is any doubt, a Commander's Certificate of Medical Suitability can be escalated to a 'Medical Officer confirmation of JMES' and repeat physical examination may be required at the discretion of the examining MO. This process also applies to transferees conducting Initial Trade Training on transfer.

b. **Army Reserve Recruits and Officers.** SME is not required. Army Reserve personnel will be medically examined to confirm their JMES prior to mobilisation at MRTC. Reservist recruits who are below the minimum in-service medical standard required for their Arm or Service are to be discharged in accordance with AGAI 49, Annex C or PAW 20, Article 199.

[61] Including probationary passes from PSMA.
[62] Weight management course for example
[63] If there is more than one sub-phase of Initial Trade Training (e.g. RE), the Service Medical Examination is to be performed at the end of the second sub-phase. This also applies to Gurkhas who complete ITC Catterick and go on to a subsequent initial trade course.
[64] In exceptional circumstances authority can be granted by Pers Pol (A) for an individual to move into the Field Army below the minimum medical standard. Applications are to be made on an AFB203A

Medical Board Procedures for Regular Army Personnel Under Training

78.829. Introduction. Having passed an IMA, if a SuT or OCdt is unable to meet the in-service standard of MFD A4L1M4E2 they are to be assessed by a FWA, and, where below the standard of any Arm, discharged. The FWA is to comply with the instructions set out in JSP 950 Part 1 Leaflet 6-7-7. The ARITC Cons OM has responsibility for ratification of all FWAs conducted on personnel under training that lead to transfer of discharge action. Prior discussion with ARITC OCC MED is recommended especially if there is a likelihood of appeal against discharge.

78.830. Award of P Grade and JMES. Individuals are to be graded in accordance with the guidance at Table 6. MOs should also consider the likely duration of the grade and any likely restrictions required and note these on the FMed 23. When considering a Temporary or Permanent marker, the approach at **para 78.112** applies. If it is considered that the individual does not meet the criteria of L5E5, the case is to be discussed with HQ ARITC Occ Med to consider whether a FMB needs to be arranged to consider *Medically Unfit For Service L6E5*. Temporary changes to the S grade may be initiated by the MO. Permanent changes to the S grade require the recommendation of a Consultant Psychiatrist at a DPHC DCMH[65].

78.831. Medically Unfit for Service L6E5 ('P8') Discharges. The majority of discharges of trainees for medical reasons are authorised by **QR(Army) para 9.381 Defective in Enlistment or para 9.385 Ceasing to Fulfil Army Medical Requirements.** Occasionally, a trainee will become medically unfit for any form of Army service and is likely to remain so permanently. In these rare cases, *medically unfit for service* (P8) medical discharge is appropriate under **QR(Army) para 9.386/7 Ceasing to Fulfil Army Medical Requirements (Temp/Perm)**. The process differs from discharge under **QR(Army) paragraph 9.381 Defective in Enlistment** and **9.385 Ceasing to Fulfil Army Medical Requirements**, because the discharge must be recommended by a FMB. The HQ ARITC Cons OM has authority to convene a FMB to consider recommendations for *medically unfit for service* (P8) discharge.

78.832. Initiating Transfer or QR(A) 9.385 Discharge Action. For all cases relating to a SP in training who has become unwell or injured and is assessed as *Ceasing to Fulfil Army Medical Requirements,* an Appendix 21 is to be completed using PAPMIS. The Appendix 21 is an administrative form and must not include any medical details. Once the application for transfer or discharge has been made, unit commanders are responsible for ensuring that the administrative processes and required timelines are adhered to.

78.833. Pregnant Personnel. SuT and OCdts who are pregnant may not be medically discharged on the grounds of pregnancy. They are to be graded MND A4L5M4E6, on RtW new mothers[66] are to be graded MLD(T) L4E4 during their RtW Medical, for a period of 6 months from their RtW date and the CoC given appropriate advice regarding restriction of their employment, where possible continuation of an appropriate level of training should be permitted. Pregnant personnel with other medical conditions, unrelated to their pregnancy, may be considered for medical discharge, see **para 78.1002**. In such cases advice should be sought from HQ ARITC Occ Med. The Pregnancy and Maternity in the British Army Servicewoman's' and Unit Guides give direction on further considerations for the CoC.

78.834. Final Medical of SuT/OCdts Electing to Discharge During Training. All SP undergoing discharge should have a final medical which will confirm/award the JMES. The examining MO may consider whether a medical discharge might be more appropriate and, if so, is advised to engage with HQ ARITC Occ Med. It should be noted that QR(Army) para 9.379g specifies an administrative or discipline discharge precedes that of a medical one.

[65] This must be iaw with JSP 950 Medical Policy Part 1 Leaflet 6-7-7 Joint Service Manual of Medical Fitness Section 5 Annex L Para 6
[66] Including those who have experienced perinatal death or stillborn.

Medical Board Procedures for Army Reserve Personnel Under Training

78.835. Medical Board procedures for Army Reserve personnel under training are identical to those for Regular Army personnel.

Permissible Downgrading Timelines

78.836. Individuals under training may be considered for transfer to a more appropriate CEG or discharge at different stages depending on their progression through the training pipeline[67]. If transfer or discharge is recommended, the Appendix 21 for SP in Basic Training and Initial Trade Training (Appendix 28 is for trained SP) is to be followed except in cases where *medically unfit for service* L6E5 Perm (previously known as 'P8') recommendation would be appropriate[68].

a. **Basic Training.** Individuals who have passed the IMA and present with a medical condition that requires limited duties for a consecutive period exceeding 28 days will be downgraded at a FWA(T) or, by exception, a FWA(P)[69]; this rule is to be robustly applied at Basic Training establishments. When 56 days have expired in the TJMES (making a total of 84 days), or if from the outset it is anticipated that the period of TJMES will exceed 56 days, the Appendix 21 discharge process is to be initiated. All trainees with a TJMES will be subject to Unit Health Committees (UHCs) commanders monthly case conference review which is to be recorded in their PAPMIS record (with notification of each case to HQ ARITC Occ Med). Private Health Care Initiative (PHCI) funds may be provided to hasten the recovery or diagnosis. The Appendix 21 discharge process must be initiated once it is apparent that the individual will not meet those recovery timelines. In exceptional circumstances where the UHC and ARITC Occ Med agree that an individual is likely to return to an MFD and complete the training (supported by the CO), the SP may be retained in the TJMES for a maximum period of 6 months from the date of downgrading before the reallocation or Appendix 21 must be initiated. Cases for extension in the unit on TJMES beyond the maximum 6-month period must be staffed by the unit CO to Workforce Policy, Pers Pol (A).

b. **Progression from Basic Training and Initial Trade Training.** Individuals in Basic Training on limited duties or TJMES who have completed all training objectives may progress to Initial Trade Training where the MO confirms a prognosis that will see recovery to MFD within a total of 84 days, both training establishment COs are in agreement and the LWC training establishment can facilitate their recovery, following a MO to MO handover of the clinical care. The AF B203a paperwork must be used to communicate the evaluation of medical and employment risk and acknowledges the formal transfer of the recruit/ trainee between units.

c. **Initial Trade Training (including officers who have commissioned from RMAS but not completed Initial Trade Training).** At Initial Trade Training establishments, an individual with a medical diagnosis that requires limited duties for a consecutive period exceeding 28 days will be downgraded. When 56 days have expired in the TJMES (making a total of 84 days), or if from the outset it is anticipated that the period of TJMES will exceed 56 days, ARITC Occ Med must be consulted by the responsible MO and CO. Confirmation of this discussion will be recorded in DMICP and the UHC minutes. The discharge process will not be initiated if the individual is realistically expected to return to the in-Service retention standard within six months from the date of downgrading (not including any periods of limited duties) and the training unit can accommodate their rehabilitation. Private Health Care

[67] Training providers that have intergraded basic and Initial Trade Training (i.e., School of Infantry) are to ensure apply the Appendix 21 policy appropriate to the individuals training progression.
[68] See para 0831 for discharge procedures.
[69] The 84 days cannot be a summation of limited duties for a series of separate medical conditions. A medical diagnosis is required to process Appendix 21 but must not to be used in circumstances which should attract an administrative discharge.

Initiative (PHCI) funds may be provided to hasten the recovery. The discharge process must be initiated once it is apparent that the individual will not meet those recovery timelines. In exceptional circumstances where the UHC and ARITC Occ Med agree that an individual is likely to return to an MFD JMES and complete their training (supported by the CO), the SP may be extended on TJMES for a maximum period of 12 months from the date of downgrading before the Appendix 21 must be initiated. Cases for extension in the unit on TJMES beyond the maximum 12 month period must be staffed by the unit CO to Workforce Policy, Pers Pol (A)

Transfer or Discharge Action

78.837. The medical discharge process for SuTs and RMAS OCdts. Termination on medical grounds is described in **QR(Army) para 9.385-9.387**. Termination under **QR(Army) para 9.381 Defective in Enlistment (Defect in Enlistment Procedure)** is not on Medical Grounds and should be completed using the AF B204 process described in para 78. 826 – 78.833. Once initiated, the Appendix 21 discharge process should take no more than 28 days to complete. To facilitate this all discharge applications must be processed using PAPMIS. However, this relies on each section being completed as fully as possible to allow the appointed ARITC Occ Med[70] to confirm if the grade awarded by the unit Medical Board is appropriate and to recommend the appropriate QR(Army) for discharge. Where possible the UMO should be involved in the Medical Board process of individual trainees. Guidance on the completion of each section of the Appendix 21 is given below. Any queries relating to this process should be directed to HQ ARITC Occ Med.

a. **Role of the UMO.** The role of the UMO within the Appendix 21 is to oversee the Medical Board and confirm the medical grading and to ensure that all the necessary medical documents are attached prior to the Appendix 21 being forwarded to HQ ARITC Occ Med.

b. **Section A – Completed by the Unit CO.** The CO initiates this process and should ensure that the individual has been interviewed prior to completion of the Appendix 21, to inform the individual of the implications of this process and understand its possible outcomes, including the employment, financial and welfare implications, as per **para 78.1015**. The CO signs this section to confirm that they have briefed the recruit to this effect.

c. **Section B – Completed by the SuTs and RMAS OCdts.** The individual is asked to confirm that they have been fully briefed on the Appendix 21 and the implications. ARITC staff should consider whether a recruit is fit to be transferred to a different Corps, to whom they are eligible to transfer. Should this be the case then the individual should state which Arm or Service, for which they are eligible, they would be prepared to transfer to. On PAPMIS this will be typed in by a Unit Witness Authoriser/Adjt/RCMO.

d. **Section C – Completed by UMO or delegated representative.** The FMed23 should be completed following a FWA(T) in accordance with Appendix 1 (paying particular attention to para 22) and Appendix 2. There may be situations where an FMed 23 is completed following a FWA(P) but this is unlikely for SP in Basic Training (should an FMed 23 be a result of a FWA(P) then Appendix 1 and Appendix 3 apply). Only the UMO or delegated representative should sign/authorise Section D. Overarching guidance for Boards is provided by JSP 950 Medical Policy Part 1 Leaflet 6-7-7.

e. **Section D – Attachments.** Those completing the Appendix 21 are to confirm all documentation is attached by annotating this on PAPMIS. Submitted Applications lacking the necessary documentation will be returned to the unit. The following will always be

[70] The appointed ARITC Occupational Health Clinician, formally referred to in this policy as the HQ ARITC OM, may be an Cons OM or Spec Nurse.

required however additional documents may also be inserted at the discretion of the UMO and CO:

(1) F Med 23 (UMO). This should be augmented with a clinical update as necessary.

(2) Appendix 9 (UMO).

(3) Appendix 17 (UMO).

(4) FMED 133.

f. **Section E – Completed by the appointed ARITC Occ Med.** ARITC Occ Med will review the medical information and advice on the future employability of the SuT/OCdt. The appointed ARITC Occ Med will ratify the FMed 23 and make an entry on DMICP to this effect and inform the UMO. If the appointed ARITC Occ Med does not agree with the recommendations of the FWA(T) or FWA(P), they will discuss this with the UMO or delegated representative separately and return all documents to the CO/UMO with comments. Care is to be taken to ensure that documents marked 'PROTECT MEDICAL' are not released outside the medical chain.

g. **Section F – Completed by the Receiving / Retaining Staff & Personnel Selection Officer (SPSO).** This section is not required where the individual is unfit for transfer to a different cap badge. In this instance, it should be forwarded directly to the SMO for completion of Section D. On receipt of the Appendix 21 and accompanying medical documents, the SPSO completes Section C.

(1) If the individual is within the Medical Employment Standards on Entry to another cap badge but is otherwise not suitable or is unwilling to transfer, the SPSO forwards the documents direct to ARITC Occ Med.

(2) If the individual is within the medical standards for transfer to another cap badge and is willing to do so, the SPSO returns the documents to the CO for action in accordance with AGAI Volume 2, Chapter 48. There is no longer any requirement to submit a transfer application on AF B241 as the Appendix 21 is all that is required.

78.838. On receipt of the completed Appendix 21, the CO carries out the transfer procedure if recommended. If discharge is recommended, the CO completes Part 2 as follows:

a. Recommended under **QR(Army) para 9.381 Defect in Enlistment**[71] – soldiers who have not completed Basic or Initial Trade Training (for those beyond 2 weeks of service). The CO, as Competent Military Authority, approves discharge of the soldier on AF B130 and forwards all documents to the APC CM Pol. This is also the usual QR(Army) para for failures at IMA (through the AF B204).

b. If discharge is recommended in accordance with **QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements**[72], then the discharge will be authorised by the CO on an AF B103 and the CO will have completed Part 2 of the Appendix 21 after ratification by ARITC Occ Med. It is the Unit responsibility to set the Last Day of Service (LDoS).

c. **Temperamental Unsuitability (TU).** Cases of TU fall outside of the Appendix 21 process and follow confirmation that there is not the presence of a mental health condition.

[71] QR(Army) para 9.381: Defect in Enlistment Procedures.
[72] QR(Army) para 9.385: Considered Unsuitable for further Army Service on Medical Grounds.

HQ ARITC Occ Med is not involved in this process. These cases are handled and processed in accordance with **QR(Army) para 9.434**.

d. It should be noted that termination on medical grounds is described in **QR(Army) para 9.385-9.387**. Termination under **QR(Army) para 9.381 Defective in Enlistment (Defect in Enlistment Procedure)** is not on Medical Grounds.

78.839. Soldiers Under Training (SuT) Graded MND L6E5 Permanent (Medically Unfit For Service (P8)). Under **QR(Army) Para 9.386** or **9.387** individuals Temporarily or Permanently Medically Unfit for any form of military Service should be discharged. The application for a discharge on medical grounds will be generated automatically from the FMB to APC SO1 OH. It should be noted that SuT graded L6E5 *medically unfit for service* (P8) do not follow the Appendix 21 process as the discharge is processed automatically between the FMB and APC. In exceptional circumstances, on a case by case basis, SuT graded *medically unfit for service* (P8) by the ARITC Occ Med can be assessed by ARCAB and assigned to a PRU. In cases where the UMO or their delegated representative is unclear of whether the correct grading is L5/6 E5, early referral to the ARITC Occ Med is recommended. The Appendix 21 should not be delayed whilst an FMB decision is awaited.

Progression Out of Training Below the Medical Employment Standard

78.840. AF B203A Application for Medical Employment Standard Waiver on Initial Assignment. A SuT or OCdt must normally be MFD A4L1M4E2 by in-service standards on completion of Initial Trade Training (ITT). In order to prevent holdover, where an SuT or OCdt is downgraded but reasonably expected to return to MFD by in-service standards within a reasonable time frame or, will return to a suitable functional state within their retention standards to be employable, deployable and progress within their CEG, then their training unit may apply to Pers Pol (A) to approve their progression. Re-trades that have previously completed ITT and progress to Fd Army, can do so again in line with the in-service retention standards (MLD A4L4M4E4).

78.841. The AF B203A staffing process is as follows:

a. **Section 1. Applicants personal details.** This section is to be completed by the applicants CoC, the training unit.

b. **Section 2**. **Medical Consent.** The SP must consent to release the functional restrictions related to their JMES, limited duties proformas, and MEP Appendices in order for the application to progress, If the applicant does not consent the Appendix 21 process is to be initiated by the CoC. The Applicant also has the option to consent to ARITC Occ Med to discuss specific clinical the Medical in Confidence details of their condition with the Workforce Policy Team, Pers Pol (A). Such disclosure will allow the discussion of evidence based decisions as to whether or not they are medically fit enough to serve in the Regular or Reserve Army. All personal Data will be processed and managed in line with the extant legislation.

c. **Section 3**. **Current Medical Grading.** This section is to be completed by the training unit MO; it is the only opportunity for a clinician that has conducted an *in propria persona* medical assessment to influence the application. This section must not contain specific clinical medical in confidence information.

d. **Section 4**. **Sponsorship.** This section is initially to be completed by the CO of the training unit before being forwarded to the proposed future employing CO of the Regular Army unit. It is the training unit's responsibility to liaise with the APC CM and identify a suitable assignment for the applicant. It is essential that the sponsor incorporates adequate detail of the applicants proposed employment for an occupational medical recommendation

to be offered. This must include proposed duties and responsibilities, proposed hours and patterns of work, the precise proposed role and location, any special requirements of the proposed role. Once fully completed and appropriately sponsored the AF B203A should be staffed to G1 Branch HQ LWC (LWC-G1-Ops-GroupMailbox (MULTIUSER) for LWC units, or Army Manning-Pol-SPEnlist-Waiver (MULTIUSER)[73] for non-LWC units.

e. **Section 5. Recommendation by ARITC Occ Med.** Once complete forwarded to appropriate E1 Workforce Planners.

f. **Section 6. E1 Workforce Planners Recommendation.** Once complete forwarded to Workforce Pol, Pers Pol (A).

g. **Section 7. Competent Military Authority Decision.** Pers Pol (A) will review the case before endorsing or rejecting the application. The final decision will be sent to the sponsor(s), ARITC Occ Med and E1 Workforce Planners representatives. It should then be staffed by the training unit to APC CMs permitting the promulgation of an assignment order.

h. **Section 8**. **Mandatory Employment Responsibilities.** A summary of the medical employment policy requirements to be undertaken by the sponsor.

78.842. Point of Contact. For queries relating to either the AF B203 or AF B203A the key Point of Contact is:

- SO2 Recruiting, Workforce Policy, Personnel Policy (Army).

78.843 – 78.900. Reserved.

[73] The word ‘manning’ in this email address is recognised as non-inclusive language and will be amended in due course.

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PART 9 - INSTRUCTIONS FOR FITNESS FOR WORK ASSESSMENTS (FWA)

General

78.901. The task of a FWA is to advise the executive of a SP's fitness for military duty. A Board[74] may comprise one or more suitably trained Medical Officers[75] convened by authority of the local Senior Administrative Medical Officer (MO)[76]. Normally this should be undertaken by the SP's UMO or equivalent. The Board's advice is communicated to the CoC by the award of a JMES which, although coded, constitutes a formal Occupational Medicine (OM) report.

78.902. When necessary the unit can also approach the ROHT directly using the Line Management Referral Form[77]. This promotes the proactive management of occupational health concerns and functional issues. Reserve units and exceptionally Regular units[78], can approach the ROHT directly to request a FWA subject to the SP being issued with an Appendix 7.

78.903. The President of a Board is normally the initiating MO who should be familiar with the case. Members of a Board may confirm the proceedings in absentia. In these cases, they must familiarise themselves with the case before doing so[79]. To ensure that reports are valid and robust, Boards must award grades based on accurate and contemporary clinical information, evidence of function and policy[80], and ensure that this is recorded appropriately.

78.904. SPs must give consent for the Board's report to be conveyed to the CoC and other agencies by completion of the form at **Appendix 17**. If consent is withheld or unobtainable, then the MO is to enter the JMES of A6L6M6E1 onto DMICP. This JMES is not a grade that could occur in any other circumstance and will inform the CoC that the SP has not consented for their medical information to be shared. They will not be entitled to invaliding leave or additional resettlement leave that would be granted specifically for a normal Medical Discharge. See **para 78.1032**.

78.905. Exceptionally, where a SP is either unable or declines to attend (either face to face or virtually), a Board may produce a report based on the contemporary medical record and relevant reports. The proceedings should be annotated to note that the Board was conducted in the patient's absence. In these cases, the SP must be given at least 14 days' notice of the Board, be informed that it is their right to attend and have the opportunity to provide written representation.

78.906. Indication for Formal Review of PULHHEEMS / JMES. From the initial award of a PULHHEEMS/JMES, a Medical Board is required for any mandated review or to change a JMES. A SP's grade is to be reviewed when a period of sickness absence has exceeded (or is likely to exceed) 28 days (**para 78.708**) or when a SP has been (or is likely to be) unfit for full duties for a period greater than 28 days.

78.907. Training. All MOs[81] and medical centre administrative staff are to be trained in the content of this instruction.

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[74] Excepting MOD(A) Board.
[75] Includes service specialist Occupational Health nurse.
[76] For example: Dir DPHC, Div Comd Med (for Army Reserve) and ARITC Occ Med.
[77] 20210624-DPHCSOP_03-04-006_Army ROHT Line Management Referrals
DPHCSOP03-04-006_Annex A Line Management Referral Form - Editable Word Version
[78] Where there is unavailability of either a regular UMO or DPHC assigned MO to advise the CoC.
[79] As a minimum it should involve discussion with the President and review the App 9.
[80] MOs should formulate an opinion as to whether the individual has the functional capacity to pass the objective tests, and that instances where additional evidence is required by the MO or CoC that they are capable of achieving the functional standards, requiring an objective test.
[81] To include CMPs, sessional doctors and locums.

78.908. Types of FWA. The constitution of Boards convened to upgrade personnel should, wherever possible, reflect that of the Board that made the initial award[82]. The constitution and authority of each type of Medical Board is as follows:

1. **Fitness for Work Assessments (Temporary Downgrading) (FWA(T)).** Usually conducted by the UMO but can also be awarded by a Service Specialist Occupational Health Nurse or OH clinician who is deemed competent in the course of delivering OH assessments and OH case management or Allied Health Professionals. FWA(T)s are used to temporarily downgrade a SP for a period not exceeding a maximum of 12 months in total and can be used to initiate Appendix 21. Administrative instructions are at Appendix 2.

2. **Fitness for Work Assessments (Permanent Downgrading) (FWA(P)).** Usually conducted by the UMO. A FWA(P) is required to downgrade a SP for any period exceeding 12 months and for all Appendix 28 applications (with Cons OM presiding). Administrative instructions are at Appendix 3.

c. **Full Medical Board (FMB).** Presided over by a Service Cons OM, a FMB is required for the consideration of (P8) medical discharge and related appeals. Administrative instructions are at Appendix 4.

d. **MOD(A) Medical Board.** The MOD(A) Medical Board is convened under SHA(A) direction, principally for the purpose of appeals. The MOD(A) Medical Board will always include two Cons OM. Administrative instructions are at Appendix 5.

78.909. Role of Specialists and Consultants. An appropriate specialist or consultant may volunteer or be requested to provide an opinion to assist a Board making an occupational recommendation[83]. Specialists[84], unless invited to comment or acting as a member of a Board, should avoid making any recommendations on grading or comment on medical discharge in accordance with published policy. Interpretation of specialist clinical opinion and advice for the purpose of a FWA is the responsibility of the presiding MO supported by Service Cons OM. Changes to the JMES of aviators which could affect their ability to operate within their CEG are to draw upon specialist CAM membership advice, and where necessary advice from an aviator operator as a matter of course.

78.910. Role of Specialist Occupational Clinician. Service Specialist Occupational Health Nurses or OH Clinician deemed competent may conduct FWA Boards leading to a temporary or permanent[85] change in JMES during the course of their OH assessment and OH case management.

78.911. Reports and Proceedings. Medical Board reports are recorded on the **Appendix 9-12** an electronically signed copy should be emailed to the CoC. The Boards' proceedings are to be recorded as follows:

5. **FWA(T).** Recorded in SP's case notes (and on FMed 23 if in support of Appendix 21) as described at **Appendix 2**.

6. **FWA(P).** Recorded on FMed 23 as described at **Appendix 1.**

c. **FMB.** Recorded on FMed 23 as described at **Appendix 1**.

[82] Unless otherwise specified.
[83] Consent is required when seeking reports and a consent form, information sheet and specimen request are at Appendices 14, 15 and 16.
[84] Including Service consultants and DMRC and RCDM advice, but not DCAs.
[85] With Consultant ratification, in line with 0908.b and Appendix 3.

d. **MOD(A).** Recorded on FMed 23 as described at **Appendix 1**.

General Instructions for FWAs

78.912. Appeals. An Officer or soldier may appeal, through the CoC, against the findings of a FWA using the process and paperwork as described at **Appendices 19 and 20**. Any appeal will not delay a SP's discharge date but, if the results are overturned at a future date, the SP will be reinstated from the day of discharge with associated back pay and benefits.

78.913. Review of Downgraded Personnel. Personnel who are downgraded are to undergo annual review[86] to confirm that the JMES awarded remains appropriate. Provided no alteration is indicated this review may be recorded in the notes as at **Appendix 2**. If it is necessary to alter the grade a FWA(P) is required and the proceedings recorded as at **Appendix 3**. The report is communicated to the CoC using **Appendix 9**. The attendance of the SP may not be necessary provided the MO is confident that the SP's current state of health and functional capacity is known.

78.914. Pregnancy. Pregnant Service personnel (including those in training) are to be graded L5E6 for periods from formal notification of their pregnancy to the CoC until reviewed at their Return to Work (RtW) Medical. At which point they are to be graded L4E4 for 6 months. The Return to Work (RtW) FWA will be conducted in line with JSP 760, Chapter 24 and JSP 950 Leaflet 6-7-7 which will take account of any specialist post-natal review but will in any case be determined on an individual basis. The RtW FWA must always be conducted in the Servicewoman's presence and should be conducted having had sight of the workplace risk assessment[87] completed for the Servicewoman by the CoC, so that any Appendix 9 can be tailored specifically to the employment aspirations of both the Servicewoman and CoC.

78.915. Occupational Report. A Board should, in line with **para 78.1005**, and with the subject's consent, seek evidence of the subject's capacity to perform military duties from commanders using the form at **Appendix 18**. This is preferable for consideration for permanent medical grades below the SP's minimum medical retention standard. A subject's refusal to consent will not delay a board and may lead to administrative discharge. The Appendix 18 Occupational Report is mandatory in the case of trained personnel as the content relates to the SP's ability to 'fulfil current role' and continue employment in CEG (both of which are unlikely to be applicable in the case of soldiers still undertaking Basic Training or Initial Trade Training). Should the CoC wish to convey specific information to the Board regarding a trainee then the Appendix 18 can still be used but is not mandatory. In the cases of IMA failure in the first 2 weeks of service the Appendix 18 is **not** required.

78.916. Use of the grade L6E5 Temp (previously 'P0'). SPs temporarily unfit for all duties whilst under medical care are graded L6E5 MND Temp. It is recommended that the L6 Temp grade follows discussion at UHC with ROHT involvement. FWAs should award this grade for no longer than six months before formal review. If it is anticipated that the SP is likely to remain unfit for longer than six months, the presiding MO must refer to the ROHT who should undertake formal review and ensure expedient return to duty or recommendation of discharge as appropriate. Periods of medical downgrading in excess of 12 months[88] require Cons OM authority and periods beyond 18 months will only be approved exceptionally by Pers Pol (A), on application to SO2 Empl Pol by the Cons OM. Early referral for rehabilitative assessment and potential rehabilitation is required where appropriate for L6 Temp cases as early intervention improves the clinical outcome (and increases the chance of an effective transition to civilian life for those that go on to L6 Perm and are recommended for medical discharge).

[86] Performed by the individual's usual / responsible MO.
[87] In line with JSP 375 Pt 3 Vol 1 and JSP 950 Part 1 Leaflet 6-7-7
[88] This calculation is to includes any period of Temp downgrade for the same condition i.e. a L5 MND(T) grade prior to the current L6 MND(T) that was given for the same condition.

78.917. Audit. Primary healthcare providers are to ensure adequate arrangements for audit of FWA procedures and outcomes.

78.918. Dental. Medical boards for dental re-grading purposes are to be carried out in accordance with the extant policy from SHA(A).

78.919 – 78.1000. Reserved.

PART 10 - MANAGEMENT OF PERSONNEL BELOW THE MINIMUM STANDARD REQUIRED FOR EMPLOYMENT IN THEIR ARM OR SERVICE

General

78.1001. This Part outlines the mechanisms for the management of Service Personnel (SP) who are below the minimum medical requirement for their Arms and Services as defined in Tables 4 and 5[89]. When an officer or soldier is assessed by a FWA to be permanently below the minimum medical grading required by their Arms and Services they will be medically discharged. However, Commanding Officers may apply to retain an individual in unit or recommend employment elsewhere via an Appendix 28. This does not affect a SP's right to apply for Premature Voluntary Release (PVR)/Notice To Terminate (NTT) nor does it prevent an individual from being regraded due to changes to their medical condition.

78.1002. Pregnant SP are not to be retired/discharged for any reason connected with their pregnancy. Servicewomen are to be treated at all times in accordance with JSP 760 and not treated less favourably because they are pregnant, absent on maternity leave or for any other reason connected specifically with their pregnancy. Secondary conditions resultant from pregnancy may lead to medical discharge.

78.1003. The process applies to all trained Regular and Reserve personnel. For ease of reference, flow charts are included at Appendices 23 and 24.

78.1004. An enduring principle is that SPs are to be managed carefully throughout the process and must be fully informed at all times with frank and pragmatic advice on the financial, welfare and career implications of their medical condition, employability and potential outcomes. This is a CoC responsibility, supported by APC using Appendix 27[90].

78.1005. Whilst treatment is on-going, SPs should be employed and managed in accordance with Appendices 10-12 and procedures laid out in AGAI Volume 3, Chapter 99 (Command and Care of the Wounded, Injured and Sick). The table below directs which appendixes the CoC are required to complete when a SP is graded below MFD (noting that Appendix 18 is only mandatory for trained soldiers (**para 78.915** refers):

	App 18	App 27	App 26[91]	App 28
MLD(T)	Optional[92]	N/A	Yes	N/A
MLD(P)	Required	Exceptionally[93]	Yes	Exceptionally[94]
MND(T)	Optional[91]	N/A	N/A	N/A
MND(P)	Required	Required	N/A	Req for L5 (N/A for L6)

78.1006. In certain circumstances some MFD personnel may be given a medical E2[95] JMES marker which will require management by the CoC. In these cases, the CoC can complete any of the relevant Appendices above to help in this management.

[89] The minimum standard, as defined in Tables 4 and 5. Personnel graded L6E5 MND(P) will routinely be discharged.
[90] The Appendix 27 is not required for BT/ITT trainees undergoing Appendix 21 where the ARITC Appendix 21 SOI Annex F is used (as this performs the same function).
[91] For deployment – only required for SP deploying on an exercise or operations. Can also be used at a CO's discretion (e.g. Adventure Training). For MND N/A unless exceptional circumstances allow deployment.
[92] Optional – there maybe instances where a unit feels it would be beneficial to complete these appendices for personnel not permanently downgraded, for example in advance of a medical board, or if it is apparent the individual will become downgraded in the future.
[93] Not required unless an employment decision is being made by exception through Pers Pol (A)
[94] See note 92
[95] Fit for unrestricted duties but with a medical risk marker. Formerly referred to as an L2 marker.

Joint Discharge Policy and Definitions

78.1007. The Armed Forces will discharge all those medically unfit for military service. However, the Armed Forces may retain those seriously injured, if they wish to stay, for as long as there is a worthwhile role and it is judged to be in the interest of the SP and the individual Service to which they belong[96]. It requires the Army Employment Board (AEB) to consider all relevant factors in assessing whether the benefits of retention meet the interests of the Service and the SP[97]. It includes factors such as medical, welfare, financial and presentational factors and may also include the circumstances leading to the injury or illness[98].

Authority

78.1010. Under the provisions of PAW 20[99]and QR(Army), consideration may be given to invaliding officers and soldiers from the Service. In pursuit of effective governance, it is the responsibility of Pers Pol (A), in conjunction with APC to consider, when requested, cases for both officers and soldiers whose change of medical category will affect their future employability in the Army. Through this process Pers Pol (A) will monitor current medical retirement/discharge trends and figures and provide policy guidance on employability issues where required. As the Competent Army Authority and Inspectorate for the respective Arms and Services, Regimental/Corps Colonels and E1 Workforce Planners also have a role in the provision of advice and policy.

Management of Downgraded Personnel

78.1011. Initial Downgrading. Once a SP has been formally medically downgraded, they will be issued with an Appendix 9 to notify their unit of their functional restrictions. The Appendix 9 will explain to the CoC what the SP can and cannot do and aid in the appropriate employment with regards to their condition. When a SP is downgraded, they will also automatically have a record created on PAPMIS (see Part 13).

78.1012. FWAs. SP will ordinarily be directed to attend a FWA by the Unit Medical Officer (UMO)[100]. In exceptional circumstances, there may be occasions where the CoC feel the need to seek Regional Operational Health Team (ROHT) opinion and may do so as per **78.902**. All SP who are overdue any medical review must be discussed at the monthly Unit Health Committee.

78.1013. Deployment on Exercise or Operations. If the CoC want to deploy[101] a downgraded SP then they must ensure that an Appendix 26 (Deployed Medical Risk Assessment) is completed where necessary. For UK exercises/deployments there might not be the requirement where the SP role is unchanged, access to medical support is unchanged and the employment is within the bounds of the Appendix 9. Where there is doubt regarding the requirement for Appendix 26 completion, then the Appendix 26 should be completed; the risk of deploying a downgraded SP lies with the CO and the decision should be made having discussed the case with a Medical Officer[102] and in consideration of the medical facilities available while deployed (see **Paras 78.510-78.514** for further detail). For SP deploying on UK based COVID Ops a bespoke medical risk assessment is available at Appendix 26C.

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[96] The period of retention will be directed by the AEB and will be subject to review.
[97] **Worthwhile Role.** 'Worthwhile role' is defined as the ability to perform useful military employment, for which a SP is suitable, qualified or can be reasonably trained.
[98] Injury refers to an acute event that results in damage to one or more systems e.g. musculoskeletal, burns, hearing etc. Illness encompasses a range of aetiologies e.g. infections, organ damage from poisoning, inflammatory arthropathies etc. In the case of medical discharge cases, the MB(T)/FMB will not state direct causality/attribute-ability, as this is for the DMS Pensions to determine as part of the pension settlement process.
[99] PAW 20 superseded PAW 09 with effect 14 Dec 20.
[100] See Part 9 – Instructions for Medical Boards.
[101] Appendix 26s can be completed for Exercises, Operations, Adventure Training and (if the CoC deem it necessary) everyday work.
[102] If one is not available then the information can be taken from the Appendix 9.

Permanently Downgraded SP

78.1014. A temporary downgrading can only last for a maximum of 12 months[103] and, after this time, the SP must attend a FWA to provide them with a permanent grading. Prior to all FWA(P) the CoC is required to complete an Appendix 18 in order to support the medical assessment. The Appendix 18 is an occupational report for employment purposes and looks at how the SP will be managed over the next 12 months – including, depending on the employment, the requirement for the SP to use weapons and other aspects which can have an effect on the JMES. This is produced by the SP's Officer Commanding (OC) and submitted to the ROHT prior to the medical board. Submission must be through PAPMIS as the ROHT will access the document through PAPMIS. A COs waiver is required to support the continued employment of SP who are recorded as 'non-weapon handling[104]' on their Appendix 9. If applicable, a record of the CO's support for a waiver is to be annotated in Box 7 of the Appendix 18. Where the Appendix 18 is not signed by the CO, an email from the CO supporting 'a waiver to the requirement to use weapons' is required. Both the Appendix 18 and email must be uploaded to the DMICP record. Weapon waivers can only be given for a maximum of 12 months and should only be granted where there is reasonable expectation that the SP will return to weapon handling within this timeframe.

78.1015. If a SP is assessed by a FWA as being MND(P)[105] the CO is to ensure that a SP is fully aware of the implications of the FWA's grading prior to an employment decision being made. Drawing on respective subject matter expertise (including OH, Veterans UK and Personnel Recovery Unit staff as necessary), the CO must ensure that a SP is provided with an Appendix 27 Unit Implications Brief[106]. An Appendix 27 is required by exception if an employment decision is being made for a SP who is MLD(P). The Appendix 27 to be agreed and completed on PAPMIS and is to contain the following information:

a. Initial career advice on the implications of the outcome of the FWA's decision.

b. Financial advice, including pay, pensions and compensations, with support from Veterans UK.

c. Additional medical advice and clarification.

d. Explanation of the potential outcomes of an employment decision.

e. Resettlement entitlement advice and support.

f. Welfare support to ensure a SP is aware of the implications on their welfare provision.

g. Assistance in completing and submitting an Armed Forces Compensation Scheme application.

h. A copy of Appendix 18 (occupational report for a SP).

78.1016. Personnel Graded L6E5 MND(P). SP graded L6E5 MND(P) by a FWA(P) will routinely be retired or discharged[107] with the application being generated automatically from the FMB to APC SO1 OH. CoC input will be sought prior to the FMB. It should be noted that SP permanently graded L6E5 MND (P) do not follow the Appendix 28 process as the retirement or discharge is processed automatically between the FMB and APC. The exceptions to this are SPs

[103] By exception this can be extended beyond 12 months, see 78.111
[104] The assessment of fitness to handle weapons is to be based on the personal weapon allocated to an individuals role.
[105] Can be prior to the Fit for Work Assessment when the decision is predicted with a high level of certainty
[106] Implications Briefs (App 27) are required for personnel who are graded permanently below MFD when an employment decision will be taken (this can include MLD). The Appendix 27 is not required for BT/ITT trainees undergoing Appendix 21 where the ARITC Appendix 21 SOI Annex F is used (as this performs the same function).
[107] Under QR(Army) para 9.386 or 9.387 Temporarily or Permanently Medically Unfit for any form of military service.

who are graded L6E5 MND (P) who wish to be retained in the Army and who must therefore apply to the AEB for this (Part 11). It should be noted that it is unlikely that SP who are graded L6E5 MND (P) will be retained unless there is a compelling argument for retention. Once a SP has been permanently graded L6E5 MND they are no longer allowed to work without the authority of the AEB and it is therefore essential that a handover is conducted by any SP who has the potential to be permanently graded L6E5 MND **prior** to them attending their FWA.

78.1017. Personnel Graded L5 MND(P). If an SP is graded L5 MND(P) [108] the Commanding Officer must initiate an Appendix 28 within 28 days of the FWA. The Appendix 28 should be initiated having interviewed the SP and taking into consideration any relevant personal circumstances. The final employment decision sits with Pers Pol(A), following medical advice and in consultation with APC and the unit CoC on the roles available. The decision will be based on Service need and individual SQEP. Where an individual wishes to appeal an employment decision they may do so via the AEB. The CO's request for an employment offer must be made using an Appendix 28 on PAPMIS.

78.1018. Exceptions to 78.1017. For SP in FTRS HC/LC, MPGS and limited Army Reserve roles who are employed under ToS limited to UK only, the retention standard is L5 MND(P). There is no requirement for an Appendix 28 to be completed to retain SP in this grade, however PAPMIS must be annotated to clearly state that the SP is employed as UK only. SP are still subject to annual JMES reviews and must have an in date Appendix 9 recorded on PAPMIS. Individuals graded MND(P) L6 will be Medically discharged following a Full Medical Board, unless retained by the AEB in the interests of the Service.

MND Employment Offer

78.1019 MND Employment offer application process. Prior to WF Pol making an employment decision on SP graded L5 MND(P) the unit is responsible for investigating all employment opportunities with APC Career Mangers and E1 workforce planners. Where suitable employment opportunities are identified they are to be annotated on an Appendix 28. The SP can then make an informed decision as to whether they wish to apply to be retained in service for a period of time or wish to be Medically Discharged following any resettlement and leave entitlements. Where an employment offer is not made, the SP will have no choice and will be Medically Discharged. The application template is at Appendix 28 and must be completed using PAPMIS in the following manner:

a. **Section A – Completed by the Commanding Officer'.** The CO initiates the Appendix 28 within 28 days of the medical downgrading and should interview the SP to ensure that the Unit has completed an Appendix 27 and the SP understands the implications of their current JMES grading. Having interviewed the SP and conducted initial consultations with the medical chain and APC, the CO must recommend one of the following: employment in unit, employment elsewhere considered or both employment in unit and elsewhere considered. Supporting evidence should be provided, including any welfare concerns and any impact on the unit. By exception an Appendix 28 may be completed for SP who are graded MLD (P). The CO must clearly articulate why retention in unit is not appropriate and must gain Pers Pol (A) authority prior to completing the Appendix[109]. Before forwarding the Appendix 28 the CO is to ensure that the appropriate appendices have been completed on PAPMIS. Section A can must be authorised by the CO. **NOTE: Completion of this section cannot be delegated.** The only exception is if CO powers have been delegated to an OF3, in which case authorisation to proceed must be given by Pers Pol(A) (Units to apply via email to SO2 Empl Pol) and annotated on the Appendix 28 in the comments section.

[108] And exceptionally permanently Medically Limited Deployable.
[109] Units must present the case to SO2 Empl Pol via email for consideration prior to starting the Appendix 28 process.

b. **Section B - Completed by the Adjt/RCMO.** The Adjt/RCMO in conjunction with APC Career Managers are to investigate all employment opportunities within the current unit. Where employment opportunities are identified they are to be annotated in Section B. Consideration may be given to extending SP in their current role where structure and FORM allow. If no employment opportunities are identified this must be clearly annotated along with the reasons in Section B and any supporting evidence uploaded to the PAPMIS library.

c. **Section C - Completed by APC Career Manager.** APC Career Managers in conjunction with E1 Workforce Planners are to investigate all employment opportunities outside the current unit. Where employment opportunities are identified they are to be annotated in Section C. Consideration may be given to E2 roles where appropriate, but this process is not about identifying transfer opportunities. If no employment opportunities are identified this must be clearly annotated along with the reasons in Section C and any supporting evidence uploaded to the PAPMIS library. Employment offers are to come with an end date, neither units or APC should be retaining SP where there is no justified Service need and never to the disadvantage of another SP progression.

d. **Section D – Completed by the SP.** The SP is to confirm that they have been fully briefed on the Appendix 28 process and its implications. Where employment opportunities have been offered the SP is to indicate their preference. Any domestic or welfare considerations should be discussed with the CoC and where appropriate included in the comments box within Section A of the Appendix 28. SP may decline all offers of employment, ORs will be discharged under **QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements** and OFs will be retired under **PAW 20 Article 199.** SP who are not offered an employment opportunity will not have an option to select a role and will be Medically Discharged. On PAPMIS this section will be typed in by a Unit Witness Authoriser.

e. **Section E – Completed by APC Occupational Health (OH).** APC OH will review all medical and employment information and provide an assessment for Pers Pol (A) explaining how the suggested role will affect their medical condition. APC OH may recommend that a SP be re-assessed by an appropriate FWA(P) or FMB if it is believed that the SP's medical condition may have changed or if the original grading appears incorrect. If the SP does not wish to be retained or no suitable employment has been identified, Medical discharge/retirement will be authorised under **QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements** or **PAW 20 Article 199.**

f. **Section F - Pers Pol (A) Employment Decision - completed by WF Pol.** Pers Pol (A) will review all applications and make an employment decision based on CO/APC recommendations and the SP's choice. Retention will be aligned to the end date of the employment offer (typically one assignment length, subject to a continued Service need) having been agreed by both the unit and APC CM. This should be annotated on the Appendix 28 under assignment end date. It is important that units ensure that this is correct prior to submission and that the SP understands that at this date they will be medically discharged. WF Pol will issue a letter to the individual via the Chain of Command confirming the employment decision. Should the SP wish to change their minds then they may do so in writing to WF Pol or via email to ArmyManning-Retro-Med-Group@mod.gov.uk[110] within 28 days of receipt of the letter. SP whose employment offer takes them to their normal End of Engagement Date will be given the option to either be medically discharged on this date or run out normally[111].

g. **Section G – APC Career Manager ratification.** APC Career Manager is to acknowledge the employment decision, ensure that the appropriate assignment action is taken and the SP's EED is amended on JPA to reflect the employment offer.

[110] The word 'manning' in this email address is recognised as non-inclusive language and will be amended in due course.
[111] SP are advised to ensure they understand the financial implications of their decision.

78.1020 Changes to an employment offer. Changes to employment decisions will not be accepted unless via appeal to the AEB (see part 12), except in the following circumstances:

a. If following a JMES review a SP's JMES is upgraded to above the minimum retention standard the Appendix 28 application will be withdrawn, and any discharge/retirement action cancelled. SP who wish to continue to discharge may do so as of right but will lose any entitlements specific to a Medical Discharge.

b. The CO may submit a new Appendix 28 application for employment elsewhere to be considered if the continued employment of the SP in unit can no longer be sustained. This may result in a SP who has not reached the end of their current assignment being medically discharged earlier than the previously stated offer end date.

c. SP who have accepted an employment offer following completion of the Appendix 28 process may apply to NTT/PVR. If the NTT/PVR is approved, SP will be discharged under QR 9.385/PAW Article 199 following a 12 month notice period. SP are to apply via the normal NTT/PVR process but should make clear on their application that they have an approved Appendix 28. Applications for Early Release and withdrawal of NTT/PVR may be considered as per SToS/ACR's.

Assignment and Extension in Post

78.1021 Employment offers are time bound. Once an employment decision has been made, SPs graded L5 MND(P) are not eligible to be assigned between units. Extensions in post will not be granted. At the end of assignment L5 MND(P) SPs will be medically discharged. SP wishing to appeal their medical discharge may do so through the AEB (see Part 12).

78.1022 Army Reserves on FTRS or Additional Duty Commitments who would otherwise be medically discharged in the grade of L5 MND(P) may complete their commitment and apply for an extension or further commitments. At the point at which their commitment ends, where no Army Reserve or FTRS appointment has been found through APC or by the individual themselves, the APC must initiate the SP medical discharge.

Promotion

78.1023 MND SP who continue to be employed on an Appendix 28, may still filter to promotion boards, however if subsequently run and successful, SP will have to be upgraded to substantively promote. In the case where a SP has already selected for promotion, where substantiative promotion can be realised employment offers in the higher rank should be considered by APC.

Resettlement Training

78.1024 SPs for whom the Appendix 28 has been initiated and sent to APC are eligible to commence resettlement training in accordance with JSP 534 while their case is being processed[112]. SP subject to medical discharge, who are Wounded, Injured or Sick (WIS) and those who are likely to be invalided from the Army on medical grounds, can access resettlement entitlements at an earlier stage than other Service leavers. It is the responsibility of the SP's CO to ensure early access to resettlement is given to SPs under their command (WIS and medical discharge). Access is available prior to attendance at FWA and is not a pre-cursor to any Medical Discharge decision. Decisions to that effect, made at the Unit Health Committee, must be shared with unit Resettlement Information Staff so that they can begin 1st Line Resettlement action.

[112] More detail can be found in AGAI 99. Entitlement to resettlement is detailed in JSP 534 Part 1, Para 406.

78.1025 Where SPs undertaking early access are deemed fit to return to duty, or the FWA decides the SP will remain in Service, resettlement entitlements cease until the SP leaves the Service based on an invaliding date. Any previous resettlement entitlement that was used during early access will not be taken into consideration when leaving under subsequent invaliding.

78.1026. Reserved

Refusal to Release Functional Restrictions Related to JMES

78.1027. If, following a change in JMES to any grade below MFD (SP graded MFD do not have functional restrictions to withhold), a SP does not consent to the CoC having access to their medical grading information (JMES and Appendix 9 Notification of Functional Restrictions) then the MO is to enter the JMES of **A6L6M6E1** onto DMICP and notify the CoC. This JMES could not occur in any other circumstance and will inform the CoC that the SP has not consented for this information relating to their medical record to be released. Following this grading, the SP should be interviewed (this should be recorded) by their CoC. At this point it must be explained to the SP that their consent to disclose this information enables an informed assessment of the health risks of their employment. It should be made clear to the SP with whom the information will be shared and why this is required. Explaining the control measures and limit of disclosure may help to reassure the SP and in turn inform a positive decision. However, should the SP continue to withhold consent, without an understanding of the SP's JMES and functional restrictions the CoC will have difficulty in meeting its obligations under the Health and Safety at Work Act 1974. In the absence of this information the executive are required to manage the risk(s) relating to condition(s) and/ or medical restriction(s) for which they have no knowledge. In such circumstances, it **may** be considered necessary to terminate the SP's Service on administrative (rather than medical) grounds, namely **QR(Army) para 9.414 Services No Longer Required** for soldiers, and resignation of commission under **PAW 20 Article 191** for officers. Should this option be pursued, the SP will forfeit GRT, TL, carried over ILA and the right to apply for a Retrospective Medical Discharge. The nature of this administrative discharge will be reflected in the SP's AFB108 Certificate of Service/Discharge and the SP will be precluded from re-joining the Army at a later stage. If the SP is subject to an outstanding Return of Service (RoS), costs in lieu of that unexpended RoS will be recovered from the SP[113]. Upon notification of the JMES A6L6M6E1, and prior to any decision being made on termination of Service, the CoC must consider that SP to have the potential to pose a significant risk on deployment in the land environment. Accordingly, they should not be deployed outside the UK or in locations with reduced health care provision. Such SP should be allocated only 'light duty' work commensurate with the SP's functionality (Units can seek case-by-case direction and guidance from Pers Pol (A) if required) and must have no access to weapons or equipment that could put their own health and safety, or that of those working alongside them, at risk.

Notice to Terminate

78.1028. Unless critical to a SP's immediate health, medical staff must not plan treatment or surgery for those in working grades who have given their notice (NTT/PVR), and for which such treatment will impact their function on transitioning to civilian life. The priority must be to transfer any ongoing or future care to the NHS or other agencies as appropriate, thus allowing the SP to conduct resettlement in good order. In certain circumstances those that have given notice may unexpectedly become WIS during their notice period. In such instances, a SP may apply to withdraw their notice:

a. If the withdrawal is supported by the CoC then approved by APC CMs and AEB[114], the SP will be subjected to the normal downgrading process, which may lead to medical

[113] JSP 750 Pt 1.
[114] ACR Ch 7.

discharge. In such circumstance's APC CMs should consult Unit Medical Officer/Cons OM regarding the SP's likely future employability.

b. Having consulted the Unit Medical Officer/Cons OM and confirmed the medical chain have recorded this justification on DMICP, where a SP's withdrawal of NTT is not supported by the CoC or approved by APC CMs an extension to their EED for medical reasons should be made to Pers Pol (A) on an AF B10034. Pers Pol (A) will consider applications against the policy for Extensions in Service on Medical Grounds articulated in this Part.

Extension in Service on Medical Grounds

78.1029. Requirement for extensions in service on medical grounds. The Army supports SP in recovery and seeks to enact the most effective transition to civilian life and employment for those undergoing medical discharge/retiral action. Whilst the timelines for the discharge will have been carefully considered by the FMB in determining the LDoS (up to 12 month deferral routinely and beyond 12 months in exceptional circumstances), it is acknowledged that clinical recovery is complex and there may be occasions in which an individual's DMS healthcare cannot be easily transferred to NHS providers within the given timeframe. In such cases an application for an extension in service on medical grounds can be made which, if policy compliant, will enable an extension to support healthcare transition. The duration of such an extension beyond that recommended by FMB will usually be no more than 6 months in a given extension (in rare cases where a further extension is then required the 6 months enables review to ensure the mandated clinical timelines are being met, including engagement with NHS providers). It must be noted that medical extensions in service can only be awarded by Pers Pol; clinicians may recommend an extension but have no power to award one and must be clear in this regard to the CoC and the SP themselves. Only policy complaint and medically assured applications can be approved, regardless of clinical aspiration.

78.1030. Eligibility. This mechanism is available to Regular SP, FTRS(FC) or mobilised Service and NRPS SPs (i.e. those already eligible for and under Defence Medical care)[115] and supports the transition of military care to NHS providers for those SP who are undergoing medical discharge/retirement action (or in rare cases, those that are likely to undergo medical discharge/retirement action but have not yet had a FMB). The policy also supports SP who have not been able to plan or implement an effective transition due to the intensity of medical treatment/recovery (aspects that fall under the 'HARDFACTS' assessment headings). Becoming UNFIT shortly before the termination of service is not justification for an extension in service unless a case that satisfies the factors can be made.

78.1031. Employable SP reaching EED. There is a clear distinction between those undergoing Medical Discharge/Medical retirement who may require a service extension on medical grounds and those who are approaching EED who are in an employable grade, are not WIS SP[116] and are undergoing medical treatment. Only in exceptional circumstances (such as where vital military medical care cannot be interrupted) will there be the requirement for a short extension to EED for non-Medical Discharge/retirement personnel. The policy and process for service extensions on medical grounds can be seen at **para 78.1034**. Key considerations:

a. The fact that the NHS or Veteran provided medical care may not be delivered to the same standard or as expediently as the Defence medical care is not grounds in itself for an

[115] Those on part-time obligatory training, part-time Voluntary Training and Other Duties (VTOD), part-time Voluntary ex-Regular Reserve (VeRR) Service, High Readiness Reserve (HRR) and Sponsored Reserve Service, a part-time Additional Duties Commitment (ADC), FTRS(LC), FTRS(HC), FTRS(HC) RSG are normally only entitled to receive Defence medical care if their medical condition is directly attributable to their military Service, and in such circumstances will only be continued until it can be transferred to NHS providers.

[116] AGAI 99 defines WIS Service Personnel as all those regular and reservist SP 'who are unable to undertake their normal military duties, within defined medical categories, in accordance with JSP 950: Medical Policy Volume 6: Chapter 7 Leaflet 6-7-7: Joint Service Manual of Medical Fitness. who are on authorised sick leave or a Graduated Return to Work programme (GROW)'.

extension in Service. Unless absolutely necessary, medical staff should not plan treatment or surgery for those approaching the end of their Service and for whom such treatment will severely impact their function on transitioning from military to civilian life. The Pre-release medical is the platform upon which healthcare transitional arrangements must commence (although for complex clinical transition such arrangements should be planned over 3 months prior to discharge in accordance with JSP 950).

b. The priority must be to transfer any on-going or future Defence medical care to NHS providers (or other agencies as appropriate), at or prior to EED thus allowing the SP to conduct their resettlement, if entitled, and transition into civilian life effectively. The pre-release medical is the platform upon which healthcare transitional arrangements must commence if they have not already.

78.1032. Exclusions. The service extension on medical grounds relates specifically to medical recovery (or difficulties in transition matters that are directly related to medical recovery). In complex WIS cases a Multi-Disciplinary Team meeting which includes future NHS providers is recommended to ensure the JSP 950 transitional principles and timelines are met – failure to meet these timelines by the clinical chain will not force a service extension. Whilst returning a SP to civilian life with employable functionality (where possible) is part of transition, unrealistic employment aspirations relating to functionality do not constitute grounds for an extension. The policy also does not grant medical extensions to cover loss of leave (factored into the LDoS by the FMB), increase pension entitlement, guarantee financial income or access untaken resettlement entitlement (JSP 534 specifically addresses this with the Post Discharge Resettlement provision). Additionally, DMS treatment such as residential rehabilitation should not be planned beyond the EED and is not justification for an extension in itself – the authorisation of extensions must not be assumed and only those compliant with the factors articulated in this policy will be authorised.

78.1033. Access to DCMH. Veteran's arrangements articulated in JSP 950 Lflt 1-3-4 enables the access to DCMH facilities for SP for 6 months post-discharge to support transition. As such, service extensions on medical grounds relating solely to access to DCMH are only applicable in exceptional cases. The application for an extension must satisfactorily demonstrate a strong justification for why the 6-month access arrangements post-discharge are not sufficient to meet the SP's needs (i.e. the requirement for high-intensity DCMH treatment that cannot be conducted through NHS providers) and that the guidance in DPHC Standard Operating Procedures around the Unified Care Pathway for Common Mental Health Disorders were given due consideration. Any extension will only be granted for a time period that will reasonably allow the specific treatment to be completed (high intensity DCMH treatment up to a maximum of 30 sessions on a weekly basis with allowance for unavoidable breaks in therapy).

78.1034. Process and factors. If the CoC believe that the SP meets the eligibility criteria and requires a Service extension on medical grounds (that also meets the factors below in this paragraph), they are to make an application using the AF B10034 to SO1 OH APC having first consulted the Unit Medical Officer/Occ Med Cons and confirmed the medical chain have recorded this justification on DMICP. The AF B10034 must contain all the required justification within the form (as documentary evidence will be contained in DMCIP there should be no requirement for additional attachments). The SP must also give explicit consent for each AF B10034 submission made. SO1 OH APC has delegated authority from Pers Pol (A) to authorise the extension of SP for up to 28 days if they are receiving treatment or for administrative reasons[117]. For periods exceeding 28 days, or where SO1 OH APC does not wish to use the delegated power, applications are then submitted to Pers Pol (A) containing an OH APC medical assurance/recommendation. Pers Pol (A) then consider each application against the following factors (considering previous extensions where applicable):

[117] Such an administrative extension must be JSP 760 compliant and is not to include additional time to take Annual leave.

a. **Clinical recovery timeline and functionality.** A medical (functional) assessment of the estimated recovery timeline and the expected outcome in relation to current ADL functionality and the likely improvement to the SP's functionality if extension is authorised. Are there functional issues that are currently preventing transition to civilian employment? If so, is there a clear treatment plan and timeframe for transition of care to NHS? This non-medical information relating to treatment is required on the AF B10034 as non-clinical staff involved in judging the policy compliance of the case do not have access to the medical information contained in DMICP.

b. **Is the treatment required available on the NHS?** If no, then the application must provide supporting evidence of the specific clinical specialities that are being provided by keeping the individual in Service regarding the deficiencies in NHS expertise and availability (noting that failure to adhere to JSP 950 timelines on transition of care does not justify an extension in Service). If the required treatment is available on the NHS then the application must account for why the care has not been transitioned and give detail on the plan/timeframe for the healthcare transition (the application must be clear what, if anything, is preventing it).

c. **Is the care available on the NHS of the same standard as in-Service care?** Due to the residential multidisciplinary approach adopted by some Defence Medical facilities it is accepted that care in military facilities can occasionally, be superior to that offered by NHS providers. Whilst this may be preferable in the short term for injured SP (particularly in cases where the treatment is at a significant point in the clinical pathway and it is not appropriate for it to be transferred at that time), the Army cannot keep SP indefinitely and this is not a factor that will prevent transition of SP.

d. **Is retention in the SP's interest?** Repeated extension requests and overreliance on military care often lead to SP becoming institutionalised, resulting in other medical and social complications. Such complications significantly compromise the SP's ability to transition to civilian life and employment. It is essential that a holistic approach to the SP's wellbeing is considered when applying for an extension and repeated extensions are less likely to be approved. In rare cases of repeated extension requests totalling 24 months beyond the FMB's recommended LDoS deferral there may be a case for additional medical scrutiny of the request.

e. **Do all the medical specialists and the CoC agree.** In many cases, it is recognised that there will be disagreements between SP medical specialists, and the CoC. In these cases, the medical assurance provided by the Occupational Heath Physician will inform Pers Pol (A)'s decision after careful consideration of the case against the policy factors.

f. **Are there other extenuating circumstances?** Limited functional capacity and medical treatment may impact on other aspects of the transition process, particularly with regard to resettlement training and future employment. The CoC should use the HARDFACTS[118] acronym to highlight any circumstances where an extension request relates to the significant detrimental effect of medical treatment on progress towards effective transition (this relates to SP who have had significant residential medical interventions or clinical recovery periods that have prevented transition activity).

g. **Assignment to a PRU.** In order to maximise the positive impact of support on transition, SP assigned to a PRU through ARCAB can be extended in service (through the AF B10034) to enable four clear months[119] residual service in the PRU. In this case the AF

[118] Health, Accommodation & Relocation, Drugs & Alcohol, Finance, Attitudes, Children & Family, Training, Education & Employment, Supporting Agencies.
[119] The effect of stand-downs such as Christmas can be taken into consideration. The PRU or unit may make a case for a longer period if supported by objective evidence.

B10034 requires the PRU assignment date and Units are to ensure that the ARCAB AF B10027 form is annotated to clearly state that an application for extension in service has or will be submitted if the WIS SP is selected for assignment to a PRU.

78.1035. Rejection of non-compliant AF B10034 applications. If an application has not clearly articulated a policy compliant justification for service extension on medical grounds in the AF B10034 application then it will be rejected. In all cases the decision of Pers Pol (A) is final. If new information pertaining to the case is identified which is policy compliant then subsequent applications can be made.

78.1036 – 78.1100. Reserved.

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PART 11 - THE ARMY EMPLOYMENT BOARD (AEB)

General

78.1101. This Part 11 describes the procedures for applications to the AEB, the potential outcomes from referral to the AEB and the construct of the AEB itself. Applications for referral to the AEB should not be considered to be the automatic process for all medical employment limitation issues, but rather the exception where retention is sought by the SP under the policy outlined at **para 78.1007**.

78.1102. The purpose of the AEB is to make decisions with respect to the continued employability of officers and soldiers who have been permanently downgraded by a FWA(P), FMB or MOD A Board. An AEB can therefore only take place on completion of the medical assessment by an FWA(P), FMB or MOD A Board and will meet as required and as convened by Offr Sec, in the following circumstances:

a. In exceptional circumstances for a soldier or officer graded L6E5 MND permanent where retention is sought by the SP.

b. For a soldier or officer graded below the minimum medical retention standard required by Arm or Service where:

(1) An employment opportunity is not found; or

(2) An employment opportunity is identified, but the SP rejects or wishes to challenge any aspect of the offer[120].

(3) Where an individual wishes to retained beyond the assignment authorised on an Appendix 28, and an employment opportunity has been identified by Unit/APC CM (having consulted WF Plans with regards to structures).

c. For cases where current guidelines are felt to be insufficient to meet complex issues. For example, where a SP's case falls outside of the definitions in Part 10 and the direction in this document is felt to be insufficient.

78.1103. Application Process. Where retention is sought by the SP, the SP is to initiate the application for referral to the AEB, using Appendix 25[121]. Where the CoC considers that discharge is more appropriate, the CO may indicate this on the Appendix 25.

78.1104. When referring a case to the AEB in the circumstances outlined in **para 78.1102** above, SO1 OH must be informed and Appendix 25 is to be initiated and forwarded to APC. Time must be spent explaining the possible outcomes of AEB action. SO1 OH, APC will provide guidance to the CoC on all the procedures and documentation required and will ensure that cases are dealt with appropriately.

78.1105. The application process to be followed is as follows:

a. **In Cases of Applications for Retention by the SP**. In circumstances where retention is sought by the SP, then the SP should initiate the Appendix 25, but the CO should give reasons why they do or do not support the application. The process is as follows:

(1) For SPs graded L6E5 MND Permanent where retention is sought.

[120] It should be noted that the AEB may still recommend medical retirement for officers or for soldier's discharge under QR(Army) para 9.385 Unsuitable for further Army Service on Medical Grounds.
[121] With the assistance of the immediate CoC.

(a) The SP should be interviewed by the CO to confirm their understanding of the employment, financial and welfare implications of remaining in Service, using SME advice as appropriate.

(b) The appropriate CM Branch should be informed in order that options can be considered and employment options can be drafted. This must be agreed by the SP (if not agreed then see **para 78.1105a (2)**) and will be a key consideration for the AEB.

(c) Appendix 25 must be initiated by the SP, supported by the CoC, providing all medical and welfare reports as stipulated. The CO should state whether they do or do not support the application for retention with reasons as necessary. This should all be forwarded to APC SO1 OH.

(2) For SPs who are graded below the minimum medical standard required by Arm or Service, where either employment cannot be found or employment offered is rejected, but retention is sought by the SP:

(a) The SP should be interviewed by the CO to confirm their understanding of the employment / financial implications of remaining in Service (this should have been completed as part of the Appendix 28).

(b) The appropriate CM Branch reconsiders employment options (this should have been completed once as part of the Appendix 28) and employment options are drafted. This must be acknowledged by the SP and will be a key consideration for the AEB.[122]

(c) Appendix 25 is initiated by the SP and the CO should state whether they do or do not support the application for retention with reasons as necessary, providing all medical and welfare reports as stipulated. This should be forwarded to APC SO1 OH.

(3) Where an individual wishes to retained beyond the assignment authorised on an Appendix 28, and an employment opportunity has been identified by Unit/APC CM (having consulted WF Plans with regards to structures).

(a) Applications should only be submitted within the last 12 months, having completed the annual JMES review and with an in date Appendix 9.

(b) The SP should be interviewed by the CO to confirm their understanding of the employment / financial implications of remaining in Service (this should have been completed as part of the Appendix 28).

(c) The appropriate CM Branch reconsiders employment options (this should have been completed once as part of the Appendix 28) and employment options are drafted. This must be acknowledged by the SP and will be a key consideration for the AEB.[123]

[122] CM Branch will be responsible for ensuring that all welfare and medical reports are compiled as necessary and that in conjunction with the CoC a suitable employment plan is available. Transfer options should be considered and evidence provided where this has not been possible.
[123] CM Branch will be responsible for ensuring that all welfare and medical reports are compiled as necessary and that in conjunction with the CoC a suitable employment plan is available. Transfer options should be considered and evidence provided where this has not been possible.

(d) Appendix 25 is initiated by the SP and the CO should state whether they do or do not support the application for retention with reasons as necessary, providing all medical and welfare reports as stipulated. This should be forwarded to APC SO1 OH.

78.1106. All cases for retention must be accompanied by employment options drafted by the Career Manager and seen by the SP and the CO within the employing unit. The employment options summarise what could be offered to the SP in respect of future assignment and should incorporate broader implications on training and employment opportunities. The employment options are to be informed by medical (including OH) advice regarding what type of work or activity can or cannot be undertaken.

78.1107. A personal statement from the soldier/officer is required for all cases referred to the AEB secretariat along with supporting statements. The appropriate CM Branch will be responsible for aiding in submitting all paperwork described in Appendix 25 para 5 to the AEB Secretary prior to the commencement of the AEB.

78.1108. Governance. The AEB reports to the Army Health Committee[124]. The AEB will produce an annual summary of cases and AEB decisions to the AHC to inform Army policy.

78.1109. Board Composition. Membership of the AEB consists of:

Post [1]	Voting Member	Adviser Role	Remarks
DMS	No	No	President and casting vote[2]
Col CM Ops	No	No	If not available, deputised by Col CM Branch
Col AMS	Yes	No	For AMS cases only
Col CM Branch	No	Yes	For Regimental personnel, as appropriate. Voting member if Col CM Ops not available
AH Workforce Policy, Pers Pol (A)	Yes	No	
DACOS Current Plans, HQ HC	Yes	No	
Asst Hd Workforce Ops Army Sec	Yes	No	
DACOS Pers, Fd Army	Yes	No	Newly appointed AEB Member
Asst Hd WF Plans	Yes	No	Newly appointed AEB Member
President of the Full, Army Central or MOD(A) Medical Board[3]	No	Yes	The president of the most senior medical board that has considered the case is required
APC SO1 OH	No	Yes	Secretary
Army Sec representative	No	Yes	For presentational issues
Legal advisor	No	Yes	Employment Law

78.1110. Board Procedure. Prior to the AEB convening to consider a case the following should occur:

a. All documents to be relied upon at the AEB will be provided to the SP.

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[124] The Army Health Committee is chaired by D Pers (delegated by DCGS IAW AGAI 57 Para 57.095) and is the highest committee considering both the personnel and welfare aspects of health policy together with the individual aspects of Health care.
[1] Or nominated representative, not below the rank of OF4.
[2] If not available a suitable AH OF5 can deputise.
[3] The President of each FMB will be expected to attend the AEB but may delegate attendance to a nominated Cons OM cognisant with the medical aspects of the case. They will only be asked to discuss those cases for which they are responsible and therefore each board may require the attendance of more than one President.

b. The SP may provide written representations no later than 10 working days prior to the AEB. If they wish to attend the AEB in person or to examine witnesses, they should indicate this NLT 10 working days from the date of the hearing. The President of the Board will consider any request to examine witnesses out of committee in conjunction with the Secretary and having taken legal advice[125].

c. Where circumstances permit the Secretary of the Board will normally consult the Consultant OH due to advise the AEB and legal adviser NLT seven days prior to the AEB to address any outstanding points prior to the Board convening.

d. **Voting.** Decisions of the Board may be made by simple majority. The views of dissenting members should be recorded in Records of Decisions (RoDs). The President has a casting vote.

e. **Record of Decisions.** The RoDs should include the reasons for the decision of the AEB and should have reference to the case consideration factors as applied to the facts of the case.

f. Written reasons for the decisions of the board should be provided to the SP within 10 working days of the Board's decision[126].

78.1111. Case Considerations. In determining whether the SP who is seeking retention or discharge/retirement has the potential to fulfil a worthwhile role and whether it is judged to be in the best interests of the SP and the Army for them to be retained, the AEB will consider all relevant factors, drawing on Regimental/Corps Colonels and the E1 Workforce planners advice where necessary, including the following:

a. Length of Service and the extent to which a SP is able to complete their respective Commission / Engagement.

b. Whether medical, welfare, health and safety restrictions preclude continued employment within the SP's current commission / trade / CEG or any other capacity. It is critical that continued employment can be found within a SP's medical capacity that will not exacerbate their medical condition or have other health and safety considerations.

c. The likelihood or possibility of gainful employment and whether a full career can be offered (including promotion / advancement prospects and operational liability, where appropriate).

d. Whether employment can be offered elsewhere in the Army either through transfer to a different cap badge or through placement in General Service.

e. Operational effectiveness, deployability and the impact of retaining a SP within extant workforce levels.

f. Welfare, resettlement and access to medical support and care, including Care, Recovery and Transition Plans as appropriate.

g. The written personal statement of the SP together with any supporting documentation and / or representations that they or their CO may present to the AEB.

[125] The President will take legal advice from SO1 Employment Law, HQ DALS.
[126] Col CM Ops is the authority in the absence of DMS for notification.

h. The Commanding Officer's report[127].

i. The circumstances resulting in the serious injury or illness may be considered.

78.1112. The **AEB Options.** The Board has the authority to direct one of the following options, giving reasons for its direction:

a. Retention in employment at A4L6M4E5 MND (P8), providing direction where appropriate on the length of retention. The AEB may also comment on a SP's fitness for a Conversion of Commission or Engagement. In addition, a detailed risk assessment will need to be performed in order to advise the CoC on any restrictions/adaptations required in the workplace. The medical status of the SP must be reviewed annually.

b. Retaining a SP, subject to a review within a specified timeframe[128]. This is to be applied where the prognosis of a SP's condition is uncertain, or where there is an obligation to ensure a SP is given sufficient time to make the transfer to civilian life. This must be reviewed at six monthly intervals[129] within the parameters of the SP's current Engagement or Commission type and will not normally be extended beyond 24 months. A temporary grading of L6E5 MND temporary will also be recommended should this be required.

c. Invaliding from the Service after a period of resettlement, with invaliding and terminal leave in accordance with the current regulations[130]. Such a recommendation may allow for temporary retention, for a period specified by the Board, in accordance with WIS procedures.

d. Discharge / retirement from the Service after a period of resettlement in accordance with current regulations. This option is only likely in circumstances when employment can be found for a SP but the SP declines the offer[131].

78.1113. SP Attendance at AEBs. The AEB is focussed on making decisions regarding employability. The SP is not required to attend the AEB, however, a unit representative or the CO may be asked to attend. SPs may request attendance at an AEB to APC SO1 OH; the President of the Board will decide on the relevance of such requests.

78.1114. Withdrawal of Request for AEB Action. Requests by the SP to withdraw an application for retention must be submitted to APC SO1 OH and copied to the appropriate Officer / soldier CM Branch.

78.1115. Resettlement Training. SPs recommended for invaliding from the Service who are eligible should continue with resettlement training in accordance with JSP 534 while their case is being processed and submitted to the AEB.

78.1116. Post Board Action. The following will take place after each AEB:

a. **Notification.** The results of the AEB will be notified in writing to the CO. It is the CO's responsibility to brief the SP. In cases where it is deemed appropriate, the AEB may advise the CO by telephone of the outcome of the Board. Notification will be sent within 48 hrs from completion of the AEB.

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[127] This should include additional information not in Appendix 18. As a minimum, the CO should take a view on current and future employment prospects based on the individual's capability and aptitude.

[128] Downgraded personnel are reviewed routinely on an annual basis.

[129] By APC SO1 OH.

[130] In accordance with JSP 760 Tri-Service Regulations For Leave And Other Types Of Absences and JSP 534 The Tri-Service Resettlement Manual.

[131] If discharged under QR(Army) para 9.414 Services No Longer Required, this will have significant financial/pension implications.

b. **Retention.** The JMES awarded by the President of the FWA will remain unchanged. If the SP is being retained in a non-working grade the authority for retention in military service is provided by the AEB, including the duration of retention. The CoC is to conduct an appropriate risk assessment on any restrictions/adaptations required in the workplace to facilitate the proposed employment (as required).

c. **Discharge.** Individuals recommended for Medical Discharge by the AEB will continue in accordance with the Medical Discharge letter issued by OH APC.

d. **Retirement.** Invaliding retirement for Officers will be authorised in accordance with the provisions of the Army PAW 20 and actioned by APC CM Ops Offr Sec SO1.

Appeals

78.1117. The SP has the right of appeal against the AEB's recommendation only in the following circumstances:

a. Where new factors or evidence have come to light that were not considered by the original board, the SP may, at any time prior to their discharge / retirement, request that their case be considered before a reconvened Board. In order to expedite this process, this review may take place out of committee.

b. Where a SP disagrees with any decision of the Board with regard to invaliding, retention or review, they may request in writing, within a maximum of one calendar month from the promulgation of the board result, a review by the Army Employment Appeals Board (AEAB).

78.1118. The AEAB will meet as and when required but within three calendar months of the acknowledgement of the appeal application by SO1 OH (in accordance with **para 78.1120**).

78.1119. Composition of the Appeals Board. The AEAB is composed of:

Post	Voting Member	Adviser Role	Remarks
D Pers	Y		President
Hd Pers Pol (A)	Y		
Hd APSG	Y		
Army Sec Representative	N	Y	SCS Level
APC SO1 OH	N	Y	Secretary
CAOM	N	Y	Where medical issues are contested
Legal Advisor	N	Y	Employment Law

78.1120. Appeals Procedure. An application for appeal should be submitted in writing to the relevant CM Branch through the appellant's CO, clearly stating the grounds for the appeal and the desired outcome. The appropriate officer / soldier CM Branch will forward the application to SO1 OH. Further medical, welfare and unit reports will be raised as required and determined by SO1 OH. Appeals must clearly state, including details of any supporting evidence:

a. The grounds of the appeal.

b. What outcome the appellant is seeking.

78.1121. SO1 OH will acknowledge receipt of the appeal through the SP's CO and convene a meeting of the AEAB. SO1 OH will prepare a brief for AEAB and forward the papers to members for consideration prior to the AEAB meeting. These papers (less any legal advice which is privileged) will be also disclosed to the appellant consistent with the AEB procedure at

para 78.1110. SO1 OH will also inform the CO, in writing, of the Board's decision, copied to the relevant CM Branch at the APC. The CO is to brief the SP on the outcome of any appeal.

78.1122. AEAB Powers. The AEAB will hear the application of the SP afresh and may take the following action:

a. Uphold the SP's appeal and substitute its own recommendation for that of the AEB.

b. Reject the SP's appeal and uphold or vary the AEB's original recommendation.

In each case, the AEAB will give reasons for its decision. Although the decision of the AEAB is final, a SP may make a Service Complaint under section 334 of the Armed Forces Act 2006 and in accordance with JSP 831.

78.1123 – 78.1200. Reserved.

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PART 12 - RETROSPECTIVE MEDICAL DISCHARGES/ RETIREMENTS

General

78.1201. This Part 12 clarifies circumstances where both Officers and Soldiers are required to attend a FWA close to or after their Engagement Expiry Date (EED).

78.1202. It is essential that all Service Personnel (SP) leaving the Service have a pre-release medical at least eight weeks prior to the date they are due to leave the unit[132]. This is the last opportunity for referral to a FMB and if the pre-release medical is not carried out in these timelines then the SP will not have enough residual service to attend the FMB in service. In these circumstances a SP can apply for a medical discharge sometime after leaving. This Part gives direction on how these cases should be managed.

78.1203. Personnel Graded L5 MND(P). If a SP is graded L5 MND(P) by a FWA, then the parent unit must start the process laid down in Part 10[133] and complete an Appendix 28. If a SP has Notice to Terminate (NTT) / Premature Voluntary Release (PVR) or is within 12 months of the End of Engagement Date then they will be given an option to:

a. Receive a medical discharge via the Appendix 28 process. If a SP has NTT/PVR then employment will not be offered and the SP will be medically discharged unless they opt to refuse a medical discharge.

b. Refuse a medical discharge and continue to be discharged / retired on their original date. This must be done in writing to APC OH[134], including reference to financial implications[135], and acknowledging they will have no right to apply for a retrospective medical discharge at a later date. In these cases the SP's medical grade will be updated to show they were graded L5 MND(P) on discharge. The final FWA grading will be applied and any restrictions that this grade will have on future Service / Reserve liability will be imposed.

78.1204. Personnel Graded L6E5 ('P8') MND(P). All SP graded L6E5 MND(P) by a FMB prior to discharge will receive a medical discharge/retirement with the date being set by APC OH unless their planned discharge date is prior to this. In these cases they will be given the option to:

a. Extend their current discharge date to the date set by SO1 OH and receive a medical discharge[136].

b. Refuse a medical discharge and continue to be discharged / retired on their original date. This must be done in writing to APC OH[137], including reference to financial implications[138], and acknowledging they will have no right to apply for a retrospective medical discharge at a later date. In these cases the SP's medical grade will be updated to show they were graded L6E5 on discharge. The final FWA grading will be applied and any restrictions that this grade will have on future Service / Reserve liability will be imposed.

78.1205. It is essential that if a SP with less than 12 weeks service remaining is graded L6E5 (Perm) by a FMB then the FMB President is to ensure that SO1 OH at the APC is informed. If a unit receives an App 12 (informing them that a SP in their last 12 weeks of service has been

[132] This is eight weeks before the date on which terminal leave begins for a UK based unit. If overseas, this is eight weeks before returning to the UK for commencement of release procedures.
[133] Even if it appears that there is not enough time for this process to be completed it should be started in case there is a delay to the planned discharge / retirement date.
[134] This refusal is to be placed on the individual's P file.
[135] The SP may wish to consult the Forces Pension Society or other agencies to help understand any financial implications.
[136] Calculated in accordance with JSP 760 and JPA entitlement.
[137] This refusal is to be placed on the individual's P file.
[138] The SP may wish to consult the Forces Pension Society or other agencies to help understand any financial implications.

recommended for a L6E5 medical discharge) then they are to liaise with APC OH. These procedures will ensure that the SP is not discharged without being offered the option of delaying the date to receive a medical discharge.

78.1206. All SP who receive a medical discharge date prior to their current EED will not be extended to allow them to complete their service; the FMB determination takes precedence.

78.1207. If a SP is referred for a FMB prior to discharge in some circumstances they will reach the EED prior to attendance at the board. If they are subsequently graded L6E5 MND(P) they can apply to Pers Pol (A)[139] for a retrospective medical discharge. This is only applicable if they would have received the same grade at a FMB prior to discharge.

78.1208. SP administratively discharged for disciplinary reasons prior to receiving a medical discharge will not be entitled to a retrospective medical discharge.

Appeals for Retrospective Medical Discharge[140]

78.1209. SP can appeal to Pers Pol (A) to consider a retrospective medical discharge. In order for their case to be considered evidence needs to be presented to support the case for appeal. Appeals will only be considered if sufficient information is provided to support the change and if the SP confirms that they are aware of the financial implications[141]. SP graded L6E5 MND(P) prior to their EED who previously refused a medical discharge cannot subsequently claim for one.

78.1210. Pers Pol (A) will conduct an initial assessment of all appeals to determine if the case meets the policy criteria (which includes the time limit for applications as articulated in para **78.1212**). This will be presented to the RMD review panel[142], if the criteria is not met at this stage the appeal will be rejected and the individual informed in writing.

b. Where the policy criteria is met, the RMD lead in Wf Pol, Pers Pol (A) will seek written consent from the applicant to progress the application (this must be the ex-SP in question, not a third party unless appointed by a Lasting Power of Attorney).

c. Following consent, the application will then progress to SHA(A) in which an empowered clinician will review the medical evidence relating to the medical circumstances at the time of discharge (RMD relates to the known medical conditions at the time of discharge, not medical conditions that have been diagnosed following service).

d. The RMD review panel[143] will convene to look at all the evidence presented including SHA(A)'s medical recommendation. It will reach one of the following decisions:

(1). **Reject.** If it is clear from the files that the SP is not eligible for a retrospective medical discharge, then the appeal will be rejected.

(2). **Approve.** If, on review of their medical and personnel documentation, it is clear that the SP was eligible or should have received a medical discharge (e.g. has a clear OH recommendation for medical discharge that could not be enacted in time prior to discharge) then the RMD will be authorised. A RMD will only be granted if it is clear

[139] SO2 Discharges for soldiers and SO2 Officer ToS for Officers.
[140] Special to Type Service Complaint process under JSP 831 Redress of Individual Grievances; Service Complaints
[141] The SP may wish to consult the Forces Pension Society or other agencies to help understand any financial implications as in certain circumstances they may be required to pay back part of any lump sum they had received.
[142] The RMD Review panel is chaired by SO1 Wf Pol, with representation from Army Health, Army Employment Law, SO2 Empl Pol and SO2 Discharges. Authority is given to the review panel by Pers Pol (A) to decide all RMD cases.
[143] The RMD Review panel is chaired by SO1 Wf Pol, with representation from Army Health, Army Employment Law, SO2 Empl Pol and SO2 Discharges. Authority is given to the review panel by Pers Pol (A) to decide all RMD cases.

that the SP would have met the criteria for L6E5 MND(P) under the policy extant at the time of discharge.

e. Wf Pol will inform the individual of the outcome via letter. A copy of the decision letter is also sent to Veterans Up.

78.1211. Pers Pol (A) will not authorise a retrospective medical discharge for any SP where the injury / illness was not apparent to the medical chain or recognised in medical policy at the time of leaving the Service. In all of these cases the SP can still apply through Veterans UK for a War Disablement Pension and (if applicable) to the Armed Forces Compensation Scheme. The decision of Pers Pol (A) will be final, there is no subsequent right to appeal a Pers Pol (A) decision for retrospective medical discharge.

78.1212. If a SP (/ex-SP) believes their Primary Invaliding Condition (PIC) code should be changed they are to staff an appeal using Appendix 20 to the Unit CO who will then direct the appeal to the Regional Clinical Director (through the ROHT) (cases are not to be staffed to Army Headquarters). The Regional Clinical Director or the ROHT's Cons OM will consider the case to change the PIC code and, whether successful or not, must notify the SP and CoC. Where the case for PIC code change is successful, the approving authority must also notify Veterans UK.

78.1213. The time limit for all retrospective medical discharge and PIC code appeals is **12 months** from the discharge or retirement date. This timeframe applies *ex post facto* to all appeals.

78.1214 – 78.1300. Reserved.

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PART 13 - PAPMIS

General

78.1301. PULHHEEMS Administrative Pamphlet Management Information System (PAPMIS) is the Management Information System for the CoC to ensure the enacting and tracking of the required PAP processes relating to medically downgraded SP. Use of PAPMIS ensures that mandated processes are carried out in the most effective and efficient manner whilst also enabling appropriate levels of assurance. As such, its use is mandated for all Army personnel, regardless of their current TLB. **Where the AGAI 78 policy has been updated and the PAPMIS Appendices have not yet been updated, the PAPMIS Appendices are still to be used (as opposed to printed copies).**

Access, Roles and Responsibilities

78.1302. Access. PAPMIS, access is limited to those personnel directly involved in the medical welfare management of soldiers. Those who require access to PAPMIS are to apply for access in LUMS (the Army Application Access Management System). The Unit PAPMIS Point of Contact (usually the Adjutant or RCMO) should then authorise and complete the access request in LUMS. All 1* formations/organisations and above with subordinate PAPMIS using units must identify a PAPMIS PoC who has the appropriate KSE. Further PAPMIS User Account administration support can be obtained by the formation PAPMIS PoC through the Army Information Front Door – The Army Apps Service Catalogue or via contacting the PAPMIS team RC-PERS-ARC-PAPMIS-0Mailbox@mod.gov.uk].

78.1303. Management of Accounts. The Unit is responsible for creating and deleting accounts. PAPMIS roles are linked to a SP's PUID and not to their post or role within a Unit. It is therefore paramount that when a SP moves away from the Unit that their PAPMIS access is withdrawn immediately by the Unit System Admin for data protection reasons. If the departed SP requires PAPMIS access at their new unit, it can be restored by their receiving unit System Admin once they arrive.

78.1304. Roles. The type of account authorised is dependent on the role of the SP within the Unit and the level of access they require. The different PAPMIS roles are detailed below.

a. **'Unit CO / OC / Adjt / RCMO / RAO / Welfare Officer' Roles.** Self-explanatory.

b. **'Unit User' Role.** For those who require 'write' access to records (e.g. 2IC/CSM/SSM for drafting CO / OC comments) but cannot 'authorise' sections on appendices.

c. **'Unit Witness Authoriser' Role.** For those who need to witness a SP's signature on Appendices 18, 21 or 22. This is automatically included in unit CO/OC/Adjt /RCMO roles.

d. **'Unit Read' Role.** For those members of staff who do not require any 'write' access to records.

e. **'Unit System Admin' Role.** For those members of staff who are required to create new PAPMIS user accounts (e.g. Adjt / RCMO / RAWO / RCMO / iHub / ISO / ISA), manage the system and deactivate accounts when SPs are posted out of the unit.

78.1305. The table below highlights positions within a standard unit and the PAPMIS roles required for those positions. This is a guide; units may choose other people to have specific PAPMIS roles.

Ser	Post	PAPMIS Accounts Required	Remarks
1	CO	Unit CO role	Role includes Witness Authoriser rights
2	Unit 2IC	Unit User role	Can be delegated CO role for administrative purposes when the CO is absent.
3	Sub Unit OC	Unit OC role	Role includes Witness Authoriser rights
4	Adjt	Unit Adjt role, Unit System Admin role	Role includes Witness Authoriser rights
5	RCMO	Unit RCMO role, Unit System Admin role	Role includes Witness Authoriser rights
6	RAO	Unit RAO role	
7	RMO	AMD[144] Medical Authoriser role	This role cannot be created by a Unit System Admin, only by a AMD[154] System Admin (usually the Practice Manager)[145]
8	Welfare Officer	Unit Welfare Officer role	
9	Sub Unit 2IC	Unit User Role, Unit Witness Authoriser role	
10	RSM	Unit User role	Can populate OC section for Appendix 18
11	SSM	Unit User role, Unit Witness Authoriser Role	Can populate OC section for Appendix 18
12	RAWO	Unit System Admin role	
13	Tp Cmdr	Unit Read role	
14	Prac Mgr	AMD[154] System Admin role	
15	Asst RCMO	Unit User role, Unit System Admin role	

78.1306. Responsibilities. Once access to PAPMIS has been granted on LUMS, PAPMIS users are required to carry out the following detailed responsibilities to enable PAPMIS to work efficiently:

a. **Commanding Officer.** The Commanding Officer is responsible for authorising an Appendix 28. **NOTE: This responsibility cannot be delegated except for circumstances as detailed in 78.1019a.**

b. **Sub Unit Officer Commanding.** The OC is responsible for ensuring all permanently downgraded soldiers have an Appendix 18 completed on PAPMIS. OCs can act as a Witness Authoriser for an Appendix 28.

c. **Adjutant.** The Adjt is responsible for the authorising of accounts and preparation of Appendix 28's on behalf of the CO. Adjt's are to monitor and ensure compliance with procedures by all sub units and should input notes to the "Notes" section of records during (or following) Unit Health Committee meetings. Adjt's may act as a Witness Authoriser if required. **NOTE: Under no circumstances can the Adjt be delegated the role of CO on PAPMIS**.

d. **RCMO.** The RCMO is responsible for ensuring all relevant parts of each Appendix requiring RCMO action are completed. The RCMO is to ensure that all permanently downgraded personnel (both MLD and MND) have an Appendix 18 and Appendix 27 completed on their record. RCMO's may act as a Witness Authoriser if required.

e. **RAO.** The RAO is responsible for ensuring the relevant RAO sections of the Appendix 27 are completed.

[144] Army Health (annotated as AMD on PAPMIS only)
[145] If the RMO does not have a practise manager in their medical centre then they can apply directly.

f. **RMO.** The RMO is responsible for ensuring that all relevant parts within each appendix which require RMO action are completed on receipt from units and RHQ. RMO's are to ensure that SP who are downgraded have an Appendix 9 which should be sent to the CoC. It is the unit responsibility to make sure the Appendix 9 is loaded onto PAPMIS, Unit Medics may assist with this where capacity allows.

g. **Welfare Officer.** Unit Welfare Officers are responsible for ensuring that the relevant section of Appendix 27 is completed.

h. **Sub Unit 2IC.** Sub Unit 2IC's are responsible for assisting the SSM in the drafting of Appendix 18 for all permanently downgraded personnel within the sub unit. Only in the absence of the OC and SSM are they to act as a Witness Authoriser.

i. **Sub Unit Sergeant Major.** The sub unit Sergeant Major is responsible for the day to day management of all sub unit personnel being managed under PAPMIS. In addition, the sub unit Sergeant Major is required to draft Appendix 18s on behalf of the OC, ensure all soldiers under PAPMIS have completed the Appendix 27 process and to act as the unit Witness Authoriser to authorise signatures on Appendix 18s.

j. **RAWO.** The RAWO is to ensure that all accounts are created and managed correctly across the unit including being responsible for the deletion of accounts when SPs are assigned.

k. **Medical Centre Practice Manager.** The Practice Manager is responsible for the creation and management of AMD accounts for the Medical Centre staff.

78.1307. Medical in Confidence. Medical Employment Policy (MEP) and PAPMIS are strictly administrative processes and systems. There should be no medical in confidence information recorded in PAPMIS, either in the notes area of a MEP Record, or in any appendices. If medical information is inadvertently saved, the unit must contact the PAPMIS team immediately to request its removal.

78.1308. Unit Admin Inspection. PAPMIS has been successfully implemented across all army units and forms a key part of Unit Admin Inspections. Where units cannot demonstrate compliance with this AGAI through PAPMIS then this will highlight a failure of the Unit's management of their medically downgraded personnel. As such, the use of PAPMIS is required in the Unit Admin Inspection and units will fail if they cannot show appropriate engagement and compliance with PAPMIS.

78.1309. Reserves. Reserve units are to comply with PAPMIS in the same way as Regular units. Given the geographically dispersed nature of many Reserve units, PAPMIS is often even more beneficial for the Reserve. If Reserve units do not have access to a military Medical Officer (MO), they should contact their ROHT for further guidance.

Appendices on PAPMIS

78.1310. Appendix 9. This form notifies a unit of a SP's medical or functional restrictions. The Appendix 9 is currently completed on DMICP and it is the unit's responsibility to upload the current in-date copy, signed by the SP, to PAPMIS. All existing hard copies of Appendix 9 are to be uploaded to a SP's PAPMIS Library to ensure complete histories are retained on PAPMIS.

78.1311. Appendix 18. This is the Occupational Report on a SP for Employment Purposes (including FWA). **It must be completed annually for all permanently downgraded**

personnel[146] (and can be completed for any downgraded person who would benefit from it). Initiated by the sub unit and authorised by the sub unit OC. The form is completed through PAPMIS and printed copies of the Appendix 18 should be retained in the SPs P file (especially as 'refreshing' the Appendix 18 annually will overwrite the previous content).

78.1312. Appendix 27. This is the Unit Implications Brief. **Must be completed for all MND(P) personnel**[147] and should be given to the SP before an employment decision is made. It should be reviewed annually and updated where required. The Appendix 27 is not required for BT/ITT trainees undergoing Appendix 21 where the ARITC Appendix 21 SOI Annex F is used (as the Annex F performs the same function).

78.1313. Appendix 26. This is the Deployment Medical Risk Assessment Form. This form is the obligatory risk assessment which must be completed for SPs graded below MFD prior to deploying on overseas exercise or operations where necessary (see **78.517** and **78.1013**). An appendix 26 is not required for exercise within the UK within the limitations of the SP's Appendix 9 (the CoC may choose to conduct an Appendix 26 if a specific risk relating to the exercise is identified). The form is to be used to provide a risk assessment for a SP's training, deployment against a specified role or suitability to be employed in a @R ORBAT. The document is to be generated by the sub unit, in consultation with the Appendix 9 and authorised by the CO with MO guidance.

78.1314. Appendix 21/28. This is the Application for Transfer or Discharge of BT/ITT trainees (Appendix 21) or Application for an Employment Offer for SP graded L5 MND(P) (Appendix 28). An Appendix 28 must be initiated by the unit when a soldier is downgraded to L5 MND(P) (or MLD(P) in exceptional circumstances). The Appendix 28 must be authorised by the CO. Printed copies of the Appendix 28 should be retained in the SP's P file and a scanned image of the signed copy should be uploaded into the PAPMIS Record Library. **Appendix 28s that are not signed by the CO (or an appointed Field Officer where the CO is absent) will be rejected**.

78.1315. PAPMIS Queries. There is no formal training package for PAPMIS, however support is available via the PAPMIS team RC-PERS-ARC-PAPMIS-0Mailbox@mod.gov.uk]. Issues with PAPMIS functionality should be addressed through the unit CoC, before being elevated to Bde and then Div levels. For IT related PAPMIS issues, users are to submit an incident report via the Army Information Front Door https://itsm.ahe.r.mil.uk/ux/myitapp/#/catalog/home.

78.1316. Summary. PAPMIS is an essential tool in managing SPs who do not meet the required JMES for their Arm or Service, but it must be used correctly. It is imperative that all commanders and managers within the Unit Health Management chain embrace and utilise PAPMIS to help improve the deployability and Combat Effectiveness of the Army.

78.1317 – 78.1400. Reserved.

[146] Less those in basic or Initial Trade Training.
[147] Exceptionally completed for SP who are MLD(P) when an employment decision is being made and authority has been given by WF Pol to proceed.

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Table 1

Minimum Medical Standards for Officers, by Arms, On Entry and on Commission

Serial	Arm	P	U	L	H	H	E	M	S	CP	Refer to Note
1	Household Cavalry	2	2	2	2	2	8/2 8/6	2	2	4	4
2	RAC	2	2	2	2	2	8/2 8/6	2	2	4	4
3	RA	2	2	2	2	2	8/3 8/6	2	2	4	
4	RE	2	2	2	2	2	8/3 8/6	2	2	4	
5	R SIGNALS	2	2	2	2	2	8/3 8/6	2	2	4	
6	Foot Guards	2	2	2	2	2	8/3 8/6	2	2	4	
7	Infantry (incl PARA[redacted])	2	2	2	2	2	8/3 8/6	2	2	4	
8a	[redacted]	[redacted]									
8b	[redacted]	[redacted]									
9a	AAC Pilot	See Appendix 6 for Entry Standards to Army Flying Appointments									
9b	AAC DE Ground Officer	2	2	2	2	2	7/2 7/3	2	2	3	6
10	RAChD	2	2	2	2	2	8/3 8/6	2	2	4	
11	RLC[151]	2	2	2	2	2	8/3 8/6	2	2	3	
12	RAMC	2	2	2	2	2	8/3 8/6	2	2	4	
13	REME	2	2	2	2	2	8/2 8/6	2	2	4	4
14a	AGC: RMP/MPS	2	2	2	2	2	8/3 8/6	2	2	3	
14b	AGC: All other	2	2	2	2	2	8/3 8/6	2	2	4	
15	RAVC	2	2	2	2	2	8/3 8/6	2	2	4	
16	RADC	2	2	2	2	2	8/3 8/6	2	2	4	
17	INT Corps	2	2	2	2	2	8/3 8/6	2	2	2	
18	General List	2	2	2	2	2	8/3 8/6	2	2	4	
19	QARANC	2	2	2	2	2	8/3 8/6	2	2	4	
20	RCAM	2	2	2	2	2	8/2 8/6	2	2	4	4, 5

[redacted]

[151] Port and Maritime Regulations may require CP1 (See MSN 1756 (M)) Seafarer Medical Examination System and Medical any Eyesight Standards (to be superseded by MSN 1822(M) dated 6 Apr 10).

Notes:

1. Officers of any Arm employed as parachutists or attached to the PARA [redacted] must conform to the medical standard required for entry to those regiments as either badged or attached ranks as appropriate.

2. Officers employed on the crew of armoured vehicles (irrespective of cap-badge) must have visual acuity of not less than (also see Note 4):

E
$\frac{8}{2}$ $\frac{8}{6}$

3. Officers who are to be employed in the handling of food are to undergo a special medical examination and be certified by a Medical Officer (MO) to be in a fit state of health in accordance with the policy contained in Chapter 4 to Volume 3 (Defence Food Safety Management) of JSP 456 (Defence Catering Manual). Food handling is not permitted until this process has been successfully completed.

4. Unless stated otherwise, the only eye specific requirement is that all entrants to the Army must be at least E3 in the right eye. As long as this criterion is met, side specific standards requiring a higher VA than E3 may be reversed. For example:

Tabled Grade	Acceptable Alternative
$\frac{8}{2}$ $\frac{8}{6}$	$\frac{8}{3}$ $\frac{8}{2}$

5. RCAM standards apply to Officers in Army Reserve bands.

6. If candidate fails Ishihara Pseudo-Isochromatic Plates testing by Holmes-Wright or Fletcher CAM Lantern is mandatory to ensure red/green, signal colour safety, IAW JSP 950.

7. Candidates to the Army with hearing impairment identified by audiometry must be graded according to Annex A to SHAPL 001/16. Candidates considered MLD by in-service standards must be graded *medically unfit for service* (P8), unfit for entry. The suitability for Army service of those candidates who attract an E2 JMES marker must be discussed with ARITC Occ Med.

Table 2

Minimum Medical Standards for Entry to the Army, by Arm and Employment - Soldiers

MINIMUM MEDICAL STANDARDS FOR ENTRY TO THE ARMY FOR SOLDIERS											
Serial	**Arm and Employment/CEQ**	**P**	**U**	**L**	**H**	**H**	**E**	**M**	**S**	**CP**	**Refer to Notes**
1	**Household Cavalry** AFV Crewman/Mounted Duty	2	2	2	2	2	8/2 8/6	2	2	4	3
2	**RAC** AFV Crewman	2	2	2	2	2	8/2 8/6	2	2	4	3
3	**RA** (all)	2	2	2	2	2	7/2 7/3	2	2	4	
4	**RE** ME (Heating & Plumbing)	2	2	2	2	2	8/3 8/6	2	2	2	9
	RE ME (Surveyor Engineering)										
	RE ME (Draughtsman) (all)										
	RE ME (Bldg. & Structural Finisher)										
	RE ME (Electrician)	2	2	2	2	2	8/3 8/6	2	2	2	3, 9
	RE ME (Geographic Technicians)[152]	2	2	2	2	2	7/2 7/3	2	2	2	9
	RE ME (Construction Materials Technician)										
	RE ME (Fitter General)										
	RE ME (Air Con & Refrigeration)	2	2	2	2	2	8/3 8/6	2	2	2	9
	RE ME (C3S)[166]	2	2	2	2	2	7/2 7/3	2	2	4	
	RE ME (Plant Op Mechanic)										
	RE ME (Plant Operator) (Reserve)										
	RE ME (Driver)[166]										
	RE ME (Amphibious) (Reserve)										
	RE ME (Engr Log Specialist)										
	RE ME (Logistic Specialist) (Reserve)										
	RE EOD&S	2	2	2	2	2	8/3 8/6	2	2	2	2
	RE ME (Armoured)	2	2	2	2	2	7/2 7/3	2	2	4	3
	RE ME (Combat)[166]	2	2	2	2	2	8/3 8/6	2	2	4	
	RE ME (Bricklayer & Concreter)										
	RE ME (Carpenter & Joiner)										
	RE ME (Fabricator)										
	RE ME (Search) (Reserve)										
	RE ME (Platelayer) (Reserve)										
	RE ME (Infrastructure) (Reserve)										
	RE Bandsman										
5	**R SIGNALS** Network Engineers	2	2	2	2	2	8/3 8/6	2	2	3	
	R SIGNALS Communications Infrastructure Engineers										
	R SIGNALS Information Services Engineer										
	R SIGNALS Electronic Warfare Signals Intelligence	2	2	2	2	2	7/2 7/3	2	2	4	
	R SIGNALS Supply Chain Operator										
	R SIGNALS Power Engineer	2	2	2	2	2	7/2 7/3	2	2	2	
6	**Foot Guards** (all)	2	2	2	2	2	8/3 8/6	2	2	4	

[152] Applies to all TACOS (Regular and Reserve)

MINIMUM MEDICAL STANDARDS FOR ENTRY TO THE ARMY FOR SOLDIERS											
7	**Infantry** (all) (incl **PARA**)	2	2	2	2	2	8/3	8/6	2	2	4	
8	**Brigade of Gurkhas**	2	2	2	2	2	8/3	8/6	2	2	4	
9	[redacted]	[redacted]										
	[redacted]	[redacted]										
10	**AAC** Pilot	No direct entry for OR pilots										
	AAC Soldier	2	2	2	2	2	7/1	7/3	2	2	3	3
11	**RLC** Air Dispatcher	2	2	2	2	2	5/2	7/2	2	2	3	5
	RLC Mariner[156]	2	2	2	2	2	3/1	3/1	2	2	2	6
	RLC Marine Engineer	2	2	2	2	2	7/1	7/6	2	2	3	3
	RLC Driver	2	2	2	2	2	7/1.5	7/1.5	2	2	4	
	RLC Port Operator **RLC** Driver (Comms specialist) **RLC** Postal and Courier Operator **RLC** Logistic Specialist (Supply) **RLC** Movement Controller	2	2	2	2	2	7/2	7/3	2	2	4	
	RLC Ammunition Technician **RLC** Petroleum Operator	2	2	2	2	2	7/2	7/3	2	2	3	6
	RLC Railway Operator	2	2	2	2	2	1/1	6/3	2	2	2	6
	RLC Pioneer **RLC** Chef	2	2	2	2	2	8/3	8/6	2	2	4	7
12	**RAMC**	2	2	2	2	2	8/3	8/6	2	2	4	
13	**REME** Vehicle Mechanic	2	2	2	2	2	7/2	7/3	2	2	3	3
	REME Armourer	2	2	2	2	2	7/2	7/6	2	2	4	
	REME Metal smith										3	
	REME Technician Electronics										2	3
	REME Technician Aircraft										2	
	REME Technician Avionics										2	
	REME Shipwright										3	
	REME Recovery Mechanic	2	2	2	2	2	7/2	7/3	2	2	4	
	REME Technical Storeman	2	2	2	2	2	7/2	7/6	2	2	4	
14	**AGC (RMP)**	2	2	2	2	2	8/3	8/6	2	2	4	
15	**AGC (MPS)**	2	2	2	2	2	8/3	8/6	2	2	3	
16	**AGC (MPGS)**	3	3	3	2	2	8/3	8/6	2	2	4	
17	**AGC (SPS)**	2	2	2	2	2	8/3	8/6	2	2	4	
18	**RAVC**	2	2	2	2	2	8/3	8/6	2	2	4	
19	**SASC**	2	2	2	2	2	8	8	2	2	4	

[redacted]

[156] Port and Maritime Regulations may require CPI (See MSN 1756 (M)) Seafarer Medical Examination System and Medical any Eyesight Standards (to be superseded by MSN 1822(M) dated 6 Apr 10).

MINIMUM MEDICAL STANDARDS FOR ENTRY TO THE ARMY FOR SOLDIERS											
							3 6				
20	**RADC**	2	2	2	2	2	8/3 8/6	2	2	4	
21	**INT CORPS**	2	2	2	2	2	8/3 8/6	2	2	2	
22	**RAPTC**	2	2	2	2	2	8/3 8/6	2	2	4	
23	**Locally Enlisted Personnel**	2	2	2	2	2	8/3 8/6	2	2	4	
24	**QARANC** Student Nurse **QARANC** Qualified Nurse **QARANC** Healthcare Asst	2	2	2	2	2	8/3 8/6	2	2	4	
25	**RCAM**	2	2	2	2	2	8/2 8/6	2	2	4	3, 8
26	**RLC/EFI** All	2	2	2	2	2	8/3 8/6	2	2	3	

Notes:

1. SPs employed as either a driver or commander of armoured vehicles (irrespective of cap-badge) must have visual acuity of not less than.

E
8/2 8/6

2. SPs employed as a driver of a vehicle requiring a C licence (irrespective of cap-badge) must have visual acuity of not less than (also see note 1).

E
7/2 7/3

3. Unless stated otherwise, the only eye specific requirement is that all entrants to the Army must be at least E3 in the right eye. As long as this criterion is met, side specific standards requiring a higher VA than E3 may be reversed. For example:

Tabled Grade	Acceptable Alternative
8/2 8/6	8/3 8/2
8/1 8/6	8/3 8/1

4. The full Air Dispatcher medical standard is published in Air Publication AP1269A - Assessment of Medical Fitness in the Royal Air Force at Leaflet 4-04, Annex W.

5. See Part 8 for the full aircrew medical standards.

6. Holmes/Wright or Fletcher CAM Lantern Test is mandatory.

7. Soldiers who are to be employed in the handling of food are to undergo a special medical examination and be certified by a medical officer to be in a fit state of health in accordance with the policy contained in Chapter 4 to Volume 3 (Defence Food Safety Management) of JSP 456 (Defence Catering Manual. Food handling is not permitted until this process has been successfully completed.

8. RCAM standards apply to musicians in Army Reserve bands.

9. Colour Perception level 2 required.

10. Candidates to the Army with hearing impairment identified by audiometry must be graded according to Annex A to SHAPL 001/16. Candidates considered MLD by in-service standards must be graded *medically unfit for service* (P8), unfit for entry. The suitability for Army service of those candidates who attract an E2 JMES marker must be discussed with Occupational Medicine at Army Recruiting and Training Division.

[redacted]

[redacted]

[redacted]

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	[redacted]	[redacted]		[redacted]			[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Table 4a

Minimum Retention JMES Coding for Officers

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	MND
1	Minimum JMES Coding – for trained Officers all ranks (less those listed below)	A4L1M4E2	A4L4M4E4	below retention standard
2	Minimum JMES Coding - FTRS (LC/HC), MPGS and limited Army Reserve (UK only)	A4L1M4E2	A4L4M4E4	A4L5M4E5

Assumption: E6 coding automatically leads to a MND Temporary grading.

Table 4b

Minimum Retention Eyesight Employment Standards for Officers

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	(MND)
1	Minimum Eyesight Grading (less those listed below)	8 8 3 6	8 8 3 8	8 8 3 8
2	[redacted]	[redacted]	[redacted]	[redacted]
3	AAC - Pilots	5 5 1 1	7 7 1 1	7 7 1 1
4	AAC - Ground Appointments (pilots and non-pilots)	7 7 2 3	7 7 2 3	7 7 2 3
5	RAChD	8 8 6 6	8 8 6 8	8 8 6 8
7	RLC	8 8 3 6	8 8 3 6	8 8 3 8
8	RAMC	8 8 3 6	8 8 3 6	8 8 3 8
9	REME	8 8 2 6	8 8 3 8	8 8 3 8
10	RAVC	8 8 3 6	8 8 3 6	8 8 3 6

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	(MND)
11	RADC	8 8 3 6	8 8 3 6	8 8 3 6
12	INT CORPS	8 8 3 6	8 8 3 6	8 8 3 6
13	RAPTC	8 8 3 6	8 8 3 6	8 8 3 6
14	LE Commissions (all Arms)	8 8 3 6	8 8 3 8	8 8 3 8
15	Staff (Colonel & above)	8 8 3 6	8 8 3 8	8 8 3 8
16	QARANC	8 8 3 6	8 8 3 6	8 8 3 6
17	RCAM	8 8 2 6	8 8 3 6	8 8 3 6

Table 5a

Minimum Retention JMES Coding for Soldiers

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	MND
1	Minimum JMES Coding (less those listed below)	A4L1M4E2	A4L4M4E4	below retention standard
2	RLC Seaman/Navigator	A4L1M1E2	A4L4M3E4	below retention standard
3	Minimum JMES Coding – FTRS (LC/HC), MPGS and limited Army Reserve (UK only)	A4L1M4E2	A4L4M4E4	A4L5M4E5

Assumptions:

1. All soldiers with a JMES coding below those listed under MLD are by definition MND.
2. An E6 coding automatically leads to a MND Temporary grading.

Table 5b

Minimum Retention Eyesight Employment Standards for Soldiers

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
1	Minimum Eyesight Grading (less those listed below)	$\frac{8}{3}\ \frac{8}{6}$	$\frac{8}{3}\ \frac{8}{8}$
2	RE (trades listed below only): ME (Driver) ME (Driver Specialist (Plant Transporter)) ME (Driver Specialist (Crane)) ME (Driver Specialist (Automotive Bridge Launching Equipment)) ME (Amphibious) (Reserve) ME (Driver Specialist (Tank Bridge Transporter)) ME (Resources Specialist) ME (Logistic Specialist) (Reserve) ME (Armoured Engineer) ME (Plant Operator Mechanic) ME (Plant Operator) (Reserve)	$\frac{7}{2}\ \frac{7}{3}$	$\frac{7}{2}\ \frac{7}{3}$

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
	ME (Geographic Technician)[157] ME (Construction Materials Technician) ME (C3S)[171] ME (Fitter Gen)		
3	R SIGNALS (trades listed below only): Foreman of Signals Yeoman of Signals Foreman of Signals (Information Systems) Yeoman of Signals (Electronic Warfare) Networks Engineer Electronic Warfare Signals Intelligence Power Engineer Supply Chain Operator Information Services Engineer Communications Infrastructure Engineer [redacted]	7 7 2 3 8 8 [redacted]	7 7 2 3 8 8 [redacted]
4	Infantry (trades listed below only): Dvr Lic Cat C & E Dvr Lic Cat B & E	7 7 2 3 8 8 3 6	7 7 2 3 8 8 3 6
5	[redacted]	[redacted]	[redacted]
6	AAC – Pilots	5 5 1 1	7 7 1 1
7	AAC - Ground Appointments (pilots and non-pilots)	7 7 2 3	7 7 2 3
8	RLC (trades listed below only): Driver Driver (Communications Specialist)		

[157] Applies to all TACOS (Regular and Reserve)

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
	Driver (Tank Transporter) Port Operator Ammunition Technician Postal and Courier Operator Logistic Specialist (Supply) Vehicle Support Specialist Photographer Petroleum Operator Chef Systems Analyst	7 7 2 3	7 7 2 3
	Air Dispatcher	5 5 2 2	5 5 2 2
	Mariner	3 3 1 1	3 3 1 1
	Marine Engineer	7 7 1 6	8 8 3 6
	Movement Controller	7 7 2 6	8 8 3 8
9	RAMC	8 8 3 6	8 8 3 6

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
10	REME (trades listed below only): Artificer Vehicles Recovery Mechanic Vehicle Mechanic Artificer Aviation Artificer Weapons Artificer Electronics Technician Avionics Technician Aircraft Metal smith Armourer Electronics Technician Technical Support Specialist	7 7 2 3 7 7 2 7	7 7 2 3 7 8 3 8
11	RAVC	8 8 3 6	8 8 3 6
12	SASC	8 8 3 6	8 8 3 6
13	RADC	8 8 3 6	8 8 3 6
14	INT CORPS	8 8 3 6	8 8 3 6
15	RAPTC	8 8 3 6	8 8 3 6
16	QARANC	8 8 3 6	8 8 3 6

Note: SPs employed as a driver of a vehicle requiring a C licence (irrespective of cap-badge) must have visual acuity of not less than 7/2 x 7/3.

Table 6

Functional Interpretation of JMES / PULHHEEMS Grades

P - Physical Capacity U – Strength, Range of Movement & General Efficiency of Upper Arm, Shoulder & Upper Back L - Strength, Range of Movement and Efficiency of Feet, Legs, Pelvic Girdle and Lower Back	MDS	Function Capacity and Employment/ Deployment Limitations
	Medically Fully Deployable (MFD)	**Medically Fit For Unrestricted Service Worldwide (L1)**. The absence of a medical condition or functional limitation that would prevent the SP from undertaking all elements expected of both rank and Career Employment Group (CEG) in barracks and whilst deployed on any unrestricted world-wide operation.
		Objective Tests: • Ability to pass all MATTs which means physically 'fit to attempt', enabling the start of any required build up training (completion of MATTs is not required for the award of MFD)[158]
	Medically Limited Deployability (MLD)	**Medically Fit For Duty With Minor Employment Limitations (L2-4)**. A SP who has a medical condition or functional limitation that prevents the meeting of all MFD requirements. The SP must: • Be able to undertake full-time employment in barracks, there may be minor limitations on their employment on exercise or deployments. • Not be vulnerable to a significant deterioration of their condition if there is an interruption to the supply of medication[159], delay in planned medical review or interruption in treatment. • Not impose a significant and / or constant demand on the medical services if deployed. • Have no limit in their ability to function wearing personal equipment demanded of the environment and their CEG and rank. • Not be vulnerable to exacerbation of their medical condition as a result of deployment or employment providing reasonable precautions are put in place.
	Medically Not Deployable (MND)	**Medically unfit for deployment. Fit for branch/trade and limited UK operations (L5)**. A SP who has a medical condition or functional limitation that prevents the meeting of all MLD requirements. They may require regular, continued medical care or supervision, regular long-term medication and/or access to secondary level (hospital) medical facilities. They are not fit to deploy on military operations but should be able to deploy on exercises in the UK and limited British bases overseas[160], subject to the appropriate risk assessment. If employed in accordance with their CEG the condition or functional limitation should not be exacerbated. The SP must be: • Capable of performing the requirements of their CEG and/or formally established (i.e. has a PiD) employment within limits of restrictions. • Able to work effectively for at least 32.5 hours per week (inc: 1 hr per day for treatment or rehabilitation, not including travel time).
		Medically Unfit for Service in the land environment (L6). The SP meets one or more of the following criteria: • Unable to independently organise and manage travel to work requirements. • Unable to perform the SP's primary employment/CEG with reasonable adaptation and restrictions. • Unable to work effectively for 32.5 hours per week. • Employment would exacerbate the SP's condition and have a significant effect on the SP's health. And, depending on employment of SP: • Unable to pass MATT 1 Level 2 (including all live firing), or being unable to independently adopt required firing positions unless Appendix 18 is explicit that the SP is able to carry out the functions of their current employment **and** the CO supports waiving the requirement to use weapons which would enable an L5 grade (see 78.1017).

[158] As mandated by the SPs current role/assignment.
[159] This requirement may be waived in the MLD grade following discussion with CAOM / ROHT: in such cases the Appendix 9 must be explicit that uninterrupted supply of medication is essential and specify whether this is reliant on a reliable cold chain.
[160] For example employment in BATUS - CROWFOOT, but only where medical facilities exist to accommodate the requirements of the condition or limitation.

	JMES	Medically Fully Deployable (MFD)	Medically Limited Deployability (MLD)	Medically Not Deployable (MND)	
	P Grade	2	3	7	8
HH	**Audiometrically Assessed Acuity of Hearing.**	Acceptable practical hearing for service purposes.	Impaired hearing but the SP is able to fire a personal weapon with normal or operationally issued hearing protection, operate equipment related to their CEG and communicate using telephone or radio without significant medical restrictions and without likelihood of causing further hearing damage.	Impaired hearing but the SP is able to fire a personal weapon with additional hearing protection, operate equipment related to their CEG and communicate using telephone with medical restrictions and without likelihood of causing further hearing damage.	Unable to safely fire personal weapon or operate equipment related to the SP's CEG, with hearing protection, or communicate using a telephone without likelihood of causing further hearing damage.
EE	**Visual Acuity. The Degrees under EE are Simple Records of Distant Visual Acuity**	Right eye correctable to 6/12			Right eye not correctable to 6/12 (E3) or loss of sight in both eyes.
M	**Mental Capacity**	The absence of a medical condition affecting normal mental function.	The presence of a limitation to mental function likely to affect the SP's ability to perform in their CEG. Able to perform commensurate with the SP's CEG, current rank and training. Able to provide supervisory, leadership and management responsibilities commensurate with their rank and CEG. Fit to perform MATTs.	Able to read, speak and to operate a computer (or be trained to do so). Able to perform commensurate with the SP's CEG, current rank and training. Able to provide supervisory, leadership and management responsibilities commensurate with their rank and CEG.	Unable to either: - read - speak - operate a computer - undertake training - provide supervisory, leadership and management responsibilities commensurate with their current rank and CEG.
S	**Emotional Stability (Combat Temperament)**	The absence of a medical condition affecting normal emotional stability.	The presence of a minor limitation to emotional stability likely to affect the SP's ability to perform in their CEG and at their appropriate rank. Fit to attempt ACMT and pass all MATTs. Able to handle live ammunition and operate a weapon without any risk to themselves or others.	The presence of a significant limitation to emotional stability likely to affect the SP's ability to perform in their CEG and at their appropriate rank. Not able to handle live ammunition and operate a weapon without risk to themselves or others for a period not exceeding 12 months. Able to function within a military work environment.	The presence of a major limitation to emotional stability likely to affect the SP's ability to perform in their CEG (at their substantive rank). Unable to function in a military work environment or handle live ammunition for a period exceeding 12 months.

APPENDIX 1 TO CHAPTER 78

GUIDANCE FOR MEDICAL OFFICERS

Completion of FMED 23

1. The FMed 23 is used to justify the findings of a FWA and record any recommendations made. The narrative should not be an exhaustive repetition of the medical history but rather a targeted synopsis of any pertinent facts, alongside the justification for the board's recommended JMES and outcome.

2. This guidance on the completion of the FMed 23 is provided in order to ensure all relevant information is consistently and clearly provided[161]. When other documents in the electronic health care record are referred to, they should be referenced and if loose leafed sheets are incorporated, personal details (minimum service number, rank and name) and the date of the board must be included on each sheet.

Procedure

3. For convenience, the front sheet of the FMed 23 (see pages App 1-6 & 1-7) has been annotated with numbers referred to in the notes below. The relevant boxes on the FMed 23 should be completed in line with the guidance notes below.

Guidance Notes Relating to Annotated FMed 23 Front Sheet:

*1. **Full Service Number**. Self-explanatory.*

*2. **Rank/Rating**. Use the approved abbreviations.*

*3. **Branch/Trade**. Use the approved abbreviations (e.g. RLC/Dvr, RAMC/Cbt Med Tech etc). Branch and Trade names are subject to change, and the correct terminology should be checked with the patient at the time of the Board during the initial interview.*

*4. **Total Full Time Service**. NOT REQUIRED.*

*5. **Surname and Forename(s)**. Current full names, as they appear on the medical record, should be used.*

*6. **Dates.** To avoid any possible confusion with dates, the correct Service date format should be used throughout. This is in the form of numbers for the day, a 3-letter abbreviation for the month, and 2 numbers for the year, such as 08 Dec 15.*

*7. **Command**. NOT REQUIRED.*

*8. **Ship/Unit/Station**. NOT REQUIRED.*

*9. **Type of Enlistment / Commission**. NOT REQUIRED.*

*10. **Authority of Board**. The extant Army Medical Regulations.*

*11. **Principal Condition(s) Affecting the Medical Employment Standard Leading to FWA**. This section should be completed with all conditions leading individually or*

[161] Additional guidance on the completion of FMed 23 for candidates discharged from training is at para 5.

collectively to the overall P grade which then relates to the JMES. For example, in a board grading L5 MND perm, only those conditions attracting a grade of L5 should be listed here.

*12. **Place of Board**. This will normally be listed as the Medical Centre or ROHT.*

*13. **Date of Board and Signatures**. All dates for the Board are to be the same and are to be the date on which the patient was seen and the PES awarded. Dates of the signing, if recorded, should reflect the date of signature itself.*

*14. **Other Condition(s) Affecting the Medical Employment Standard at the Time of the FWA**. Details of other medical conditions affecting the patient and that would result in a lowered JMES. Resolved or minor conditions should not be listed.*

*15. **Date (of Principal and other Conditions)**. The date listed should be as accurate as possible, to the day. If the exact date of onset is uncertain, such as when a patient presents late with a problem, then the date of presentation should be stated with the fact noted (e.g. 01 Feb 08 (presented)), and the matter noted in the narrative (e.g. "on 01 Feb 08, LCpl Bloggs presented with a history of wheeze of several months duration"). A separate date should be noted for each condition listed, using the same numbering system.*

*16. **Place of Origin**. The Place of Origin should be confined to a broad geographical area, (e.g. UK, Germany, SBA Cyprus, or USA etc). If the event occurred on operations, then list the operation name (e.g. Op HERRICK). A separate place should be noted for each condition listed in the Principal Disabilities box, using the same numbering system.*

*17. **Ceased Duty On**. NOT REQUIRED.*

*18. **PULHHEEMS and JMES**. The PULHHEEMS and JMES blocks should be completed in accordance with JSP 950.*

*a. **Place, Type and Date of Next FWA**. If the FWA wishes to review a PES at a set interval, the appropriate information should be entered here.*

*b. **Probable Period of Unfitness**. Those awarded a JMES other than L5E5 are deemed to be fit. For those graded L5E5 temp the probable period of time before return to duty / next FWA should be noted**.** If a period of SL is granted, then the appropriate period should be noted here.*

c. Any employment restrictions should be recorded here.

*19. **Normal Date of Termination**. NOT REQUIRED.*

*20. **Narrative for FWAs.** The following information should be recorded noting that the quality of an FMed 23 narrative is not dependent on its length and using bullet points will convey information clearly and concisely. There is no requirement to replicate the DMICP record; a brief summary of relevant events will suffice. It is essential to assess functional capacity, identify employment restrictions, comment on risk and interpret findings in accordance with the standards set at MEP, Table 6. A four paragraph approach is suggested to help order thoughts and ensure all relevant information is included:*

*a. **History**. Provide a brief overview. Start dates are useful but the date of every operation / admission is not required[162]. The names of treating consultants, hospitals and lengthy descriptions of causation are only required if they assist with*

[162] e.g. Injury caused by x doing y on date z in location a whilst on/off duty or illness diagnosed date x major treatment interventions have included: DMRC/ RRU/ PCRF/ injection.

understanding the current situation. Significant medical history and current medication are required.

*b. **Summary of Current Situation**. Describe current symptoms and identify stage of rehabilitation / treatment[163]. How and where is the soldier employed; including working hours, length of current employment and workplace adaptation required to facilitate employment. Include social circumstance if informative.*

*c. **Functional Capacity Evaluation**. The bulk of the narrative should be in this paragraph and include any relevant examination. Begin with the limit of their function[164], what can the soldier do/ not do include the activities of daily living.[165] What effects do their injuries or conditions have on their ability to work in their current rank/trade or any other military role. Comment on recovery time needed after an activity.[166]*

*d. **Recommendation**. Comment on the risk the condition represents and interpretation of how your assessment translates to the employers' standards as set out in table 6 to PAP[167]. You are drawing a conclusion here that will justify altering the soldier's grade. It should be coherent and make sense to the second member of the board. If it does not the second member should reflect this to the initiating doctor as this represents the built-in quality control in the process.*

*21. **Narrative for FWAs grading Medically Unfit for Service L6 MND Perm**. The following information should be recorded noting that the quality of an FMed 23 narrative is not dependent on its length and using bullet points will convey information clearly and concisely. There is no requirement to replicate the DMICP record; a summary of relevant events will suffice. It is essential to assess functional capacity, identify employment restrictions, comment on risk and interpret findings in accordance with the standards set at PAP, table 6.*

*a. **Narrative**. Present at board, documents used at board, purpose of board, current / previous employment activities (including adaptations), social History.*

*b. **Principal Condition(s)**. History, previous, current and planned treatment and/or rehabilitation, current situation, prognosis, advice on estimated further time required for DMS specific care.*

*c. **Other Condition(s)**. History, previous, current and planned treatment and/or rehabilitation, current situation, prognosis, advice on estimated further time required for DMS specific care.*

*d. **Current Situation**. Current medication, current mobility aids, functional capacity evaluation with reference to Table 6, activities of daily living, employer's perspective, SP's perspective and mental health evaluation.*

*e. **Recommendations of The FWA**. Grading outcome and justification (as per table 6), recommendations to SP, Medical Officer, employer and for APC on LDoS (including justification) justification.*

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[163] e.g. The most recent specialist opinion was that diagnosis is x, treatment is y and prognosis is z.
[164] e.g. Can walk 5 miles maximum pain free.
[165] These include communication; eating and drinking; elimination; washing and dressing; mobilising; social circumstances and sleeping.
[166] e.g. Currently able to work a 37.5 hr week; however, requires maximum pain relief to achieve this; has to spend weekend recovering.
[167] e.g. *They are MND perm because they cannot do a, b or c, would not be able to withstand x, y, z or their medical condition cannot be supported. May presents a risk to the deployed med chain. This condition may change in X years / will not change ever.*

f. Confirmation that the patient understands the on-going treatment and prognosis and that the SP, has been given the opportunity to ask questions and clarify any points, has consented to the ROHT accessing their medical records, has been offered a copy of the FWA, has asked to see the FWA before it is released to APC (iaw AMRA 88), has consented to the distribution of the FMed23 used App 17.

*22. **Narrative Additional Information Relating to Army Candidates During Training**. A contemporaneous version of FMed 23 is to be used and, if loose-leafed sheets are incorporated, personal details (minimum name and service number) are to be included on each sheet. The completion of a FMed 23 for every medical discharge recommendation is mandatory. The FMed 23 must contain sufficient information to justify the recommendation made, i.e. contain sufficient details of history, examination, investigation results and specialist opinion, allowing the Confirming Officer to be able to determine a recommendation for discharge (without reference to the contents of the Medical Record)[168]. FWA(P) ratifying consultants are to ensure that the FMed 23 is completed fully and accurately by the board member. The following minimum information is to be included on the FMed:*

a. Date and place of pre-service medical examination.

b. Date of and place of IME.

c. Diagnosis and history including date of onset (and week of training of initial presentation). Include details of back-squadding if appropriate.

d. If the medical condition existed pre-service, provide details of the following:

(1) Was the condition declared/undeclared?

(2) The source of information, e.g. RG8 Part 1/GP records.

(3) Was the trainee encouraged to withhold declaration and by whom (if applicable)?

e. Summary of examination, investigation, treatment (including rehabilitation and specialist opinion).

f. The board is satisfied that the treatment has been appropriate.

g. Personal aspirations of trainee.

h. Re-join criteria to be satisfied.[169]

i. Recommendations given to SP.

j. Confirmation that the SP has been offered and will be sent a copy of the FMed 23.

k. FWA initiated by (Medical Officer's name).

l. Additional information relating to Army candidates during training.

[168] Although there may be supporting evidence within the Medical Record, this does not necessarily stay with the medical discharge documents as they are further processed.
[169] See Table 5/6.

*23. **President's Signature**. This space is for the President's signature and GMC number. (Electronic signatures may be used).*

*24. **Board Member(s) Details**. These boxes should contain the rank, initials and surnames of the Board President and Member(s) as well as their GMC and NMC numbers and indicate if the member was present or in absentia.*

*25. **Member(s) Signature(s)**. These spaces are for the Member(s) signature(s). (Electronic signatures may be used).*

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MEDICAL IN CONFIDENCE (when completed)

FITNESS FOR WORK ASSESSMENT RECORD

Service No	Rank/Rating	Branch/Trade	Date of entry
See note 1	See note 2	See note 3	NOT REQUIRED
Surname	See note 5	Command / Cap Badge	NOT REQUIRED
Forename(s)	See note 5	Ship/Unit/Station	NOT REQUIRED
Date of Birth	See note 6	Engagement / Commission	NOT REQUIRED
Date and Place of Board	See notes 6, 12 and 13	Normal Date of Termination of Full Time Service	NOT REQUIRED
Authority for Board	See note 10	Ceased Duty On	NOT REQUIRED

Principal condition(s) affecting the medical employment standard leading to the Fitness for Work Assessment		**Other condition(s) affecting the medical employment standard at the time of the Fitness for Work Assessment**	
See note 11		See note 14	
Date(s) of origin	Place(s) of origin	Date(s) of origin	Place(s) of origin
See notes 6 & 15	See note 16	See notes 6 & 15	See Note 16

FINDINGS OF THE BOARD

P	U	L	H	H	E	E	M	S

Period of validity of JMES	

Date awarded	Date of review	Perm / Temp	MDS

Medical Limitations* including any specific restrictions on employability and future plans

See note 18

JMES			
A	L	M	E

*** Codes: 800 – Refer to App 9; 801 – Unfit APWT; 802 – Unfit PFA; 803 – Unfit BCFT**

MEDICAL IN CONFIDENCE (when completed)

MEDICAL IN CONFIDENCE (when completed)

Service Number	Rank / Rating	Surname	Date of Board

Narrative (continued on FMed 15 as necessary)

See Note 20-22

The SP has been advised on the distribution of this information and has given consent.

	Name (with GMC / NMC No.)	Rank	Signature
President	**See note 24**		**See note 23 (FWA(T))**
Ratification	**See note 24**		**See note 25 (FWA(P))**
Member	**See note 24**		**See note 25 (FMB)**

Approval (used for MOD(A) Board)

Discharge approved under QR(Army) para *[insert para]*	**Name**	
	Rank	
Signature of MO	**Appointment**	
	Date	

MEDICAL IN CONFIDENCE (when completed)
OFFICIAL SENSITIVE - PERSONAL

APPENDIX 2 TO CHAPTER 78

INSTRUCTIONS FOR FITNESS FOR WORK ASSESSMENT (TEMPORARY DOWNGRADING) (FWA(T))

1. **Authority.** FWA(T) is convened under the authority of Army Medical Employment Policy (this AGAI). A Medical Officer (MO) must be suitably trained in order to conduct FWA(T)s. FWA(T)s may downgrade SPs for up to 12 months in total at a time[170]. FWA(T) regularly conduct assessments as part of the Appendix 21 however, any board conducted in support of, or likely to lead to an Appendix 28 and all MND perm grades must be passed to a FWA(P).

2. **Composition.** A FWA(T) is to be composed of:

a. A single Suitably Qualified and Experienced (SQEP) member of a Regional Occupational Health Team (ROHT), Cons OM[171], nominated MO, or;

b. Where DPHC Clinical Specialist Service assessment has already been undertaken a Suitably Qualified Experienced (SQEP) Allied Health Professional (AHP) including Specialist Occupational Health Nurse (OHN), Physiotherapist, Psychologist, Community Mental Health Nurse or Psychiatrist have the authority to undertake a FWA(T) to award a restrictive protective JMES of L5E5 for a maximum of 3 months.

3. The appointed clinician conducting the FWA(T) must have current clinical responsibility for the patient or have been provided with recommendations and a clinical overview by the MO with current clinical responsibility for the patient.

4. **Administration.** The findings of a FWA(T) are to be recorded in the subject's usual medical record using an appropriate Read Code for the associated condition and provide clear justification for the JMES awarded, set out an appropriate management plan and make clear arrangements for follow up of the patient In most cases this will be on DMICP but where this is not possible an FMed 23 should be used and recorded on DMICP. FMed 23 form is to be used in cases where a FWA(T) for a BT/ITT trainee leads to initiation of Appendix 21. In all cases, the Board's recommendation (JMES only) is to be communicated to the SP's unit (usually via DMICP link to JPA) and any further restrictions using **Appendix 9**. Gradings of L6E5 MND(T) should be recorded on an **Appendix 10** (PHC) or an **Appendix 11** (ROHT).

5. **Consent.** An Appendix 17 is to be completed and signed in all cases and included in the patient's medical record, usually as a scanned copy on DMICP.

6. **Refusal of consent to release medical information.** Should a medically downgraded SP not consent to the CoC having access to their medical limitation information then the MO is to enter the JMES of A6L6M6E1 onto DMICP. This JMES is not a grade that could occur in any other circumstance and will inform the CoC that the SP has not consented for their medical grade to be released. See **para 78.1027** for more information.

7. **Pregnant Personnel.** For pregnant personnel FMed 790 (Pregnancy Certificate) is also to be initiated.

8. The Appendix 20 appeal process remains applicable.

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[170] Grading JMES L6E5 should usually be done in no greater than three monthly periods and extensions over six months must be carried out by ROHTs Para 78.916 details further.

[171] The Cons OM may be a civilian employed or commissioned MOD Cons OM with current registration with GMC and Faculty Occupational Medicine (FOM) to work in OM. They will have suitable previous and substantial military experience either within DPHC or ROHT and have maintained clinical currency if retired. CAOM is responsible for assuring the delivery organisations that an individual fulfils these criteria and has sufficient familiarity with the extant version of AGAI 78.

APPENDIX 3 TO CHAPTER 78

INSTRUCTION FOR FITNESS FOR WORK ASSESSMENTS (PERMANENT DOWNGRADING) (FWA(P))

1. **Authority.** FWA(P) are convened under the authority of Army Medical Employment Policy (this AGAI). The presiding medical officer must be suitably trained in order to conduct FWA(P)s. FWA(P)s are required to downgrade SPs for any period exceeding 12 months.

2. **Composition.** The President of the board is normally the initiating UMO who should be familiar with the case. The minimum composition of the FWA(P) is a suitably trained MO acting under the authority of ROHT.

a. If the MO with current clinical responsibility for the patient is not the primary member, they should be an additional member (this member may be *in absentia*). Their role is to acknowledge and consider acting on any recommendations made by the board.

b. For all MND (P) grades, a FWA(P) must be ratified by a Cons OM (either present or *in absentia* if necessary)[172]. They are to confirm that the FMed 23 functional limitations are in line with the JMES awarded and that the detail is sufficient should the employment decision lead to a medical discharge.

3. **Administration.** The findings of a FWA(P) are to be recorded on an FMed 23 and retained on DMICP and must provide clear justification for the JMES awarded, set out an appropriate management plan and make clear arrangements for follow up of the patient. The Board's recommendation (JMES only) is to be communicated to the SP's unit (usually via DMICP link to JPA and PAPMIS) and any further restrictions using **Appendix 9**.

4. **Consent.** An **Appendix 17** is to be completed and signed in all cases and included in the patient's medical record, usually as a scanned copy on DMICP.

5. **Refusal of consent to release medical information.** Should a medically downgraded SP not consent to the CoC having access to their medical limitation information then the MO is to enter the JMES of A6L6M6E1 onto DMICP. This JMES is not a grade that could occur in any other circumstance and will inform the CoC that the SP has not consented for their medical grade to be released. See **para 78.1027** for more information.

[172] The Cons OM may be a civilian employed or commissioned MOD Cons OM with current registration with GMC and Faculty Occupational Medicine (FOM) to work in OM. They will have suitable previous and substantial military experience either within DPHC or ROHT and have maintained clinical currency if retired. CAOM is responsible for assuring the delivery organisations that an individual fulfils these criteria and has sufficient familiarity with the extant version of AGAI 78.

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APPENDIX 4 TO CHAPTER 78

INSTRUCTIONS FOR FULL MEDICAL BOARDS

1. **Authority.** A Full Medical Board (FMB) is convened under the authority of Army Medical Employment Policy (this AGAI). It is a consultant led and Medical Officer (MO) delivered service.

2. **Composition**

a. **President.** The President should be a Cons OM where possible a serving Army MO and Cons OM[173] (for recruits this will be Cons OM ARITC). The President is responsible for: ensuring the JMES awarded is in accordance with this document, recording any outstanding issues identified by the Board on the F Med 23 and selecting appropriate members of the Board. The President is not required to be present but their review and ratification of board outcomes is mandatory. In more complex cases, they may choose to attend in person.

b. **Members.** The FMB members comprise two other medical professionals to satisfy Defence requirements stipulated in JSP 950. One member is required to be present if the president is *in absentia* and will be responsible for the smooth running of the Board. Both members may be absent when the president is attending, though one or both may be required to attend at the request of the President. The purpose of the sitting member is to run the board, while the other is to provide *in absentia* scrutiny of the F Med 23 narrative.

c. One member, normally the *in-absentia* member, should be the MO employed by the MoD with current clinical responsibility for the patient[174]. Their role is to acknowledge and consider acting on any recommendations relating to medical care made by the Board. Where appropriate, the member can be invited to attend the Board in person (e.g. at the patient's request or as their RMO).

d. The other sitting member can be any other MoD employed doctor or Occupational Health Nurse at the request of the President, such as a specialist relevant to the patient.

3. **Function.** FMBs are to assess officers and soldiers for invaliding, discharge or retirement recommendations on medical grounds from the Service in grade L6E5 *medically unfit for service* (P8).

4. **Application.** MOs should refer patients to the Army ROHT responsible for an FMB. Referrals for FMB should contain sufficient information to allow the President to convene an appropriate board and provide a brief overview of the case focusing on any outstanding issues, such as treatment.

5. **Pre-Board Administration by Referring MO:**

a. Confirm current Visual Acuity is correctly recorded on DMICP, ensuring accuracy in cases referred for ophthalmic conditions. Screening audiometry should be either confirmed as in date for Army Hearing Conservation requirements (either within last 12 months or since incident leading to referral in the case of instances whereby hearing may have been affected) or arrange for it to be carried out. Where potential hearing loss is detected the MO should act

[173] The Cons OM may be a civilian employed or commissioned MOD Cons OM with current registration with GMC and Faculty Occupational Medicine (FOM) to work in OM. They will have suitable previous and substantial military experience either within DPHC or ROHT and have maintained clinical currency if retired. CAOM is responsible for assuring the delivery organisations that an individual fulfils these criteria and has sufficient familiarity with the extant version of AGAI 78.

[174] The President is authorised to request an alternative member if required, but in such circumstances must ensure that any recommendations relating to medical care arising from the Board are acknowledged by the Medical Officer with current clinical responsibility for the patient.

on the findings without delaying referral where the primary cause for requesting an FMB is not hearing related.

b. A referral is to be made on either an FMed 7 or by consultation entry linked to the referral on DMICP (this may include an Appendix 10). The consultation should contain the Read Code relating to the principal condition leading to referral.

c. Consider opportunistic screening for mental health issues which are prevalent in the population referred for FMB.

d. Request that an Appendix 18 is completed by the unit whilst concurrently referring the patient for FMB. This is a unit responsibility to provide but it is not to delay FMB if the President deems it is not essential for the Board to make its recommendations.

6. Immediate Post Board Administration by ROHT if the FMB grades *medically unfit for service* (L6 Perm):

a. The President of the FMB is to complete an Appendix 12 and provide the patient with a copy and ensure a copy is provided for the unit (ideally sent as a soft copy so that this can be retained on PAPMIS).

b. The President will suggest the patient completes an FMed 24 (personal statement of the history from the patient's perspective) especially where it is felt this will inform APC/Veterans UK (formerly known as VETERANS UK) or if the patient wishes to provide additional information.

c. The President is to ensure that, following the Board, an Appendix 17 is completed by the patient who should be provided with a copy in addition to an Appendix 15. An appropriate Patient Information Leaflet should also be given.

7. If an FMB does not grade *medically unfit for service* ('P8' L6 MND (P)) then either Appendix 2 or 3 should be followed.

8. **Following Completion of an FMB Grading L6E5 MND(P).** The following must be scanned onto DMICP and an email sent to APC-CMOps-OH-Group-Mailbox@mod.gov.uk stating that the App 17b is signed and consent is available for OH APC with a copy of the App 12 attached.

a. Appendices 12 and 17.

b. Appendix 18[175/176] provided by the unit (this is not mandatory). If this information is on PAPMIS[177] then no further action is required.

c. An FMed 24 where completed (this is not mandatory)[178].

d. The completed FMed 23 is to be endorsed (in the text) with a recommendation for discharge under the appropriate paragraph of PAW or QR(Army). Any request for extension to service on the grounds of access to service specific medical care must be clearly justified in the summary paragraph.

[175] In the event the President requires an Appendix 18 for the board's recommendations and it has not been provided, the board should proceed and the FMed 23 narrative should record its absence.
[176] The Appendix 18 is not required for BT/ITT trainees or the Appendix 21 process.
[177] PAPMIS is the electronic version of the process, see Part 13 for more details.
[178] Forwarding of board paperwork should not be delayed beyond 10 working days if it has not been completed.

9. **Notes on the application of the PAW 20 and QR(Army) to leaving the Service on Medical Grounds**.

a. All Officers are to be retired in line with the **PAW 20 paragraph 199.**

b. All Soldiers may be discharged on the basis of the authorities contained in QR(Army). The appropriate paragraphs are summarised below:

(1) **QR(Army) Paragraph 9.381 'Defect in Enlistment Procedure'. This is used for conditions which were overlooked, inappropriately assessed, or were not declared at the time of the initial medical examination.**

(2) **QR(Army) Paragraph 9.382 'Having made a False Declaration to a Question on the Attestation Paper'.** A failure to disclose previous medical discharge from the Service is the only medical reason to invoke this paragraph and a FWA must precede discharge action in these circumstances.

(3) **QR(Army) Paragraph 9.385 'Ceasing to Fulfil Army Medical Requirements, that is, Medically Unfit (for continued duty in their Arm or Service) Under Existing Standards'.** This paragraph applies to a soldier who is graded L5 MND (P) and who has fallen below retention standards for their Arm or Service. The Appendix 28 procedure is to be followed to allow, where appropriate employment in unit or elsewhere. If employment is not possible or the SP does not wish to be retained then discharge action must be taken, see **QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements** for instructions. This QR(Army) paragraph relates to SP with medical limitations that mean further service is not appropriate but are unlikely to be a significant limitation to civilian employment.

(4) **QR(Army) Paragraph 9.386 'Ceasing to Fulfil Army Medical Requirements, that is, Temporarily Unfit for any form of Army Service'.** This applies to a SP graded medically unfit for service ('P8' L6 MND (P)) for a condition that may at a later date improve. SPs discharged under this paragraph are transferred to the Reserve and may be mobilised in future emergencies. If the SP's medical condition is incompatible with this commitment, discharge must be affected under paragraph 9.387.

(5) **QR(Army) Paragraph 9.387 'Ceasing to fulfil Army Medical Requirements, that is, Permanently Medically Unfit for any form of Army Service (now or in the future)'.** This is the correct type of discharge in the grade medically unfit for service ('P8' L6 MND (P)) if the condition is permanent.

10. **Refusal of consent to release medical information. Refusal of consent to release medical information.** Should a medically downgraded SP not consent to the CoC having access to their medical limitation information then the MO is to enter the JMES of A6L6M6E1 onto DMICP. This JMES is not a grade that could occur in any other circumstance and will inform the CoC that the SP has not consented for their medical grade to be released. See **para 78.1027** for more information.

11. **Appeals.** The appeals process is at Appendix 19.

12. **Release Medical.** Personnel graded L6E5 MND(P) at FMB must undergo a combined pre-release and final medical as close as is practical to terminal leave. This is to ensure their medical condition is recorded at the point of discharge and that handover of medical care to the NHS has been completed. The FMed 133 should be issued at this medical.

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APPENDIX 5 TO CHAPTER 78

INSTRUCTIONS FOR THE MOD(A) MEDICAL BOARD

1. **Authority.** The MOD(A) Medical Board is convened when policy (JSP 950 or PAP) is challenged based on additional credible medical evidence. It can only be requested while a SP is still in service however may take place following discharge – an application for a MOD(A) board is not however a justification for an extension in service.

2. **Composition.**

a. **President.** The President is Consultant Adviser in OM (CAOM) or their nominated representative.

b. **Members.** In addition to the CAOM, the board members will include at least two other Cons OM. One member of the board must be the consultant specialty adviser, or their nominated representative, relevant to the patient's condition. The other member must be a Consultant Occupational Physician. A minimum of 2 members plus the President of the board must simultaneously conduct the board. The third member is not required to be present as long as this medical officer has seen the patient previously and is satisfied with the conduct of the board. If two Occupational Medicine consultants are in attendance, then it may be possible for the consultant specialty adviser to attend by VTC.

3. **Function.** The MOD(A) Medical Board may be convened to review the decision of any other medical board.

4. **Application.** Regional Clinical Directors or other MOD Departments may apply to the Chief of Staff, Army Medical Directorate to convene a MOD(A) Medical Board. If approved, SHA(A) is to ask CAOM to initiate a MOD(A) Medical Board. If the findings of a board presided over by CAOM are subject to review by the MOD(A) Medical Board then SHA(A) will nominate an alternative President.

5. **Location.** The MOD(A) Medical Board will be convened at a location most appropriate to the President, members and the patient. Agreement of the patient to the location date and time of the Board will be obtained in writing. If the patient is unable to attend at the agreed Board, the Board may postpone and convene at a further mutually acceptable opportunity. If the patient fails to attend at the second opportunity the Board will normally convene and determine the case irrespective of the absence of the patient. If the patient confirms in writing that they do not wish to attend in person, the Board may convene and consider the case in their absence. In these cases, written representation may be provided.

6. **Administration.** The Regional OH Team QEMH Tidworth will provide the clerical support for the MOD(A) Medical Board unless alternative arrangements are made. A FMed 23 is to be completed and returned to the patient's Medical Centre or other relevant authority.

7. **Confirmation.** The findings of the MOD(A) Medical Board are to be confirmed in writing by the Board President.

8. **AEB.** The medical appeal process (including MOD(A) if relevant) must be completed before any case is considered by the Army Employment Board. If a SP has already had an appeal to the Army Employment Board (AEB) rejected they are not then entitled to appeal to the MOD(A) board. The appeal against the medical grade must be completed prior to an appeal to the AEB.

9. **Appeals.** The decision of the MOD(A) Medical Board is final however a SP may make a Service Complaint under section 334 of the Armed Forces Act 2006 and in accordance with JSP 831.

APPENDIX 6 TO CHAPTER 78

MEDICAL STANDARDS FOR OFFICERS AND SOLDIERS ON ENTRY TO AND DURING SERVICE IN ARMY FLYING APPOINTMENTS

Introduction

1. The Department of Aviation Medicine is responsible to Colonel Army Air Corps for the medical assessments of candidates for Army flying training, the subsequent award of aircrew employment standards and the periodic examination of serving aircrew. The administration of medical examinations and standards differs from other personnel and these differences are highlighted in this Appendix.

2. This instruction describes the medical procedures and appeals process for all Army pilot candidates, including civilian candidates, officer cadets, and military personnel. It also describes the procedures for Army Aviation Crewmen, gives the retention standards for Army aircrew and outlines the procedures for periodic medical examinations. Army Air Corps FWA procedures and appeals processes are described, where they differ from the general procedures.

Entry Standards for Pilot Duties In The Army

3. All Army pilot candidates will be medically examined by a Royal Air Force medical board at Recruitment and Selection, Department of Occupational Medicine (R&S DOM), RAF Cranwell. An aircrew employment standard will be allotted in accordance with *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force*, by the Department of Aviation Medicine at Middle Wallop.

PULHHEEMS Profile

4. The minimum PULHHEEMS profile for Army pilot candidates is as follows:

P	U	L	H	H	E	E	M	S	CP
2	2	2	1	1	$\frac{3}{1}$	$\frac{3}{1}$	2	2	2

Medical Standards

5. **Hearing Standards.** All candidates must have intact tympanic membranes, positive Valsalva tests and no upper respiratory tract pathology. In addition to the standard H grading, candidates will have their audiogram assessed in accordance with the age-related standard below, derived from ISO 1999, to ensure that functional hearing at age 40 remains satisfactory. In order to screen out those who have early progressive Noise Induced Hearing Loss (NIHL), the sum of the high frequency loss should not exceed 123 dB(A) (PULHHEEMS level of H2), and the **average** at 1,2 and 3 kHz must not exceed the age-related limits in the following table. Candidates whose hearing falls outside the standards should be discussed with the Department of Aviation Medicine.

Age	**Average** hearing threshold (1, 2 and 3 kHz)	**Sum** of hearing thresholds (3, 4 and 6 kHz)
18-22	≤ 10	< 123
23-27	≤ 15	< 123
28-32	≤ 20	< 123
33+	≤ 25	< 123

6. **Visual Standards:**

a. Vision in each eye unaided must not be less than 6/12 and each eye must be correctable to 6/6. The strength of the required correction is not to exceed -0.75 to +1.75 dioptres (spherical), and the astigmatic element must not be greater than $\pm$ 0.75 dioptres (cylindrical).

b. Failure of convergence at more than 10 cm may disqualify and will require consideration and/or referral.

c. Accommodation using N5 type, and with correction if required, should correspond to the value in centimetres for the appropriate age group as shown below:

Age (years)	Centimetres
17-20	Up to 11
21-25	11 – 13
> 25	Normal age parameters

d. Corneal Refractive Surgery (CRS) may be acceptable subject to the criteria in AP1269A, Leaflet 5-14. Candidates who have had CRS must be reviewed by the Department of Aviation Medicine and an approved Service Ophthalmologist prior to acceptance into flying training.

e. Full details of the vision standards are available in AP1269A Leaflet 4-02 Annex A.

7. **Anthropometry and Body Weight**. Strict anthropometry and nude body weight limits apply to all candidates, due to the limitations of aircraft cockpits and the crashworthy design features. Full details of current limitations are available in AP1269A Leaflet 4-05 Annex C.

Aircrew Employment Category - Pilots

8. On entry to flying, the JMES of all Army pilots will include one of the following A (aircrew) categories:

a. **A1.** Fit full flying duties.

b. **A2.** Fit full flying duties but either uses visual correction or has a reduction in functional hearing in one or both ears.

c. **A3.** Fit for duties in the air within the stated employment or Med Lims.

Potential Officer Candidates

9. Civilian candidates will be required to complete a pre-selection medical questionnaire, which must be sent to the Army Consultant Adviser in Aviation Medicine (CA Avn Med), HQ AAC, Middle Wallop. A candidate may be rejected based on the results of this questionnaire. The CAM may seek clarification of medical details by writing either to the candidate or to the candidate's general practitioner or hospital specialist with the candidate's consent.

10. If the medical questionnaire is found to be acceptable and the candidate has passed Army Aptitude Testing, they will attend R&S DOM for an aircrew medical board, and the results will be forwarded to the Department of Aviation Medicine. Although the R&S DOM Medical Board is valid for five years, each candidate will be reassessed whilst at RMA Sandhurst, even if the R&S DOM

Medical Board remains within its period of validity. Should new medical evidence become available, a candidate's suitability for flying duties may be reconsidered. The final decision on medical suitability for pilot training will be taken by the Army Consultant Adviser in Aviation Medicine (CA Avn Med) and only once all relevant medical tests have been completed. An appropriate aircrew medical category will be awarded at the start of the Army Pilot Course.

11. **Appeals**. Candidates may appeal against decisions made at the pre-employment medical assessment or after the R&S DOM board. In accordance with Appendix 19, Level 1 appeals are to be directed in the first instance to CA Avn Med, who may convene a board with a second Army CAM to review the decision. Level 2 appeals should be directed to Colonel AAC, HQ AAC. HQ AAC is the competent authority on the medical standards for Army flying training and, as such, is the final level of medical appeal for potential officers.

Officer Cadet Candidates

12. Officer Cadet candidates for flying training will be managed in accordance with procedures in paragraph **9** and **10** above. In addition, the Army CAM at the Department of Aviation Medicine will review the Primary Health Care Records and Recruiting Group Medical Declaration (RGMD) of all candidates.

13. **Appeals.** Officer Cadet candidates may appeal against decisions made at the pre-employment medical assessment, or after the R&S DOM board, via their CO. In accordance with Appendix 19, the CO may then request the CA Avn Med to review the findings of the board. If a further medical assessment is required CA Avn Med may convene a board with a second Army CAM to review the decision. Subsequent appeals should be directed to Colonel AAC, HQ AAC. HQ AAC is the competent authority on the medical standards for Army flying training and, as such, is the final level of medical appeal for Officer Cadets.

Military Candidates

14. Military candidates are to comply with the instructions in AGAI Volume 2, Chapter 43. Candidates will be required to have a pre-selection medical assessment by their MO. Full guidance notes for unit MOs on the minimum medical employment standards for Army pilot candidates are contained in AGAI Volume 2, Chapter 43, Annex K. Candidates may be rejected based on their medical history or the results of this pre-selection medical assessment, without the candidate being called forward for a medical examination at R&S DOM. The CAM may seek clarification of medical details by writing to the candidate's MO or hospital specialist, with the candidate's consent, or by arranging a specialist opinion.

15. If medically acceptable, candidates will attend R&S DOM for an aircrew medical board and the results will be forwarded to the Department of Aviation Medicine for review. The medical board from R&S DOM is valid for five years and will need to be repeated if the candidate enters flying at a later date. The final decision on medical suitability for pilot training will be taken by CA Avn Med and an appropriate aircrew medical category will be awarded at the start of the Army Pilot Course.

16. **Appeals.** Appeals against the findings of the Department of Aviation Medicine or the R&S DOM Medical Board are to be directed in the first instance to CA Avn Med, who may convene a board with a second Army CAM to review the decision. Subsequent appeals should be directed to Colonel AAC, HQ AAC. HQ AAC is the competent authority on the medical standards for Army flying training and, as such, is the final level of medical appeal for serving candidates.

Entry Standards for Army Aviation Crewmen

17. Air Crewmen (AC) perform flight safety duties in Army aircraft and now follow a similar selection pathway to military pilot candidates.

18. The initial medical examination of a potential AC is conducted at R&S DOM. The results are forward to the Department of Aviation Medicine at Middle Wallop.

19. Medical Selection Standards. The medical selection standards for crewmen will be the same as those for an Army pilot, as detailed in AGAI Volume 2, Chapter 43, Annex K and Paragraphs 4-7 above. However, there is scope for some variation to pilot medical standards but only following consultation with CA Avn Med (Army). A history of childhood asthma or hay fever will not automatically disqualify candidates[179].

20. **Aircrew Employment Category.** On entry to flying and during service as an AC, the JMES of AC may be A1, A2 or A3, depending whether they meet the full pilot medical standard. Those not meeting the pilot medical standard will be graded A3, fit AC duties only.

21. **Administrative Requirements.** The initial medical examination should be recorded on DMICP by the examining CAM or Military Aviation Medicine Examiner (MAME). When conducted by a doctor that is not an MAME, secondary approval must be sought from CA Avn Med (Army), or the Army Aviation Centre Consultant in Aviation Medicine, who will ultimately determine fitness for AC duties. It must be stressed that rear crew candidates will not be declared fit to attend a training course until the above procedures have been completed.

Second and Subsequent Flying Tours

22. All Army aircrew in an active flying appointment should maintain their aircrew medical category by means of the annual aircrew medical examination. Aircrew in ground appointments who are likely to return to flying duties should also maintain a current aircrew medical category; if the period between medicals exceeds 2 years, the renewal must be conducted by a Consultant in Aviation Medicine.

Medical Certification for Army Aircrew

23. **Illness in Aircrew.** Any significant abnormality detected in aircrew by a doctor without MAME training, should be discussed with a CAM to determine the impact on flying duties.

24. **Army Aircrew Medical Certification.** Under *MMA Regulation* (RA 2135) all aircrew must be certified medically fit to conduct flying duties. The aircrew medical examination is to be conducted annually by a Military Aviation Medical Examiner (MAME). A MAME is an MO authorized by either a Consultant Advisor in Aviation Medicine (CA Av Med (RN and Army)) or Command Flight MO (RAF) (CFMO(RAF)) respectively. The aircrew medical category is to be entered in the medical records and the flying logbook and is to be signed by the MAME. The annual medical examination is valid until the last day of the month in which it is next due.

25. **Annual Army Aircrew Medical Examinations.** A comprehensive medical examination is to be performed. The general details of the requirement can be found in *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force*. The specific detail for Army aircrew is available from any CAM.

[179] Consultation with CA Avn Med (Army) is required.

26. **Administrative Requirements.** The annual aircrew medical examination is to be recorded on DMICP in accordance with DPHC guidance and best practice. Logbook entries should be restricted to the JMES and any associated waiver; waivers should be entered in red.

27. **Occupational Restriction of Aircrew.** It is essential that aircrew with a restriction to flying duties are recognised by the Army Avn Med system and the CoC. To that end, two parallel systems of notification are in operation. These are the:

a. **HQ AAC Waivers.** The HQ AAC waiver system is designed to identify and grant **limited flying status** to pilots that are not fit for **full flying duties**[180]. Pilots graded A3 must be granted a waiver, by CA Avn Med (Army), that states their flying limitation. MAMEs must discuss any cases that require an A3 grade with CA Avn Med (Army) before completion of a medical board.

b. **Limitation Codes (Med Lims).** Limitation codes are four figure codes that are added to the JMES and are used to communicate functional limitations to the CoC. Aviation codes are contained within the 2000 series and should be added to DMICP templates; waiver statements should be added to aircrew logbooks in red.

Retention Standards for Army Aircrew

28. **Army Aircrew Retention Standards.** Retention standards for Army aircrew, in relation to their A, L, M and E characteristics are given at Tables 4 and 5. As for other personnel, the JMES will follow the P grade, but it is possible for the A grade to change independently[181]. SPs downgraded to P7/MND will be managed in the same way as other MND personnel. The table below outlines the differing minimum requirements in the other U to S categories for award of the relevant P grade to aircrew.

JMES	P	U	L	H	H	E	E	M	S
MFD	2	2	2	2	2	$\frac{5}{1}$	$\frac{5}{1}$	2	2
MLD	3	3	3	3	3	$\frac{7}{1}$	$\frac{7}{1}$	2	2

29. **Hearing.** Aircrew that develop a hearing category of H3 or below need careful monitoring and may require a functional check to ensure both flight safety and protection of their remaining hearing. Hearing assessments should be managed in accordance with JSP 950 Leaflet 6-4-2.

30. **Vision.** Pilots are unfit to fly if their corrected vision is worse than 6/6. However, SPs with uncorrected vision below 6/24 may be permitted to be MFD following assessment of their vision and their correction requirements; this may require specialist referral. Similarly, SPs with uncorrected vision at or below 6/60 may be graded MFD or MLD but they must be free of significant eye disease and a specialist assessment will be required. All such patients will require careful annual assessment.

31. **Mental Capacity and Emotional Stability.** M and S grades below 2 are incompatible with flying duties. Pilots may become fit to fly again when they return to M2, S2 but only after appropriate specialist assessment.

[180] 'A' grades can be changed independently of the L, M or E grades within the remainder of the JMES. But, when there is a change in fitness for ground duties, the air and ground limitations must be reviewed in together.
[181] It is possible for pilots to be A3 but MFD or A1 but MND, depending on their condition.

Army Aviation Medical Boards

32. One Member may be performed on aircrew by any MO, but the aircrew must consult with a MAME prior to a return to flying duties. A change of aircrew employment category may only be carried out by a MAME. Complex aircrew cases should be referred to CA Avn Med who may convene an Army Aviation Medical Board (AAMB).

33. An AAMB will consist of CA Avn Med as president, an Army CAM, a representative from the AAC Flight Safety and Standards Inspectorate, and a G1 representative.

34. **Appeals.** Appeals against FWA(T) or FWA(P) decisions relating to an aircrew employment category are in the first instance to be addressed to the Board that made the original decision. The Medical Board should review its decision and offer the SP an opportunity to discuss the boarding process and outcome. If the appeal is not resolved at this stage, the SP is to apply to the CA Avn Med via their CO, normally within three months of the original decision. The SP is to complete the form at Appendix 20 when submitting the appeal to the CO. CA Avn Med may convene an AAMB. Appeals against FWA decisions unrelated to the aircrew employment category should be conducted in accordance with guidance at Appendix 19.

APPENDIX 7 TO CHAPTER 78

INSTRUCTIONS TO BE GIVEN TO A SP ON NOTIFICATION OF THE REQUIREMENT TO ATTEND A FITNESS FOR WORK ASSESSMENT (FWA)

1. **Introduction.** You have either been advised to make an appointment or have had an appointment made for you to attend a FWA with a Medical Professional.

2. **Purpose of FWA.** The purpose of the FWA is to assess the effect your medical condition has (positively or negatively), or may have, on your ability to undertake your trade role within your Career Employment Group (trade), or the effect that your trade role and wider military employment may have (positively or negatively) on your medical condition and overall health.

3. **Aim.** The aim is to provide the greatest level of employability and deployability capability for both yourself and the Army while serving to also protect both you and the Army from unnecessary risk of further harm, physical and mental, as a direct or indirect result of continued employment within your trade.

4. **Outcome.** The outcome may require varying levels of adaptation to your current trade role, or restriction in your employment to reduce exposure to any hazards that may exacerbate or worsen your condition. This may have an effect on how you undertake your trade and how you may be employed and deployed on military exercise or Operations.

5. **Consent.** By attending a FWA you are inherently consenting to the process being undertaken but not at that point in the release of the JMES employment standard. You can withhold consent for both the FWA being undertaken and release of the JMES to the CoC as of right (Appx 9 box and Appx 17A/B). Without consent the medical chain cannot convey any legitimate and appropriate risk management advice to the CoC in relation to your appropriate and safe employment. This may lead to new employment considerations in relation to continued Service*,* see **para 78.1032**.

6. **Non- Attendance.** You do not need to participate directly in the assessment if you do not wish to and it may be considered that your review medical FWA can be coordinated by telephone or email. However, this is your opportunity to discuss the practical implications of your health and employment. You are strongly encouraged to engage in the process and attend all assessments. It is important to understand that without the assessment your CoC cannot be assured of your safety in your employment and that any risk is appropriately managed to protect you. If you do not attend the safest and most restrictive employment grade is likely to be recommended based on a reading of your medical record. This permanent protective grade may however prevent the CoC from employing you in a meaningful, regular and gainful way. In this situation Appendix 28 may be initiated.

7. **Concerns.** If you have any questions regarding your FWA they can be addressed to your CoC or local Med Centre.

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APPENDIX 8 TO CHAPTER 78 – Replaced by APPENDIX 28

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APPENDIX 9

FORM FOR NOTIFYING MEDICAL/ FUNCTIONAL RESTRICTIONS TO UNIT

Guidance for MO. The form should provide sufficient information for the Unit to manage the individual's career for the period until the review date. The individual should be given a copy and asked to confirm that they have read the paragraph below and sign the form (this may be done electronically). The signed copy should be sent to the CoC via email. It is the unit's responsibility to hold the signed copy. There is no requirement to retain a signed copy on DMICP. If the individual refused to consent to the distribution of the App 9, you are still required to complete the DMICP JMES template. You **must** inform the CO of safety critical duties (weapon handling, driving etc). This is a public safety duty that surpasses that of confidentiality.

Guidance for Unit. The unit are responsible for ensuring promulgation to OC, line manager, RCMO and the appropriate APC Career Manager as required. This form allows the Unit to conduct a risk assessment on the individual's role. The form remains valid until the review date only. It is signed by the individual to ensure they are aware of the restrictions advised. If overdue review the unit should assume the individual is restricted all activities previously indicated and arrange a review. **THIS APP MUST BE UPLOADED ONTO PAPMIS.**

Guidance for Individual. You must read this form and **comply with its direction** - it explains to your Unit any medical/ functional restrictions you have been given. The form will be used at Unit Health Committee meetings, will be held by your unit and a copy will be passed to your APC Career Manager. The APC Occupational Health Branch may access your medical record to provide further functional advice if requested. You have been given the opportunity to ask questions regarding the form and the Medical / Assessment Board proceedings, on-going treatment and likely outcome. You will need to sign (this may be done electronically) section 8 to say you have been given a copy, consent to its use and will abide by its direction.

No:		**Rank:**		**Name:**	
Unit:		**JMES:**	**Date of board:** **MDS:** **MES temp/perm:** **MES:** A L M E	**Board Type:** **Review date:**	
Anticipated Outcome: (e.g. return to MFD)* ***Anticipated Timeline / Stability:**					
* Where appropriate these fields can be populated with relevant information in order to support employment decisions/discussions at UHC in addition to the PAPMIS record (which is key). The information is for guidance only and is subject to change.					

1. DEPLOYABILITY/EMPLOYABILITY ON OPERATIONS

MND (L5-L6)	Not	Not deployable on operations
MLD (L2-L4)	Limited	PJHQ CAT 1: personnel whose duties remain within the confines of designated main operating bases
		PJHQ CAT 2: personnel whose duties may require periodic deployment outside defensive locations
MFD (L1)	Full	PJHQ CAT2+: personnel whose duties may require routine deployment outside defensive locations
		PJHQ CAT 3: personnel whose duties encompass the full spectrum of operations in theatre. CAT2+ by exception

Deployability Category
[SP]'s Deployability Category is:

Functional Capacity on Operations	**Deployment Risk**
Take cover/prone position - Yes Run a short distance (100m) - Yes Carry own bergan to transport - Yes Wear Operational Body Armour - Yes Stand 2 hours in PPE with weapon - Yes - -	Incapacitation (Low Risk) Worsening condition (Low Risk) Primary care requirement (Low Risk) Rehabilitation requirement (Low Risk) Secondary care requirement (Low Risk) Emergency aeromed (Low Risk) Interference with treatment (Low Risk)
Overall risk assessment for deployment:	Overall risk assessment for deployment (Low Risk)
Comments: Deployability/Employability on Operations – User comments	

2. DEPLOYABILITY/ EMPLOYABILITY ON EXERCISES/TRAINING SUPPORT DEPLOYMENTS

Weight-personal kit & equipment Weight - personal kit & equipment - No specified limit -	Full trade exercise activities Full trade exercise activities - No specified restriction -
Infantry activities (Including digging) 3100: Infantry activities - No specified restriction -	Living in field conditions 3200: Living in field conditions - No specified restriction -
Travel on foot across rough terrain 3101: Travel on foot across rough terrain - No specified restriction -	Move tactically and adopting fire positions 3102: Move tactically and adopting fire positions - No specified restriction -

Comments: - exercise cat 5

3. SPECIFIC LIMITATIONS - *complete if appropriate*

Trade restrictions	- trade cat 5
Noise Restrictions	Noise Restrictions - No specified restriction - as per HCP -
Climatic Restrictions	5100: Climatic - No specified restriction -
Other restrictions	Other Restrictions - No specified restriction -
Requires ongoing primary health care	Does not require ongoing primary health care
Comments: - limitations cat 5	

4. FUNCTIONAL CAPACITY

Level 3 PT	Unit mainstream or operational specific PT Programme (conditioning PT). Will have passed RFT(S)/AFT.
Level 2 PT	Personnel with reduced physical ability, not quite ready to conduct mainstream PT (reconditioning PT). Will have completed the SCR to a satisfactory standard but not RFT(S)/AFT.
Level 1 PT	Personnel who are medically exempt, un-acclimatised, on weight management programme, or who have not reached a satisfactory SCR, RFT(S)/AFT level. Requires rehabilitation and/or reconditioning before advancement.

Recommended Physical Training Level *NB: PT prescriptions and PT Levels 1-3 detail can be found in AGAI 7. This relates to medical fitness to participate in physical training and medical fitness to attempt the fitness assessments/tests (i.e. physical fitness is not a factor that can prevent medical upgrading).* Recommended PT Level: Level 3 PT	**Rehabilitation:** Individual has been given a PT prescription Rehabilitation programme - risk of prolonged recovery if rehab interrupted - No

Functional Activities

Walking 6007: Walking - No specified restriction -	Working Hours 1210: Working Hours - No specified restriction -	Boots 9301: Boots - No specified restriction -
Standing 6004: Standing - No specified restriction -	Workplace 1213: Workplace - No specified restriction -	Clothing 9300: Clothing - No specified restriction -
Sitting 6003: Sitting - No specified restriction -	Marching / drill 6006: Marching/drill - No specified restriction -	Combat Body Armour Combat Body Armour - No specified restriction -
Lifting 6200: Lifting - No specified restriction -	Guard duties 9200: Guard duties - No specified restriction -	Helmet Helmet - No specified restriction -
Comments: - functional activ cat 5		

5. SAFETY CRITICAL TASKS

Driving 1403: Driving - No specified restriction -	Weapons 9004: Weapons - No specified restriction -	Working at Heights 1203: Working at Heights - No specified restriction -
Passenger 1212: Passenger - No specified restriction -	Ranges 9003: Ranges - No specified restriction -	Workplace Assessment Workplace Assessment - No specified restriction -
Comments: - safety cat 5		

6. MEDICAL REVIEW

Medical review required before commencing MST/ Deployment	5500: Medical review before MST/Deployment - No
Approval by an ROHT required before commencing MST/ Deployment	ROHT approval required before commencing MST/Deployment - No
Comments: - med rev 5	

7. COMPLETED BY

Name:		**Date:**	
Rank and Appointment:		**Signature:**	

8. INDIVIDUAL'S ACKNOWLEDGEMENT OF RECEIPT (Sign before giving to line manager)

Name:		**Rank**		**Signature:**	

APPENDIX 10 TO CHAPTER 78

INSTRUCTIONS ON AN MO FINDING A SP – TEMPORARILY UNFIT FOR MILITARY DUTIES

Guidance for SP. You must read this form – it informs your Unit of appropriate restrictions that you have been given. A copy will be passed to your APC Career Manager. The APC Occupational Health Branch may access your record to provide further functional advice if requested. You need to sign (this may be done electronically) to say you have been given a copy and consent to its use.

No:		**Rank:**		**Name:**	
Unit:		**Regt/Corps:**			
Date of Board:		**Review Date:**			

The above named was assessed by an MO, awarded a JMES **L6E5 MND Temp** and is temporarily unfit for military duties.

1. **Estimated Return to Military Duty:**

☐ Return to military duties likely within 3 ☐ 6 ☐ months

☐ Return to military duty unlikely, a referral to ROHT has been completed for assessment within 6 months

☐ Prognosis unknown. May require OH assessment and guidance.

Comments:

2. **Advice on Suitability for ATAB[182]:**

☐ Resettlement activity can be commenced

☐ Not Applicable- likely to return to duty within 3 months

Comments:

3. **Instructions from the MO to the Unit:**

☐ SP able to complete recovery duties

☐ MO review will be required at unit medical centre ☐ at nearest DMS medical centre ☐ at NHS GP

☐ Unit to complete an App 18.

Comments:

4. **Instructions from the MO to the SP:**

☐ Remain in Hospital

☐ Contact your unit, commence Recovery activity on Sick Leave (at Residence at Work address unless UHC decide otherwise).[183]

☐ Contact your unit, clinically exempt Recovery activity on Sick Leave.

[182] Army Transition Assessment Board. The aim of ATAB is to ensure that service personnel likely to be medically discharged are given the level of support they need to access resettlement requirements.

[183] WIS SP commencing Sick Leave, cease normal military duty and automatically assume Recovery duty (which includes all Recovery Activity) and will lead to either a Return to Duty (RTD) or Transition to civilian life. Recovery activity may include both Return to Work (RTW) or transition activities, the type and level of which will be in accordance with the WIS SP's clinical ability and Individual Recovery Plan (IRP).

☐ Return to your unit for further instructions.[184]

You will be contacted at the correspondence address you have provided overleaf:

Address: **Email Address:**		**Telephone number: Mobile Telephone** **Comments:**
No:	**Rank:**	**Name:**

5. Functional Capacity Assessment and adaptations required:

Upper Limbs and Dexterity Include comment on strength, dexterity and consider ability to work with IT and to write:

No Impairment ☐ Impairment ☐ Comment on all impairments:
……

Lower Limbs and Locomotion Include comment on ability to walk, stand, kneel, climb stairs, bend, Lift/Carry, sit for prolonged periods

No Impairment ☐ Impairment ☐ Comment on all impairments:
……

Safety, Awareness and Senses Include comment on suitability for safety critical tasks such as Driving, Climbing ladders, Working at heights. Comment on relevant mental function including communication, understanding & memory. Comment on vision or hearing problems

No Impairment ☐ Impairment ☐ Comment on all impairments:
……

Environmental Considerations Include comment on suitability for Exposure to: dust and fumes, Skin Irritants, Outdoor work in all weathers. Comment on work place issues including working hours and access within and transport to the workplace and suitability for work in the military environment

No Impairment ☐ Impairment ☐ Comment on all impairments:
……

6. Recommendation for ARCAB[185] (complete this section for all SPs):

Not required ☐ On strength PRU ☐ Unit applied to ARCAB ☐ Recommend Unit apply to ARCAB ☐
Comment to support application: ……..

7. Considerations for Recovery and Transition Activities:

BattleBack and Adventurous training[186] (outdoor based)- Is the SP able to undertake an entry level course to allow assessment by instructor for further suitability?

Yes ☐ Comment:
……

Recovery Event Courses (classroom based) Is the SP able to undertake class room based and other learning activities

Yes ☐ Comment:
……

Civilian Work placements Is the SP able to be considered for placements to inform future civilian employment?

Yes ☐ Comment:
……

[184] For specific cases where SP is graded medically unfit for service/duty and under medical care at Med Board and special clinical dispensation is granted to remain in work. Note SP authorised as TU or Appendix 28 must be medically upgraded, as they are no longer eligible for Recovery activity and cannot be recorded on WISMIS.
[185] Army Recovery Capability Assessment Board.
[186] BattleBack consists of supervised activities aimed at the recovering service person. This does not replace the requirement for activities that require specific medicals such as parachuting/ SCUBA diving.

8. **SP has signed App 17b consent form** ☐

MO: User Name **(Original to be completed on PAPMIS)**	**Location:** **(Original to be completed on PAPMIS)**
Rank and Appointment: **(Original to be completed on PAPMIS)**	**Date:** **(Original to be completed on PAPMIS)**
Signature of MO: **(Original to be completed on PAPMIS)**	**Signature of SP (to acknowledge receipt):** **(Original to be completed on PAPMIS)**

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APPENDIX 11 TO CHAPTER 78

INSTRUCTIONS AFTER AN OCCUPATIONAL HEALTH ASSESSMENT FINDS A SP - TEMPORARILY UNFIT FOR MILITARY DUTIES

Guidance for SP. You must read this form – it informs your Unit of appropriate restrictions that you have been given. A copy will be passed to your APC Career Manager. The APC Occupational Health Branch may access your record to provide further functional advice if requested. You need to sign (this may be done electronically) to say you have seen a copy and consent to its use.

No:		**Rank:**		**Name:**	
Unit:		**Regt/Corps:**			
Date of Board:		**Review Date:**			

The above named was assessed by an ROHT, awarded a JMES **L6E5 MND Temp** and is temporarily unfit for military duties.

2. Estimated Return to Military Duty:

☐ Return to military duties likely within 3 ☐ 6 ☐ 12 ☐ months

☐ Return to military duty unlikely, a Full Medical Board will be convened within 6 months

☐ Prognosis unknown. May require OH assessment and guidance.

☐ Will require Pers Pol (A) authorisation for extension to A4L6M4E5 MND Temp beyond 12 months

Comments:……..

2. Advice on Suitability for ATAB / UHC[187]:

☐ Not Applicable- likely to return to duty

☐ Resettlement activity can be commenced

☐ Resettlement activity may need to be deferred until after future discharge

☐ Resettlement activity may need to be transferred to spouse, civil partner, entitled partner or nominated proxy

Comments:……..

3. Recommendations of the ROHT:

☐ Unit to assess SP against MATT 1 Level 2: (WHT) ☐ Live Fire Shoot 3 (25m G+0) ☐

☐ Unit to assess SP against Table 6 objective tests MND ☐

☐ MO review will be required at unit medical centre ☐ at nearest DMS medical centre ☐ at NHS GP ☐

Comments:……..

4. Instructions from the MO to the SP:

☐ Remain in Hospital

☐ Contact your unit, commence Recovery activity on Sick Leave (at Residence at Work address unless UHC decide otherwise).[188]

[187] Army Transition Assessment Board. The aim of ATAB is to ensure that service personnel likely to be medically discharged are given the level of support they need to access resettlement requirements.

[188] WIS SP commencing Sick Leave, cease normal military duty and automatically assume Recovery duty (which includes all Recovery Activity) and will lead to either a Return to Duty (RTD) or Transition to civilian life. Recovery activity may include both Return to Work (RTW) or transition activities, the type and level of which will be in accordance with the WIS SP's clinical ability and Individual Recovery Plan (IRP).

☐ Contact your unit, clinically exempt Recovery activity on Sick Leave.

☐ Return to your unit for further instructions.[189]

You will be contacted at correspondence address you have provided overleaf:

Address:	**Telephone number:**
	Comments:
Email Address:	

No:	**Rank:**	**Name:**

5. Functional Capacity Assessment and Adaptations Required:

Upper Limbs and Dexterity Include comment on strength, dexterity and consider ability to work with IT and to write:

No Impairment ☐ Impairment ☐ Comment on all impairments……..

Lower Limbs and Locomotion Include comment on ability to walk, stand, kneel, climb stairs, bend, Lift/Carry, sit for prolonged periods:

No Impairment ☐ Impairment ☐ Comment on all impairments
……..

Safety, Awareness and Senses Include comment on suitability for safety critical tasks such as Driving, Climbing ladders, Working at heights. Comment on relevant mental function including communication, understanding & memory. Comment on vision or hearing problems:

No Impairment ☐ Impairment ☐ Comment on all impairments
……..

Environmental Considerations Include comment on suitability for Exposure to: dust and fumes, Skin Irritants, Outdoor work in all weathers. Comment on work place issues including working hours and access within and transport to the workplace and suitability for work in the military environment:

No Impairment ☐ Impairment ☐ Comment on all impairments……..

6. Recommendation for ARCAB[190] (complete this section for all SPs):

Not required ☐ On strength PRU ☐ Unit applied to ARCAB ☐ Recommend Unit apply to ARCAB ☐
Comment to support application ……

7. Considerations for Recovery and Transition Activities:

BattleBack and Adventurous training[191] (outdoor based)- Is the SP able to undertake an entry level course to allow assessment by instructor for further suitability?

Yes ☐ Comment
……

Recovery Event Courses (classroom based) Is the SP able to undertake classroom based and other learning activities?

Yes ☐ Comment……

Civilian Work placements Is the SP able to be considered for placements to inform future civilian employment?

Yes ☐ Comment
……

[189] For specific cases where a SP is graded medically unfit for service/duty and under medical care at Med Board and special clinical dispensation is granted to remain in work. Note SP authorised as TU or Appendix 28 must be medically upgraded, as they are no longer eligible for Recovery activity and cannot be recorded on WISMIS.
[190] Army Recovery Capability Assessment Board.
[191] BattleBack consists of supervised activities aimed at the recovering service person. This does not replace the requirement for activities that require specific medicals such as parachuting/ SCUBA diving.

8. **SP has signed App 17b consent form** ☐

ROHT Staff member: **(Original to be completed on PAPMIS)**	**Location:** **(Original to be completed on PAPMIS)**
Rank and Appointment: **(Original to be completed on PAPMIS)**	**Date:** **(Original to be completed on PAPMIS)**
Signature of ROHT Staff member: **(Original to be completed on PAPMIS)**	**Signature of SP (to acknowledge receipt):**

Intentionally blank

APPENDIX 12 TO CHAPTER 78

INSTRUCTIONS ON A FULL MEDICAL BOARD FINDING A SP- PROVISIONALLY CONSIDERED UNFIT FOR FURTHER MILITARY SERVICE

No:		**Rank:**		**Name:**	
Unit:		**Regt/Corps:**			
Date of Board:		**Review Date:**			

The above named was assessed at a Full Medical Board, awarded the JMES **L6E5 MND Perm** and been provisionally considered unfit for further service. **The SP must cease normal duties immediately and proceed with Recovery duties as per para 5.** The board's recommendation is subject to confirmation by APC OH, on behalf of Pers Pol (A). The Army Personnel Centre (APC) will notify of the final decision or an interim notification within one month of receipt of FMB documentation. A copy of this form will be sent to the CoC. The unit should forward to the IERO for resettlement action.

1. **Recommendations of the Medical Board for retirement/discharge:**

☐ Retirement under the Army PAW 20 199

☐ Discharge under QR(Army) Para 9.386☐ / 9.387 ☐

2. **Recommendations of the Medical Board for Last Day of Service (LDoS):**

☐ None beyond that normally awarded

☐ LDoS awarded should be set no sooner than ☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ months from date of FMB to permit access to specific DPHC facilitated medical care (in exceptional cases recommendation for deferral beyond 12 months up to 24 months can be articulated in the comments).
Comments: ……

3. **Recommendations of the Medical Board for resettlement activity[192]:**

☐ Resettlement activity can be commenced

☐ Resettlement activity may need to be deferred until after future discharge[193]

☐ Resettlement activity may be transferred to spouse, civil partner, entitled partner or nominated proxy
Comments: ……

4. **Instructions from the Medical Board on healthcare transition (JSP 950 Leaflet 1-3-4):**

☐ No on-going health care needs- MO to arrange final medical

☐ On-going health care needs- MO to arrange final medical and liaise with NHS GP

☐ Complex health care needs- requires non-clinical (CoC led) MDT meeting to plan healthcare transition

☐ Complex health care needs-requires clinical (primary care led) MDT meeting to plan healthcare transition

5. **Instructions from the Medical Board to the SP:**

☐ Remain in Hospital

☐ Contact your unit, commence / continue Recovery activity.[194]

☐ Contact your unit, clinically exempt Recovery activity

☐ Return to your unit for further instructions.[195]

Await APC and resettlement instructions[196] which will be sent to the correspondence address overleaf.

[192] Regular, FTRS(FC) and mobilised Reserves only.
[193] With a post discharge activity submission in accordance with JSP 534
[194] WIS SP commencing Sick Leave, cease normal military duty and automatically assume Recovery duty (which includes all Recovery Activity) and will lead to either a Return to Duty (RTD) or Transition to civilian life. Recovery activity may include both Return to Work (RTW) or transition activities, the type and level of which will be in accordance with the WIS SP's clinical ability and Individual Recovery Plan (IRP).
[195] For specific cases where SP is graded medically unfit for service/duty and under medical care at Med Board and special clinical dispensation is granted to remain in work.
[196] Regular, FTRS(FC) and mobilised Reserves only

Address: **Civilian Email*:** ***Mandatory to enable IERO contact.**	**Telephone number:** **Comments:**

No:	**Rank:**	**Name:**

6. Functional Capacity Assessment and Adaptations Required:

Upper Limbs and Dexterity Include comment on strength, dexterity and consider ability to work with IT and to write:

No Impairment ☐ Impairment ☐ Comment on all impairments ……

Lower Limbs and Locomotion Include comment on ability to walk, stand, kneel, climb stairs, bend, Lift/Carry, sit for prolonged periods:

No Impairment ☐ Impairment ☐ Comment on all impairments ……..

Safety, Awareness and Senses Include comment on suitability for safety critical tasks such as Driving, Climbing ladders, Working at heights. Comment on relevant mental function including communication, understanding & memory. Comment on vision or hearing problems

No Impairment ☐ Impairment ☐ Comment on all impairments
……..

Environmental Considerations Include comment on suitability for Exposure to: dust and fumes, Skin Irritants, Outdoor work in all weathers. Comment on work place issues including working hours and access within and transport to the workplace and suitability for work in the military environment

No Impairment ☐ Impairment ☐ Comment on all impairments
……...

7. Recommendation for ARCAB transfer (complete this section for all SPs)

Not required ☐ On strength PRU ☐ Unit applied to ARCAB ☐ Recommend Unit apply to ARCAB ☐
Comment to support application ……

8. Considerations for Recovery and Transition Activities:

BattleBack and Adventurous Training[197] (outdoor based)- Is the SP able to undertake an entry level course to allow assessment by instructor for further suitability?

Yes ☐ Comment
……

Core Recovery Event Courses (class room based) Is the SP able to undertake class room based and other learning activities?

Yes ☐ Comment
……

Civilian Work Placements Is the SP able to be considered for placements to inform future civilian employment?

Yes ☐ Comment
……

9. SP has:

Signed App 17 Consent form at FMB ☐

Given prior Notice to Terminate (NTT) ☐

President of the Medical Board:	**FMB Location:**

[197] BattleBack consists of supervised activities aimed at the recovering service person. This does not replace the requirement for activities that require specific medicals such as parachuting/ SCUBA diving.

(Original to be completed on DMICP or PAPMIS)	**(Original to be completed on DMICP or PAPMIS)**
Rank and Appointment: **(Original to be completed on DMICP or PAPMIS)**	**Date of FMB:** **(Original to be completed on DMICP or PAPMIS)**
Signature of President: **(Original to be completed on DMICP or PAPMIS)**	**Signature of SP (to acknowledge receipt):** **(Original to be completed on DMICP or PAPMIS)**

No:	**Rank:**	**Name:**

Intentionally blank

APPENDIX 13 TO CHAPTER 78

MEDICAL STANDARDS FOR UNMANNED AIRCRAFT SYSTEM OPERATORS

1. **General.** Unmanned Aircraft Systems (UAS) have been used by the military for several decades but, in recent years, their development has been very rapid and is still accelerating. There has recently been considerable civilian interest, initially from government organisations but now from civilian commercial endeavours. This has necessitated the development of regulations to which the military must adhere if civilian airspace, both national and international is to be utilised. These regulations will affect the medical clearance and monitoring of the operators, as well as the operation of the vehicles.

2. **Regulation.** UK military UAS are regulated by *Military Aviation Authority Regulatory Publications*. Under these regulations, UAS operator medical standards will be set on a tri-Service basis[198]. MAA Regulations set the additional Medical Employment Standards related to UAS operation and have the authority over AGAI 78.

3. **Terminology.** Unmanned Aerial Vehicle (UAV) is still occasionally used to refer to the vehicle. Unmanned Air System (UAS) refers to the unmanned aircraft and all equipment, network and personnel necessary to control the unmanned aircraft.

4. **Definition.** UAS are powered aerial vehicles that do not carry a human operator. They may operate autonomously or be operated remotely, from the ground or from an aircraft. They may be expendable or recoverable and may carry a non-lethal or a lethal payload. Although the term ‘unmanned’ suggests the absence of human interaction, the human operator is a critical element in the success of any UAS operation.

5. **Characteristics.** UAS vary in size, weight, range, endurance and payload. As these factors increase so does the potential for harm to other air users and personnel on the ground. Some UAS are entirely autonomous, others follow pre-set commands from their operators and some are actively flown by the operator. Additionally, larger UAS will operate outside military restricted or operational areas and will use civilian, regulated airspace. It is essential that medical standards reflect this increasing risk and seek to minimise the potential for human operator failure through incapacitation or reduced performance.

6. **UAS Classification.** The classification of UAS are governed by NATO and MAA taxonomy (RA 1600 Annex A) depending on the size and other characteristics of the system. For medical operator certification purposes, UAS are divided into three Classes:

a. **Class 1** are otherwise termed ‘Nano', ‘Mini’, ‘Micro’ and 'Small' UAS. They are small, short range, low endurance UAS.

b. **Class 2** are otherwise termed ‘Tactical’ UAS (TUAS). They are medium sized UAS of long endurance operating from fixed airfield facilities. Although flying may be automated they will need to interact with Air Traffic Control and the operators must manoeuvre platforms in an airfield environment. Technically, these platforms may be armed.

c. **Class 3** are otherwise termed Medium / High Altitude Long Endurance (MALE / HALE) UAS. They are medium or large UAS operating in both restricted areas and controlled airspace shared with civil manned traffic which will be operating according to Visual and Instrument Flight Rules. These platforms may be armed.

[198] Remotely Piloted Air Systems are governed by Regulatory Article 1600.

7. **UAS Operator Classification.** UAS aircrew include pilots (handling and payload operators) and non-handling operators (mission commander, signallers and launch recovery). Only pilots require aircrew medical certification.

8. **Operator Demands.** UAS operators must, like other soldiers, be fit to operate for extended periods in austere environments. They must be safe to operate in an aviation environment, communicate with ATC and use Display Screen Equipment for prolonged periods. Additionally, they must not pose a risk to flight operations through an increased risk of incapacitation or reduced function.

Medical Standards

9. UAS pilot medical standards are related to the Class of the UAS and have been developed to comply with international standards such as NATO STANAG 7192, CAA/EASA and FAA standards. They seek to minimise the risk of UAS as the potential hazards related to UAS and demands of UAS operations increase.

10. Army UAS pilot standards will be applied in accordance with Tri-Service UAS policy. Medical supervision will be the responsibility of the UAS Force Commander, the Aircraft Operating Authority, and the AMS. Currently, medical standards will be overseen by the CA Avn Med (Army) at HQ AAC as the representative of ACGS, the Release to Service Authority for all Army aerial platforms.

11. **PULHHEEMS Profile.** The UAS pilot medical standards will be applied at entry to UAS training. However, in the case of Category 1 UAS, if this is at Service entry, any (higher) Army entry standard for the applicants' trade must be met. The minimum PULHHEEMS profiles for UAS pilots, by UAS category are:

UAS Class	P	U	L	H	H	E	E	M	S	CP
1	2	2	2	2	2	$\frac{8}{2}$	$\frac{8}{3}$	2	2	4
2	2	2	2	2	2	$\frac{8}{1}$	$\frac{8}{1}$	2	2	3
3	2	2	2	1	1	$\frac{8}{1}$	$\frac{8}{1}$	2	2	2

12. **Additional Requirements:**

a. **Class 2**. In addition to the stated requirements in the table, Class 2 UAS pilots must comply with the Class 2 UAS pilot medical requirements in *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force*[199]. These include:

(1) **Near Point**. The corrected near point must be no worse than N5 at 30-50cm.

(2) **Intermediate Vision**. The corrected intermediate vision must be no worse than N14 at 100cm.

(3) **Hearing**. Hearing must comply with the AAC Aircrew retention standard at Appendix 6.

b. **Class 3**. In addition to the stated requirements in the table, Class 3 pilots must comply with the RPAS operator medical requirements in *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force*199. These include:

[199] Leaflet 4-02.

(1) **Visual Refraction**. Spherical correction limits are –7.00D to +8.00D. Cylindrical correction limits are +/- 5.00D.

(2) **Visual acuity, muscle balance, convergence and accommodation** are aligned with piloted aircrew standards.

(3) **Hearing**. Hearing must comply with the AAC Aircrew retention standard at Appendix 6.

(4) **ECG**. Class 3 UAS pilots require an ECG at selection and at the intervals stated in *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force* Leaflet 3-01 to coincide with their annual medical examinations in those years.

13. **Aircrew Employment Category.** The JMES of Class 1 and 2 UAS pilots will remain A4, other than those that are already trained aircrew to whom the relevant aircrew standards at Appendix 6, Table 4 or Table 5 will apply[200]. Class 3 UAS pilots will be graded A3, 'Fit RPAS and EFT flying duties only' (MedLim 2003). UAS pilots trained and employed to operate UAS from aircraft must achieve the relevant aircrew medical category for that platform/role.

UAS Operator Retention Standards

14. UAS pilot retention standards will be those of their trade listed at Tables 5 and 6. However, to remain fit to operate Category 2 & 3 UAS, pilots must continue to comply with the PULHHEEMS requirements at paragraph 11 above. The aircrew hearing standards and functional testing principles in the Army Hearing Conservation Programme at AGAI Volume 2, Chapter 66 will also apply to UAS pilots that fall below H2. If the requirements for vision, hearing, mental capacity and emotional stability are met, UAS pilots may continue to operate UAS at JMES categories of MLD and MND provided that the employment limitations of their other medical conditions are fulfilled.

UAS Pilot Medical Examinations

15. Under *Military Aviation Authority Regulatory Publications*, UAS pilots must hold a valid medical certificate appropriate to the type of UAS operation that they conduct. The medical clearance is to be entered in the pilot's logbook as well as recorded in the medical record.

16. **Class 1 UAS Pilot Medical Certification.** The medical clearance of Class 1a and 1b UAS pilots is by maintenance of normal RA retention standards, class 1c UAS pilots require an initial and then 5 yearly level 3 PME by a medical officer to DVLA class 1 standards, class 1d pilots require an initial and then 5 yearly level 4 PME by a medical officer to DVLA class 2 standards. Pilots and medical officers are to note that even Class 1 pilots must not operate UAS if they develop an illness making them unfit to do so. Class 1 pilots should have their fitness reviewed on a 5-yearly basis, which may be by paper review of the medical record and standard PULHHEEMS run-ups.

17. **Class 2 and 3 UAS Pilot Medical Certification.** Class 2 and 3 UAS pilots must be certified medically fit to conduct their UAS duties. The UAS pilot medical examination is to be conducted annually by a MAME. The annual medical examination is valid until the last day of the month in which it next becomes due.

18. **Administrative Requirements.** At each medical examination, the PULHHEEMS/JMES is to be recorded in the UAS pilot's logbook and DMICP.

[200] Aircrew Medical Requirements are contained within RA 2135.

APPENDIX 14 TO CHAPTER 78

CONSENT FORM – DISCLOSURE OF MEDICAL INFORMATION FROM A GENERAL PRACTITIONER OR HOSPITAL SPECIALIST

1. This consent form must be signed before a request for medical information can be sent to a doctor who has previously provided clinical care to you.

2. **You are signing to say you have been shown the information sheet (App 15) summarising your principal rights under the Access to Medical Reports Act, 1988 and are content for the General Practitioner or Hospital Specialist to provide the report.**

3. **You will be offered the chance to see the report before it is sent to the requesting doctor. If you do want to see it, you must read Information Sheet (App 15) to understand your responsibilities.**

4. **Consent - please read and delete as appropriate:**

   a. **I AGREE*/ DO NOT AGREE* that [***Insert Medical Officer's name***] may write to [***Insert GP/ Hospital specialists name*** *of* ***Surgery/ Hospital name***] about my medical care and that a report can be provided giving medical information about me.**

   b. **I DO*/DO NOT* wish to have access to this report before it is provided. Understanding my responsibilities laid out in Information Sheet (App 15).**

   (Delete as appropriate)

Name of GP/ Specialist: .....

Address: .....

.....

Telephone: .....

Signature: _____ Date: DATE

Full name: NAME

Date of birth: DOB Telephone: NUMBER

Address: ADDRESS

Intentionally blank

APPENDIX 15 TO CHAPTER 78

INFORMATION SHEET ON YOUR PRINCIPAL RIGHTS UNDER ACCESS TO MEDICAL REPORTS ACT 1988

You should be aware of your rights under the Access to Medical Reports Act 1988, which is concerned with reports provided for employment, insurance or other purposes by a medical practitioner who is, or has been, responsible for your clinical care. Summarised, your rights are:

1. You may withhold your consent to an application for the report from a medical practitioner.

2. You may consent to the application but indicate your wish to see the report before it is supplied. It is your responsibility to make the necessary arrangements with a medical practitioner to see the report; it will not be sent to you automatically.

3. The medical practitioner will be told that you wish to have access to the report and will allow 21 days for you to see and approve it, before it is supplied to the candidate. If the medical practitioner has not heard from you, in writing, within 21 days of the application of the report being made, they will assume that you do not wish to see the report and that you consent to it being supplied. *Please note where a copy of the report is supplied to you, the practitioner may charge a fee to cover the cost of supplying it.*

4. When you see the report, if there is anything in it that you consider to be incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amends the report, but they are not obliged to do so. If the medical practitioner refused to amend it, you may:

   a. Withdraw consent for the report to be issued.

   b. Ask for a statement setting out your own views to be attached to the report.

   c. Agree to the report being issued unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report that they believes may cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied information about your health, unless the third party also consents. In those circumstances, the medical practitioner will so inform you and your access to the report will be appropriately limited.

5. You may consent to the application for the report but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made and notify the medical practitioner, in writing, they should allow 21 days to elapse after such notification so that you may arrange to have access to the report (if it has not already been supplied before you changed your mind).

6. Whether or not you decide to seek access to the report before it is supplied, you have a right to seek access to it from the practitioner or any time up to six months after it was supplied.

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APPENDIX 16 TO CHAPTER 78

TEMPLATE FOR GUIDANCE WHEN WRITING TO REQUEST INFORMATION FROM A GP OR SPECIALIST

Dear Doctor [Insert Name of GP / Specialist]

PATIENT NAME, ADDRESS AND DATE OF BIRTH

1. The above named patient of yours is a *[insert rank and brief job description, e.g. infantry soldier]* in the British Army and has been under your care for the treatment of *[insert condition]*.

2. I am responsible for their occupational healthcare and in order that I may advise on their fitness for work, I would be grateful if you could provide me with a medical report outlining their diagnosis, treatment and prognosis for this condition whilst they have been under your care. This should be based on your records, without requiring further examination.

3. *[Further information as relevant to the case may be added]*

4. *[Insert soldier's name]* has been informed of their rights under the Access to Medical Reports Act 1988 and has stated that they do/do not wish to see your report before it is sent to me. A copy of their signed consent is enclosed.

5. We will be willing to pay a reasonable fee for this report on submission of an account.

6. If you require any further information, please contact me.

Yours sincerely

[Insert own signature block]

Intentionally blank

APPENDIX 17A TO CHAPTER 78

CONSENT TO DISCLOSURE OF MEDICAL RECORDS FOLLOWING A FITNESS FOR WORK ASSESSMENT (FWA) GUIDANCE

1. The Army is obliged to provide a safe system of work for its Service Personnel under the Health and Safety at Work Act 1974 (HASAWA 74). The Army needs to understand your functional restrictions (non-medical information) through the Medical Employment Policy Appendices in order to safely employ you and ensure the safety of others employed with you. Furthermore, it may be beneficial to you and Defence for you to release elements of your health record to other departments.

2. The information that may be requested is confidential and cannot be disclosed without your specific consent. If your records are required for any purpose other than those detailed in the table below, further consent will be required. You may withdraw your consent at any time and if you do so it is your responsibility to inform both the Chain of Command and Medical Officer. The consent that you provide here is not continuous and will need to be re-issued if your JMES changes. It only applies to this FWA and the actions that follow as shown in the table below. If your records are required after you leave the Service for reassessment of your entitlements, further consent from you will be required before your records may be released to the requesting agency. The form may be signed electronically by entering your details and ‘signed electronically’ in the relevant boxes during the consultation or via email following a consultation.

3. Should you refuse to release information regarding your functional restrictions (non-medical information) to the Chain of Command the army may no longer be able to employ you in your current role and you may be subject to an administrative discharge with loss of entitlement, liability to pay back any Return of Service (RoS) and the nature of the discharge recorded on your AFB108 Certificate of Service/Discharge. You will also be precluded from re-joining the army.

APPENDIX 17B TO CHAPTER 78

CONSENT TO DISCLOSURE OF MEDICAL RECORDS FOLLOWING A MEDICAL ASSESSMENT BOARD

In accordance with GMC Guidance, the Access to Medical Records Act 1988, Regulation (EU) 2016/679 (General Data Protection Regulation) and the Data Protection Act 2018.

Agency	Records to be disclosed	Purpose of disclosure	Consent Given	Consent Withheld
MEDICAL TEAMS – YOUR MEDICAL INFORMATION WILL BE MANAGED CONFIDENTIALLY				
Regional Occupational Health Team (ROHT)	All Personal Medical Records	ROHT provide advice to UMOs on grading decisions and you may be referred to them for a medical board. In order to make a decision on your employability or deployability, access to your medical records is required.	☐	☐
APC Occupational Health Branch	All Personal Medical Records	APC OH are a medical team who may use your medical information to advise Career Managers and Personnel Policy (Army) on your employability and deployability. Medical information will not be shared with anyone outside of their team.	☐	☐
AGENCIES WHO RECEIVE MANAGEMENT INFORMATION ONLY IN ORDER TO SAFELY EMPLOY YOU> THEY DO NOT RECEIVE ANY CONFIDENTIAL MEDICAL INFORMATION				
Unit (including UHC)	JMES, LDP and Appendices (All)	To enable assessment of your employability using non-medical information relating to what you can and cannot safely do at work.	☐	☐
SP Education & Resettlement Officer (IERO)	JMES, LDP and Appendices (All)	To enable provision of adequate resettlement advice.	☐	☐
AGENCIES INVOLVED IF YOU ARE MEDICALLY DISCHARGED				
Defence Business Service: Veterans UK-Pensions	All Personal Medical Records	To enable assessment of your eligibility for War pension/ AFPS (75, 05, 15 & RFPS) Invaliding & Service Attributable benefits, Armed Forces Compensation Scheme benefits to be determined.	☐	☐
Discretionary Awards Review (DAR) and Appeals Review (DAAR)	All Personal Medical Records	To enable assessment of your eligibility for AFPS (75,05, 15 & RFPS) Invaliding & Service Attributable benefits if further scrutiny is required in the case of an appeal against a DBS decision.	☐	☐
Defence Statistics (Health)	FMed 23	For statistical recording and analysis of anonymised information.	☐	☐
AGENCIES INVOLVED IF YOU ARE A RECRUIT OR SERVICE PERSON IN TRAINING				
Army Recruiting and Initial Training Command (ARITC) MO & Support Staff	All Personal Medical Records	Required to ratify medical board proceedings and enable discharge process (where required) for the SP. Also conduct medical reviews and provide employment advice to ARITC, the CoC, the Army Employment Board and the Directorate of Personnel (Army).	☐	☐
Capita and Recruiting Group CMOs & Support Staff	All Personal Medical Records	To enable a full and proper assessment of the employability and deployability. This may lead to permanent change of medical grade and /or medical or admin discharge. To enable recycling of IMA failures and identify areas for improvement in the recruiting medical process.	☐	☐

I consent to the agencies listed and ticked above accessing the specified documents for the stated purposes.

- I wish to receive a copy of the completed FMed 23 ☐

Name & Signature of SP:	Date (of FWA):
Signature of Witness:	Name, rank and Appointment of witness:

ONCE COMPLETED THIS DOCUMENT MUST BE UPLOADED TO BOTH PAPMIS AND DMICP

OFFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 18 TO CHAPTER 78

OCCUPATIONAL REPORT ON A SP FOR EMPLOYMENT PURPOSES (INCLUDING FWA)

Must be completed for all trained SP permanently downgraded. This appendix is not mandatory for SP undertaking Basic Training or Initial Trade Training. This appendix is optional for SP temporarily downgraded or MFD. This form should not contain any Medical in Confidence information.

Personal Details					
No:		**Rank:**		**Surname:**	
Unit:		**Regt / Corps:**		**Forename(s):**	
Branch / Trade:				**Age:**	
Total Full Time Service	**Years**		**Months**		
Type of Enlistment / Commission:				**Marital Status:**	
Address (to which completed Appendix 18 will be sent).					
Name and Role of SP requesting report:					
Address:					
Notes for Commanding Officer / Officer Commanding					

The **Data Protection Act 2018** allows the subject SP to view, should they so wish, what you have written about them (unless you consider that this information may cause them serious physical or mental harm). You should make a copy of this completed form and file it in the SP's personal file. If the subject SP subsequently asks to see the form this copy should be made available to them. Under DPA 98 the subject SP may make objections to factual inaccuracies that must be corrected by forwarding an amended copy of this form to the original recipient. However, the SP may only request withdrawal of this form if it is agreed that further processing of the information held therein is likely to cause unwarranted substantial damage or substantial distress to the subject SP or another.

Occupational Report (to be completed by the Commanding Officer / Officer Commanding)

The above named officer / soldier has served under my command since …… *(Insert date).*

1. **CEG and description of officer/soldier's current duties/role** (attach job descriptions where available):

Planned changes to employment in next 12 months:

2. **Are they able to fulfil this current role?** ☐ Yes ☐ No

OFFICIAL SENSITIVE – PERSONAL (when completed)

OFFICIAL SENSITIVE – PERSONAL (when completed)

a. If No, please state why not:

b. If No, please state if they are fulfilling any other role or other tasks and duties:

c. Or give details of activities and education carried out while TNE.

3. **What allowances are made or have been made for this officer / soldier**

Reduced hours, no lifting, support with mobility etc….

4. **Performance in current or last post:**

5. **SP FOE over next 12 months** (include all planned deployments, exercises and courses / CLM):

6. **If not fit for current trade, are there any other jobs / roles that the officer / soldier may be employed in?** *Comment on advisability of retention within current unit:*

a. In present posting:

b. In present employment:

c. With re-training:

7. **Based on observations, is the SP able to carry out the functions of their current employment?** *Comment on MATTs inc use of Weapons (being clear if this is not required of the role which may affect the JMES awarded), Exercises, deployments and any specific limitations.*

SP is able to pass MATT 1 Level 2? Yes/NO

SP can adopt all firing positions? Yes/No If No please state which firing positions could not be adopted

OFFICIAL SENSITIVE – PERSONAL (when completed)

OFFICIAL SENSITIVE – PERSONAL (when completed)

If the SP is medically assessed as unable to handle weapons does the CO support a weapons waiver[201]? Yes/No Additional Comments:

8. **Likely career progression based on standard career pathway irrespective of performance since the onset of their illness / injury / disability:**

9. **When already known by the author, a general description of circumstances leading to request for the report** (e.g. awareness within the unit of the change in ability of the subject, discussions of career management, at the request of a Medical Officer or Occupational Health nurse):

10. **Conduct in Unit** (including any disciplinary action contemplated):

11. **Comments on motivation, morale, increased sickness absence and effect of the subject's medical condition on unit functioning:**

12. **Other relevant information including relevant social / welfare circumstances:**

13. **In your opinion, should the SP be retained in Service?** ☐ Yes ☐ No

Occupational report completed by:

Surname & Initials:		**Rank:**	
Regt / Corps:		**Unit:**	
Appointment (CO / OC):			
Signature:		**Date:**	

Subject

14. **Personal Statement:** (Include agree/disagreement with above, if you can complete your job and areas of difficulty)

[201] Weapon waivers are only to be granted for a maximum of 12 months and only where there is a reasonable expectation of a return to weapon handling within this timeframe.

OFFICIAL SENSITIVE – PERSONAL (when completed)

OFFICIAL SENSITIVE – PERSONAL (when completed)

I (Name) ……..…(Rank) …… (No) ……acknowledge the completion of this form by my Commanding Officer (CO) or Officer Commanding (OC). I also acknowledge that my CO or OC is able to obtain the opinion of other SPs (when considered necessary) to aid in the completion of this form. If Temporarily Non-Effective, I acknowledge the PRU staff are able to contact my previous CO/OC for necessary details. I have had the purpose of this form explained to me and that I understand that under the terms of the Data Protection Act 1998, I will be able to see a copy of the completed form if I so wish.

Date: ……/……/20…… Signature: ……..

OFFICIAL SENSITIVE – PERSONAL (when completed)

OFFICIAL SENSITIVE – PERSONAL (when completed)

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OFFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 19 TO CHAPTER 78

APPEALS PROCESS RELATING TO FITNESS FOR WORK ASSESSMENT (FWA) DECISIONS

General

1. Army Employment Policy (AGAI 78) is not medical policy; it is written and determined by the employer. A medical board will consider a SP's medical condition and relate any functional limitations to this employment policy as stipulated by Pers Pol (Army).

2. The medical board does not determine the employment of the SP, rather it advises the CofC on permissions and restrictions to employment determined by the medical condition.

3. Not being content with the grading and associated permissions/restrictions does not constitute sufficient grounds for appeal**.**

Soldier Candidates and Potential Officers

4. Boarding procedures for recruits, potential recruits, potential officers, and officer cadets are the responsibility of the Army Recruiting and Initial Training Command (ARITC). Candidates may appeal against decisions made at the pre-employment medical assessment or during training. HQ ARITC is the competent authority on pre-employment medical standards and as such is the final level of medical appeal for potential recruits and potential officers. HQ ARITC are the authority for Army Reserve pre-entry medical reviews with advice from SHA(A).

a. **Appeals Arising at the Pre-Service Medical Assessment (PSMA)**. The administration of appeals following deferral or rejection at the PSMA is detailed in ARITC Occupational Health Appeals Process Standard Operating Instruction (SOI). These appeals are defined as follows:

(1) **Level 1 Appeal.** The candidate is attempting to provide additional evidence countering the initial decision to reject/defer.

(a) **Level 1 A (Alpha) Appeal.** The candidate appeals to the Assessment Centre Senior Medical Officer (SMO).

(b) **Level 1 B (Bravo) Appeal.** The candidate appeals the SMO decision to the Medical Admin Team, National Recruiting Centre, Chief Medical Officer (CMO).

(2) **Level 2 Appeal.** This is the highest level of appeal for potential candidates. All avenues of investigation by Capita (at Level 1A and 1B) have confirmed that the standard which equates to A4L1M4E2 MFD has not been met but the candidate continues to contest either the interpretation of the guidelines or indeed the entry standards themselves ARITC Level 2 appeals must provide new medical or functional evidence or demonstrate that the interpretation of the guidelines has been incorrect. ARITC Level 2 Appeals are to be referred to ARITC Occ Med, ideally electronically to: ARITC-OccMed-Appeals@mod.gov.uk. ARITC Occ Med's decision is final and further appeal is not permitted.

Recruits and Officer Cadets[202]

5. **Appeals Arising During Training.** A recruit or Officer Cadet under training (basic and Initial Trade Training) may appeal against the decision of a FWA to their CO. The CO should then progress the appeal through the following levels as follows:

a. **Level 1 - Review.** The SMO, (must not have conducted the initial Board / Assessment) is to review the case and explain in detail to the recruit or Officer Cadet the reasons for the Board's decision. Increased understanding may satisfy the recruit or OCdt.

(1) **Level 1 - Appeal.** The candidate appeals the medical board decision to the training establishment SMO via the CO by completing the Appendix 20 including consent.

b. **Level 2 - Appeal.** If the recruit or OCdt is still unsatisfied and/or if the SMO identifies inconsistencies during the review, the CO may then request that ARITC Occ Med reviews the findings of the board. If a further medical assessment is required, the Cons OM may convene a FMB to re-assess the SP. Those undertaking training out-with ARITC (mainly some elements of Army Reserve) should appeal using the process described for trained personnel.

Trained Personnel

6. The route of appeal depends on the challenge by the SP.

a. **Appeals to FWA & FMB decisions.** Appeals will only be considered where the SP presents credible evidence that the board decision is incorrect. Appeals will normally be considered as a review of the medical record and the outcome will be communicated to the appellant in writing. There is no entitlement to a further face-to-face board.

b. **Medical Policy.** Where the medical policy used to determine the board decision (JSP 950) is challenged, the appeal may be made at Level 2: App 20 appeal via CO, where RCD/Comd Med may refer to SHA(A) for consideration of a MOD(A) Board.

7. **Level 1 Appeal.** A Level 1 appeal is to be made in writing, via letter or email, to the board which gave the grading[203]. The appeal must state:

a. Why the appeal is being made.

b. What solution is sought.

c. Supporting evidence must be presented.

8. **Level 2 Appeal.** If the appeal is not resolved at Level 1, the SP is to apply to the Comd Med (Army Reserve)/Regional Clinical Director (RCD) (Regular) via their CO. This appeal must be submitted using Appendix 20. The CO should consult with the original board to determine if the appeal is appropriate and to ensure the appeal is directed using the correct process as per para 2 above. The RCD or Comd Med will act as the non-clinical facilitator of the appeal as follows:

a. Where FWAs have not involved Cons OM, the RCD/Comd Med will request case review by the Regional Cons OM at the Regional Occupational Health Team.

[202] Including UOTC
[203] This may be a board conducted in Primary Care or, where ROHT has given direction on grading, the appeal should be directed to the ROHT, submitted in writing by letter or email. Where ROHT have simply ratified a primary care grading, the level 1 appeal is to be submitted to primary care.

b. In the case of an appeal against a FMB (or other board presided over by Cons OM), the case may be referred to CAOM for review by another Cons OM not previously involved with the board.

Timelines

9. Appeals are to be submitted within three months of date of the FWA, late applications will not be considered unless justified by the Commanding Officer. Routinely a response to an appeal will take up to 12 weeks at each level.

Complaints about the appeals process

10. A SP may submit a complaint against the appeals process in accordance with JSP 831[204].

Appeals to Employment policy.

11. If the employment policy or employment decision is being challenged, the SP may appeal to the AEB using the Appendix 25 and process described at part 11 of AGAI 78.

[204] JSP 831: Redress of Individual Grievances: Service Complaints

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APPENDIX 20 TO CHAPTER 78

SUBMISSION OF A FORMAL APPEAL AGAINST A FITNESS FOR WORK ASSESSMENT

TO THE COMMANDING OFFICER OF……..…….*(Unit)*

1. I ……..*(Number, Rank and Full Name)*

of ……..*(Regt/Corps)*, serving with ……*(Unit)*

or discharged on ……*(Date)* hereby wish to appeal against the decision

made by the Fitness for Work Assessment that took place on ……*(Date)*

at …….*(Medical Centre or other board location)*.

2. My reason(s) for this appeal is/are:

a.	
b.	

3. I would like the following outcomes:

a.	
b.	

Date:		**Signed:**	

4. CONSENT. Individuals are required to provide or withhold consent for access to their military medical record on DMICP by annotating and signing the Appendix 20. This access to medical records will allow the Occ Health team[205] to make an unbiased decision on the outcome of the Fitness for Work Assessment. All personal data will be processed in accordance with the Data Protection Act (DPA18).

I DO / DO NOT* give my consent for the Occ Health team to access my electronic medical records (on the DMICP IS system) for the purpose of reviewing my Fitness for Work Assessment.

I confirm that I understand the purpose for requiring such medical information. YES/NO*

[205] Occ Health team describes healthcare professionals providing occupational health advice to the chain of command and includes the Unit MO, ROHT, Occ Med Dept ARITC, etc.

I DO / DO NOT* wish to have access to this information.
If you chose to see your medical information and, upon review, you chose to withdraw consent to disclose specific aspects, you may do so in discussion with the CoC.

**(Delete as required)*

Signed: ……..……Date……

Date of Birth: ……Telephone:……

Address:……

……..

Email address: ……..

Note - This form should not contain confidential clinical information unless the SP wishes this information to be seen by their Commanding Officer. If the SP does wish to submit medical information confidentially it should be submitted by an appropriately marked, sealed means.

OFFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 21 TO CHAPTER 78

APPLICATION FOR REALLOCATION OR DISCHARGE OF A RECRUIT[206] MEDICALLY UNFIT FOR EMPLOYMENT WITHIN CURRENT CEG OR ARM/CORPS

Details of Recruit:

No:		**Rank:**	
Surname:		**Unit:**	
Regt/Corps:		**Forename:**	
CEG:		**Date of Enlistment:**	
Marital Status:			

Section A To be completed by the Unit CO

Notes:
(1) If a recruit is below MFD A4L1M4E2 by in-Service standards for their present Corps but within entry standards for another Corps this form is to be forwarded to the appropriate SPSO together with completed AF B6730 and Appendix 1 to Annex B of AGAI Volume 2 Chapter 48.
(2) If recruit is below Medical Employment Standards on Entry for any Corps this form is to be forwarded to ARITC SO1 Occ Med.

1. I can confirm that:

☐ a. The trainee is below Medical Employment Standards on Entry for their present Corps or Regt but is within Medical Employment Standards on Entry for another Corps or Regt.

☐ b. The trainee is below Medical Employment Standards on Entry for any Corps or Regt.

2. The trainee has been fully briefed on the implications of the Appendix 21.

Name:		**Signature:**	
Appointment:		**Date:**	

Section B To be completed by the Recruit

3*. I can confirm that:

☐ a. I am willing to be reallocated to another Arm or Service, my preferences are listed below **(this section should only be completed where the recruit is medically fit for transfer)**:

(1)
(2)
(3)

[206] Including Officers who have finished RMAS and ITT trainees.

OFFICIAL SENSITIVE – PERSONAL (when completed)

☐ b. I am not willing to be considered for transfer to another Arm or Service for the following reasons:

*****Tick as applicable

4. I have been fully briefed on the implication of the Appendix 21 and understand its possible outcomes.

Name:		**Signature:**	
Rank:		**Date:**	

Section C To be completed by the UMO

Notes:

(3) Where possible the UMO should be involved in conducting the Fitness for Work Assessment. The UMO is responsible for ensuring that sufficient information is provided to ARITC Occ Med to allow an employability or discharge decision to be made. Only the UMO or their delegated representative should sign Section D.

(4) An appropriately qualified Medical Officer should make comments below where medical condition has changed since the Fitness for Work Assessment has been conducted.

---

5. A Fitness for Work Assessment was conducted on …… to consider the employability of the soldier

listed and the SP is graded (JMES) as: ……

*****Tick as applicable

6. The F Med 23 is attached to this form and contains sufficient information to allow employability / discharge decisions to be reached. I have the following additional comments:

Name:		**Signature of Medical Officer[207]:**	
Appointment:		**Date:**	

Section D Attachments

7. The following documents should be attached to this form before forwarding to HQ ARITC Occ Med. Any documents classified as 'Medical in Confidence' should be placed in a sealed envelope which should only be opened by HQ ARITC Occ Med. Appendix 17 must be completed to allow ARITC SO1 Occ Med access to medical records.

☐ FMed 23 (UMO)

[207] See Note (6)

OFFICIAL SENSITIVE – PERSONAL (when completed)

☐ Appendix 9 (UMO)
☐ Appendix 17 (UMO)
☐ FMED 133
☐ Additional documents as listed:

Appendix 27 at unit discretion. Appendix 18 by exception

Section E To be completed by ARITC Occ Med

To the CO[208] …… *(Unit)*

8. Does the SP meet the selection criteria? ☐ Yes ☐ No

9. Is there the opportunity to maintain employment under a waiver (AF B203)? ☐ Yes ☐ No

10. Can the SP be transferred to another cap badge? ☐ Yes ☐ No

11. Discharge is recommended under the terms of ……

12. I have following additional comments[209] (inc justification for Qu 8-10):

Name:		**Signature:**	
Appointment:		**Date:**	

Section F To be completed by the SPSO (where medically fit for transfer)

Notes:
(5) This section is not completed where the individual is unfit for transfer to a different Arm or Service.
(6) If the SPSO considers the SP suitable for transfer, the Appendix 21 should be returned to the unit CO for transfer action to be initiated.

---

[208] For Officers in probationary commission, App 21 is to be sent to the Army Employment Board for ratification at Section F.
[209] ARITC SO1 Occ Med may wish to make comment regarding the appropriateness of re-joining.

13*. I can confirm that:

☐ a. This soldier is within Medical Employment Standards on Entry for reallocation to another Corps but is not suitable for the following reasons:

☐ b. This soldier is within Medical Employment Standards on Entry for reallocation to another Corps but is not willing to be reallocated.

☐ c. This soldier is within Medical Employment Standards on Entry for reallocation to another Corps and is willing to be reallocated.

14. The SP is considered suitable for employment as:

Name:		**Signature:**	
Appointment:		**Date:**	

PART 2 To be completed by Unit CO

Notes:

(7) Recommendation for discharge under QR(Army) para 9.381 Defective in Enlistment is to be completed by the CO on an AF B204.

(8) Recommendation for discharge under QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements is to be completed by the CO on an AFB 130.

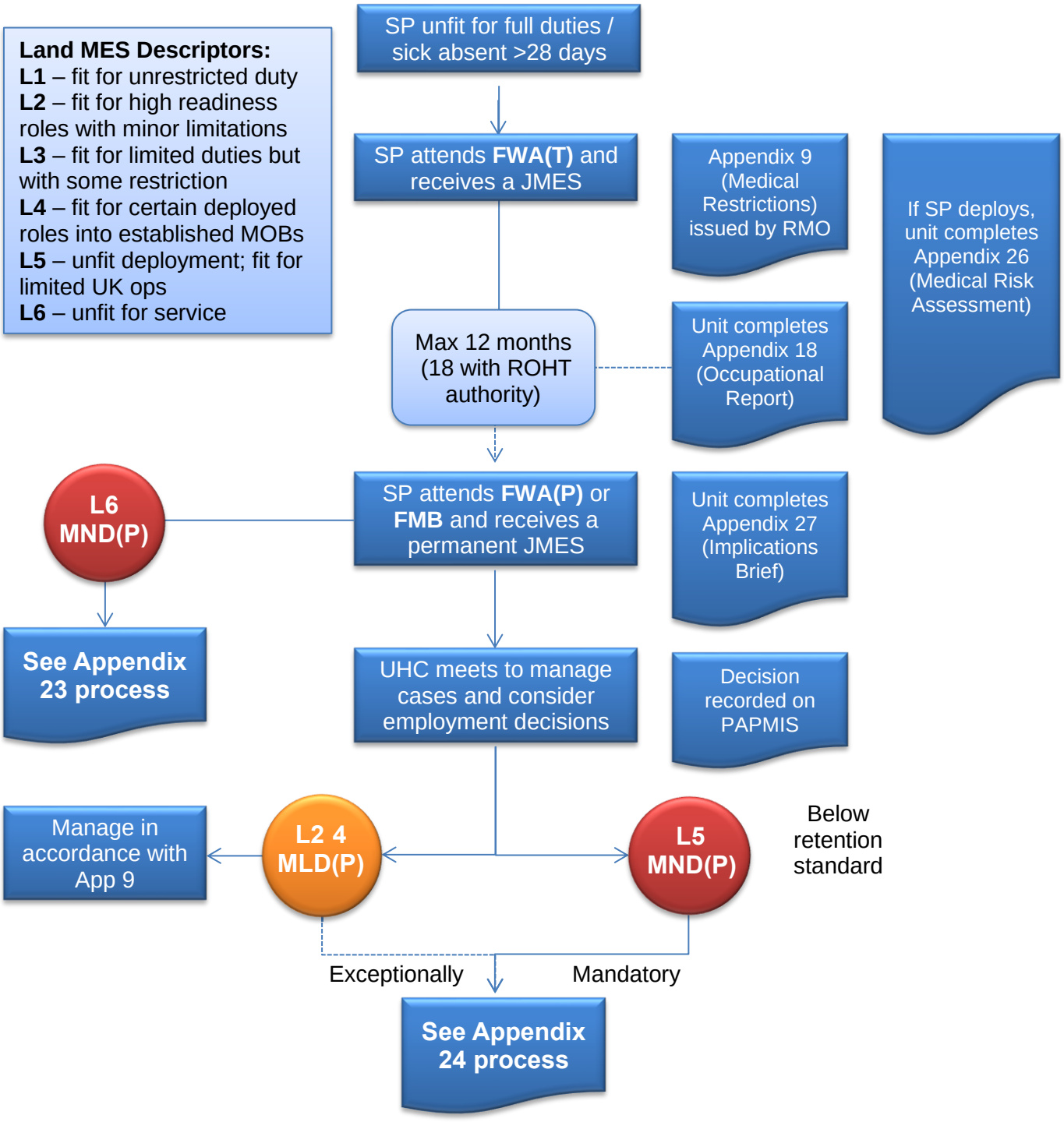
(9) Recommendation for retirement under PAW 20 paragraph 199 Medical Unfitness. (OFs in ITT only).

(10) Recommendation for reallocation to another capbadge is to be sent to APC CM Desk Officer.

15. Discharge is hereby authorised under the terms of ……

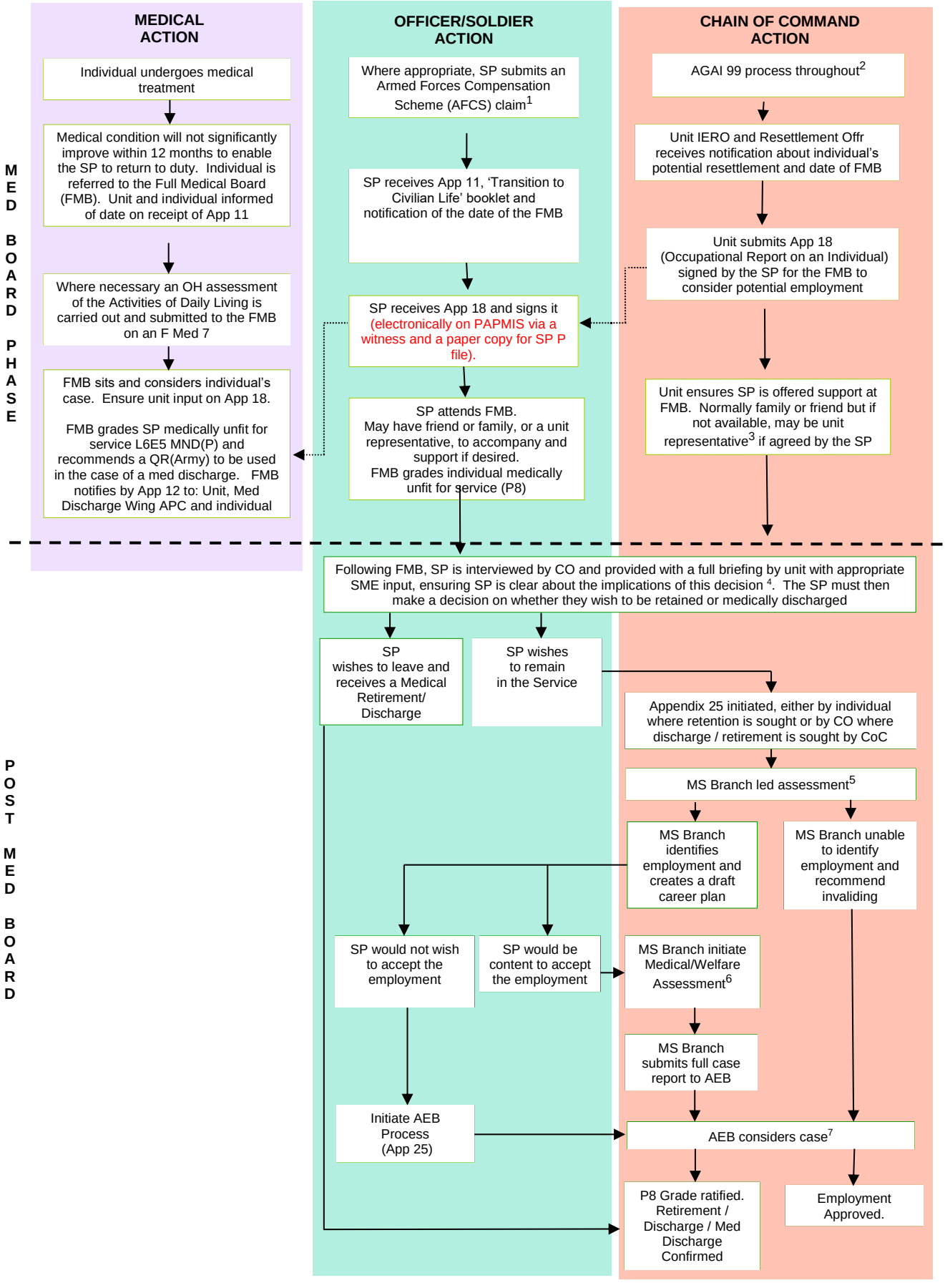
Name:		**Signature:**	
Appointment:		**Date:**	

APPENDIX 22 TO CHAPTER 78
CHAIN OF COMMAND AIDE MEMOIRE TO THE MEP PROCESS



APPENDIX 23 TO CHAPTER 78

AIDE MEMOIRE L6 MND(P) WHO WISH TO BE RETAINED



Notes:

1. Armed Forces Compensation Scheme (AFCS) information and claim forms can be obtained from the Veterans UK website at Veterans UK - GOV.UK (www.gov.uk)**,** Unit RAO and UWO and the Veterans Welfare Staffs can advise and assist with applications. The AFCS replaces the War Pensions Scheme and the Armed Forces Pension Scheme for injuries, illnesses or deaths caused by service in the Armed Forces after 6 April 2005. Applications can be submitted at any stage up to seven years after the injury / event.

2. This will normally be applied as soon as a SP is downgraded. AGAI Vol 3 Ch 99 (Command and Care of Wounded, Injured and Sick).

3. Role of unit representative is to support the SP, not to influence the board.

4. Subjects are to include financial/pensions (RAO), resettlement (IERO) and welfare (UWO) as a minimum. Where appropriate, the AFCS payment should also be confirmed (see **para 78.1015**).

5. MS Branch should consult with Regimental / Corps Colonels and the E1 workforce planners prior to the formulation of employment plans. Should also include further Occ Health assessments where necessary.

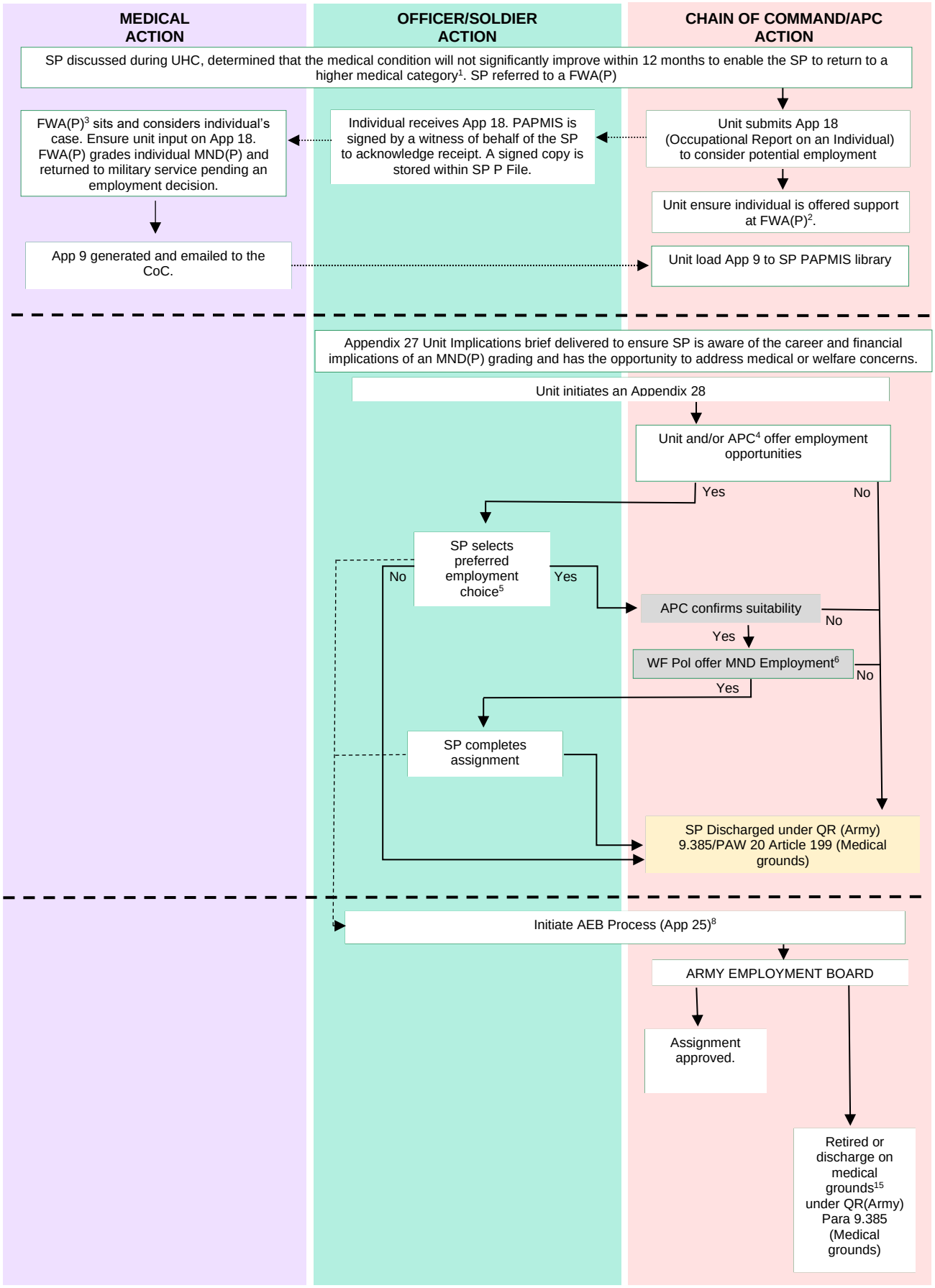
6. Assessments to be carried out by Army Welfare Service (AWS) Casualty Key Workers or Army Welfare Workers as appropriate. A report is to be produced for the Employment Board that covers all medical and welfare issues linked to continued employment. Issues such as costs for Service Families Accommodation (SFA) / Single Living Accommodation (SLA) and workplace modifications for activities of daily living; estimated future medical / welfare costs, additional necessary leave for attending appointments/convalescence and to include likely additional Travel and Subsistence bill etc.

7. Army Employment Board (AEB) will consider FWA recommendation, CO's comments, a personal statement by the SP, the potential career plan, medical / welfare report and retirement / discharge / retention options (see Part 11).

8. SPs approved for continued employment will remain in their current JMES (including medically unfit for service (L6 MND (P)) and subject to conditions specified by the AEB. Additionally, SPs unable to maintain employment may apply through their CO to the APC (SO1 Occupational Health) for medical discharge. The APC will decide on the most appropriate course of action to facilitate this.

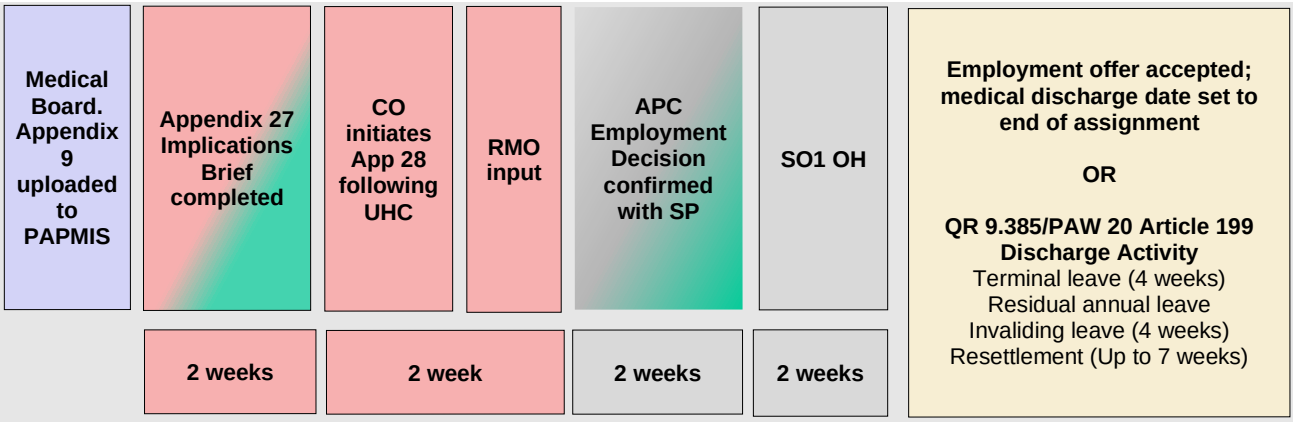
APPENDIX 24 TO CHAPTER 78

AIDE MEMOIRE FOR SP GRADED L5 MND(P)



Timings:

The following timeline is to be adhered to for submission and management of the Appendix 28:



Notes:

1. If appropriate throughout the process the SP may consider an application to the Armed Forces Compensation Scheme (AFCS). Information and claim forms can be obtained from the Veterans UK website at Veterans UK - GOV.UK (www.gov.uk)**.** The AFCS replaces the War Pensions Scheme and the Armed Forces Pension Scheme for injuries, illnesses or deaths caused by service in the Armed Forces on or after 6 April 2005. Applications can be submitted at any stage up to seven years after the injury/event.

2. Normally family or friend but if not available, may be unit representative if agreed by individual. Role of unit representative is to support the SP, not to influence the board.

3. All FWA(P) resulting in a MND(P) grading are to be ratified by a Con OM. This should be done concurrently and does not prevent the unit proceeding with an employment recommendation.

4. Employment opportunities will be considered on a case by case basis and may be offered within the current unit and/or elsewhere in the Army. Where no suitable employment is available this should be annotated on the Appendix 28.

5. Where employment opportunities are identified the SP is to indicate their preference. SP who do not wish to be retained in service may annotate this as a preference.

6. Wf Pol will consider both the needs of the SP and the Service when making an employment offer. Retention in service will be granted to the FAD annotated on the Appendix 28.

7. Appeals to the AEB only initiated where either the SP requests a review of an Employment Decision or where the Army wishes to retain the individual due to SQEP/Service needs.

FFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 25 TO CHAPTER 78

APPLICATION FOR ACTION BY THE ARMY EMPLOYMENT BOARD (AEB)

1. The AEB action is requested in the case of:

No:		**Rank:**	
First name:		**Surname:**	

2*. The SP named above has signed **Appendix 17** consenting to disclosure of medical and administrative records and this is attached.

☐ Yes ☐ No

3. In the case of an application **for retention**, the SP is to give the reasons why they wish to be retained:

(This should include the key reasons why the AEB is requested to review the case including a clear articulation of why retention is sought. These could include whether the grade assigned by the FMB is challenged, welfare and medical considerations)

Name:		**Signature:**		**Date:**	

4. In the case of applications for retention, the Commanding Officer is to confirm whether they support retention and why the AEB is requested to review the case:

(Comments could also include whether the grade assigned by the FMB is challenged, the wishes of the SP, the wishes of the unit, welfare considerations and presentation issues)

FFICIAL SENSITIVE – PERSONAL (when completed)

Name:		**Signature:**		**Date:**	

*****Tick as applicable

5*. The following information is to be submitted with all applications by the unit:

	Documents	**JMES**	**Action**	**Remarks**
☐	F Med 23 & 24	L6 MND(P) L5 MND(P)	FMB automatic to APC SO1 OH request from MC	
☐	Appendix 28 (if appropriate)	L5 MND(P) (Exceptionally L2-4 MLD(P))	Unit	SO1 OH POC to advise on completion of documentation
☐	Appendix 12	L6 MND(P)	FMB Automatic	
☐	Appendix 17	L6 MND(P) L5 MND(P)	FMB Automatic SO1 OH request from MC	AEB Consent form in addition through SO1 OH
☐	Appendix 18	L6 MND(P) L5 MND(P)	FMB automatic SO1 OH request from unit	
☐	Appendix 20 (Appeal cases only)	L6 MND(P)	SP	Appeal through unit CO to AEB.
☐	Personal statement from SP	L6 MND(P) L5 MND(P)	FMB automatic SP	As required.
☐	Interview record with SP and signed statement to the effect that they have been fully briefed on options and implications surrounding medical discharge	All	Unit	Send to SO1 OH
☐	APC Career Plan	All	MS Branch	SO1 OH to request
☐	Welfare Report	All	AWS/Casualty Key Worker	As required SO1 OH to request
☐	CO's Report (in addition to Appendix 18)	All	Unit CO	Where required to support Appendix 18

Note: SO1 OH will direct CofC, MS Branches and other key organisations (i.e. AWS, Veterans UK etc) as to who is responsible for providing the information.

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

*****Tick as applicable

6. **For SO1 OH Action.** The following additional documents were considered by the FMB and are attached to this application:

Name:		**Signature:**	
Appointment:		**Date:**	

7. **Decisions of AEB and Reasons:**

Name:		**Signature:**	
Appointment:		**Date:**	

FFICIAL SENSITIVE – PERSONAL (when completed)

Intentionally blank

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 26 TO CHAPTER 78

DEPLOYMENT MEDICAL RISK ASSESSMENT FORM

This assessment must be completed for soldiers with a medical grading below MFD who are at readiness (R1-3) or warned for deployment[210]. The aim of the form is to:

- Articulate relevant medical limitations
- Identify the risk these present to the soldier, the mission or the Commander
- Confirm any mitigations which will be put in place to enable deployment

It is to be initiated by the subunit commander in conjunction with the Appendix 9 with input as required from the soldier, UMO and ROHT. **The decision on fitness for deployment is owned by the CO and must be agreed by the deployed commander.**

No:		**Rank**		**Surname:**	
Unit:		**Regt/Corps:**		**JMES:**	**A __ L __ M __ E__**
Branch / Trade:				**Role:**	
Reason for App 26	**Deployment and MST for** _____ ☐ **Overseas Training Exercise or short term training team** _____ ☐ **Held at R1-3 (complete section 2-4 on activation) for** _____ ☐				

SECTION 1 - ROLE SPECIFIC ASSESSMENT

1. **Role**. Details of activity required in deployed role:

Operational/deployed Role[211]:

BLUE SECTIONS ARE A GUIDE – KEEP INFORMATION RELEVANT AND USE OR DELETE AS USEFUL

Physical and mental demands of role: *work environment, accommodation, working hours*

Training Locations and associated health threats:

Weapon systems carried:

Personal protective equipment requirements: *Body armour/EOD suit*

Vehicles and transport:

Other considerations:

Previous Demonstration of fitness for role:

Recent exercise and training performance consistent with deployment role:

Previous CASEVAC requirements or use of medical services:

Previous successful deployment in role:

[210] MND personnel are non-deployable but may be held at readiness for some UK Ops and may rarely deploy on OTX
[211] Job Spec to be attached where available.

No:		**Rank:**		**Name:**	

FFICIAL SENSITIVE – PERSONAL (when completed)

2. **Relevant medical restrictions**. Refer to Appendix 9 and seek MO/ ROHT advice as necessary.

Medical Restrictions:
Mandated need for proximity to medical facilities (specify capability required CMT/ MO/ deployed hospital):
Requirement for monitoring or attendance at appointments or follow up:
Requirement to store medications: refrigerated/ambient:
Requirement to carry specific equipment or use an electrical supply:
Ability to carry weight and conduct military tasks patrol, tab and run:
Requirement for hearing protection:
Specific environmental restrictions:
Likelihood of generating workload for available medical support:
Other factors:

3. **Mitigations**. This section identifies measures which will be put in place to support deployment. These must articulate how risk to the SP or to the mission may be avoided.

Mitigation of Risk
How will we avoid exacerbation of the condition and identify a deterioration in health if it occurs?
How will we ensure follow up treatment or outstanding rehabilitation is not missed?
Is there likely to be exposure to exacerbating conditions NOISE, HEAT, COLD in this role and how can this be managed?
Can sudden incapacitation be avoided- if not how will the condition be managed?
Can I ensure appropriate Medical support, transport, equipment and facilities are available to support the condition?
Are additional force preparation measures required in advance of deployment?

4. **Provisional acceptance of employment in role**. This endorsement is required only for those held at readiness without a specific task. All other MRAs should be continued in Section 2.

Record CO provisional acceptance of employment for non-MFD force elements at readiness. **UHC date (quarterly review)** _____ **Comments/caveats:** **Risk of deployment (High/ Low)**	☐

End of initial MRA for F@R until activation

No:		**Rank:**		**Name:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

SECTION 2 - DESTINATION SPECIFIC ASSESSMENT

5. **Additional risks to health from deployed environment**. Identify any new issues related to the deployed environment which could affect the health of this soldier.

I have referred to the mounting instruction/ Op Order for _____
Environmental conditions: Austerity, endemic health threats- disease
Medical support availability: capacity, capability, timelines
Exposure to hostile activity: DCC, resilience, unexpected noise exposure
Other factors:

6. **Additional Mitigations**. Any additional protective measures required to enable deployment in this environment:

Restrictions or measures in place to ensure sustainable deployment:

SECTION 3 – MEDICAL REVIEW IF REQUIRED

7. Review Appx 9 section 6. Is a medical review required?

Yes ☐ (UMO to review App 26 and refer to ROHT as required)
No ☐ (**Go to 8**)

UMO Comments (including ROHT as necessary):
Date of App 26 review
Decisions recorded in DMICP

SECTION 4 – COMMAND ENDORSEMENT

8. **Command endorsement**.

Commanding Officers decision on risk of deploying SP in specified role.
Deployment in proposed role - Accepted ☐
Deployment in proposed role - Refused ☐
Comments:

9. The MRA has been completed with the input required from CO, MO, soldier and deploying command team.

Name:		**Rank:**		**Post:**	
Signature:		**Dated:**		**Contact No:**	

Copy to:
Deploying Comd and MO
Adjt for PAPMIS
SP for carriage on Op
MO for scan to DMICP

No:		**Rank:**		**Name:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 26C TO CHAPTER 78

DEPLOYMENT MEDICAL RISK ASSESSMENT FORM FOR UK COVID OPERATIONS

This assessment must be completed for soldiers with a medical grading below MFD who are being considered for employment as part of UK COVID Operations.

The aim of this form is to guide and document the Medical Risk Assessment by:

- Stating role requirements.
- Identifying risks to the soldier, the mission or the Commander from medical limitations or potential exposure to COVID-19.
- Confirming what mitigations will be put in place.

This form is to be initiated by the Sub-Unit Commander who must review the Appendix 9 carefully and seek input from the soldier, Unit Medical Officer (UMO) and Regional Occupational Health Team (ROHT) as required.

Please note **Clinical information should not be sent to this address.**

Additional notes:

- **Medical Deployment Standards (e.g. MND) are not specifically aimed at MACA tasks.**
- **Downgraded SP may have greater utility for UK COVID Ops than for Combat Ops, but COVID poses a different threat and impact on health support.**
- **If in doubt seek medical advice from the ROHT.**

The decision on fitness for deployment is owned by the Commanding Officer (CO), who must agree the required mitigations with the deployed commander.

No:		Rank:		Surname:		
Unit:		Regt/Corps:		JMES:	A__ L__ M__ E__	Temp/Perm
Branch / Trade:		Proposed Role:				
Contact details of SP (for consent)		Mobile Number:		Email:		
Contact details of CO's representative		Mobile Number:		Email:		

No:		**Rank:**		**Name:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

SECTION 1 – ROLE SPECIFIC ASSESSMENT
Chain of Command to complete

1. **Role requirements.** Details of physical and mental demands of activity required in role:

Is the SP expected to break social distancing rules? Yes/No

Will the SP be expected to interact with other people in a way that breaks social distancing rules? Yes/No

If Yes are the other people:

Vulnerable? Yes/No

Suspected/confirmed COVID-19 cases? Yes/No

Will Personal Protective Equipment (PPE) be worn?

Civilian PPE? Yes/No

Military PPE? Yes/No

If Yes, please detail here:

What are the expected physical demands of the role?

Is the role sedentary/office-based? Yes/ No

Is the role physically-demanding? Yes/No

Please detail here:

What are the expected working hours? Routine office hours/extended hours/shift pattern/night duty

Does the role involve driving? Yes/No **HGV licence required?** Yes/No

If yes to driving role, is this:

Green Fleet? Yes/No

White Fleet? Yes/No

Has the SP demonstrated ability to fulfil this role before? Yes/No

If Yes, please detail here:

Will the SP need to carry a weapon system? Yes/No

If yes please detail here:

Is there any risk of unexpected/persistent noise exposure? Yes/No

If Yes, please detail here:

Is there any risk of cold or heat exposure? Yes/No

If Yes, please detail here:

Will the SP have access to a reliable electricity supply? Yes/No

i. **If Yes, will the SP have access to refrigeration facilities?** Yes/No

What accommodation will be provided:

ii. **Sleeping arrangements?** Bed/Camp Cot/Field Conditions/Unknown

iii. **Toilet and washing facilities?** Individual/Shared/Field Conditions

No:		**Rank:**		**Name:**	

FFICIAL SENSITIVE – PERSONAL (when completed)

2. Special considerations

Does this individual have any specialist skills specifically needed for UK COVID Ops or are there any other factors that should be taken into consideration? Yes/No

If Yes, please detail here:

3. Mitigations

Considering the Appendix 9 limitations, how will you ensure this individual is employed appropriately and will not burden the limited medical support available?

Please detail here:

4. Appendix 9 Consideration

Is the proposed role compatible with Appendix 9 restrictions? Yes/No

If No STOP and reconsider proposed role and possible mitigations.

If Yes please refer for medical advice through UMO if available, or direct to ROHT.

SECTION 2 - MEDICAL REVIEW
Medical team to complete.

5. Medical assessment

No:		**Rank:**		**Name:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

Risk Assessment by UMO (if available)

Comments and Recommendations:

Are UMO decisions recorded in DMICP? Yes/No

Is ROHT referral required*?* Yes/No

If Yes, please detail reason here:

Risk Assessment by ROHT (if required)

Comments and Recommendations:

Are ROHT decisions recorded in DMICP? Yes/No

6. Medical chain endorsement.

Supported/ Not Supported	Name:		Rank:		Post:	(UMO)
	Signature:		Dated:		Contact No & Email:	

Supported/ Not Supported	Name:		Rank:		Post:	(ROHT)
	Signature:		Dated:		Contact No & Email:	

SECTION 3 - COMMAND ENDORSEMENT

7. **Command endorsement**.

Commanding Officers decision on risk of deploying SP in specified role.
Deployment in proposed role - Accepted ☐
Deployment in proposed role - Refused ☐
Comments:

8. The MRA has been completed with the input required from CO, MO, soldier and deploying command team.

Name:		**Rank:**		**Post:**	
Signature:		**Dated:**		**Contact No:**	

No:		**Rank:**		**Name:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

FFICIAL SENSITIVE – PERSONAL (when completed)

Copy to:
Deploying Comd and MO
Adjt for PAPMIS
SP for carriage on Op
MO for scan to DMICP

No:		**Rank:**		**Name:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

OFFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 27 TO CHAPTER 78

EXAMPLE OF A UNIT IMPLICATIONS BRIEF

Must be completed for all permanently downgraded MND(P) and exceptionally MLD(P) if the CoC have applied to WF Pol to make an Employment decision. This appendix is optional for SP temporarily downgraded.

1. **Introduction**. Immediately on receipt of an Appendix 9 from the RMO confirming a permanent medical grading of MND or MLD (where the CoC are completing Appendix 28), this brief must be given to the SP by their OC or an appropriate alternative, which may include WIS staff[212]. It is to be completed before an employment decision is made and should be reviewed annually where the SP is retained.

2. **Personal Details**.

Number	Rank	Name	Sub-unit	JMES[213]	Remarks

3. **OC Interview:**

a. Outline the implications of the SP's JMES Grading and the process.
b. Does the SP wish to be retained? YES / NO
c. Is the SP a volunteer to transfer for alternative employment? YES / NO

OC Comments

Signed:

4. **Adjt/RCMO Interview**. The Adjt/RCMO should confirm that the SP understands they will be medically discharged. For those graded L5 MND(P) this should include information on the employment offer process. They should outline:

Adjt/RCMO Comments including:

- The potential outcomes of the Appendix 28
- Retirement/discharge through Appendix 28 or as a result of being graded MND(P) L6E5 Perm both constitute retirement/discharge on medical grounds (not administrative).
- An explanation of the AEB and appeals processes.
- The SP should also be given resettlement entitlement advice and support, including outline planning and booking of initial resettlement interviews/workshops (if applicable).

Signed:

[212] If an individual is designated WIS, it is the PRO or Unit WIS officer, under the direction of the UWO and in consultation with the RMO, who delivers the Implications Brief.
[213] Either MND Perm or MLD Perm.

OFFICIAL SENSITIVE – PERSONAL (when completed)

5. **RAO Interview**. The RAO should give broad financial advice, including pay, pensions, and compensations and 'signpost' the SP towards independent financial advisers for more detailed advice. If appropriate, the RAO should assist in completing and submitting an Armed Forces Compensation Scheme application and submitting a request for information on pension entitlements from Veterans UK.

RAO Comments   **Signed:**

6. **Welfare Interview (if applicable).** The UWO should outline additional welfare support if applicable.

UWO Comments   **Signed:**

7. **Medical Advice (if applicable).** The RMO should provide additional medical advice and support if required by the SP.

RMO advice (if requested) **Signed:**

8. **Completion Procedure.** Once complete, the OC and soldier must sign below, and the Adjt/RCMO must sign to acknowledge receipt of the completed form for their inclusion on the soldier's P-File.

OC Signature…… **Date**…….

SP Signature…… **Date**…….

Adjt/RCMO Signature…… **Date**……..

OFFICIAL SENSITIVE – PERSONAL (when completed)

APPENDIX 28 TO CHAPTER 78

APPLICATION FOR AN EMPLOYMENT OFFER FOR SP GRADED L5 MND(P)

The Appendix 28 is initiated at unit level for all SP graded L5 MND(P). The Employment offer is to be made by the unit following consultation with APC CM Branches and where necessary E1 workforce planners. If no suitable employment is identified or a SP rejects an offer of employment they will be medically discharged. This appendix is for trained SP only.

** Tick as appropriate*

Section A To be completed by Unit CO

No:		**Rank:**	
Surname:		**Unit:**	
Regt/Corps:		**Forename:**	
CEG:		**Date of Commission / Enlistment:**	
EED:		**FAD:**	

1. The SP listed above is currently employed within my unit as ……

2.* ☐ I certify that the SP has been fully briefed on this process and its possible financial, welfare and career implications. I have ensured that an Appendix 27 has been completed.

3.* Following initial consultation with the medical chain and the relevant APC CM, I recommend the following[1].

☐ Offer of employment in unit.
☐ Offers of employment in unit and elsewhere considered.
☐ Offers of employment elsewhere to be considered.

4. The following circumstances and factors support my recommendation (to include impact on the unit):

5. The following documents should be uploaded to the SP's PAPMIS record or in extremis attached to this form before forwarding to APC-CMOps-OH-Group-Mailbox@mod.gov.uk.

- Appendix 18 (Complete on PAPMIS)
- Appendix 9 (Uploaded to PAPMIS library)
- Appendix 17 (Uploaded to PAPMIS library)
- Appendix 27 (Complete on PAPMIS)
- For MLD(P) L2 – L4 SP. Exceptional authority to sought via Hd Pers Pol, Workforce Pol

OFFICIAL SENSITIVE – PERSONAL (when completed)

Branch.

Name:		**Signature:**	
Rank:		**Date:**	

Notes:
(1) On consideration of the facts, the CO may request that APC considers all possible employment options.

Section B (retained in unit) To be completed by the Adjt / RCMO (in consultation with APC Career Manager)

6*. ☐ I can confirm that all in unit employment opportunities have been explored (and agreed with APC):

7. The SP has potential for employment in the following roles.

a. Position title……PID …….. Assignment End Date ……..

b. Position title……PID …….. Assignment End Date ……..

c. Position title……PID …….. Assignment End Date ……..

Or

8. No employment offer can be made to the SP for the following reasons:

Name:		**Signature:**	
Appointment:		**Date:**	

Section C (retained elsewhere) To be completed by APC Career Manager

9*. ☐ I can confirm that all employment opportunities have been explored (in consultation with E1 WF Planners) or this SP is a Reservist and Career Managed within Unit.

10. The SP is assessed as suitable for employment in the following roles:

a. Position title……Unit……PID …….. Assignment End Date ……..

b. Position title……Unit……PID …….. Assignment End Date ……..

c. Position title……Unit……PID …….. Assignment End Date ……..

Or

OFFICIAL SENSITIVE – PERSONAL (when completed)

11. No employment offer can be made to the SP for the following reasons:

Name:		**Signature:**	
Appointment:		**Date:**	

Notes:
(2) If employment options are identified at this stage an APC OH assessment must be undertaken, and medical limitations highlighted to the future employer to inform a risk assessment, once complete the CM is to convene an E1 appointment board or to submit to MS7 for E2 appointment board.

Section D To be completed by Individual (completed by Adjt / RCMO in individuals presence)

12.* ☐ I am fully aware of the career, financial and welfare implications of the Appendix 28.

13.* Where employment opportunities have been identified, the SP must choose whether they wish to accept or decline the offer and confirm the role they wish to accept. Where it has not been possible for an employment offer to be made individuals should select the decline box. (see note 4).

☐ I wish to accept the employment offer ☐ I wish to decline the employment offer/no employment offer was made

14. I confirm that the employment offer I wish to accept is:

Position title……PID …… Assignment End Date ……

Name:		**Signature:**	
Appointment:		**Date:**	

Notes:
(3) The unit must ensure that the individual has been fully briefed and is aware of the implications of the Appendix 28 prior to the completion of question 12.
(4) If a SP has not been offered an employment opportunity and must decline Question 13 it will not affect their right to appeal via the AEB.
(5) Appeal against the employment offer or discharge decision is to the Army Employment Board via APC OH using the Appendix 25 application.
(6) Unit to communicate SP's employment decision with APC CM, whilst application is approved by OH and WF Pol.

Section E To be completed by APC SO1 OH

15. I confirm that the above-named SP, whose JMES is……., appears to be functionally able to perform the duties of…… in ……(Unit) and that if they are retained in this employment, this should not exacerbate their reason for being downgraded or place at risk the health and safety of others.

OFFICIAL SENSITIVE – PERSONAL (when completed)

Or

16. I can confirm that no suitable MND Employment opportunities are available for the SP named in Section A or the SP does not wish to be retained in Service. Discharge is authorised under the terms of PAW 20 Article 199 / or QR(Army) para 9.385 Ceasing to Fulfil Army Medical Requirements

Name:		**Signature:**	
Appointment:		**Date:**	

Section F WF Pol Approval

17*. Workforce Policy

☐ Approve ☐ Reject

18. Employment is approved in the following role:

Position title……Unit……PID …….. Assignment End Date …….

Or

19. The application for employment is rejected for the following reasons:

Name:		**Rank**		**Signature:**	
Date:		**Appt:**		**Unit:**	

Section G To be completed by Career Manager

20. I acknowledge the SP choice and can confirm assignment/ discharge action will be taken with respect to PID……. (new PID or extant PID).

Name:		**Signature:**	

OFFICIAL SENSITIVE – PERSONAL (when completed)

Appointment:		**Date:**	