ARMY

PULHHEEMS Administrative Pamphlet 10 (PAP10)

PULHHEEMS Administrative Pamphlet

10

Supersedes 2010/07 Edition

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DEFINITIONS

PULHHEEMS

1. The PULHHEEMS system of medical classification is a tri-Service 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' eg 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 JMES comprises a deployment and employment standard and gives detail of any medically recommended restrictions based on the PULHHEEMS assessment (para **0122 et seq**).

Colour Perception (CP)

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

INTRODUCTION

Purpose of Pamphlet

1. This pamphlet 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

2. The instructions contained in this pamphlet are applicable solely to the Army and apply to all ranks serving in the Regular Army, Regular Army Reserve and Territorial Army (TA). The general principles given in this pamphlet also apply to locally enlisted personnel (LEP). Except where stated to the contrary, all the provisions of the pamphlet are applicable to male and female soldiers/officers.

Sponsorship

3. The minimum medical standards in Tables 1 to 6 are the responsibility of the Directors of Arms/Services (A&SD) concerned, operating through sponsor branches, who are also responsible for supplying Directorate of Manning (Army) (DM(A)), with required amendments for the whole pamphlet in a regular and timely system of review. These branches are listed in Appendix 27. Medical advice is co-ordinated by Health Branch of the Army Medical Directorate (AMD Health) on behalf of the Director General of Army Medical Services (DGAMS). Headquarters Army Recruiting and Training Division (HQ ARTD) advises upon entry standards for officers and soldiers, and should be consulted on all matters affecting entry standards. DM(A) co-ordinates the A&SD requirements and lays down the procedures for operating the PULHHEEMS system. Queries on the chapters in this pamphlet should normally be addressed to DM(A), although queries of a purely medical nature are best directed to AMD. Queries on the tables should normally be addressed to the sponsor branch concerned.

4. 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 undertaken. This policy is due for review not before 2013.

CHAPTER 1

General Principles of the PULHHEEMS System of Medical Classification

GENERAL

0101. The PULHHEEMS system are 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 P grade and associated JMES grading is the responsibility of medical staff. In individual cases Directorate of Manning (Army) (DM(A)) has the authority (after taking appropriate medical advice) to waive or vary employment restrictions contained within the definitions of the P grade or JMES grade. Any application for such a waiver should be made through the chain of command to the appropriate MS Branch at the Army Personnel Centre (APC) prior to submission to DM(A).

0102. 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 individual's future physical performance.

0103. Paras **0105-0126** 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 definitions are at para **0123-124.**

0104. The PULHHEEMS system of medical classification and JMES grading is designed to:

a. provide a functional assessment of the individual's capacity for work;

b. assist in expressing the physical and mental attributes appropriate to the individual'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 in light of their physical, intellectual and emotional make-up, and thus to economise in manpower;

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

METHOD OF ASSESSMENT

0105. 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.* Guidance for medical officers is given in Chapter 7 Medical Employment Standards Policy .

The Qualities Assessed under the PULHHEEMS System

0106. In order to record in detail the physical and mental capacity of an individual, medical classification under the PULHHEEMS system is considered and recorded under the following qualities.

a. **Physical Capacity (P).** This quality is used to indicate an individual's overall physical and mental development, his or her 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 individual's ability to handle weapons and loads. A reduced 'U' grading will affect the 'P' grading.

c. **Locomotion (L).** Indicates an individual's ability to march/run. The 'L' grading refers to the functional efficiency of the locomotor system. This quality must therefore take into account 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. However, 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. However, severe loss of visual acuity will affect the 'P' grading.

f. **Mental Capacity (M).** Indicates the individual's ability to learn Army skills and duties. Mental capacity is not subject to formal medical assessment at recruitment. However, the recruit selection procedure, including interviews, and the individual'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 individual'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.

The Meaning of P Grades

0107. The meaning of each P grade is linked to employment and are further described in Table 7. P grades arise from the PULHHEEMS assessment. This classification applies to males and females equally. The exact criteria for each P grade and associated deployability standards are discussed below. Deployment standards are described in full at para **0122**. The P grade may be Temporary (annotated with T suffix – see para **0120**) or Permanent.

a. **P2 – Medically fit for unrestricted service worldwide**. The functional meaning of P2 is the absence of a medical condition or physical limitation that would prevent the soldier undertaking all aspects of his/her military duties. This grade would attract a JMES deployment standard of Medically fully deployable (MFD).

b. **P3 – Medically fit for duty with minor employment limitations.** The P3 grade is to be used for an individual who has a medical condition that prevents him/her undertaking the full range of military duties. Such individuals are able to perform useful duties in barracks, but may not be able to carry out all aspects of their employment. They may require medication or medical follow-up. The individual's condition is unlikely to significantly deteriorate if there is an interruption to the supply of medication or the delay in planned medical review. The individual's condition is unlikely to impose a demand on the medical services if deployed on operations. A medical risk assessment by the unit, supported by an up to date Appendix 9 and if appropriate additional advice from a Medical Officer (MO) or a Regional Occupational Medicine (OM) Consultant is required for routine activities, OTXs and deployment. This grade will attract a JMES deployment standard of Medically limited deployability (MLD).

c. **P4** – **Medically fit for duty within the limitations of pregnancy.** Pregnant personnel are graded P4 and attract a JMES deployment standard of Medically not deployable (MND).

d. **P5 and P6.** P5 and P6 are not to be used.

e. **P7 – Medically fit for duty with major employment limitations.** P7 is to be used for an individual who is capable of performing useful military duties within the limits of his/her disabilities, expected to give regular and efficient service and not likely to deteriorate if suitably employed and allowed time for regular meals and rest. Individuals may be restricted in their ability to work at night or undertake shift work. They may require regular, continued medical care or supervision and may require regular long-term medication. They may require access to secondary level (hospital) medical facilities. They are not normally fit to deploy on military operations. This grade will normally attract a JMES deployment standard of MND, or exceptionally MLD.

f. **P8** – **Medically unfit for service**. This grade will attract a JMES deployment standard of MND.

g. **P0 – Medically unfit for duty and under medical care**. To be used for an individual who is unfit for duty and under treatment, they may undertake

recovery activity in support of an Individual Recovery Plan. This grade will attract a JMES deployment standard of MND (Temp). The individual must be reviewed no later than the 9 month point by a Service Occupational Health Consultant. This is to determine functional capability and review the recovery pathway in order to advise the CoC if return to work within a further 9 months is likely. By the 18 month point the Service Occupational Medicine Consultant must have convened a FMB and awarded a JMES taking into account the functional standards at Table 7. The grade of P0[1] cannot be allocated for longer than 12 months without written authority from DM(A). This will only be granted in exceptional circumstances[2].

0108. Degrees of Assessment

a. Under quality P - assessed under degrees 2, 3, 4, 7, 8 and 0.

b. Under qualities U and L - assessed under degrees 2, 3, 7 and 8.

c. Under quality HH - assessed under degrees 1 to 4 and 8.

d. Under quality EE - visual acuity (i.e. ability to see at distance aided or unaided) in both eyes is recorded in certain ratios, i.e. 6/6, 6/9, 6/12, 6/24, etc. For simplicity in recording a PULHHEEMS assessment, these ratios are expressed in degrees as follows.

6/6 or better	=	1
6/9	=	2
6/12	=	3
6/18	=	4
6/24	=	5
6/36	=	6
6/60	=	7
Less than 6/60	=	8

(1) Distant visual acuity for the right eye is recorded under the first E and the left eye under the second E. The degree of unaided vision is recorded in the same way as the degrees for the other qualities. The degree of aided vision, when applicable, is shown below the degree of unaided vision. Thus a man/woman whose visual acuity is unaided-right eye 6/12, left eye 6/18, and aided-right eye 6/6, left eye 6/9 is recorded as:

E	E
3	4
1	2

(2) A man/woman whose unaided vision in both eyes is 6/6 is recorded as:

[1] P0 extending beyond 56 days is classed as Temporary Non Effective
[2] In conjunction with advice from SO1 OH APC

E	E
1	1

Note: The wearing of contact lenses in no way alters the provisions of JSP 346 in regard to eye diseases.

e. Under quality M - assessed under degrees 2, 3, 7 and 8.

f. Under quality S - assessed under degrees 2, 3, 7 and 8.

0109. Table 7 shows in detail the functional requirements for the degrees used. These functional requirements are the same for both male and female.

Colour Perception

0110. For certain Arms and employments the ability to distinguish colours is essential. Colour perception (CP) is assessed as follows.

Standard 1. (CP1) Not in use in the Army, except RLC Maritime personnel (see Table 1).
Standard II. (CP2) Normal red/green colour perception.
Standard III. (CP3) Able to distinguish accurately white, signal red and signal green.
Standard IV. (CP4) Unable to reach Standard III.

The minimum CP accepted for each Arm and employment are given in Tables 1, 2 and 5.

The Effect of the Loss of a Limb

0111. The effect of the loss of a limb during service will be assessed on residual functional ability, each case being considered on its merits. The following is a guide to the assessments likely to be given by a medical board:

a. **Upper Limb.** Personnel with amputation of a hand or arm (above or below the elbow) will not normally be assessed higher than U7, but may exceptionally be U3. Double upper limb amputations will normally be graded U8.

b. **Lower Limb.** Personnel with amputation of a foot or leg (above or below the knee) will not normally be assessed higher than L7, but may exceptionally be L3. Above knee and hind-quarter are to be graded no higher than L7. Double lower limb amputations will normally be graded L8.

0112. The assessment under the quality P cannot be higher than degree 3. Where the amputation has been carried out because of some pathological condition with a constitutional basis, the assessment of P will depend on the nature of the condition.

The Effect of the Loss of Sight in One Eye

0113. Persons who have had one eye removed or who have lost the sight of one eye are not to be accepted for entry to the Army. The loss of sight in the left eye will not

preclude further service provided the JMES is up to the minimum for retention. The loss of sight in the right eye will normally be graded P8.

Use of Degree 8 Under Any Quality except EE

0114. When it is considered that:

a. a candidate for entry into the Army is unfit for any form of Army service;

b. the individual is unfit for further service. They should be invalided from the service following consultation with SO1 OH APC (para **0604**);

he/she will be assessed degree 8 under the appropriate quality. For the effect of degree 8 in JMES see para. **0129.**

Use of Degree 0

0115. Such an individual is unfit for duty and under treatment. However, if appropriate, they may undertake recovery activity in support of their Individual Recovery Plans in accordance with AGAI 99 (Command and Care of Wounded, Injured and Sick Personnel) and/or Graduated Return to Work (GROW) under the supervision of a qualified occupational health practitioner. The assessment 0 is to be shown under the appropriate quality.

0116. When degree P0 is allotted, a medical board may at the same time, in anticipation of the patient becoming fit for duty, recommend that a medical grading be automatically effective at a date not more than 3 months from the date of the board. If, however, the patient does not become fit for duty on approximately that date, a further medical board will be held.

Procedure on Assessment of Degrees 3 or 7 Under Two or More Qualities

0117. Where an assessment of degree 7 under two or more qualities is given by a medical board, the president of the board will consider whether the effect of the combined disabilities warrants an assessment of degree 8 under the P quality.

0118. Where an assessment of degree 3 under two or more qualities is given, the president of the board will consider whether the effect of the combined disabilities warrants an assessment of degree 7 under the P quality.

Effect of P7 on Non-Operational Service Overseas

0119. A grade of P7 will normally restrict the JMES to MND with an Environmental Support value other than E1. For those graded MND and considered for service overseas, a documented individual assessment of suitability for employment in that location should be carried out (see para **0123**).

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

0120. a. If an officer or soldier's condition is temporary, the P grading is qualified with the use of a T suffix. As soon as it is clear that a condition is 'Permanent', i.e. likely to last 12 months or more, a further medical board should be conducted to award a permanent grade. Any subsequent changes in functional capacity may be reviewed by another medical board. A One-Member Medical Board (OMMB) may award the T suffix for a maximum period of 12 months in total. The time awarded by the board must reflect the estimated time to achieve a permanent grading. Periods of medical downgrading in excess of 12 months require a Two Member Medical Board (TMMB) with an OM Consultant presiding or a Full Medical Board(FMB) and will only be approved exceptionally by DM(A) through the process contained in AGAI 99 Command and Care of the Wounded, Injured and Sick .

b. Service personnel Cas-evaced from an operational theatre or admitted to a hospital for in patient care, including RCDM and DMRC, should be boarded P0[3] following an appropriate medical assessment (with further medical board if needed).

0121. **Light Duties**. An officer or soldier may alternatively be placed on light duties when medical staff assess that a condition is mild and temporary in nature. However, in all cases the period of light duties cannot extend beyond 56 days, and on the 57th day an officer or soldier's PULHHEEMS assessment must be amended.

JOINT MEDICAL EMPLOYMENT STANDARDS (JMES)

0122. The JMES is awarded by medical staff in order to inform commanders of the employability and deployability of Service personnel. It describes the functional and geographical employability and specific medical restrictions. The JMES award has the same temporary or permanent marker awarded by the medical board to the associated PULHHEEMS grading.

0123. **Medical Deployment Standard**. The Medical Deployment Standard describes the medical capacity for deployment and is determined by the P quality.

Code	Meaning	Awarded when P category is:	Notes
MFD	Medically fully deployable	P2	
MLD	Medically limited deployable	P3 or exceptionally P7	1. A grade of MLD requires the unit to carry out a deployment medical risk assessment for each deployment and the decision on that deployment will depend on the medical condition, individual function, the proposed employment, length of the deployment, operating environment and the medical support available. 2. The MLD code may only be awarded with P7 by a medical board with at least one consultant in occupational medicine.
MND	Medically not deployable	P0, P4, P7, P8	

[3] This is to be conducted by the UMO (rear party if appropriate) and may be conducted in abstentia.

0124. **Medical Employment Standard**. This relates an individual'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, Land, and Maritime environments and any requirement for Medical and Environmental Support. All elements of the MES are to be allocated for each individual and are determined by the P quality. Gradings A1-A3 will only be used by Army aircrew with A4 being the most common grading for the remainder of Army personnel. Similarly, M1-M4 will only be used by RLC Seaman/Navigator trades and Army personnel serving within 3 Cdo Bde, with M6 being the default grading for the remainder of Army personnel. They are outlined in the table below:

	MES Code	Description	P Category	Notes
Air	A1	Fit for flying duties without restriction	P2	To be used by Army aircrew
	A2	Fit for flying duties but acknowledging sub-optimal hearing or sight	P2	
	A3	Fit for limited flying duties	P2, P3, P7	
	A4	Fit to be flown in a passenger aircraft	P2, P3, P7, P0, P4, P8	Default for Army personnel less aircrew
	A5	Unfit to be taken in the air	P3, P7, P0, P4, P8	By exception
	A6	Air assessment not currently required	N/A	N/A for Army personnel
Land	L1	Fit for unrestricted duty	P2	
	L2	Fit for unrestricted duties but with a medical risk marker	P2	
	L3	Fit for limited duties but with some restriction subject to medical risk assessment	P3, P7	
	L4	Fit for specific limited duties within branch/trade	P4, P7	
	L5	Unfit for service in the land environment	P0, P8	
	L6	Land assessment not currently required	N/A	N/A for Army personnel
Maritime	M1	Fit for unrestricted duties	P2	May be used by certain Army trades that have a maritime element, e.g. RLC Seaman/Navigator
	M2	Fit for restricted duties with caveats to be stated	P3	
	M3	Fit for limited duties in harbour or ashore with caveats to be stated	P4, P7	
	M4	Fit for limited duties ashore only, may not necessarily be in own trade or skill, with caveats to be stated	P7	
	M5	Unfit for service in the maritime environment	P0, P8	
	M6	Maritime assessment not currently required	P2, P3, P7, P0, P4, P8	Default for Army personnel
Environmental and Medical Support	E1	Fit for Word Wide Service in all environments	P2	
	E2	Restricted employment outside UK	P3, P4, P7	For example unfit cold or hot environments
	E3	Employment in UK	P4, P7	Including BFG and the Low Countries and Nepal for Gurkhas only
	E4	Employment subject to single-Service Manning Authority restriction	P2, P3, P7	DM(A) authority required
	E5	Medically unfit for duty and under medical care (holding category)	P0, P8	
	E6	Pregnancy	P4	

0125. **Medical Limitations**. In addition to the JMES grading a number of medical limitations can also be provided. For Army personnel these are limited to (five):

a. Unfit APWT
b. Unfit PFA
c. Unfit AFT
d. Individual must have MRA undertaken by ROHT prior to deployment.
e. Refer to Appendix 9 of PAP 2010.

0126. **Temporary or Permanent Marker**.

a. When a Medical Board awards a JMES of MLD or MND, a decision will be made as to whether the JMES is Temporary or Permanent. The maximum period of validity of a Temporary JMES is 12 months for Army personnel. Only L5 E5 MND Temp cases may be extended beyond 12 months and then only in exceptional circumstances. This requires the written authority of DM(A)[4].

b. A Permanent JMES must be awarded at any time, if clinically indicated. When a Temporary JMES becomes Permanent, a Medical Board will be required. Permanent does not imply that the JMES can never change. However, it is intended to assist personnel staff involved with employment decisions by distinguishing the longer term health problems affecting an individual from the relatively short term ones. The abbreviations 'Perm' and 'Temp' are to be used. The term 'not applicable (abbreviated N/A)' will be the marker used with the JMES award of MFD.

METHOD OF CALCULATION

Officers

0127. The minimum PULHHEEMS standards required by officers in all Arms/Services are in Table 1 (Entry and on Commission) and Table 5 (Retention). JMES for officers are not linked to specific employment, as an officer must normally be capable of carrying out any duty of his/her Corps in any area in which he/she is fit to serve.

Soldiers

0128. The minimum PULHHEEMS standards required by soldiers in all Arms/Services are in Table 2 (Entry) and Table 6 (Retention) and are linked to specific employment (CEG or CEQ).

8 or 0 Assessments

0129. a. When the assessment under any quality except E is 8, the deployment standard is to be expressed as MND (Perm) and the Environmental and Medical Support Grading will be E5.

b. Where the assessment under P, U, L, M or S is 0, the deployment standard is to be expressed as MND (Temp) and the Environmental and

[4] In conjunction with advice form SO1 OH APC

Medical Support Grading will be E5.

Pregnancy

0130. The Environmental and Medical Support Grading of E6 is only to be used where an officer or soldier has formally advised their employer of pregnancy (eg using F Med 790) and written consent given for JMES to be displayed as E6 or a contemporaneous record made in clinical notes confirming that permission is granted. Regardless of whether the grading of E6 is used, the deployability coding is reduced to MND (Temp).

0131-0199. Spare.

CHAPTER 2

Instructions for Classification

PULHHEEMS ASSESSMENTS

Responsibility

0201. 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 paras **0202-0209** and Appendix 6. The PULHHEEMS reviews detailed in paras **0206-0207** 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 of time (6 months), a further PULHHEEMS review need not be completed unless there has been a change in the individual's medical condition.

Non-Serving Applicants for Commission and Enlistment

0202. The process for these applicants is defined in Chapter 8.

Serving Candidates Applying for Commission

0203. a. All applicants are to have their PULHHEEMS assessment verified P2 by a OMMB at the time their applications are submitted.

b. Soldier candidates who are to undertake the Commissioning Course are to be examined by a serving, retired or appropriately trained medical officer before starting training. When the applicant has appeared before a medical board in the preceding 12 months, the PULHHEEMS assessment allotted then will be accepted following verification by a serving medical officer. When the applicant is allocated a place on the Commissioning Course the service medical record is to be sent to the Royal Military Academy Sandhurst (RMAS) in time for the initial medical examination.

c. All other applicants are to be examined by a serving, retired or appropriately trained medical officer before their commissions are gazetted. When the applicant has appeared before a medical board in the preceding 12 months, the PULHHEEMS assessment allotted then will be accepted following verification by a RMO/CMP.

Reserves.

0204. a. **Mobilised Personnel**. Mobilised personnel are to be examined prior to acceptance into service at the mobilisation centre.

b. **Full-Time Reserve Service (FTRS) Personnel**. Following selection for an FTRS post, MS Reserves will write to the applicant informing the individual of suitability and inviting him/her to approach Reserves Training and Mobilisation

Centre (RTMC) to arrange a pre-induction FTRS medical and dental check in order to confirm eligibility[1].

The Army Regular Reserve, Long Term Reserve (LTR) and Pensioners

0205. a. A JMES is mandatory for the Regular Reserve, LTR and pensioners (also for the Regular Army Reserve of Officers (RARO) - see para **0306**).

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

c. The JMES in Table 6 applies to those joining the Regular Reserve, whether by transfer from the Colours or by enlistment, and also to those volunteering to re-engage in it.

d. The JMES assessment at the time an individual leaves the Colours remains valid (under normal circumstances) throughout the time he/she remains liable for recall for full-time service. A medical examination, however, will be arranged by the MS Wing whenever a significant disability comes to their notice.

e. Further details regarding the medical assessment of all categories of reservists are contained in *AC 13386 Regulations for the Mobilisation of the Army.*

Occasions for Review of PULHHEEMS Assessment

0206. All Ranks.

a. Annually when deployability coding is other than MFD. This review will not normally need a consultation and can be based on a review of the medical record with input from the employer, as needed. Any changes to the assessment will require the individual's consent for the release of the Appendix 9 (therefore requiring a consultation).

b. Prior to substantiation or confirmation of the appropriate authority for an individual to move from one career stage to another and the conversion of engagement or commission.

c. Before termination of full-time service with the Regular Army, in accordance with para **0604.** This includes those on mobilised service and FTRS.

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.

[1] Annex E to 2006 DIN 02 – 159.

f. On the 57th day of a period of light duties.

0207. Soldiers. On the application for change of engagement, extension or continuance in the Service, the PULHHEEMS 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.

TA Re-Engagement

0208. When a member of the TA applies to re-engage, he/she is to be medically examined. Part 3 of the AF E7546 must only be signed by a medical officer.

Alterations to PULHHEEMS Assessments

0209. Alterations to PULHHEEMS assessments are to be notified using Appendix 9 and via DMICP/JPA.

Instructions by Medical Boards to Personnel on Terminal Leave

0210. The instructions are given in Appendix 7.

Documentation

0211. Documentation as laid down in Chapter 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.

b. An automatic review is carried out in accordance with paras **0206-0208.**

d. On termination of full time service.

JOINT MEDICAL EMPLOYMENT STANDARDS - JMES

Responsibility

0212. The allocation of a JMES is the responsibility of medical boards/unit medical officers.

Occasions for Allocating a JMES

0213. A JMES is to be allocated at all PULHHEEMS assessments.

Documentation

0214. Commanding Officers of units are to ensure that the documentation in Chapter 6 is completed when a JMES is allocated or when any changes to a JMES is required.

0215-0299. Spare.

CHAPTER 3
Standards for Officers

ENTRY STANDARDS

Commissions in the Regular Army

0301. 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 of:

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

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

b. **From the Ranks or from another Officer Service.** The normal standard required is a JMES assessment of MFD as shown in Table 5.

c. The common Army entry standard also applies to those candidates seeking Commissions through:

Welbeck College
The Defence Technical Undergraduate Scheme
The Army Sixth Form Scholarship Scheme
The Army Undergraduate Bursary Scheme
The Army Undergraduate Cadetship Scheme
Pre-RMAS courses

d. Candidates from serving personnel of the Regular Forces of the Crown, including those from Commonwealth States, the normal standard required is a JMES assessment of MFD as shown in Table 5.

e. The common entry standards also applies to candidates from the Reserve forces (Including the TA), and from individuals with previous reckonable military service.

f. **All applicants below minimum entry standard**. Arms and Service Directors wishing to commission an individual who is below the normal entry standard may apply to DM(A) for authority outlining the exceptional circumstances as to why they wish this to take place.

Commissions into the Territorial Army

0302. The entry standards for candidates wishing to be commissioned into the Territorial Army are the same as in para **0301** above. Selection boards may consider candidates below these standards with prior approval of MS Reserves Branch, APC, Provided they are:

a. Fit to undergo all training, including camp and, where applicable, the TA Potential Officers selection course.

b. Such training will not be likely to aggravate any disability from which the volunteer is suffering.

c. Each candidate has been identified by the relevant selection board as being of particular value to the TA and outlining what that value is.

Commission as a Cadet Force Officer

0303. Standards are as laid down in Combined Cadet Force Regulations (JSP 313) and Army Cadet Force Regulations (Army Code No 14233).

MINIMUM STANDARDS FOR RETENTION OF REGULAR AND TA OFFICERS

0304. 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 5.

0305. Officers with a JMES assessment below that required of their own Arm or Service but not graded P8, may be either considered for transfer to another Arm or Service, permanently employed in sedentary duties at E2, or apply to retire voluntarily. If an Officer has been seriously wounded, injured or is seriously sick and no employment can be found, either at E1 (in their own or another Arm or Corps) or E2, and they wish to be retained, they may be retired on medical grounds or may apply for their case to be referred to the Army Employment Board (see Chapter 12).

MEDICAL STANDARDS FOR CONVERSION OF COMMISSION, PROMOTION AND APPOINTMENT BOARDS

0306. Normally, medical employment standards 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 Officers, and Soldiers that are commissioning, the final authority for all changes of engagement will be the Army Commissions Board. For appointment boards, including command 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.

MEDICAL STANDARDS FOR THE REGULAR ARMY RESERVE OF OFFICERS

0307. The JMES assessment awarded at the time of retirement remains valid throughout the time the officer remains liable for recall for full-time service. However, a recall re-entry medical will be conducted prior to any RARO officer being recalled to the Service.

MEDICAL STANDARDS FOR OFFICERS APPLYING TO RE-INSTATE

0308. The re-instatement standards for trained officers, including those joining from FTRS, RARO and mobilised service, are as laid down in Table 5. Submissions for officers

falling below those standards, and considered desirable to the interests of the service for re-employment, are to be submitted to DM(A) for approval.

CHAPTER 4

Standards for Soldiers

ENTRY STANDARDS

Common Army Entry Standard

0401. 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 3	8 6	2	2	4

Note. Certain specific 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 A&SDs to DM(A) in support. Variations from the Common Army Entry Standard are shown in Table 2.

b. Applicants for entry who are below the normal entry standard may be considered as special cases by DM(A) (see also para **0405c**).

Regular Soldiers

0402. The minimum medical standards by Arms or Service and employment are given in Table 2.

Volunteers for the TA

0403. The minimum medical standards acceptable by Arms or Service and employment are given in Table 2. Soldiers below the standard required for a particular employment may, however, be accepted on the submission, by the Commanding Officer, of a case via DM(A) (via MS Reserves Branch at APC), provided they:

a. Are fit to undergo all training, including camp;

b. Such training will not be likely to aggravate any condition.

Regular Reserve

0404. The minimum standard for entry on transfer to the Reserve is the same standard as for retention.

RETENTION STANDARDS

During Phase 1 and Phase 2 Training in the Army

0405. Medical standard for entry must be maintained throughout Phase 1 and Phase 2 training. When an individual falls below entry standard 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 (QRs) for the Army, following grading to below entry standard (see Chapter 11). On completion of Phase 2 training, a recruit's initial assessment is to be confirmed or altered to a Service assessment and a JMES allocated (see Chapter 8). Where this assessment is lower than the minimum entry standard for his/her Arm or Service, as shown in Table 2, the following action is to be taken:

a. **In Peace.** He/she is to be offered the option of a voluntary transfer to another Corps for which he/she is suitable, or a discharge under *QR 9.385 or 9.414*.

b. **In War or During an Emergency (on Instructions from the Ministry of Defence).** He/she is to be compulsorily transferred to another corps or discharged in accordance with the then current instructions for reallocation.

c. Individuals accepted for entry as special cases under para **0401b** must maintain their entry PULHHEEMS profile throughout training.

Further details are at Chapter 8.

After Phase 1 and Phase 2 Training in the Army, or for Retention in the TA

0406. a. **Regular soldiers.** If a soldier's PULHHEEMS assessment does not meet the standard (see Table 6) for his/her Arm or Service and employment, he/she may be permitted to continue to serve on his/her current engagement for as long as suitable approved employment is available with the authority of DM(A) obtained through the APC (through completion of an Appendix 8). If and when suitable employment compatible with his/her assessment cannot be found:

(1) In his/her own Arm or Corps and employment;

(2) In his/her own Arm or Corps in another employment;

(3) In another Arm or Corps to which he/she is willing to transfer;

(4) At extra-regimental employment;

he/she is to be discharged under the provisions of *QR 9.385* on the authority of MS/DGAPC or *QR 9.414* on the authority of DM(A). Before a case is submitted for discharge, the soldier's PULHHEEMS is to be reassessed irrespective of the date of his/her last assessment. The procedure in Chapter 10 is to be followed.

b. **TA**

(1) **Re-Enlistments.** Ex-Regular soldiers enlisting into the TA or TA personnel currently serving in the TA or within 12 months of discharge are to comply with the standards laid down in para **0406a**. Audiometric tests must be undertaken in accordance with the Army hearing conservation policy.

(2) **Retention.** Provided a volunteer is up to the retention standard of MLD for his/her Arm or Corps, and suitable employment is available, he/she is eligible to complete his/her current engagement.

STANDARDS FOR OTHER TYPES OF SERVICE

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

0407. The re-entry standards for trained soldiers, including those joining on or from FTRS and mobilised service, are laid down in Table 6. Applicants who are below a deployable standard of MLD or do not meet the standards in Table 6, but whose enlistment is thought to be desirable, can only be accepted subject to DM(A) approval.

0408. The PULHHEEMS assessment allotted by the medical authorities at the time application is made to re-enlist or rejoin the Colours is to be regarded as a provisional assessment. The Officer Commanding the unit to which the individual first reports is to arrange for his/her medical examination within 6 days of reporting. The individual should be assessed and a PULHHEEMS grade and JMES grading allocated. Further guidance is at Chapter 8.

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

0409. 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 Employment in Table 6.

b. Soldiers who do not meet the Table 6 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 applicant is aware that should suitable employment compatible with the PULHHEEMS assessment cease to be available, an administrative discharge under *QR 9.414* might have to be sought.

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

Standards for Continuance *(QR 9.098 - 9.107)*

0410. Provided a soldier meets the standard of MLD (see Table 6) for his/her Arm and suitable employment is available, he/she may be considered for an initial period of continuance in the Service. The same will apply to any further periods of continuance.

0411. Any acceptance of a category other than MFD or MLD is subject to DM(A) approval.

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

0412. The reallocation or retransfer of a soldier is not to be considered unless his/her JMES is within the standards contained in *AGAI 48*.

0413-0499. Spare.

CHAPTER 5

Rules for the Assignment and Employment of Officers and Soldiers

General

0501. The normal minimum PULHHEEMS assessments for each JMES in all Arms or Service and for all employments are given in Table 5 for Officers and Table 6 for Soldiers.

0502. The JMES shows the medical limitations on employment, operational deployment and assignment.

Assignments

0503. 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 required may only be assigned to another unit on the approval of their Career Manager or as directed by the Army Employment Board. A&SDs and the chain of command are to assist APC Career Managers in ensuring that any requirements for a specific post to deploy is clearly annotated against a post to ensure that someone with employment limitations which fall below these requirements is not assigned to that post.

Specialist Employment

0504. Personnel employed on Special Forces/Flying duties must be up to the minimum PULHHEEMS assessment for the appropriate JMES for Flying Duties as given in Appendix 6, or UKSF given in Table 4. 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 UAV operators is defined in Appendix 13.

0505. Reserved..

Assignment of Officers and Soldiers

0506. Assignment authorities are to ensure that individuals are assigned in accordance with the limitations of their JMES (see para **0503**). Officers of Major rank and above are generally more broadly employable as a result of staff posts available.

0507. The normal minimum PULHHEEMS assessments for each JMES for all employments in each Arm or Service are given in Tables 5 and 6. Individuals who are other than MFD are limited in their employment by the minimum JMES laid down for each employment.

0508. A CO may apply to retain an officer of Capt rank or below or a soldier with a

JMES below the retention standard for their Arm or Service. He / she is to apply for authority to retain the individual from DM(A) through the appropriate APC Career Manager using the form at Appendix 8 with a current Appendix 9 attached. Appendix 8s are to be reviewed annually but DM(A) may grant extensions to this period under exceptional circumstances.

0509. Should a CO not wish to retain an Officer or soldier with a JMES below the minimum standard for his / her present employment, he / she is to follow the Restricted Employability in Current Unit (RECU) process outlined in Chapter 10. For individuals below the minimum standard required by their Arm or Service and who wish to be retained, the process is slightly different and is described in Chapters 10 and 12.

0510. Individuals whose JMES is below the minimum retention standard for their corps and who cannot be re-employed though the RECU process are to be dealt with as in paras **0305/0406.**

Minimum Medical Employment Category for Deployments

0511. COs are to determine for Officers and Soldiers with a JMES of MLD, whether they are fit to deploy. To automatically exclude an individual with a JMES of MLD from all operational deployments is contrary to the principles of the PULHHEEMS system. The CO will need to consider the standards laid down in the operational mounting instructions and take advice from the UMO and Regional OH Team using the Appendix 9 and Unit Health Committee. A Deployment medical risk assessment form, Appendix 26 must be completed by the unit and authorised by the CO before an individual commences Mission Specific Training for a deployment.

0512. Officers / Soldiers can be deployed within the limitations laid down in paras **0505/0507**, subject to:

a. The agreement of the deploying and Theatre Headquarters that employment is consistent with the Employment Standard and;

b. Advice from a Medical Officer that the Soldier's medical condition is not likely to deteriorate as a result of a assignment to that theatre and;

c. That suitable medical facilities exist in theatre for management of the condition for which the soldier has been graded and;

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

Assessments are mandatory for all personnel graded MLD. Responsibility for the medical advice used in completing the risk assessment of P3 MLD cases rests with the UMO and for P7 MLD cases with the Regional Occ Med consultant. Specialist occupational health advice may additionally be sought for personnel graded P3. The SMO and CO RTMC provide advice for mounting Individual Reinforcements (IRs) and Reservists.

0513. It should be noted that allowable medical categories for a particular theatre and

operation will change over the life of the deployment / operation. It is likely that on initial mounting, service may need to be restricted to MFD. However, as the operation matures, it may become appropriate to allow soldiers with medical categories other than MFD to deploy.

Medical Risk Assessments for Routine Activities

0514 The principles for medical risk assessments for deployments outlined in paras **0511-0513** also apply to routine activities for all personnel who are permanently graded below MFD. The Appendix 9 is to be used by the unit for all such personnel to plan the activities anticipated in the 12 months following a medical board which either downgrades an individual permanently or reviews that grading. Routine activities include ranges, exercises and courses etc

0515- 0599. Spare.

CHAPTER 6

Documentation

Responsibility

0601. a. Commanding Officers are responsible for ensuring that personnel are referred to medical authorities for assessment or reassessment as required on entering the Army, on completion of Phase 2 training, during service and before termination of service (see chapter 2).

b. Medical authorities are responsible for:

(1) Notifying results to commanding officers.

(2) Recording results in the medical record.

c. Commanding Officers are responsible for:

(1) Publishing the results.

(2) Recording the results in Service records.

d. All concerned are responsible for ensuring that **JMES assessments are treated as RESTRICTED – PERSONAL and PULHHEEMS assessments as RESTRICTED –MEDICAL and to ensure that they** are not disclosed to any unauthorised person.

Notification

0602. Assessments and reassessments, including those showing no change, are to be notified to officers commanding on the form at Appendix 9. If a medical board recommends discharge on medical grounds, the decision is notified on the form at Appendix 12.

Recording

0603. 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. **JMES assessments are to be recorded electronically onto the electronic medical and personal record. Where electronic systems are not available the appropriate medical and personal documents are to be completed.**

b. **Pre-Service and During Training.** Form RG8 parts 1 to 4 are completed and held by unit until completion of Phase 2 Training. They are then retained in the individual's medical record. See Chapter 8.

c. **FMed 1.** The pre-release and release PULHHEEMS **and JMES** assessments are recorded on the FMed 1.

d. **FMed 23.** This is used to record all medical board proceedings (for guidance on completion, see SGPL 05/07 and the notes at Appendix 1).

e. **FMed 4.** This is the paper medical record held by unit, normally with the MO. Assessment, reassessments and **JMES (from FMed 23) are recorded**.

f. **Electronic Medical Record.** Where electronic medical records are held, assessment, reassessments and **JMES** (from FMed 23) are to be recorded.

g. **FMed 143.** Used to record details of routine career related PULHHEEMS**, JMES**, TA Re-Engagement, etc.

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

Assessment on Termination of Service

0604. Before termination of service all personnel are to be reassessed as follows and the assessment notified, published and recorded as in para **0603.**

a. **Termination of Service on Medical Grounds.** The President of the Medical Board will complete FMed 23.

(1) Officers unfit for service on medical grounds/medically unfit for service under existing standards will be retired under *The Promotions and Appointments Warrant 2009*.

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

(3) Soldiers medically unfit for service under existing standards will be discharged under *QR para 9.385*.

(4) TA Officers unfit for service on medical grounds / medically unfit for service under existing standards will be retired under *TA Regs Chapter 4, Part 9.*

(5) TA Soldiers unfit for service / medically unfit for service under existing standards will be discharged under *TA Regs Chapter 5, Part 6*.

Note: In all cases the individual is to be informed as soon as the decision to invalid him/her is made.

b. **Termination of Service other than on Medical Grounds**. Commanding Officers 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 at least 8 weeks prior to the date the individual is due to leave the unit. For units in the UK this is 8 weeks before the date on which terminal leave begins, if such leave has been authorised, or discharge. **For units overseas, this is 8 weeks before returning to a UK unit** for commencement of release procedures (eg start of resettlement course and/or terminal leave). The medical officer will complete a FMed 1 and the resultant **PULHHEEMS and JMES** assessment is to be recorded on the electronic **medical record and the JMES on the** personnel record. **This medical is to be carried out in theatre for personnel in units overseas.** This is the last opportunity for referral to Full Medical Board in service.

(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 8 weeks prior to the date the individual 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 individual'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 6.

Admission to Hospital within 5 Months of Normal Termination of Service or During Normal Terminal Leave

0605. When an individual, who is entitled to full pay and allowances, including under the provisions of para **0712**, is admitted to hospital, the Unit of the individual 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 56 days (8 weeks) duration - at

the end of the 8 week period.

b. A final medical board will be held 4 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 8 weeks.

0606. Boards held under para **0605** are to recommend whether the individual should be retired/discharged on medical grounds or by normal administrative procedure.

0607 – 0699. Spare.

CHAPTER 7

Command and Care of the Wounded, Injured and Sick, Full Pay Entitlement During Absence from Duty, Sick Leave, Invaliding Leave and Terminal Leave

GENERAL

Application

0701. The provisions of this chapter apply to all officers and soldiers of the Regular Army, and to personnel of the TA and Individual Reservists including RARO when called out for permanent service or serving on FTRS.

Command and Care of the Wounded, Injured and Sick

0702. *AGAI Vol 3 Chapter 99* gives the policy for the management of soldiers 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 soldier is sick-absent.

Definition of In-Patient Treatment

0703. For the purposes of this chapter, 'in-patient treatment' is defined as:

a. Personnel actually under treatment requiring retention in hospital or, for whom such treatment has been determined by a medical board as being definitely and immediately required.

b. Personnel granted periods of sick leave between successive stages of in-hospital treatment, for example 2-stage surgical operations. It will not include personnel who may eventually require further in-hospital treatment, but for whom such treatment cannot be immediately and affirmatively diagnosed as necessary.

0704. Any reference to absence from duty will be assumed to have resulted from sickness or injury and from no other cause.

Applicable Categories

0705. The following categories will be considered:

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

b. Those temporarily unfit.

c. Those permanently unfit.

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

0706. Notwithstanding anything stated hereafter, in exceptional cases the service of an individual may be terminated on medical grounds at any time before the due date for termination of service.

Disabilities Incurred Before Entry into the Service

0707. An individual who, as a result of a disability incurred before entry, is deemed unlikely to become fit for service is to have his/her Commission terminated or be discharged under *QRs para 9.381*, as appropriate, 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 6 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 form RG8 Part 1 at the pre-service medical examination.

Temporarily Non-Effective

0708. A soldier who is or is likely to be sick-absent from duty for more than 56 days is to be assessed by a medical board and graded P0. The unit is then to apply to APC Glasgow for the soldier to be assigned to the Temporarily Non-Effective (TNE) list. An individual may be retained exceptionally in the Service on full pay beyond a period of 12 months TNE on the authority of DM(A) provided that, in the opinion of the approved medical authority (TMMB with OM Consultant presiding or FMB), there is a reasonable prospect that the individual has a clear outcome (either returning to duty or discharge on medical grounds) and also provided that the individual's date of termination of whole-time service does not occur within that period (in which case it must be put into effect unless covered by para **0712**).

0709. For the purpose of calculating the 12 month period all periods of absence from duty due to the same disability will be aggregated, except where there has been a continuous period back to duty of 6 calendar months or more (in which case the calculation will start again). Periods of absence from duty due to different disabilities are not to be aggregated if they are separated by a period of duty.

Permanently Unfit

0710. If at any stage it becomes clear that there is no reasonable prospect of the individual becoming fit for duty invaliding action must be recommended immediately.

Becoming Unfit During Terminal Leave or Shortly Before Termination of Service

0711. An individual who is an in-patient on the due date for normal termination of service, and still requires such treatment, is to be retained on pay until:

a. In-patient treatment ceases to be required, or

b. Five months have elapsed since he/she was last at duty, whichever is the earlier.

In addition there may be an entitlement to leave under the provisions of para **0726.** It is a unit responsibility to keep the appropriate manning/pay authorities fully informed of action being taken under this paragraph.

0712. This concession does not apply to an individual already due to be invalided who becomes an in-patient during invaliding or terminal leave. This individual's retirement/discharge date is the day following the completion of invaliding leave followed by terminal leave, irrespective of the fact that part or all of that time was spent as an in-patient. This concession may not apply to any case where action is being taken to terminate an individual's service for special reasons. Special reasons include discharge on administrative and disciplinary grounds, which may precedence over medical discharges, *QRs para 9.379g* refers.

Retention Beyond Due Date for Termination of Service

0713. When an individual is likely to be receiving in patient treatment at his/her discharge date or close to his/her discharge date, authority for retention is to be obtained by the unit before termination date is reached:

a. **Officers.** In the case of officers - from Manning Branch DM(A).

b. **Soldiers.** In the case of soldiers - from the appropriate MS Branch at APC for periods up to 28 days. For periods in excess of 28 days from DM(A) via the appropriate MS Branch. Application is to be made by letter. JPA workflow/AF B6848 is not to be used.

DEFINITION OF MEDICAL ABSENCE TYPES

0714. Leave on Medical Grounds includes 3 types of absence:

a. **Sick Leave.** This is an authorised period of absence or convalescence granted to a Service person who is, due to sickness or injury, unfit for military duty. This absence type also covers a period of absence where the patient’s consultant decides a period of convalescence is required, after they have received hospital treatment, before the Service person returns to work. For administrative purposes the Service person is under the authority of their parent unit.

b. **Hospital In-Patient.** This is a period of absence granted to a Service person who is under medical care for more than 24 hours.

c. **Hospital Sick Leave.** This is a period of absence recommended by the patient's consultant whilst a patient is undergoing treatment at a secondary care facility. The patient may be required to return to hospital following leave.

SICK LEAVE

0715. Sick Leave (medical absence) on Medical Grounds is an authorised period of absence in addition to Annual Leave to allow Service personnel the opportunity to rest or receive treatment for an illness or injury.

0716. Sick leave is permissible only when all the following conditions are fulfilled:

a. The individual is unfit for military duty;

b. The individual is in or attending hospital or is under the care of a medical consultant specialist and requires sick leave before return to duty;

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

d. The individual is not assessed as unfit for further service;

e. It is not additional to normal terminal leave.

0717. Sick leave is not to be granted to an individual who:

a. Is fit to undertake recovery duties in accordance with their Individual Recovery Plan.

b. Has been assessed as unfit for service.

c. Has been assessed temporarily unfit, when no further in-patient treatment is required and he/she is due normal termination of service.

Granting Of Sick Leave

0718. In accordance with *JSP 760,* the following personnel have the authority to grant absence on medical grounds:

a. A service Medical Officer in primary or secondary care or a Civilian Medical Practitioner (ie one employed by the MOD). Additionally, sick leave may be recommended by a civilian hospital specialist and can be granted following liaison with the individual's unit medical staff.

b. The Commanding Officer of a MDHU, after liaison with the individuals unit medical staff, if the individual is in hospital or attending as an outpatient, if recommended by a civilian hospital consultant or specialist registrar.

c. A Regional Forces CO PRU after liaison with the individual's unit medical staff, on the recommendation of a civilian practitioner.

d. The President of a Medical Board.

0719. Both those granting and the individual proceeding on sick leave are to inform the unit as soon as possible and prior to the commencement of the period granted in order that the individuals record of service can be updated accordingly *(JSP 760 para 15.004)*.

0720. In the case of an individual attending the outpatients' department of a civilian hospital he/she is to return to his/her unit together with the recommendation for sick leave for confirmation by his/her Commanding Officer.

0721. The granting of sick leave is to be notified to his/her unit and the appropriate MS Branch at the APC by the hospital, Regional Forces CO PRU or president of the medical board mentioned in para **0719.**

INVALIDING LEAVE AND TERMINAL LEAVE

0722. a. An officer retired for a medical reason is to be granted 20 working days invaliding leave plus terminal leave. Until such time as JPA can record invaliding leave, both invaliding and terminal leave are to be recorded on JPA as one block under the heading terminal leave. Additionally an individual is to be granted the balance of any outstanding annual leave entitlement.

b. Except in the circumstances described in paras **0707** and **0724**, any soldier who is discharged under *QRs 1975, paras 9.385-9.387* is to be granted 20 working days invaliding leave plus terminal leave at the rate of 1 day for each month of reckonable service to a maximum of 20 working days. Until such time as JPA can record invaliding leave, both invaliding and terminal leave are to be recorded on JPA as one block under the heading terminal leave. Additionally an individual is to be granted the balance of any outstanding annual leave entitlement

0723. Invaliding and terminal leave are not admissible in the case of an individual discharged on medical grounds while serving a sentence of imprisonment, civil or military detention, or young offender training.

0724. An individual admitted as an in-patient during his/her terminal leave shall have this leave suspended on the day of admission and resumed on the day following his/her discharge from hospital, or 5 months from the day of admission, whichever is the earlier. This does not apply to an individual who is being invalided out of the Service (see para **0713**).

0725. An individual may be granted 5 working days terminal leave, if his/her service is

to be terminated on medical grounds, as a result of a disability incurred before entry and which becomes evident during his/her post-entry medical examination. The individual will not be entitled to terminal leave, if the disability incurred before entry was not admitted at the time and it lowers his/her medical category.

0726. Leave is to be reckoned from the date on which the individual is officially notified of the decision that he/she is to be invalided. The first day of leave being fixed by the APC. The date of retirement/discharge is as notified by the APC and is calculated having taken into account any entitlement to Graduated Resettlement Time, invaliding, terminal leave and the balance of any outstanding annual leave entitlement.

Personnel Whose Repatriation Overseas has been Approved.

0727. An individual who is to be invalided and whose repatriation to his/her 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 invaliding and terminal leave admissible thereafter, notwithstanding that these may involve the continuance of pay beyond the appropriate period specified in para **0708**, or beyond the normal date for termination of service. If, however, the individual is currently residing in his/her country of domicile, or has elected to remain in the country in which he/she is located at the date when the decision to invalid is taken, pay is not issuable beyond the appropriate period specified in paras **0711** and **0723**.

0728 – 0799. Spare

CHAPTER 8

The Medical Assessment of Army Candidates for Entry and During Training

INTRODUCTION

0801. Headquarters Army Recruiting and Training Division (HQ ARTD) is responsible for the pre-employment medical assessment of candidates for enlistment and commissioning and the award of an initial PULHHEEMS grade and JMES. The Occupational Medicine Department of HQ ARTD (HQ ARTD Occ Med) provides advice regarding the implementation of standards at all stages of selection and throughout training. HQ Recruiting Group (RG) is responsible for the administration and assurance of the Army Development and Selection Centres (ADSC) and the Royal Military Academy Sandhurst (RMAS) Operating Group for administration of Army Officer Selection Board (AOSB).

0802. This Chapter describes the procedures to be used for the medical assessment of applicants prior to enlistment or commission and during Phase 1 and 2 training.

GENERAL

0803. The principles and standards for medical assessment prior to employment (attestation) and during initial training are common to all applicants (officers and soldiers, Regular and Reserve[1]).

0804. **Form RG8 Part 1 and copies of GP notes**. Form RG8 is a combined health declaration, Optician, Dentist and General Practitioner's report intended for pre employment screening for all applicants (officer and soldier, Regular and TA). Successful applicants are asked to consent to their GP providing a copy of their entire medical record to ensure continuity of primary care on commencing Phase 1 training. These notes are not used for pre-employment screening.

MEDICAL ADMINISTRATIVE PROCESSES FOR PRE-EMPLOYMENT ASSESSMENT

0805. Armed Forces Careers Office (AFCO) Form 5. In all cases, Recruiting Offices (AFCO) are to show each applicant the medical section of AFCO Form 5 to ensure that the applicant does not have any of the major disqualifying medical conditions listed on the form. This list is not exhaustive but acts as a useful coarse filter. Recruiting Office staff should seek advice from with an ADSC SMO if necessary.

0806. RG8 Initiation. Applicants are to complete sections 1.1 – 1.8 of the RG8 Part 1. The AFCO / recruiter will then forward the RG8 (marked 'Protect Medical') to the

[1] Applies to all TA applicants including Group B.

applicant's General Practitioner who, on completion, is to forward it to the Senior Medical Officer of the designated ADSC, AOSB or responsible Occ Med provider.

0807. Optician Assessment. If the applicant wears spectacles or contact lenses or has a history of eye conditions (including corrective refractive surgery), a contemporaneous optician's report is required as set out in the RG8.

0808. **RG8 Review.** The completed RG8 Part 1 is reviewed by medical selection staff. Applicants may be rejected or deferred at this stage. If no adverse medical history is found applicants are to be called forward for medical examination. If further information is required medical selection staff may defer the application to seek clarification by writing either to the applicant, the applicant's GP or other agencies, and/or discussion with HQ ARTD Occ Med.

0809. **Pre-Employment Medical Examination**. The medical examination will be conducted in accordance with **JSP 346** Chapters 1 - 3. The result is recorded in the applicant's medical notes and the employer informed of the initial JMES grade. The full PULHHEEMS grade is not to be disclosed but (with the applicant's consent), grades for hearing and visual acuity and Colour Perception are disclosed to ensure eligibility for their chosen CEG.

Applicants are graded as follows:

a. Pass – MFD . The JMES grade normally[2] necessary for an untrained individual to enter the Army. Applicants who fall below entry standards but who recruiters wish to be considered as special cases by DM(A) must be discussed with ARTD Occ Med in the first instance.

b. Probationary Pass – MND (Temporary). Only to be used for applicants for Scholarships or Bursaries considered to be temporarily unfit but likely to regain full fitness in time to commence Phase 1 training (see **0811** below). 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.

b. Defer – MND (Temporary). Applicants 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 applicants 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 - MND Permanent. Applicants found to be unfit (P8) in accordance with standards laid down in JSP 346 Chapter 3 are graded MND Permanent. They do not require a further assessment by a second doctor.

0810. Officer Applicants for Direct Entry to RMAS.

[2] A&SD Entry standard may vary as either a temporary measure or for individual cases. In all circumstances, specific authority from DM(A) is required.

Applicants for direct entry[3] to the Commissioning Course (CC) are normally administered by RG or sponsoring RHQs who initiate the pre-employment medical assessment process as in paras **0803-0809** above.

a. Army Officers Selection Board (AOSB). The completed RG8 Part 1 is sent to SMO AOSB and the applicant called forward for medical examination as appropriate. The validity of the pre-employment medical assessment is 12 months. After this period the applicant is to be re-examined and the RG8 Part 1 updated / repeated. Successful applicants are to be asked to complete a consent/request form to obtain a copy of their GP records. Selection medical staff send this form to the GP and arrange for the delivery of the GP records to SMO RMAS in time for the Initial Medical Assessment (IMA).

b. Pre-Commissioning Course Briefing Course (PCCBC) Medical. Candidates successful at AOSB will undergo a second pre-employment examination at RMAS (around 3 months before the start of the CC). Candidates are to be graded in accordance with **0809** above. SMO RMAS has responsibility for all aspects of the administration of the PCCBC medical including appeals. The PCCBC medical does not substitute the IMA and copies of GP notes are not to be used.

c. Serving Applicants. Serving applicants applying for commission refer to para **0203**.

0811. Scholars and Bursars. The pre-employment medical assessment procedure for these applicants is as described in paras **0803 to 0809**. When medical fitness of at the time of the CC cannot be accurately predicted[4] but an eventual grade of MFD is expected, applicants may be graded MND Temporary (as per **0809 b**)[5]. To ensure ongoing fitness, all of the above are required to complete Form RG8 Part 1 with GP corroboration annually. Completed forms are to be submitted to SMO AOSB who will grade individuals in accordance with **0809** and inform the relevant sponsoring RHQs. Completed RG8s form part of an ongoing occupational health record and are to be retained at AOSB as part of the individual's Service medical record. Cases where eventual fitness to train or serve in the grade of MFD is in doubt are to be discussed with ARTD Occ Med. Decisions that individuals are unfit to continue as scholars or bursars are to be recorded as a 2MMB which is to be ratified by SO1 Occ Med HQ ARTD.

0812. Professionally Qualified Officers (PQOs). PQOs are recruited by procedures determined by their Corps. Pre-employment medical assessment is conducted in accordance with paras **0803-0809** above. The completed RG8 is sent

[3] 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 12).
[4] Examples include lower limb "growing pains" that would preclude declaration of fitness for the commissioning course at the time of examination (e.g. at age 16) but are likely to resolve as the candidate matures.
[5] Potential medical and dental cadets must be graded MFD

to either AOSB or an ADSC[6] for review by medical staff and the applicant called forward for medical examination as appropriate. Medical and dental officer cadets are to complete Form RG8 Part 1 with GP corroboration annually. AMD Sp Unit will forward these to SO1 Occ Med HQ ARTD for confirmation of ongoing medical fitness. Completed forms will be stored at RMAS where they will form part of the individual's Service medical notes. At the start of the PGMO Course, PQOs are to undergo an IMA at a centre agreed with APHCS and ARTD. When there is doubt about an individual's fitness to train the case is to be discussed with SO1 Occ Med ARTD.

0813. **Officer Reinstatements**. Procedures for the medical assessment of officers wishing to reinstate their commission are identical to those described for soldiers wishing to rejoin the Colours (**0815**).

0814. **Soldier Applicants for the Regular Army.** The pre-employment medical assessment and examination is conducted as paras **0803-0809** above. Applicants must be declared fit to perform the Physical Selection Standards (Recruit) (PSS(R)) assessment. Applicants graded MFD are fit for attestation and may be allocated a place on a Phase 1 training course. The military selection staffs are to ensure that the applicant meets the standards required of the chosen CEG/CEQ. Successful applicants are to be asked to complete a consent/request form to obtain a copy of their GP records. Selection medical staff send this form to the GP and arrange for the delivery of the GP records to the SMO of the Phase 1 training unit in time for the Initial Medical Assessment (IMA). The validity of the pre-employment PULHHEEMS assessment prior to commencing Phase 1 training is 12 months. After this period the applicant is to be re-examined at the ADSC .and the RG8 Part 1 updated / repeated.

0815. **Re-Enlisters and Rejoiners to the Regular Army.** Procedures for re-enlisters[7] and rejoiners[8] are published in *RG Instructions Chapter 11*. Applications are administered by the APC in conjunction with AFCO/ACIO. Pre-employment medical assessment procedures[9] are dependent upon the age, P grade, PES / JMES when discharged and the time elapsed since discharge. In outline, those graded P2 on discharge and who left within the previous 6 years must complete the RG8 only. Within 1 week of reporting to their allocated unit, they are to be medically examined and the grade of P2 confirmed. If the individual is found to be below the required standard, RECU action may be taken in accordance with para **0825** et seq below. Applicants who have been discharged more than 6 years previously, whose P grade was less than P2[10] or who are more than 30 years old must undergo the full pre-employment medical assessment as described in paras **0803-0809**. The standard for re-enlistment is normally the entry standard for that Arm/Service. Those graded below P2 may be accepted, subject to the approval of the relevant MS Branch and DM (A). SO1 OH at APC is to view the completed RG8 and advice can also be

[6] The PQO Recruiting Office is to make arrangements with AOSB/ADSC for **each** individual to be examined. The use of ADSCs as medical assessment centres is dependent upon capacity of the ADSC and is subject to periodic review by RG.
[7] Re-enlisters: An individual who has been discharged from the Army this includes recruits who have left the Army during training and are therefore returning to training.
[8] Rejoiners: An individual who is currently serving on the RAR or RARO. The appropriate MCM Div will make the decision as to what training may be required.
[9] DIN 01-092 Army Instructions for Re-employment of Personnel With Military Service dated 1 Apr 09.
[10] If P grade is <P2, the medical documents are initially reviewed by SO1 OH at APC.

sought from the HQ ARTD Occ Med. Individuals who have been the subject of RECU or P8 discharge are in all cases to be referred back to the appropriate selection centre for re assessment.

0816. **Soldiers Discharged from the Army as Temperamentally Unsuitable for Army Service under QR 9.414.** Procedures for these applicants are published *in RG Instructions Chapter 11*. A prerequisite to the pre-employment medical assessment is confirmation of temperamental suitability. This must be assessed by a psychiatrist at an Army DCMH, which will be arranged by SO1 OH at APC. If temperamental suitability is confirmed, the candidate must also undergo the full pre-employment medical assessment as described in paras **0803-0809.**

0817. **AGC Military Provost Guard Service (MPGS).** MPGS applicants are either serving personnel or those who will have left the Service for no longer than 6 years.

a. **Serving Applicants.** Those applicants still serving will have a combined pre-release and selection medical undertaken by their usual medical centre. Results will be promulgated to APC Soldier Wing (AGC, MPGS) for consideration on an Appendix 9. The minimum standard for enlistment into the MPGS is MLD and body mass index (BMI) of <32kg/m^2, however at a medical examination the Body Composition Measurement[11] (BMI in combination with waist circumference) should not be more than Increased Risk; personnel below this standard will not be considered.

b. **Applicants Discharged less than 1 year ago.** Applicants who have been discharged for less than 1 year that were graded MLD or above during their discharge medical with a suitable BMI only need complete the RG8[12]. This will be passed to APC OH Branch for screening and where indicated, the individual will be called forward for a full ADSC[13] medical. In all instances in which the applicant was graded MLD at discharge, the RG8 will be passed to APC OH Branch for scrutiny, who may advise that a full ADSC Medical is required.

c. **Applicants Discharged over 1 year ago.** Those applicants discharged for a period in excess of 1 year, but less than 6 years who are graded MLD or above and have a suitable BMI are to be considered for employment by APC OH Br. If considered eligible for Service in the MPGS, personnel are to undergo a full ADSC medical which is to be arranged by APC Sldr Wing (AGC MPGS).

0818. **Officer Applicants for the Territorial Army.** TA officer applicants who have spent a period of time in the ranks will have been subject to the procedures outlined in para **0819.** On commissioning the validity of their recorded JMES is to be confirmed. Applicants for commission directly into the TA are to undergo the full pre-employment medical assessment as described in paras **0803-0809.**

0819. **Soldier Applicants for the Territorial Army.** Applicants are to undergo the full pre-employment medical assessment as described in paras **0803-0809**. The pre-employment PULHHEEMS Assessment is conducted at a location agreed by the TA recruiters and occupational health provider. Applicants must be declared fit to

[11] The Armed Forces Weight Management Policy – 2009DIN01-181 dated Sep 2009.

[12] Recruiting Group 8 form.

[13] Army Development and Selection Centre.

perform the Physical Selection Standards (Recruit TA) (PSS(R TA)) assessment[14]. Applicants graded MFD are fit for attestation and may then commence training. The TA unit selection staff are to ensure that the applicant meets the standards required of the chosen CEG. A copy of the GP records is not required for TA personnel as the Army is not responsible for their primary health care (except when mobilised). The validity of the pre-employment PULHHEEMS assessment prior to commencing the first module of Phase 1 training is 12 months beyond which time the applicant is to be re-examined and the RG8 Part 1 updated / repeated.

0820. **Appeals**. Appeals against decisions on medical fitness at pre-employment screening and at all stages in Phase 1 and 2 training are to be directed to the relevant Chain of Command using the paperwork at Appendix 19 in accordance with current HQ ARTD Medical Appeals Policy. ARTD is responsible for all appeals concerning selection and training and is the final authority for appeals concerning selection. AMD is the final authority for any appeals against decisions made during training and for appeals against published medical standards. Appeals should be considered in the first instance by the Medical Officer or Board that made the original decision.

MEDICAL ADMINISTRATIVE PROCESSES FOR ASSESSMENT DURING TRAINING

0821. **General**. Throughout training, both Regular and TA soldiers and Officer Cadets[15] must retain the standard of P2 and thus have the potential to be awarded the JMES MFD. Personnel may not remain in training if they fall below and are unlikely to regain this standard but may be given periods of light duties for up to 84 days in total provided that there is a reasonable prospect of recovery to full fitness. This period may be further extended at the discretion of the individual's CO after consultation with HQ ARTD Occ Med[16]. If discharge is recommended, the RECU procedure is to be followed except in cases where P8 recommendation would be appropriate[17].

0822. **Initial Medical Assessment (IMA)**. This assessment is to be conducted within a week of starting training to confirm the individual's fitness to commence training as advised at the pre employment medical.

a. **Soldiers under Training (SuT) and Officer Cadets (OCdts)**. Following attestation, all SuT and OCdts are to undergo IMA. Height, weight, pulse, BP, visual acuity, PEFR, audiometry and urinalysis are to be measured and recorded in every case. Repeat physical examination may be required at the discretion of the examining medical officer. The pre-employment PULHHEEMS grade is confirmed and the medical officer's assessment (Fit to train) entered into the notes. At the discretion of the Training Unit CO, individuals who are not fit to start training may either be retained for remedial

[14] All candidates graded P2 may attend PSS(R TA). Those graded P0 (prior to referral or deferral) may undertake PSS(R TA) at the discretion of the examining MO.
[15] Officer cadets include those undertaking academic training, eg under the Defence Technical Undergraduate Scheme (DTUS).
[16] A formal referral for an Occupational Medicine opinion is required in all cases.
[17] See para 0824 et seq for discharge procedures.

treatment or discharged under the RECU procedure. Examining medical officers will have access to a completed RG 8 (within the last 12 months) and a copy of the individual's GP records. Both documents are to be retained in the medical record. GP records may be summarised and retained during Phase 1 training. They may then be destroyed (except for clinically and occupationally relevant documents) prior to posting to Phase 2 training. The RG8 is to be retained in the medical record.

b. **TA Recruits and Officers**. TA recruits and officers undertake modular Phase 1 and 2 training and it is not logistically possible to medically examine them at the start of each element. Initial Training Group (ITG) 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.

0823. **Service Medical Examination (SME) and award of JMES**.

a. **SuT and OCdts**. On completion of Phase 2 training[18], unit MOs must confirm that SuT and OCdts meet the minimum medical standards for entry to the Field Army contained in Tables 1 and 2. Height, weight, pulse, BP, visual acuity, PEFR, audiometry and urinalysis are to be measured and recorded in every case. Repeat physical examination may be required at the discretion of the examining medical officer.

b. **TA Recruits and Officers**. SME is not required. TA personnel will be medically examined to confirm their JMES prior to mobilisation at RTMC Chilwell.

MEDICAL BOARD PROCEDURES FOR REGULAR ARMY PERSONNEL UNDER TRAINING

0824. Introduction. If a SuT or OCdt is unable to meet the standard of MFD they are to be assessed by a Two Member Medical Board (TMMB) in accordance with JSP 346 Chapter 4. The TMMB is to comply with the instructions set out in Chapter 10 of this Pamphlet. The HQ ATRD OM Consultant has responsibility for ratification of all TMMBs conducted on personnel under training that lead to RECU action. Prior discussion with HQ ATRD Occ Med is recommended especially if there is a likelihood of appeal against discharge. Boards are to be conducted in accordance with the instructions at Ch 9 and Appendices 1 and 2. Boards are in all cases to contain details of the nature and history of the problem, the individual's stage in training, treatment received, outcome, functional deficit and **full** examination findings.

0825. **Award of P Grade and JMES.** Individuals are to be graded in accordance with the guidance at Table 7. MOs should also consider the likely duration of the grade and any likely restrictions required and note these on the FMed 23. If it is considered that the individual does not meet the criteria of P7, the case is to be discussed with SO1 Occ Med HQ ARTD to consider whether a FMB needs to be

[18] If there is more than one sub-phase of Phase 2 training (eg RE), the Service Medical Examination is to be performed at the end of the second sub-phase.

arranged to consider P8. S3 may be allocated in addition to an appropriate P grade by the initiating medical officer in psychiatric cases, following consultation with DCMH clinical staff.

0826. **Initiation of Appendix 21**. Once the CO is advised that an individual is unfit to train[19] and is likely to remain so for more than 84 days RECU action may be initiated[20] by the unit administrative staff. A contemporaneous version of Appendix 21 is to be used and completed in full. If loose-leafed sheets are incorporated, personal details (minimum name and service number) are to be included on each sheet. The Appendix 21 is an administrative, not a medical form and must not include any medical details of a confidential nature. Once the application for discharge has been made, unit commanders are responsible for ensuring that the administrative processes and required timelines[21] are adhered to.

0827. P8 Discharges. The majority of discharges of trainees for medical reasons are authorised by *QR para 9.381 or para 9.385*. Occasionally, a trainee will become medically unfit for any form of Army service and is likely to remain so permanently. In these rare cases, P8 medical discharge is appropriate under *QR para 9.386 / 7*. The process differs from discharge under *QR paras 9.381 and 9.385,* because the discharge must be recommended by a Full Medical Board (FMB). The HQ ARTD Occ Med consultant has authority to convene a FMB to consider recommendations for P8 medical discharge.

0828. Pregnant Personnel. SuT and OCdts who are pregnant may not be medically discharged on the grounds of pregnancy. They are to be graded MND A6L6M6E6 and the Chain of Command given appropriate advice regarding restriction of their employment. See para **1102.**

0829. **P Grade of SuT / OCdts Electing to Discharge As Of Right (DAOR) or discharge for any other reason**. All are to undergo a comprehensive medical examination prior to discharge with the award of full PULHHEEMS grade and JMES. Examining medical officers should consider whether a medical discharge might be more appropriate and discussion with Occ Med HQ ARTD is advised.

MEDICAL BOARD PROCEDURES FOR TA PERSONNEL UNDER TRAINING

0830. Medical Board procedures for TA personnel under training are identical to those for Regular Army personnel with the exception that the authority for discharge is either *TA Regulations para 5.208 (Defect in Enlistment Procedure) or para 50.199 (Ceasing to fulfil Army medical requirements, that is permanently unfit for any form of Army service)*.

FURTHER ADVICE

[19] Intended to mean take part in the full range of training activity with the expectation of the award of a JMES of MFD on completion of training
[20] Unless retained by exception – see para **0821**
[21] Discharge of SuT under QR 9.381to be completed within 21 days and under 9.385 within 28 days.

0831. Further advice on the instructions in this Appendix may be obtained from HQ ARTD Occ Med.

0832-0899. Spare

CHAPTER 9

Instructions for Medical Boards

GENERAL

0901. The task of a Medical Board is to advise the executive of an individual's fitness for military duty. A Board[1] may comprise one or more suitably trained medical officers convened by authority of the local Senior Administrative Medical Officer[2]. The Board's advice is communicated to the chain of command by the award of a JMES grade which, although coded, constitutes a formal occupational medicine report.

0902. The President of a Board is normally the initiating Medical Officer who should be familiar with the case. Members of a Board may confirm the proceedings in absentia but should familiarise themselves with the case before doing so[3]. To ensure that reports are valid and robust, Boards must award grades based on accurate and contemporary clinical information, evidence of function and policy and ensure that this is recorded appropriately.

0903. Individuals must give consent for the Board's report to be conveyed to the chain of command and other agencies by completion of the form at **Appendix 17**. If consent is withheld, the President should seek advice from the appropriate convening authority.

0904. Exceptionally, where an individual is either unable or declines to attend, 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.

INDICATION FOR FORMAL REVIEW OF PULHHEEMS / JMES

0905. From the initial award of a PULHHEEMS / JMES grade, a Medical Board is required for any mandated review or to change a JMES grade. An individual's grade is to be reviewed when a period of sickness absence has exceeded (or is likely to exceed) 56 days **(see para 0708)** or when an individual has been (or is likely to be) unfit for full duties for a period greater than 56 days.

TRAINING

0906. All medical officers[4] and medical centre administrative staff are to be trained in the content of this instruction.

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1 Excepting MOD(A) Board

2 For example: Dir APHCS, Dir BFGHS, Div Comd Med (For TA) and SO1 Occ Med HQ ARTD

3 As a minimum should involve discussion with the President

4 To include CMPs, sessional doctors and locums

TYPES OF MEDICAL BOARD

0907. The constitution and authority of each type of Medical Board is as follows. The constitution of Boards convened to upgrade personnel should, wherever possible, reflect that of the Board that made the initial award[5].

a. **One Member Medical Boards (OMMB**). Usually conducted by the UMO. OMMB are used to temporaily downgrade an individual for a period not exceeding a maximumof 12 months in total. Administrative instructions are at Appendix 2.

b. **Two Member Medical Boards (TMMB)**. Usually initiated by the UMO a TMMB is required to downgrade an individual for any period exceeding 12 months and for all RECU applications (with OM Consultant presiding). Administrative instructions are at Appendix 3.

c. **Full Medical Board (FMB)**. Presided over by a Service consultant in occupational medicine, 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 DGAMS direction, principally for the purpose of appeals. The MOD(A) Medical Board will always include two OM consultants. Administrative instructions are at Appendix 5.

ROLE OF SPECIALISTS AND CONSULTANTS

0908. An appropriate specialist or consultant may volunteer or be requested to provide a opinion to assist a Board making an occupational recommendation[6]. Specialists[7], 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 Medical Board is the responsibility of the presiding MO supported by Service OM consultants.

ROLE OF SPECIALIST OCCUPATIONAL HEALTH NURSES

0909. Service Specialist Occupational Health Nurses may act as Members of TMMBs and confirm occupational restrictions and recommendations.

REPORTS AND PROCEEDINGS

5 Unless otherwise specified

6 Consent is required when seeking reports and a consent form, information sheet and specimen request are at Appendices 14, 15 and 16.

7 Including Service consultants and DMRC and RCDM advice, but not DCAs.

0910. Medical Board reports are recorded on the **Appendix 9**[8] and forwarded to the Chain of Command. The Boards'procedings are to be recorded as follows:

a.	OMMB	Recorded in the case notes as described at **Appendix 2**
b.	TMMB	Recorded on FMed 23 as described at **Appendix 1**
c.	FMB	Recorded on FMed 23 as described at **Appendix 1**
d.	MOD(A)	Recorded on FMed 23 as described at **Appendix 1**

GENERAL INSTRUCTIONS FOR MEDICAL BOARDS

Appeals

0911. An officer or soldier may appeal, through the chain of command, against the findings of a Medical Board using the process and paperwork **Appendices 19 and 20**.

Review of Downgraded Personnel

0912. Personnel who are downgraded are to undergo annual review[9] 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 TMMB is required and the proceedings recorded as at **Appendix 3**. The report is communicated to the CoC using **Appendix 9**. The attendance of the individual may not be necessary provided the medical officer is confident that the individual's current state of health and functional capacity is known.

Pregnancy

0913. Pregnant serving personnel (including those in training) are to be graded P4 for periods up to 12 months by a OMMB. Any requirement for downgrading beyond this period for whatever reason should be addressed by a TMMB.

Occupational Report

0914. A Board must, 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 mandatory for consideration for permanent medical grades below the individual's mimimum medical retention standard.

Use of the grade P0

8 App 10 for FMBs

9 Performed by the individual's usual / responsible medical officer

0915. Individuals temporarily unfit for all duties whilst under medical care are graded P0. Boards should award this grade for no longer than 3 months before formal review. If it is anticipated that the individual is likely to remain unfit for longer than 3 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.

Audit

0916. Primary healthcare providers are to ensure adequate arrangements for audit of medical board procedures and outcomes.

Dental

0917. Medical boards for dental re-grading purposes are to be carried out in accordance with the extant DGPL.

0918 – 0999. Spare.

CHAPTER 10

Management of Personnel below the Minimum Standard Required for Employment in their Arm or Service

General

1001. The purpose of this chapter is to outline the mechanisms for the management of personnel below the minimum required for their Arm and Service as defined in Tables 5 and 6[1]. When an Officer or Soldier is assessed by a Medical Board to be permanently below the minimum medical grading required by their Arm or Service or where the CO is unable to continue to employ an individual fully due to medical restrictions[2], then the Restricted Employability in Current Unit (RECU) Process described below is to be followed[3]. This does not affect an individual's entitlement to resign or terminate their Commission / Engagement. This process allows for consideration of transfer to a different Arm or Service or, where this is not possible, discharge on medical grounds. Under certain circumstances, the individual's case may be referred to the Army Employment Board (AEB) to determine an individual's future; the processes for the AEB are described in Chapter 12. The RECU Process should not be initiated until the individual is medically assessed as being permanently downgraded and stable or having a disability that is of slow progression[4]; temporary[5] inability to perform duties due to a medical condition does not automatically fall into this category. The key objective is to ensure that the skills that personnel have acquired through long and expensive training should not be wasted if continued employment can be found, within their medical capacity, which will not exacerbate their medical condition or place at risk the health and safety of others. Legal advice has been sought and incorporated throughout the development of this complex policy.

Army Medical Discharge Policy

1002. The Joint Medical Discharge Policy with regards to permanently downgraded personnel is:

> *The Armed Forces will discharge all those medically unfit for military service. However, the Armed Forces may retain those seriously injured, if they wish*

[1] The minimum standard, as defined in Tables 5 and 6, is MND for Majors and above and MLD (P3 or exceptionally P7) for Captains and below and soldiers. Personnel graded P8 will routinely be discharged.
[2] Personnel graded below MFD should be identified and managed through the Unit Health Care Committee following a Medical Board. APC Career Managers should also monitor medical grading through JPA and bring cases to the attention of COs should neither RECU or Appendix 8 retention action be taken.
[3] The RECU process replaces the AFB 204 process. Appendices 21 and 22 replace AFB 204A and AFB 204B respectively.
[4] With regards to rehabilitation from an injury or illness, 'slow progression' is regarded as gradual improvement in functionality over a time period of 1 year up to a maximum of 18 months. This period can be occasionally extended beyond 18 months subject to an assessment that there will be continuing gain in functionality as determined by an appropriate Medical authority.
[5] A period of up to 1 calendar year.

to stay, for as long as[6] *there is a worthwhile role or it is judged to be in the interest of the individual and the individual Service to which they belong.*

The second part of this statement must be – and seen to be- dependent on the outcome of a considered Medical assessment followed by an executive led employability assessment.

Authority

1003. Under the provisions of the Promotions and Appointments Warrant 2009[7] and Queen's Regulations 1975, consideration may be given to invaliding Officers and Soldiers from the Service. In pursuit of effective governance, it is the responsibility of the DM(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 DM(A) will monitor current medical discharge trends and figures and provide policy guidance on employability issues where required. As the Competent Army Authority and Inspectorate for the respective A&S, A&SDs also have a role in the provision of advice and policy.

DEFINITIONS

Worthwhile Role

1004. 'Worthwhile role' is defined as the ability to perform useful military employment, for which an individual is suitable, qualified or can be reasonably trained.

Interests of the Individual and Army

1005. The 'interests of the individual and the Army' applies where no worthwhile role for the individual can be identified. It requires the AEB to consider all other relevant factors in order to assess whether the benefits of retention to both the individual and the Army override the absence of a worthwhile role for the individual. It includes factors such as medical, welfare, financial and presentational factors and may also include the circumstances leading to the injury or illness[8].

RECU PROCESS

General

1006. The process applies to Regular and Reserves trained personnel on and off duty (Chapters 10 and 12) and recruits (see Chapter 11). For ease of reference, flow charts are included at Appendices 23 and 24 showing 2 potential scenarios:

a. MND L5 E5 Permanent (P8) personnel – unfit for further military service – Appendix 23.

[6] The period of retention will be directed by the AEB and will be subject to review. Retention could be as long as the completion of the individual's current engagement/Commission.

[7] Issued on 3 Nov 09 and supersedes the Pay Warrant 1964.

[8] 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 TMMB/FMB will not state direct causality/attributability, as this is for the SPVA to determine as part of the pension settlement process.

b. MND Permanent personnel and **exceptionally** MLD Permanent personnel – Appendix 24.

1007. An enduring principle is that individuals are to be managed carefully throughout the process and 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 chain of command responsibility, supported by APC.

1008. While treatment is on-going individuals should be employed, including under the Graduated Return of Work (GRoW) process, and managed in accordance with PAP 10 Appendix 9 and procedures laid out in AGAI Volume 3 Chapter 99 Command and Care of the Wounded, Injured and Sick.

Events Immediately Following a Medical Board.

1009. Once an individual has been assessed by a Medical Board as being permanently downgraded the CO is to ensure that an individual is fully aware of the implications[9] of the Medical Board's grading, it is the responsibility of the CO to make an initial employability assessment (in consultation with the unit's medical advisers and the appropriate MS Branch). This employability assessment is to be based on the minimum medical retention standards required and the individual's ability to undertake different employment within that unit or another unit for which they are qualified, where there is a vacancy. Immediately following a Medical Board (or prior to the Medical Board when the decision is predicted with a high level of certainty), drawing on respective subject matter expertise where necessary (including Occupational Health, SPVA and Personnel Recovery Unit staff) the CO must ensure that an individual is provided with an implications brief, an example of which is at Appendix 27, which consists of[10]:

a. If appropriate, assistance in completing and submitting an Armed Forces Compensation Scheme application.

b. Initial career advice on the implications of the outcome of the Medical Board's decision, including prospects for promotion and a full career, with advice from APC.

c. Financial advice, based on potential career options implications, including pay, pensions and compensations, with support from SPVA as necessary.

d. Additional medical advice and clarification if required.

e. Resettlement entitlement advice and support (if applicable).

f. Welfare support to ensure an individual is aware of the implications on their welfare provision (if any).

g. Explanation of the potential outcomes of the RECU Process, if undertaken.

h. A copy of PAP 10 Appendix 18 (occupational report for an individual).

[9] Implications briefs are required for personnel who are graded permanently below MFD (including MLD).
[10] Details are to be agreed, recorded and retained in the individual's P-file. This may be retained on WISMIS in the future.

TRAINED SOLDIERS AND TRAINED OFFICERS OF CAPT RANK AND BELOW

1010. Should a trained soldier or a trained officer of Capt rank or below[11] wish to be retained but is not employable within their current unit and cap badge, then the RECU process is to be initiated by the Unit CO. This process is normally considered for trained individuals permanently graded below the minimum standard for their Arm and employment; however in certain circumstances individuals graded above this with permanent medical restrictions can also be considered[12]. The RECU process can only be completed for trained individuals once an individual has received a permanent medical grading. It is imperative that employment would not exacerbate the individual's medical condition or place at risk the health and safety of others. On receipt of information that an individual has been permanently downgraded, the CO, in conjunction with the APC Career Manager and A&SD, has the following options:

a. Retain the individual in their unit in a post for which the individual is above the minimum medical employment standard. This should be the case for the majority of individuals where employment within the unit can be found.

b. Apply for the individual to be transferred to another unit for which the individual is above[13] the minimum medical employment standard, either in the same cap badge (if appropriate) or another cap badge through the RECU Process. Should employment not be found, then that individual may be discharged (see below).

c. If the individual is below the minimum medical standard required for employment in any post within the unit, but worthwhile employment can be found in the unit, then the CO must apply to DM(A), via the appropriate APC Career Manager, for retention of that individual using Appendix 8.

Personnel Graded MND L5 E5 Permanent (P8)

1011. Personnel graded MND (L5 E5) Permanent by a Medical Board will routinely be retired/discharged[14] with the application for discharge on medical grounds being generated automatically from the Full Medical Board (FMB) to APC SO1 OH. Chain of Command (CoC) input will be sought prior to the FMB. It should be noted that personnel graded P8 do not follow the RECU process as the discharge is processed automatically between the FMB and APC. The exceptions to this are individuals who are graded MND (L5 E5) Permanent who wish to be retained in the Army and who must therefore apply to the AEB for this (see Chapter 12). It should be noted that it is unlikely that personnel who are graded MND (L5 E5) Permanent will be retained unless there is a compelling argument for retention in accordance with the definition at Para 1002.

Personnel Graded MLD or MND Above L5 E5 Permanent.

[11] The minimum retention standard for all trained officers of Capt rank and below MLD. Officers of Maj rank or above have a minimum retention standard of MND.

[12] Individuals graded MLD or MND permanently may be considered for transfer or discharge under the RECU process where the CO considers that no appropriate employment is available within current Arm or Service. .

[13] All cases of individuals above the minimum retention standard who the CO wishes to consider for RECU must be discussed with APC SO1 OH prior to submission to ensure that the appropriate medical board has been conducted

[14] Under QRs Para 9.386 or 9.387 Temporarily or Permanently Medically Unfit for any form of military Service.

1012. The RECU process applies to trained individuals whose permanent medical grade is MND, or exceptionally MLD, and thus potentially below the minimum for retention in the Army but for whom no suitable employment can be found within their unit. Prior to initiating the RECU process the unit is to explore, in conjunction with APC Career Managers and Arms and Service Directorates as appropriate, all possible transfer opportunities within the individual's current cap badge. Advice from APC SO1 OH should be sought before initiating the RECU process, but once initiated, APC Career Managers are to examine all reasonable options for external transfer to another cap badge. If no suitable employment opportunities can be identified then the individual may be discharged on medical grounds or can request that their case is considered by the AEB. If an employment opportunity is identified, then an offer will be made to the individual concerned. Should he / she reject this offer, then the individual may be retired or discharged under QRs 9.414 or can request that their case is considered by the AEB (disputed Appendix 22).

1013. The template for the RECU process application is at Appendix 22 and this should be completed in the following manner:

a. **Section A. Completed by the unit CO**. The CO initiates the Appendix 22 and should interview each individual prior to completing Section A, as per Para 1009. This will ensure that they have been fully briefed on the career, financial and welfare implications of this process and understand its possible outcomes. Section A is signed by the CO to certify that a full briefing has taken place.

b. **Section B. Completed by the Adjt / RCMO**. The Adjt / RCMO must interview the individual to ascertain any personal career goals and ensure that he / she is fully aware of the implications of any decision to transfer or to reject transfer opportunities[15] as well as what opportunities are available to them in their permanent medical grade. The RCMO must then certify that there are no internal transfer opportunities either within the individual's current unit or cap badge, consulting with APC Career Managers as necessary. If the individual is within the medical standards for transfer to another Arm or Service but is considered unfit, unsuitable or is unwilling to transfer, this should be noted. There is no requirement to submit a transfer application (AFB 241 for soldiers); Appendix 22 is all that is required.

c. **Section C. Completed by the Individual.** The individual is asked to confirm that they have been fully briefed on the RECU process and the implications. Transfer preferences can be annotated. The individual should record their transfer preferences in order to show that they are a volunteer for transfer.

d. **Section D. Completed by Unit Medical Officer (UMO)**. The role of the medical officer within the RECU process is to confirm the medical grading and to ensure that all the necessary medical documents have been attached prior to the Appendix 22 being forwarded to APC SO1 OH. The UMO is asked to insert only the JMES grade; this should have been confirmed by an appropriate Medical Board (TMMB with OM Consultant presiding or FMB). Where a MB has not taken place, the RMO must consult with APC SO1 OH to decide what level of board is most appropriate. It is extremely important that the UMO ensures that PAP 10 Appendix

[15] Those individuals who are graded above the minimum retention standard and who reject an offer to transfer to a different Arm or Service may be ineligible for discharge on medical grounds and may be discharged under QRs 9.414 Services No Longer Required, with significant financial/pension implications.

17, giving consent for documents to be seen within APC, has been completed and is attached. In addition the following documents are required:

(1) PAP 10 Appendix 18 (occupational report completed and attached by CO).

(2) FMed 23 (completed by OM consultant as President of MB).

(3) F Med 4 (completed by UMO).

(4) PAP 10 Appendix 9 (notification of result of Medical Board completed by UMO).

(5) PAP 10 Appendix 17 (consent for disclosure of medical and administrative records).

(6) Full DMICP printout.

e. **Section E. Completed by APC Career Manager**. There are 4 potential outcomes to this section:

(1) Where the Medical Board grading means that an individual is unsuitable for transfer, the APC Career Manager should sign Section E and pass the Appendix 22 straight to APC SO1 OH.

(2) Where the Medical Board grading means that an individual is suitable for transfer, then the APC Career Manager[16], with A&SDs' support and advice, must ensure that all external[17] transfer opportunities are explored and that the individual is given every chance for a full Army career. This relies on Career Managers being rigorous in their approach and examining potential options fully, retaining an audit trail to prove that all reasonable options have been considered.

(3) Where a transfer opportunity is identified an illustrative plan for employment, given the medical restrictions of the individual, needs to be developed between the losing unit and receiving Corps or Arm, developed in consultation with OH advice. This will ensure the individual fully understands promotion prospects, employment limitations and his/her future career pathway. An offer to transfer can then be made. Where a transfer offer is made and accepted the RECU process will end after completion of section E and the form is to be returned to the Unit. Should the transfer offer be rejected and the individual wishes to be discharged then the individual must be aware that if they are not willing to transfer they may still be discharged under QRs Para 9.414[18]. If the offer is rejected and the individual wishes to be retained, then the process stops at this point and the individual must apply for their case to be considered by the AEB (see Chapter 12).

(4) Where a transfer opportunity is not found, the Appendix 22 is to be passed to APC SO1 OH who will inform the unit that the application for

[16] Or delegated representative at unit level.
[17] Internal unit/cap badge transfers would have been investigated at Section B.
[18] QRs Para 9.414 Services No Longer Required, with significant financial/pension implications.

transfer has been unsuccessful and that the individual will now be subject to discharge on medical grounds under QRs para 9.385 or retirement on medical grounds. Should the individual wish to be retained at this point then the individual may apply to the AEB for their case to be considered..

f. **Section F – To be Completed by APC SO1 OH**. SO1 OH will review all medical and employment information. Where a medical assessment has been made without OH input, SO1 OH will return the Appendix 22 to the unit for further assessment. In addition SO1 OH may recommend that an individual be re-assessed by an appropriate medical board (TMMB with OH Consultant presiding or FMB) if it is believed that their medical condition may have changed. SO1 OH must ensure that the employability of the individual has been fully considered and that their level of disability has been fully assessed, as this will have an impact both on employability and on the final pension that may be offered in the event of invaliding from service.

1014. Once the Appendix 22 has been fully completed and a recommendation made, SO1 OH will inform the unit who should undertake the necessary discharge action where required, unless AEB consideration is pending:

a. If retirement on medical grounds or discharge is recommended in accordance with QRs para 9.385[19], APC SO1 OH or the Army Retirements Board will authorise this and set the discharge date. The unit[20] and the individual will be informed by a letter from APC MS Plans Medical Discharge Cell.

b. If discharge is recommended in accordance with QRs 9.414[21] then the recommendation letter and signed AFB 130A are to be forwarded to DM(A) by the unit. On return of the documents from DM(A), the CO completes the discharge procedure and forwards all documents to APC MS Occurrences Terminations.

TRAINED OFFICERS OF MAJOR RANK AND ABOVE

1015. Due to broader employability within staff appointments, the minimum retention standards for Officers of Major rank and above are lower than those required for Soldiers and Officers of Captain rank and below. As a result Majors and above graded as low as L4 E3 (P7) MND Permanent are not routinely retired. The RECU application process is not used for such Officers and instead such Officers should write to their respective Career Manager outlining their request to transfer to another cap badge or requesting alternative employment. Should transfer not be supported or if employment cannot be found or an Officer declines a job offer, the Officer is to initiate Appendix 25 for referral of his / her case to the AEB, where a decision may be taken on retention or retirement.

RESERVES

1016. As a principle, Reservists who are in permanent service (mobilised or serving on FTRS) will be treated no differently to Regular Soldiers and Officers. However the situation is often more complex and may need to be assessed on a case by case basis. It should be recognised that a Volunteer Reservist (VR) (TA) may have a wider employability when reassigned back to a TA unit than a member of the Regular Reserve (RR). A RR graded below MFD is unlikely to be selected for any future call out and therefore it may be

[19] QRs Para 9.385 Considered Unsuitable for further Army Service on Medical Grounds.
[20] The unit will be informed by e-mail prior to the letter being issued to the individual.
[21] QRs Para 9.414 Services No Longer Required.

necessary for the individual to be discharged / retired from any remaining Reserve liability. A similar situation may exist for VR personnel who may be employable within a TA unit, but may not be of a standard for selection for mobilisation. It is recognised that a VR or RR may have a civilian career or be in full time employment and therefore this must be taken into consideration when retaining the Reservist in permanent service to continue treatment of any medical condition. It must be further understood that the Army has a responsibility to release a Reservist called out for permanent service at the earliest opportunity. There is no entitlement to alternative military employment and the Army's approach is to achieve an acceptable level of fitness to permit demobilisation with referral to the NHS for further treatment where necessary. Reservists who cannot be medically treated and are below an acceptable retention standard will be provided with clear advice and support as per Para 1009 (where applicable) and demobilised, including referral to SPVA as necessary.

1017. Reservists serving on an FTRS commitment have a specific term of employment with a clearly defined end and start date and therefore to retain a Reservist beyond the commitment date requires the authority of DM(A). However, any extended period of service should be merely to facilitate medical treatment / assessment and the Reservist has no entitlement to alternative employment. Once deemed fit or that the condition cannot be further treated, following the advice and support outlined in Para 1009, the commitment will be terminated, with referral to SPVA as appropriate.

1018. Sponsored Reserves (SR) provide a contracted service and are called out for permanent service. Whilst they are administered and trained by the Army, they are paid by the contractor. Should SR be injured during their service, the MoD has a responsibility for any medical treatment. SR have no entitlement to alternative employment but should the medical condition be permanent they may be entitled to the Armed Forces Compensation Scheme and invaliding allowances.

RESETTLEMENT TRAINING

1019. Individuals for whom the RECU process has been initiated and the Appendix 22 has been sent to APC are eligible to commence resettlement training in accordance with JSP 534 while their case is being processed.

SUMMARY

1020. The aim of this process is to ensure that those medically downgraded personnel who are no longer fully employable within their current CEG are either considered for transfer or are discharged / retired from the Army. Equally it aims to ensure that those personnel seriously injured who still wish to be retained have the opportunity for their case to be considered by the AEB, should the principles outlined in Para 1002 be applicable. It should be noted that the critical factor governing the results of the RECU process is employability. We should ensure that the Army retains those Officers and Soldiers still capable of further Service and considers those for discharge / retirement whose medical condition is preventing their employment.

1021-1099. Spare

CHAPTER 11

MANAGEMENT OF RECRUITS BELOW THE MINIMUM STANDARD REQUIRED FOR EMPLOYMENT IN THEIR ARM OR SERVICE

General

1101. Recruits should be considered for the RECU process after a period of 84 days on light duties. Each recruit / officer training establishment should review all downgraded personnel at their monthly Unit Health Care Committee. All soldiers under training must retain the standard of P2 and thus have the potential to be awarded the MES of Medically Fully Deployable (MFD). They may not be graded P3, P7 or P8 and remain in training. They may be given a period of light duties for up to 84 days provided that there is a reasonable prospect of recovery to full fitness. This period can be further extended at the discretion of the individual's CO after consultation with HQ ARTD Occ Med. Unit COs must ensure that the RECU process is followed after the 84 day period has been reached and that trainees are not left Temporary Non-effective for a longer period without review. Any exceptions supported by HQ ARTD Occ Med should be reviewed monthly. Any exceptions to the agreed standards for assignment to the Field Army on completion of training must be authorised by DM(A).

Pregnant Recruits

1102. Pregnant recruits are not to be discharged for any reason connected with their pregnancy, unless the recruit wishes to be discharged, having been briefed fully on the options to complete training that are available. Servicewomen are to be treated at all times in accordance with 2007DIN02-005 and JSP 760 and not treated less favourably because they are pregnant, absent on maternity leave or for any other reason connected with pregnancy.

RECU

1103. Once initiated the RECU process should take no more than 28 days to complete. However, this relies on each section being completed as fully as possible to allow ARTD SO1 Occ Med to confirm appropriateness of grade awarded by unit Medical Board and to recommend the appropriate QR for discharge. 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 ARTD Occ Med.

a. **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 1010. The CO signs this Section to confirm that he has briefed the recruit to this effect. The CO must also ensure that PAP 10 Appendix 18 has been completed in all cases; this Appendix details the employment restrictions of the recruit and should be attached to the Appendix 21.

b. **Section B** – **Completed by the Recruit**. The individual is asked to confirm that they have been fully briefed on the RECU process and the implications. ARTD staff, in conjunction with A&SD representatives, should consider whether a recruit is fit to be transferred to a different Corps, to whom they are eligible to transfer, but this is unlikely and only in exceptional circumstances. However, 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.

c. **Section C – Completed by the 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 entry standards for transfer to another

cap badge but is otherwise not suitable or is unwilling to transfer, the SPSO forwards the documents direct to the ARTD SO1 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 Vol 2 Chapter 48. There is no longer any requirement to submit a transfer application on AFB 241 as the Appendix 21 is all that is required.

d. **Section D – Completed by SMO**. The role of the SMO within the RECU process 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 ARTD Occ Med. Where possible the SMO should be involved in the Medical Board process of individual recruits. He / she must be acquainted with the relevant clinical details of the case and should ensure that sufficient information is inserted into the F Med 23 to allow HQ ARTD Occ Med to make a decision relating to discharge. Only the SMO or his delegated representative should sign Section D.

e. **Section E – Attachments**. A list of the necessary attachments with the responsible officer can be found at Section E. Those completing the Appendix 21 are to confirm all documentation is attached by annotating this on the form. Forms sent to ARTD SO1 Occ Med without the appropriate accompanying documentation will be returned to the unit, causing a delay to the process. The following will always be required (sealed in an FMed 691), however additional documents may also be inserted at the discretion of the SMO and CO:

(1) PAP 10 Appendix 18 (completed and attached by CO).

(2) F Med 23 (SMO).

(3) PAP 10 Appendix 9 (SMO).

(4) PAP 10 Appendix 17 (SMO).

(5) FMED 133 with a full DMICP Printout.

f. **Section F – Completed by HQ ARTD Occ Med**. ARTD SO1 Occ Med will review the medical information provided and make a decision on the future employability of the recruit. In order to facilitate this, sufficient information is required on the F Med 23, to justify the given grade and is to be completed to the standard described in PAP 10 and current ARTD guidance. On receipt of the Appendix 21 and accompanying medical documents, ARTD SO1 Occ Med endorses the F Med 23, completes Section F of the form and returns all the documents to the CO. If ARTD SO1 Occ Med does not agree with the findings of the Board, he / she will discuss with the President of the Medical Board separately and will return all the documents to the CO with comments / observations.

1104. 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 75 Para 9.381[1] – soldiers who have not completed Phase 1 or Phase 2 training. The CO requests discharge of a soldier on AF B130, completes the discharge procedure and forwards all documents to the APC MS Occurrences Terminations.

b. If discharge is recommended in accordance with QRs para 9.385[2], then the discharge will be authorised by the CO on an AFB 130 after ratification by ARTD SO1 Occ Med. All documents are then to be forwarded to APC SO1 OH for authorisation and forwarding to APC MS Occurrences Medical Discharge Cell.

c. Recommended under QR 75 Para 9.414[3] – the completed Appendix 21, medical documents and AFB 130A are forwarded to DM(A) SO2 Discharges. On return of the documents from DM(A), the CO completes the discharge procedure and forwards all documents to APC MS Occurrences Terminations.

Exceptions

1105. Applications for those who fall below P2 in training, but for whom there are exceptional reasons to retain them and allow them to allow them to be assigned to the Field Army are to be submitted to DM(A) for a decision.

Reserves

1106. Reservist recruits who are below the minimum standard required for their Arm or Service are to be discharged in accordance with TA Regs 1978 Para 5.198.

1107-1199. Spare

[1] QRs Para 9.381 Defect in Enlistment Procedures.
[2] QRs Para 9.385 Considered Unsuitable for further Army Service on Medical Grounds.
[3] QRs Para 9.414 Services No Longer Required.

CHAPTER 12

The Army Employment Board (AEB)

General

1201. This chapter describes the procedures for applications to the AEB, the potential outcomes from referral to the AEB and the construct of the AEB itself. It should be noted that personnel who have been previously been re-graded as L5 E5 MND temporary (P0) in order to facilitate retention, predominantly as a result of injuries on operations should be reviewed and the policies described in this Chapter applied, with applications for retention (Appendix 8) or referral to the AEB (Appendix 25) submitted as appropriate. It should also be noted that 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 individual under the policy outlined at Para 1002.

AEB

1202. 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 Full Medical Board (FMB) or MoD A Board. An AEB can therefore only take place on completion of the medical assessment by an FMB or MoD A Board and will meet as required and as convened by SO1 OH, in the following circumstances:

a. In exceptional circumstances for a Soldier or Officer graded L5 E5 MND permanent (P8) where retention is sought by the individual.

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

(1) The Medical Board grading means that an individual is unsuitable for transfer; or

(2) Where a transfer opportunity is not found; or

(3) An employment opportunity is identified, but the individual rejects the offer[1]

and retention is sought by the individual[2].

c. Where the circumstances described in Para **1202 b (1) - (3)** apply but the chain of command considers that discharge is appropriate[3].

[1] It should be noted that the AEB may still recommend medical retirement for officers or for soldiers discharge either under QRs Para 9.414 Services No Longer Required or QRs Para 9.385 Unsuitable for further Army Service on Medical Grounds.
[2] For soldiers, this application would take the form of a disputed Appendix 22.
[3] Para 1202 a & b are where the individual wishes to stay and thus initiates the Appendix 22, which may or may not be supported by the chain of command. The option under Para 1202 c is effectively the chain of command requesting that the AEB considers discharge against the wishes of the individual.

d. For cases where current guidelines are felt to be insufficient to meet complex issues. For example where an individual's case falls outside of the definitions in Chapter 10 and the direction in PAP 10 is felt to be insufficient.

Application Process

1203. Where retention is sought by the individual, then the individual is to initiate the application for referral to the AEB, using Appendix 25[4]. Where the chain of command considers that discharge is more appropriate, then the CO either indicates this on the application by the individual or initiates an Appendix 25. In the case of a disputed Appendix 22, where the individual seeks retention, then Appendix 25 is to be initiated by the individual, but the CO may or may not support this application and is required to comment on this at Para 4 to Appendix 25.

1204. When referring a case to the AEB in the circumstances outlined in Para 1202 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. The RECU process may be initiated either because retention is sought or because the CoC (including MS Branch and A&SD advice) decides that discharge or retirement is appropriate. 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.

1205. The application process to be followed by the CoC is as follows:

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

(1) **For individuals graded L5 E5 MND permanent (P8) where retention is sought.**

i. The individual should be interviewed by the CO to confirm his / her understanding of the employment, financial and welfare implications of remaining in Service, using SME advice as appropriate and in accordance with Para 1009.

ii. The appropriate MS Branch should be informed in order that options can be considered and employment options can be drafted. This must be agreed by the individual (if not agreed then see Para 1205 a (2) below) and will be a key consideration for the AEB.

iii. Appendix 25 must be initiated by the individual, 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 individuals who are graded below the minimum medical standard required by Arm or Service, where either employment cannot be**

[4] With the assistance of the immediate chain of command.

found or employment offered is rejected, but retention is sought by the individual (for Soldiers this is a contested Appendix 22):

i. The individual should be interviewed by the CO to confirm his / her understanding of the employment / financial implications of remaining in Service (for Soldiers this should have been conducted as part of Section A of Appendix 22), in accordance with Para **1009.**

ii. The appropriate MS Branch reconsiders transfer options (for Soldiers this will have been completed once as part of the RECU process) and an employment options are drafted. This must be acknowledged by the individual and will be a key consideration for the AEB[5].

iii. Appendix 25 is initiated by the individual 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.

b. **In Cases Where Discharge / Retirement is Sought by the CoC.**[6] Where discharge / retirement is sought by the CoC, Appendix 25 is to be initiated by the CO and the individual need not agree the application; his reasons for this disagreement will be fully considered by the AEB.

(1) The individual should be interviewed by the CO to confirm his / her understanding of the employment / financial implications of remaining in Service compared to discharge / retirement (for Soldiers this should have been conducted as part of Section A of Appendix 22), in accordance with Para 1009.

(2) The appropriate MS Branch should be informed in order to confirm whether employment can or cannot be found[7]. Employment options should be drafted to inform the AEB's decision as to whether to approve discharge / retirement.

1206. All cases for retention must be accompanied by a employment options drafted by the Career Manager and seen by the individual and the CO within the employing unit. In drafting these employment options, the Career Manager is also to seek the advice of the relevant A&SDs as this will ensure that employment options incorporate broader implications on training and employment opportunities. The employment options summarise what could be offered to the individual in respect of future assignments, attendance on career courses[8] and general career opportunities. Prospects for promotion should be included, taking due account of the limitations of promotion of personnel below the minimum medical standard. The employment options are to be informed by medical (including OH) advice regarding what type of work or activity can or cannot be undertaken.

[5] MS 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.

[6] See footnote 3.

[7] Although finding employment will have been conducted as part of the RECU process, a further attempt should be made to find employment, considering any factors which may have changed.

[8] Where a career course attracts a Return of Service (ROS) in accordance with 2007DIN02-192, and an individual subsequently applies for discharge, advice must be sought from DM(A).

1207. A personal statement from the Soldier / Officer is required for all cases referred to the AEB secretariat along with supporting statements. The appropriate MS 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.

Governance

1208. The AEB reports to the Army Health Committee[9] (AHC) chaired by AG. The AEB will produce an annual summary of cases and AEB decisions to the AHC to inform Army policy.

Board Composition

1209. Membership of the AEB consists of:

Post [10]	**Voting Member**	**Adviser Role**	**Remarks**
DMS	Yes		President
Col CM Ops	Yes		If not available, deputised by Col CM Branch
Col AMS	Yes		For AMS cases only
Col CM Branch	No	Yes	For Regimental personnel as appropriate. Voting member if Col CM Ops not available
DM(A) AD Employment	Yes		
President of the Full, Army Central or MOD(A) Medical Board[11]	No	Yes	The president of the most senior medical board that has considered the case is required
APC SO1 OH	No	Yes	Secretary
LF Sec representative	No	Yes	For presentational issues
Legal advisor	No	Yes	Employment Law
Chain of Command representative	No	No	May attend
Subject matter experts	No	Yes	May attend e.g. welfare, pay and pensions
A&SD	No	Yes	May attend where a case has implications for a cap badge

Case considerations

1210. In determining whether the individual 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 individual and the Army for him / her to be retained, the AEB

[9] The Army Health Committee is chaired by AG and is the highest Committee considering both the personnel and welfare aspects of Health policy together with the individual aspects of Health care.
[10] Or nominated representative, not below the rank of OF 4.
[11] The President of each FMB will be expected to attend the AEB, but may delegate attendance to a nominated OM Consultant 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.

will consider all relevant factors, drawing on A&SD advice where necessary, including the following:

a. Length of Service and the extent to which an individual is able to complete his / her respective Commission / Engagement.

b. Whether medical, welfare, health and safety restrictions preclude continued employment within the individual's current commission / trade / CEG or any other capacity. It is critical that continued employment can be found within an individual'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 an individual within extant manning 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 individual together with any supporting documentation and / or representations that they or their CO may present to the AEB.

h. The Commanding Officer's report[12].

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

The AEB Options

1211. The Board has the authority to direct one of the following options, giving reasons for its direction:

a. A grading of L5 E5 MND temporary (P0)[13] where applicable and retain the individual, providing direction where appropriate on the length of this retention. The AEB may also comment on an individual's fitness for a conversion of Commission or Engagement. The AEB cannot change the medical grading recommended by an FMB, however, in exceptional circumstances where there is clear benefit to the Army and individual for retention, a grading of L5 E5 MND temporary may be allocated that will allow continued military Service. The medical status of individuals graded L5 E5 MND temporary will be reviewed annually. An individual so retained is unlikely

[12] 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.

[13] Personnel graded P8 are by definition unfit for employment and therefore the grading P0 is used to indicate that medical treatment is ongoing.

to be eligible for a discharge on medical grounds at the end of their engagement / Commission, other commitment or period of mobilised service.

b. Retaining an individual, subject to a review within a specified timeframe[14]. This is to be applied where the prognosis of an individual's condition is uncertain, or where there is an obligation to ensure an individual is given sufficient time to make the transfer to civilian life. This must be reviewed at 6 monthly intervals[15] within the parameters of the individual's current Engagement or Commission type and will not normally be extended beyond 24 months. A temporary grading of L5 E5 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[16]. 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 an individual but the individual declines the offer[17].

Individual attendance at AEBs

1212. While individual attendance is required for FMBs, the AEB is focussed on making decisions regarding employability. The individual is not required to attend the AEB, however, a unit representative or the CO may be asked to attend. Individuals may request attendance at an AEB to APC SO1 OH; the President of the Board will decide on the relevance of such requests.

Withdrawal of request for AEB action.

1213. In order to withdraw a request for AEB consideration the following is required:

a. **Change to Medical Condition.** Any changes to an individual's medical condition must be confirmed by a medical assessment submitted to SO1 OH. If necessary a further FMB should take place.

b. **Retention**. Requests by the individual to withdraw an application for retention must be submitted to APC SO1 OH and copied to the appropriate Officer / Soldier MS Branch.

Resettlement Training

1214. Individuals recommended for invaliding from the Service remain eligible to commence resettlement training in accordance with JSP 534 while their case is being processed and submitted to the AEB.

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[14] Downgraded personnel are reviewed routinely on an annual basis.
[15] By APC SO1 OH.
[16] In accordance with JSP 760 Tri-Service Regulations For Leave And Other Types Of Absences and JSP 534 The Tri-Service Resettlement Manual.
[17] If discharged under QRs Para 9.414 Services No Longer Required, this will have significant financial/pension implications.

Post Board Action

1215. The following will take place after each AEB:

a. **Notification.** The results of the AEB will be notified in writing to both the individual and the CO. 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.

b. **P0 Grading.** A L5 E5 temporary grading can be authorised by DM(A) to replace a medical grading of L5 E5 Permanent, thereby providing for retention in military service. The authorisation and promulgation of the revised medical category will be undertaken by SO2 Discharges or SO2 Offrs ToS within DM(A) and the unit SMO is to ensure that this grading is annotated on DMICP along with a JMES Environmental Code of E5.

c. **Discharge.** If discharge is recommended on medical grounds in accordance with QRs para 9.385, a discharge will be authorised and a date for discharge will be issued by APC SO1 OH. If discharge is recommended in accordance with QRs 9.414 then the authorisation letter and signed AFB 130 A are to be forwarded to DM(A) SO2 Discharges by the unit. On return of the documents from DM(A)/APC, the CO completes the discharge procedure and forwards all documents to APC MS Occurrences Terminations.

d. **Retirement.** Invaliding retirement for Officers will be authorised in accordance with the provisions of the Army Promotions and appointments Warrant 2009 and actioned by APC SO1 Occurrences.

Appeals

1216. The individual has the right of appeal against the AEB's recommendation in the following circumstances:

a. Where new factors or evidence have come to light that were not considered by the original board, the individual may, at any time prior to his or her 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 an individual disagrees with any decision of the Board with regard to invaliding, retention or review, he / she may request, within a maximum of 1 calendar month from the promulgation of the board result, a review by the Army Employment Appeals Board (AEAB).

1217. The AEAB will meet as and when required but within 3 calendar months of the acknowledgement of the appeal application by SO1 OH (in accordance with Para 1220).

Composition of the Appeals Board

1218. The AEAB is composed of:

Post	Voting Member	Adviser Role	Remarks
DG Pers	Y		President
DM(A)	Y		
DPS(A)	Y		
LF Sec Representative	N	Y	SCS Level
APC SO1 OH	N	Y	Secretary
PSMB	N	Y	Where medical issues are contested

Appeals Procedure

1219. An application for appeal should be submitted in writing to the relevant MS Branch through the appellant's CO, clearly stating the grounds for the appeal and the desired outcome. The appropriate Officer / Soldier MS 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.

1220. SO1 OH will acknowledge receipt of the appeal through the individual'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. SO1 OH will also inform the appellant, in writing, of the Board's decision, copied to the CO and relevant MS Branch at the APC.

AEAB Powers

1221. The AEAB may take the following action:

a. Direct the AEB to reconsider the case. The AEAB may also wish to make a recommendation for action by the AEB.

b. Uphold the individual's appeal and substitute its own recommendation for that of the AEB.

c. Reject the individual's appeal and uphold the AEB's original recommendation.

In each case, the AEAB will give reasons for its decision.

1222-1299. Spare

TABLE 1
Minimum Medical Standards for Officers, by Arms, On Entry and on Commission

Serial	Arm	P	U	L	H	H	E	E	M	S	CP	Refer To Notes
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	3	
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[1])	2	2	2	2	2	8/3	8/6	2	2	4	
8	UKSF[2]											
	(a) Badged ranks	See Table 4 for Entry Standards to UKSF										
	(b) Attached ranks	2	2	2	2	2	8/3	8/6	2	2	4	4
9	AAC											
	(a) Pilot	See Appendix 6 for Entry Standards to Army Flying Appointments										
	(b) 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	x 8/6	2	2	4	
11	RLC[3]	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

[1] Includes Army personnel serving within SFSG.
[2] Regulations apply to Army personnel within SBS, 22 SAS, SRR, 18 (UKSF) Sig Regt SFCs, 21 SAS(R) and 23 SAS(R).
[3] Port and Maritime Regulations may require CP1 (See MSN 1756 (M)) Seafarer Medical Examination System and Medical any Eyesight Standards (to be superceded by MSN 1822(M) dated 6 Apr 10).

TABLE 1 - continued

Serial	Arm	P	U	L	H	H	E	E	M	S	CP	Refer To Notes
14	AGC RMP / MPS	2	2	2	2	2	8/3	8/6	2	2	3	
	All other AGC	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	CAMUS	2	2	2	2	2	8/2	8/6	2	2	4	4, 5

Notes:

1. Officers of any Arm employed as parachutists or attached to the PARA or the UKSF 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	E
8/2	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 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	
8/2	8/6	8/3	8/2

5. CAMUS standards apply to officers in TA bands.

6. If applicant 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.

TABLE 2
Minimum Medical Standards for Entry to the Army, by Arm and Employment - Soldiers

Serial	Arm and Employment/CEQ	P	U	L	H	H	E	E	M	S	CP	Refer to Notes
1	**Household Cavalry** AFV Crewman/Mounted Duty man	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 x	7/3	2	2	4	
4	**RE** ME (Heating & Plumbing) } ME (Surveyor Engineering) } ME(Draughtsman) (all) } ME (Bldg & Structural Finisher) }	2	2	2	2	2	8/3	8/6	2	2	2	9
	ME Electrician	2	2	2	2	2	8/3	8/6	2	2	2	3, 9
	ME (Geographic Technicians) } ME (Construction Materials Technician) } ME (Fitter General) }	2	2	2	2	2	7/2 x	7/3	2	2	2	9
	ME (Air Con & Refrigeration)	2	2	2	2	2	8/3	8/6	2	2	2	9
	ME (C3S) } ME (Plant Operator Mechanic) } ME (Driver) } ME (Engr Logistics Specialist) }	2	2	2	2	2	7/2 x	7/3	2	2	3	
	ME (Armoured)	2	2	2	2	2	7/2	7/3	2	2	3	3
	ME (Combat) } ME (Bricklayer & Concreter } ME (Carpenter & Joiner) } ME (Fabricator) }	2	2	2	2	2	8/3	8/6	2	2	3	
5	**R SIGNALS** Systems Engineer Technician } Installation Technician }	2	2	2	2	2	8/3	8/6	2	2	3	

Serial	Arm	P	U	L	H	H	E	E	M	S	CP	Refer to Notes
	R SIGNALS (contd) Communication Systs Operator } EW Systems Operator }	2	2	2	2	2	7/2	x 7/3	2	2	4	
	Electrician	2	2	2	2	2	7/2	x 7/3	2	2	2	
6	**Foot Guards** (all)	2	2	2	2	2	8/3	8/6	2	2	4	
7	**Infantry** (all) (incl **PARA**[1])	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	**UKSF**[2]											
	(a) Badged Ranks	See Table 4 for UKSF Entry Standards										
	(b) Attached Ranks	2	2	2	2	2	8/3	8/6	2	2	4	3
10	**AAC**											
	Pilot	No direct entry for OR pilots										
	Soldier	2	2	2	1	1	3/1	3/1	2	2	2	3
11	**RLC**											
	Air Dispatcher	2	2	2	2	2	5/2	5/2	2	2	3	5
	Mariner[3]	2	2	2	2	2	3/1	3/1	2	2	2	6
	Marine Engineer	2	2	2	2	2	7/1	7/6	2	2	3	3
	Port Operator } Driver } Driver (Comms specialist) } Postal and Courier Operator } Logistic Specialist (Supply) } Movement Controller }	2	2	2	2	2	7/2	7/3	2	2	4	

[1] Includes Army personnel serving with SFSG

[2] Regulations apply to Army personnel serving with SBS, 22 SAS, SRR, 18 (UKSF) Sig Regt SFCs, 21 SAS(R) and 23 SAS(R)

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

Serial	Arm	P	U	L	H	H	E	E	M	S	CP	Refer to Notes
	Ammunition Technician } Petroleum Operator }	2	2	2	2	2	7/2	7/3	2	2	3	6
	Railway Operator	2	2	2	2	2	1/1	6/3	2	2	2	6
	Pioneer } 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
	Armourer } Metal smith } Technician Electronics } Technician Aircraft } Technician Avionics } Shipwright }	2	2	2	2	2	7/2	7/6	2	2	4 3 2 2 2 3	3
	Recovery Mechanic	2	2	2	2	2	7/2	7/3	2	2	4	
	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	3	
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	8/3	8/6	2	2	4	
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	

Serial	Arm	P	U	L	H	H	E	E	M	S	C P	Refer to Notes
22	**APTC**	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 } Qualified Nurse }	2	2	2	2	2	8/3	8/6	2	2	4	
	Health Care Assistant }											
25	**CAMUS**	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	3	3	

Notes:

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

E	E
8/2	8/6

2. Individuals 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	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 1269A - Assessment of Medical Fitness in the Royal Air Force* at Leaflet 4-04, Annex W.
Link: www.publications.raf.r.mil.uk/live/system/raf/rafpubs/docindex.asp?DoclDNo=2
5. See Chapter 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. CAMUS standards apply to musicians in TA bands.
9. Colour Perception level 2 required.

TABLE 3

Reserved

TABLE 4

Minimum Medical Standards for Entry and Retention – United Kingdom Special Forces[1]

General

1. UKSF Selection is an extremely arduous selection process both physically and mentally. It is conducted in remote locations both in UK and overseas. Subsequent service with UKSF is similarly demanding. It follows that a very high level of physical and medical fitness is required. Those with a predisposition to, or with conditions requiring periodic medical care or review or taking long term medication or in whom deterioration of a pre-existing condition might occur are not suitable for service with UKSF. Candidates are therefore required to undergo a special medical examination prior to attendance on selection.

2. The medical examination may be performed by Service medical officers and civilian medical practitioners employed by the MOD. Advice may be obtained from SO1 Med HQ DSF who is the authority on fitness to serve with UKSF.

PULHHEEMS Profile[2]

3. The minimum PULHHEEMS profile is as follows:

	P	U	L	H	H	E E	M	S	CP
Entry	2	2	2	2	2	3 3 1 1	2	2	4
Retention	3	3	3	3	3	8 8 3 8	2	2	4

Documentation

4. The medical examination is to be conducted not more than 8 weeks prior to the start of the selection course that the candidate is to attend.

5. The results of the medical examination are to be recorded on FMed 143, including indication in the Summary of Examination box as to whether the individual is fit to undergo arduous training.

1 Regulations apply to personnel serving in a 'badged' role within SBS, 22 SAS, SRR, 18 (UKSF) Sig Regt SFCs, 21 SAS(R) and 23 SAS(R).
2 Individuals with CP4 may have restrictions placed upon specialist boat handling employment within SBS due to extant Maritime Regulations. Further detail available via PMO SBS.

Medical Standards

6. As a general guide, the medical standards applied to Army recruits should be applied. More specifically, when examining a candidate for UKSF, particular attention should be paid to the following:

a. **P Quality**. The individual must be physically robust with a high level of aerobic and anaerobic fitness. They should not require any regular medication nor be undergoing any ongoing medical treatment. There are specific conditions, which also make the candidate unfit. These are as follows:

(1) A history of perforating chest injury or chest surgery if there is evidence of pulmonary of pleural scarring make the candidate unfit.

b. **U Quality**. Chronic shoulder conditions particularly, recurrent dislocation make the candidate unfit.

c. **L Quality**. The commonest reasons for a medical withdrawal on selection are as follows:

(1) Low back pain. Most have a previous history of the same.

(2) Tibial pain syndrome. A significant number have a previous history and/or a significant biomechanical abnormality of the lower limb.

(3) Anterior knee pain/patello femoral joint pain. Most have a previous history of the same.

d. **Vision.** Spectacles may not be worn but contact lenses are permitted to achieve the standard. Special Forces Service may be possible for individuals who have had Laser Eye Surgery. This should have been carried out in accordance with *JSP 346 Chapter 4 paras 4.20-26*. In addition the individual must have been assessed by a Service ophthalmologist before being declared fit for SF entry.

e. **M Quality**. An individual must be capable of absorbing the training and acting independently with initiative.

f. **S Quality**. An individual must be mature, stable, well adjusted and have no history of psychiatric illness or substance abuse.

Dental Fitness

7. A high standard of dental fitness is required. All candidates are to be ‘dentally fit’.

TABLE 5a
Minimum Retention JMES Coding for Officers

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	MND
1	Minimum JMES Coding – for trained Capts and below	A4L2M6E1	A5L3M6E2	below retention standard
2	Minimum JMES Coding – for Majs and above	A4L2M6E1	A5L3M6E2	A5L4M6E4

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

TABLE 5b
Minimum Retention Eyesight Employment Standards for Officers

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	(MND[1])
1	Minimum Eyesight Grading (less those listed below)	8 8 3 6	8 8 3 8	8 8 3 8
2	UKSF	3 3 1 1	8 8 3 8	8 8 3 8
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

[1] MND is only applicable to Majors and above (DE and LE).

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	(MND[1])
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
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

Serial	Arm/Service	Deployability Coding		
		MFD	MLD	(MND[1])
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	CAMUS	8 8 2 6	8 8 3 6	8 8 3 6

TABLE 6a
Minimum Retention JMES Coding for Soldiers

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
1	Minimum JMES Coding (less those listed below)	A4L2M6E1	A5/6L3M6E2
2	RLC Seaman/Navigator	A4L2M1E1	A5/6L3M2E2

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 6b
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 (Driver Specialist (Tank Bridge Transporter))	$\frac{7}{2}\ \frac{7}{3}$	$\frac{7}{2}\ \frac{7}{3}$

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
	ME (Resources Specialist) ME (Armoured Engineer) ME (Plant Operator Mechanic) ME (Geographic Technician) ME (Construction Materials Technician) ME (C3S) ME (Fitter Gen)		
3	R SIGNALS (trades listed below only):		
	Regimental Duty Foreman of Signals Yeoman of Signals Supervisor (Information Systems) Supervisor (Radio) Communication Systems Operator Electronic Warfare Systems Operator	7 7 2 3	7 7 2 3
	Electrician		
	Systems Engineer Technician Installation Technician	8 8 3 6	8 8 3 6
4	Infantry (trades listed below only):		
	Dvr Lic Cat C & E	7 7 2 3	7 7 2 3
	Dvr Lic Cat B & E	8 8 3 6	8 8 3 6
5	UKSF	3 3 1 1	8 8 3 8

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
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) Driver (Tank Transporter) Port Operator Ammunition Technician Postal and Courier Operator Logistic Specialist (Supply) Vehicle Support Specialist Photographer Petroleum Operator	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
	Railway Operator	1 6 1 3	1 6 1 3
	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 Avionics Artificer Aircraft Artificer Weapons Artificer Electronics Technician Avionics Technician Aircraft Vehicle Electrician Metal smith Shipwright Armourer Electronics Technician Regimental Specialist Technical Storeman	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

Serial	Arm/Service	Deployability Coding	
		MFD	MLD
15	APTC	$\frac{8}{3}\ \frac{8}{6}$	$\frac{8}{3}\ \frac{8}{6}$
16	QARANC	$\frac{8}{3}\ \frac{8}{6}$	$\frac{8}{3}\ \frac{8}{6}$

Note: Individuals 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 7
Functional Interpretation of JMES / PULHHEEMS Grades

	Grade	JMES	Function Capacity and Employment/ Deployment Limitations
P Physical	2	Medically Fully Deployable (MFD)	**Medically Fit for unrestricted service worldwide.** The absence of a medical condition or functional limitation that would prevent the individual from meeting any of the following requirements: – Undertaking all elements expected of both rank and Career Employment Group (CEG) in barracks and whilst deployed. – Unrestricted World-wide deployment
			Objective tests. – Pass all MATTs (appropriate to the individual's Arm or Service).
	3[1]	Medically Limited Deployability (MLD)	**Medically fit for duty with minor employment limitations.** An individual who has a medical condition or functional limitation that prevents the meeting of all MFD requirements. The individual must: - Be able to undertake full-time employment in barracks, but 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, delay in planned medical review or interruption in treatment. - Not impose a significant and / or constant demand on the medical services if deployed on exercise or deployments and therefore the individual may deploy on operations or overseas exercises providing the appropriate risk assessment is completed. - 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.
			Objective tests. - Walk 3.2 Km unassisted, without walking aids but inclusive of prosthetics where appropriate, carrying 15 Kg within one hour and repeat the test after 24 hours. - Able to pass Weapon Handling Test (WHT) without assistance - Pass MATT 1 Level 1 including ACMT (Annual Combat Marksmanship Test) using current infantry standard weapon[2] - Pass non-physical MATTs
	7	Medically Not Deployable (MND)	**Medically fit for duty with major employment limitations.** An individual 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 subject to the appropriate risk assessment. If employed in accordance with their CEG the condition or functional limitation should not be exacerbated. The individual 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 (allowing 1 hr per day for treatment or rehabilitation, not including travel time).

[1] Or exceptionally P7.

[2] At time of writing an unmodified SA80 A2. Test in accordance with the AOSP Vol 1

			Objective tests. - Able to pass WHT without assistance - Able to pass MATT 1 Level 2 (including all live firing) using current Infantry standard weapon[3] - Walk 3.2 Km unassisted, without walking aids but inclusive of prosthetics where appropriate, within one hour and repeat the test after 24 hours
	8		**Medically unfit for Service.** The individual fulfils one or more of the following: - Unable to perform the individual's primary employment/CEG with reasonable adaptation and restrictions. - Unable to attend work for 32.5 hours per week. - Employment would exacerbate the individual's condition and have a significant effect on the individual's health. - Unable to deploy, including on local exercises in any capacity.

	Grade	JMES	Function Capacity and Employment/ Deployment Limitations
U Strength, Range of Movement and General Efficiency of Upper Arm, Shoulder, and Upper Back	**2**	**Medically Fully Deployable (MFD)**	The absence of a medical condition affecting the upper limbs likely to affect the individual's ability to perform their CEG. This includes all MATTs appropriate to the individual's Arm or Service. No limit to wearing of current in-Service operational heavy body armour[4], helmet, personal weapon and personal equipment appropriate to their CEG and rank.
	3	**Medically Limited Deployability (MLD)**	The presence of a physical limitation to upper limb function likely to affect the individual's ability to perform their CEG. No limit to ability to: - Function wearing personal equipment specific to primary employment/CEG. - Wear a helmet and the minimum theatre entry standard body armour[5] - Must be able independently to lift (ie place over shoulder) and carry 300m personal equipment (holdall etc up to 55 Kg) - Note: if unable to wear full current in-Service operational body armour, then this limits deployability to designated main operating bases (PJHQ CAT 1)
	7	**Medically Not Deployable (MND)**	The individual must be: - Able to write, use a telephone and operate IT and other office equipment for 32.5 hours per week (allowing 1 hour per day for treatment or rehabilitation). - The individual may be unable to wear full current in-Service operational body armour but must be able to wear minimum theatre entry standard body armour to complete MATT 1 Level 2 (Weapon Handling including live firing).
	8		Unable to write, use a telephone and operate IT or other office equipment. Unable to pass a weapons handling test. Unable to wear full current in-Service operational body armour or the minimum theatre entry standard body armour.

[3] At time of writing an unmodified SA80 A2. Test in accordance with the AOSP Vol 1

[4] At time of publishing, this equates to OSPREY (approximate weight 10.5 Kg)

[5] At time of publishing, this equates to ECBA (approximate weight 4.5 Kg)

	Grade	JMES	Function Capacity and Employment/ Deployment Limitations
L **Strength, Range of Movement and Efficiency of Feet, Legs, Pelvic Girdle and Lower Back**	**2**	**Medically Fully Deployable (MFD)**	The absence of a medical condition affecting locomotion likely to affect the individual's ability to perform their CEG. This includes all MATTs appropriate to the individual's Arm or Service. No limit to wearing of current in-Service operational body armour, helmet, personal weapon and personal equipment appropriate to their CEG and rank.
	3	**Medically Limited Deployability (MLD)**	The presence of a physical limitation to lower limb function likely to affect the individual's ability to perform their CEG. No limit to ability to: - Function wearing personal equipment appropriate to role. - Wear a helmet and the minimum theatre entry standard body armour - If not be able to wear full current in-Service operational body armour. This will limit deployability to designated main operating bases (PJHQ CAT 1) - Walk 3.2 Km unassisted, without walking aids but inclusive of prosthetics where appropriate carrying 15 kgs, within one hour and repeat the test after 24 hours.
	7	**Medically Not Deployable (MND)**	Able to: - Independently organise and manage travel to work requirements. - Move around the proposed place of work relevant to the individual's CEG – a minimum of 2 flights of stairs and 100m over uneven ground. - Can stand for moderate (25 mins unsupported) but not prolonged periods relevant to the individual's CEG. - Walk 3.2 Km unassisted, without walking aids but inclusive of prosthetics where appropriate within one hour and repeat the test after 24 hours.
	8		Unable to pass a weapons handling test. Unable to wear full current in-Service operational body armour or the minimum theatre entry standard body armour.

	JMES	Medically Fully Deployable (MFD)	Medically Limited Deployability (MLD)	Medically Not Deployable (MND)	
	Grade	**2**	**3**	**7**	**8**
HH	**Audiometrically Assessed Acuity of Hearing. Sum of the Hearing Loss at:**	Acceptable practical hearing for service purposes.	Impaired hearing but the individual 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 individual 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 fire personal weapon or operate equipment related to the individual'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 individual's ability to perform in their CEG. Able to perform commensurate with the individual'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 individual'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 individual'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 individual'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 individual'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.

Notes:

APPENDIX 1

Guidance for Medical Officers

COMPLETION OF FMED 23

1. The FMed 23 is the form for summarising the findings of a medical board and recording decisions made. When other documents in the electronic health care record are referred to they should be referenced, facilitating their location if required. 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.

2. This guidance on the completion of the FMed 23 is provided in order to ensure all relevant information is included, consistency is achieved and that the information is presented in the most suitable form. Additional guidance on the completion of FMed 23 for candidates discharged from training is at para 5.

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 (eg 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****.* This information should be taken from the documentation provided by the parent medical centre for prelims. It should be checked with the patient during the initial interview. It is not necessary to corroborate this with the personnel record as a matter of routine*.*

5. ***Surname and Forename(s)****.* Current full names, as they appear on the medical record, should be used. Do not include previous surnames (eg maiden names) and nick names, which should be explained in the narrative if required.

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 27 May 62*.*

7. ***Command****. T*his is the cap badge of the individual not his/her current unit. This should be entered using recognised service abbreviations (JSP 101 refers).

8. ***Ship/Unit/Station****.* The current parent unit is to be listed. Note that some referrals will have come from a different unit, which has medical parenting responsibilities, and that patients may have been assigned between referral and the time of the board. This information should be checked with the patient at the time of the Board.

9. ***Type of Enlistment / Commission****.* Use the approved abbreviations, eg for officers, Reg C, IRC, SSC, etc, and for other ranks, NOTENG, OPEN, VENG etc.

10. ***Authority of Board****.* This is shown in the relevant Appendices and for Phases 1 and 2 Training may be SO1 Occ Med HQ ARTD, for APHCS may be Dir APHCS, for BFGHS – Dir BFGHS, MOD(A) Board – DGAMS. For other Boards it may be the local Senior Administrative Medical Officer.

11. ***Principal Condition(s) Affecting the Medical Employment Standard Leading to Medical Board****.* This section should be completed with care, as it may have a direct impact of the later award of a War Pension, an Armed Forces Pension or compensation under the AFCS. This should normally only list one condition. In exceptional cases where more than one condition has an equal effect on the award of P grades / PES, more than one condition may be listed. The justification for this should be included in the text.

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

13. ***Date of Board and Signatures****.* All dates for the Board and date of signing are to be the same, and are to be the date on which the patient was seen and the PES awarded. Delays due to typing are to be ignored.

14. ***Other Condition(s) Affecting the Medical Employment Standard at the Time of the Medical Board****.* Details of other medical conditions affecting the patient and contributing to the PES awarded should be listed here.

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 (eg 01 Feb 08 (presented)), and the matter noted in the narrative. (eg “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, (eg UK, Germany, SBA Cyprus, or USA etc.). If the event occurred on operations, then the inclusion of the operation is recommended (eg Op TELIC, Iraq). A separate place should be noted for each condition listed in the Principal Disabilities box, using the same numbering system.

17. ***Ceased Duty On****.* For those patients not currently at work, being TNE or on sick leave (SL), the day after the individual was last fit for duty in any capacity should be recorded. This information should be sought from the patient during the Board*.*

18. ***PULHHEEMS and JMES****.* The PULHHEEMS and JMES blocks should be completed in accordance with JSP 346.

a. ***Place, Type and Date of Next Medical Board.*** If the medical board 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 L5 E5 are deemed to be fit. For those graded L5 E5 temp the probable period of time before return to duty / next medical board should be noted**.** If a period of SL is granted, then the appropriate period should be noted here.

c. For those graded MLD and above, any employment restrictions should be recorded here.

19. ***Normal Date of Termination****.* The current exit date should be entered here, as related to the type of enlistment/commission (see note 9). If a patient is due to leave on PVR or some other mode of exit other than at the end of their normal engagement, this should be annotated here (eg 1 May 08 (PVR)), and full details noted in the narrative.

20. ***Narrative****.* The following information[1] **must** be recorded.

a. Relevant medical history including medical treatment and medication (both past and planned).

b. Relevant medical examination details and findings.

c. The board is satisfied that advice about prognosis has been obtained from a relevant clinician.

d. That the board is satisfied that on-going treatment is appropriate.

e. Current Employment (including any adaptations made for medical condition).

f. Rehabilitation.

g. Social and Employment History.

h. Other considerations (eg relevant information from Appendix 18 if used, patient's wishes, Unit view etc).

i. Recommendation.

[1] Including from DMRC as appropriate.

j. Confirmation that the patient was given an opportunity to ask questions and will be given a copy of the FMed 23.

k. That the patient had the purpose and process of the Board explained, that the opportunity for questions was given, and that they gave their consent to be examined. It should also be recorded whether they gave their consent for the FMed 23 to be sent to DASA.

21. ***President's Signature****.* This space is for the President's signature and GMC and NMC numbers.

22. ***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.

23. ***Member(s) Signature(s)****.* These spaces are for the Member(s) signature(s).

Additional Information Relating to Army Candidates During Training

5. **FMed 23**. 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, aloowing the Confirming Officer to be able to determine a recommendation for discharge (without reference to the contents of the Medical Record)[2]. TMMB Presidents are to ensure that the FMed 23 is completed fully and accurately. The following minimum information is to be included on the FMed 23:

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)?

[2] 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.

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-enlistment criteria to be satisfied.[3]

i. Recommendations given to individual.

j. Confirmation that the individual has been given an opportunity to ask questions and has been given a copy of the FMed 23.

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

[3] See Table 5/6.

MEDICAL BOARD RECORD

Service No	Rank/Rating	Branch/Trade	Date of entry
See note 1	*See note 2*	*See note 3*	*See note 4.* *Yrs Mths*
Surname	*See note 5*	Command / Cap Badge	*See note 7*
Forename(s)	*See note 5*	Ship/Unit/Station	*See note 8*
Date of Birth	*See note 6*	Engagement / Commission	*See note 9*
Date and Place of Board	*See notes 6, 12 and 13*	Normal Date of Termination of Full Time Service	*See note19*
Authority for Board	*See note 10*	Ceased Duty On	*See note17*

Principal condition(s) affecting the medical employment standard leading to the Medical Board		**Other condition(s) affecting the medical employment standard at the time of the Medical Board**	
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**

Service Number	Rank / Rating	Surname	Date of Board

Narrative (continued on FMed 15 as necessary)

See Note 20

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

	Name (with GMC / NMC No.)	Rank	Signature	
President	*See note 22*		*See note 21*	(OMMB)
Member	*See note 22*		*See note 23*	(2MMB)
Member	See note 22		*See note 23*	(FMB)

Approval (used for MOD(A) Board)

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

APPENDIX 2

Instructions for One Member Medical Boards

1. **Authority**. A One Member Medical Board (OMMB) is convened under the authority of the local Senior Administrative Medical Officer (SAMO). A medical officer must be suitably trained in order to conduct a OMMB. OMMBs may downgrade individuals for up to 6 months at a time (not to exceed 12 months in total) and may assess pensioners at the request of APC Glasgow.

2. **Content**. The Board's content and narrative should follow the instructions at **Chapter 9** and **Appendix 1**.

3. **Administration**. The findings of a OMMB are to be recorded in the subject's usual medical record using a designated Read Code. In most cases this will be on DMICP but where this is not possible an FMed 23 should be used and recorded on DMICP. The Board's recommendation (JMES only) is to be communicated to the individual and the unit using **Appendix 9**.

4. **Consent**. Consent to release the JMES grade is to be recorded in the usual medical record1 in all cases.

5. **Pregnant Personnel**. For pregnant personnel FMed790 (Pregnancy Certificate) is also to be initiated.

1 Where possible this is to be recorded in the DMICP consultation.

APPENDIX 3

Instructions For Two Member Medical Boards

1. **Authority**. A Two Member Medical Board (TMMB) is convened under the authority of the local Senior Administrative Medical Officer (SAMO). Both medical officers must be suitably trained in order to conduct a TMMB. TMMBs are required to downgrade individuals for any period exceeding 12 months and may assess pensioners at the request of APC Glasgow.

2. **Composition**. A TMMB is to be composed of:

   a. The MO with current clinical responsibility for the patient.

   b. The Regional Consultant Occupational Physician, or a suitably trained MO nominated on his / her behalf. Service Specialist Practitioner Occupational Health Nurses may also act as a member of a TMMB.

   c. In support of RECU applications, a TMMB must have the signature of two MO's one of these must be a serving or retired[1] Service Occupational Medicine Consultant[2].

3. **Administration**. The findings of a TMMB are to be recorded on an FMed 23 signed, scanned and retained on DMICP where available, or in the FMed 4. The Board's recommendation (JMES only) is to be communicated to the individual and the unit using **Appendix 9**. A copy of the FMed 23 is to be forwarded to DASA and CHRL.

4. **Consent**. An Appendix 17 (A or B as appropriate) is to be completed in all cases.

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1 Retired Service Consultants must be approved by CAOM.

2 Individuals must be given the opportunity to have the reasons for the award of the grade explained to them by the OM consultant.

APPENDIX 4

Instructions for Full Medical Boards

1. **Authority**. A Full Medical Board (FMB) or Army Centralised Medical Board (ACMB) is convened on the authority of the local Senior Administrative Medical Officer (SAMO).

2. **Composition**.

a. **President**. The President will be a serving or retired[1] Service Occupational Medicine Consultant (for recruits this will be SO1 Occ Med, HQ ARTD).

b. **Members**. The FMB members comprises two other MOs. One member of the board should be serving, or have served in the Army as a medical officer.

c. The medical board will be convened with a minimum of the President, one member and the patient in attendance. Remaining members of the Board may be *in abstentia*.

3. **Function**. FMB and ACMB are to assess trained officers and soldiers who are recommended for invaliding, discharge or retirement on medical grounds from the Service, whether this be in grade P3 or P7 *(Army Pay and Promotions Warrant Article 196 or QR 9.381 or QR 9.385 for soldiers)* or in grade P8 *(QR 9.386 or QR 9.387 for soldiers)*[2]. RECU cases may be seen by a TMMB with an OM Consultant presiding and the ACMB may review RECU cases on appeal.

4. **Application**. Unit MOs may apply to the Regional OH Team for a patient to be seen by a FMB. Unless otherwise directed by local instructions unit MOs are to prepare paperwork as follows:

a. A completed FMed24 (personal statement of the history from the patient's perspective).

b. A referral on a FMed 7 on DMICP.

c. Carry out a "Pre-release" medical examination and complete:

(1) FMed 143 (special medical examination record).

(2) FMed 133 (medical history on release from HM Forces).

d. The referring MO is to complete the Initial Resettlement Referral Form shown at Appendix 11 and forward to the IERO, copied to ROHT. This is a provisional assessment of functional ability and is designed to help the

1 Retired Service Consultants must be approved by CAOM.
2 Under TA Regulations: for soldiers these are 5.198 (temporary) and 5.199 (permanent) and for officers this is para 4.180.

AGC(ETS IERO) with the resettlement planning. It is not a medical form and clinical details must not be divulged without the express permission of the patient. The assessment is provisional and does not in any way presuppose the outcome of FMB. A copy of the form must be sent to the Unit Resettlement Officer and a second to the FMB.

e. The referral must be accompanied by Appendix 18.

f. FMed 1017 with Parts 1 and 2 completed.

g. Send all the documentation to the Regional OH team who will arrange the venue, date and time of the medical board.

5. **Administration**. The following documentation is to be completed for <u>all</u> FMB.

a. The FMed 23 is to be completed in accordance with SGPL 05/07 and the guidance at Appendix 1. A copy should be sent to DASA (with consent). A copy should also be made available to the patient.

b. Table 2 of the FMed 4 and/or electronic medical record.

c. Complete FMed 1017 Part 3.

d. Complete Appendix 17.

6. The following additional documentation is to be completed if a medical discharge is <u>not</u> recommended:

a. Appendix 9 of PAP10 to the unit (responsible for onwards distribution).

b. The medical record is to be returned to the individual's parent unit.

7. If the FMB recommends P8, the President of the board is to:

a. Give the patient one copy of the FMed 133 with DMICP Printout and a copy of Appendix 10.

b. Issue a copy of '*Transition to Civilian Life - A Welfare Guide for the Service Leader*' (AC66408) to the patient. This is to be recorded on each copy of Appendix 10.

c. In exceptional circumstances the board may recommend that the medical condition precludes access, in-service, to the resettlement support to which an individual is eligible in accordance with the Army Resettlement Manual, Section 9. Access to resettlement provision remains available for up to 2 years post-release. In exceptional cases the individual may be unable, for long-term medical reasons, to take advantage of the resettlement provision to which they are eligible. This provision may be made available to the spouse for up to two years post-release.

d. The completed FMed 23 is to be endorsed (in the text) with a recommendation for discharge under the appropriate paragraph of QRs.

e. Complete Appendix 11 and forward a copy to the unit and the appropriate AGC(ETS) IERO.

f. Forward the medical record, FMed 23, FMed 24, FMed1017 and copies of Appendices 10, 12, 17 and 18 to *Medical Discharge Cell, Mailpoint 544, Kentigern House, Army Personnel Centre, 65 Brown Street, GLASGOW, G2 8EX*.

8. **Notes on the application of Queen's Regulations (QRs) for the Army and Territorial Army Regulations (TA Regs) to Discharges on Medical Grounds**[3]. Soldiers may be discharged from the Regular Army on the basis of the authorities contained in QRs. The appropriate paragraphs are summarised below:

a. **QRs 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. AFB 204 procedure is to be followed.

b. **QRs 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 medical board must precede discharge action in these circumstances.

c. **QRs Paragraph 9.385 'Ceasing to Fulfil Army Medical Requirements, that is, Medically Unfit (for continued duty in his Arm or Service) Under Existing Standards'**. This paragraph applies to a soldier who is graded P3 or P7 and who has fallen below retention standards for their Arm or Service. RECU procedure is to be followed to allow, where appropriate, re-allocation to another arm or service. Only if other employment is not possible and if transfer to another corps is not authorised should a soldier be discharged under paragraph, see QRs 1975 para 9.385 for instructions.

d. **QRs Paragraph 9.386 'Ceasing to Fulfil Army Medical Requirements, that is, Temporarily Unfit for any form of Army Service'**. This applies to an individual graded P8 for a condition that may at a later date improve. Individuals discharged under this paragraph are transferred to the Reserve and may be mobilised in future emergencies. If the individual's medical condition is incompatible with this commitment discharge must be effected under paragraph 9.387.

e. **QRs 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 P8 if the condition is permanent.

[3] Regular Officers are retired under the Promotions and Appointments Warrant 2009.

f. **TA Officers Considered Unfit for Military Service on Medical Grounds / Medically Unfit for Service under Existing Standards**. Officers will be retired under *TA Regs Chapter 4, Part 9 Para 4.180.*

h. ***TA Soldiers Considered Unfit for Military Service / Medically Unfit for Service under Existing Standards****. Soldiers will be discharged under .*TA Regs Chapter 5, Part 6, *Para 5.198 (Medically Unfit under Existing TA Medical Standards) and 5.199 (Medically Unfit for any Form of Army Service) and for officers this is para 4.180*

9. **Appeals**. The appeals process is at Appendix 19.

APPENDIX 5

Instructions for the MOD(A) Medical Board

1. **Authority**. The MOD(A) Medical Board is convened under the authority of DGAMS.

2. **Composition**.

   a. **President**. The President is DGAMS Consultant Adviser in OM (CAOM) or his nominated representative.

   b. **Members**. The board members will include at least two other medical officers. One member of the board must be the consultant specialty adviser, or his/her nominated representative, relevant to the patient's condition. The other member must be a Consultant Occupational Physician. A minimum of 2 members 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.

3. **Function**. The MOD(A) Medical Board may be convened to review the decision of any other medical board.

4. **Application**. RCDs or other MOD Departments may apply to the Chief of Staff, Army Medical Directorate to convene a MOD(A) Medical Board. If approved, AMD 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 AMD will nominate an alternative President.

5. **Location**. The MOD(A) Medical Board will be convened at a location most appropriate to the members and the patient.

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 by DGAMS or his/her nominated representative.

8. **Appeals**. The decision of the MOD(A) Medical Board is final.

APPENDIX 6

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 Director Army Aviation for the medical assessments of applicants 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 applicants, 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 medical board 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 applicants will be medically examined by the Royal Air Force medical board at the Officers and Aircrew Selection Centre (OASC), 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 applicants is as follows:

P	U	L	H	H	E	E	M	S	CP
2	2	2	1	1	3 1	3 1	2	2	2

Medical Standards

5. **Hearing Standards**.

a. 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 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

b. Full details of the hearing standards for Army aircrew can be found in the *Army Hearing Conservation Programme, AGAI Volume 2 Chapter 66*.

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) in any meridian, and the astigmatic element must not be greater than ± 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 21-25 > 25	Up to 11 11 – 13 Normal age parameters

d. A previous history of corneal refractive surgery will disqualify. All cases should be discussed with the Department of Aviation Medicine.

e. Full details of the vision standards are available in *Annex K to AGAI Volume 2 Chapter 43*.

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 *Annex K to AGAI Volume 2 Chapter 43*.

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.

Potential Officer Applicants

9. Civilian applicants will be required to complete a pre-selection medical questionnaire, which must be sent to the Department of Aviation Medicine for review by an Army Consultant in Aviation Medicine[1] (CAM). An applicant may be rejected on the basis of the results of this questionnaire. The CAM may seek clarification of medical details by writing either to the applicant or to the applicant's general practitioner or hospital specialist with the applicant's consent.

10. If the medical questionnaire is found acceptable, applicants will attend OASC for an aircrew medical board, and the results will be forwarded to the Department of Aviation Medicine. Although the OASC Medical Board is currently valid for 5 years, each candidate will be reassessed whilst at RMA Sandhurst, even if the OASC 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, after the completion of the Part 2 medical tests at RMAS, by the Army Consultant Adviser in Aviation Medicine (CA Avn Med). An appropriate aircrew medical category will be awarded at the start of the Army Pilot Course..

11. **Appeals.** Applicants may appeal against decisions made at the pre-employment medical assessment or after the OASC 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 an Army CAM to review the decision. Subsequent Level 2 appeals should be directed to AD Avn, 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 Applicants

12. Officer Cadet applicants for flying training will be managed in accordance with procedures in paragraphs 9 and 10 above. In addition, the CAM will review the FMed 4 and RG8 of all applicants.

13. **Appeals.** Officer Cadet applicants may appeal against decisions made at the pre-employment medical assessment, or after the OASC 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 an Army CAM to review the decision. Subsequent appeals should be directed to AD Avn, 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.

1. An Army Specialist in Aviation Medicine may be authorised to perform the role of a CAM whilst under supervised training.

Military Applicants

14. Military applicants are to comply with the instructions in *AGAI Volume 2 Chapter 43*. Applicants will be required to have a pre-selection medical assessment by their medical officer, including the Part 2 medical tests, after which their FMed 4 must be sent to the Department of Aviation Medicine for review by an Army CAM. Full guidance notes for unit medical officers on the minimum medical employment standards for Army pilot applicants are contained in *AGAI Volume 2 Chapter 43 Annex K*. Applicants may be rejected on the basis of their medical history or the results of this pre-selection medical assessment, without the candidate being called forward for a medical examination at OASC. The CAM may seek clarification of medical details by writing to the applicant's RMO or hospital specialist, with the applicant's consent, or by arranging a specialist opinion.

15. If medically acceptable, applicants will attend OASC for an aircrew medical board and the results will be forwarded to the Department of Aviation Medicine for review. The OASC board is valid for 5 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 OASC Medical Board are to be directed in the first instance to CA Avn Med, who will convene a board with an Army CAM to review the decision. Subsequent appeals should be directed AD Avn, 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 applicants.

ENTRY STANDARDS FOR ARMY AVIATION CREWMEN

17. Army Aviation Crewmen perform duties in Army aircraft (e.g. Air Door Gunner, Winch operator, and Islander crewman) but do not currently go through the same aircrew selection procedure as pilots. However, for their own safety and for flight safety careful selection procedures and annual certification of their fitness must be maintained.

18. The initial medical examination of a potential crewman must be conducted by an Army CAM or a military AME in accordance with *DGPL 07/06*. Exceptionally, another type of medical officer may perform the initial medical examination but it is mandatory to clear this with CA Avn Med and forward the results to 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 *Annex K* to *AGAI Volume 2, Chapter 43* and Paragraphs 4-7 above. However, there are several exceptions; firstly, blood and ECG investigations are only required on clinical indication; secondly, a history of childhood asthma or hay fever will not necessarily disqualify candidates[2]; and finally, all deviation from aircrew medical standards must be referred to CA Avn Med (Army).

2 Consultation with CA Avn Med (Army) is required.

20. **Aircrew Employment Category**. On entry to flying and during service as a crewman, the JMES of all Army Aviation Crewmen will be A3 because they have not been through the full aircrew selection process.

21. **Administrative Requirements**. The initial medical examination should be recorded on DMICP and a FMed 143, signed by the examining CAM or AME. When conducted by a doctor that is not an AME, the FMed 143 and FMed 4 should then be forwarded to CA Avn Med (Army), or the Army Aviation Centre Consultant in Aviation Medicine, who will determine fitness for crewman duties. It must be stressed that rearcrew candidates will not be declared fit to attend a training course until the above procedures have been completed.

22. **Subsequent Pilot Selection for Crewmen**. Medical screening of crewmen in this fashion does not qualify them for pilot selection, and they are to be warned not to assume that they will be automatically cleared to commence pilot training. If they apply for pilot training in the future, they must go through the full aircrew medical selection process.

SECOND AND SUBSEQUENT FLYING TOURS

23. All Army Air Corps aircrew are required to maintain their aircrew medical category by means of the annual aircrew medical examination, even when not in a flying appointment. A non-Army Air Corps individual who undertakes a second or subsequent tour of duty with Army Aviation, following a tour of non-flying duty, will require a full assessment by the Department of Aviation Medicine at Middle Wallop, or by an Army Consultant in Aviation Medicine. There will be no requirement to attend another aircrew medical board at OASC.

MEDICAL CERTIFICATION FOR SERVING ARMY PILOTS

24. **Illness in Aircrew**. Any significant abnormality detected in aircrew during their medical examination by an AME, or at other times by another doctor, should be discussed with a CAM to determine the impact on flying duties.

25. **Army Aircrew Medical Certification**. Under *JSP 550, Military Aviation Regulations* (Regulation 135) all aircrew must be certified medically fit to conduct flying duties. The aircrew medical examination is to be conducted annually by an Authorised Medical Examiner (AME). An AME is a medical officer authorised by CA Avn Med (Army), CA Avn Med (RN) or Command Flight Medical Officer (CFMO) RAF to conduct aircrew medical examinations. The aircrew medical category is to be entered in the medical records and the flying logbook and is to be signed by the AME. The annual medical examination is valid until the last day of the month in which it next falls due.

26. **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.

27. **Administrative Requirements**. The annual aircrew medical examination is to be recorded on DMICP and in a typed F Med 143 which is to be inserted as an enclosure in the FMed4 and recorded correctly in the contents list.

28. **Medical Category**. The PULHHEEMS and the JMES category are to be entered on the front of the F Med 4, in DMICP and on the FMed 143. Additionally, the JMES grade only is to be entered into the aircrew flying logbook. The L2 category may be used as a medical marker.

29. **Occupational Restriction of Aircrew**. It is essential that aircrew that are not fit for unrestricted flying duties are known within the Army Avn Med system and that limitations to their flying duties are known to the chain of command. To that end, two parallel systems of notification are in operation. These are the:

a. DAAvn Waivers. The DAAvn waiver system is designed to identify and grant **limited flying status** to pilots that are not fit for **unrestricted flying duties**[3]. Pilots graded A3 must be granted a waiver, by CA Avn Med (Army), that states their flying limitation. Medical officers must discuss any cases that require an A3 grade with CA Avn Med (Army) before completion of a medical board.

b. Limitation Codes. Limitation codes are 3 figure codes that are added to the JMES grade and are used to communicate functional limitations to the chain of command. They will be applied in relation to aircrew medical A categories and associated waiver statements[4]. The aviation codes that will commonly be used for Army aircrew will be limited to:

Code	Meaning
050	Restricted employability because of anthropometric limitations. Only to be used for pilots at A1 or A2.
060	Unfit solo pilot - must fly with a pilot suitably qualified on type
070	Unfit specific aircraft type

However, AMEs should be familiar with the full range of limitation codes at *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force* because they may be required for pilots of other Services or, exceptionally, for

Army aircrew. In addition, the Army 800 series codes can also be used, when appropriate, for aircrew.

MEDICAL CERTIFICATION FOR ARMY AVIATION CREWMEN

30. The annual medical examination and certification of Aviation Crewmen is conducted in the same way as that of pilots, as stated at paragraphs 24-29 above. Examinations must be conducted by an Army CAM or a military AME in accordance with *DGPL 07/06*. Aviation crewmen will have a normal medical category of A3 but,

3 'A' grades can be changed independently of the L. M or E grades within the remainder of the PAP 09. But, when there is a change in fitness for ground duties, the air and ground limitations must be reviewed in together.
4 Although operated by the RAF for many years, this system is being introduced to the Army with JMES and may require adjustment once in operation.

should they need a medical employment limitation, then a medical waiver should be sought and recorded in the same way as pilots.

RETENTION STANDARDS FOR ARMY AIRCREW

31. **Army Aircrew Retention Standards**. Retention standards for Army aircrew, in relation to their A, L, M and E characteristics are given at Tables 5 and 6. As for other personnel, the JMES will follow the P grade, but it is possible for the A grade to change independently[5]. Individuals 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	5/1	5/1	2	2
MLD	3	3	3	3	3	7/1	7/1	2	2

32. **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. They will be assessed against the retention hearing standard given at the *Army Hearing Conservation Programme, AGAI Volume 2 Chapter 66*.

33. **Vision**. Pilots are unfit to fly if their corrected vision is worse than 6/6. However, individuals 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, individuals 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.

34. **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.

ARMY AVIATION MEDICAL BOARDS

35. One Member and Two Member Medical Boards (OMMB and TMMB) may be performed on aircrew by any military Authorised Medical Examiner (AME), so long as there is no change required to the aircrew employment category. A change of aircrew employment category may only be carried out by an Army CAM. Complex aircrew cases should be referred to CA Avn Med who may convene an Army Aviation Medical Board (AAMB).

36. 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.

5. It is possible for pilots to be A3 but MFD or A1 but MND, depending on their condition.

37. **Appeals.** Appeals against TMMB 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 individual an opportunity to discuss the boarding process and outcome. If the appeal is not resolved at this stage, the individual is to apply to the CA Avn Med via his Commanding Officer, normally within 3 months of the original decision. The individual is to complete the form at Appendix 20 when submitting the appeal to the CO. CA Avn Med may convene an AAMB. Appeals against medical board decisions unrelated to the aircrew employment category should be conducted in accordance with guidance at Appendix 19.

APPENDIX 7

Instructions to be Given by Medical Boards to Individuals

1. One only of the following 3 instructions will normally be given to an individual by the president of a medical board:

Instruction	Individuals to whom the instruction may be given	Remarks
a. To remain in hospital.	Individuals requiring further in-patient treatment.	When amplified to read 'to remain in hospital or on leave', it is to be indicated on the proceedings of the board whether further in-patient treatment is necessary on expiry of leave. The President of the Medical Board is to ensure that the unit is aware of the individual's location
b. To contact the individual's unit and then proceed or remain on leave.	Individuals not needing in-patient treatment who have been assessed degree 0 or 8 whatever their previous assessment.	It is important that the individual's unit contacted by the individual, or the President of the Medical Board if the individual is unable to, to ensure that the unit is aware of the individual's location. An individual is not permitted to take Annual Leave, but may depart on holiday as long as agreed by the individual's CO and that this holiday may aid recovery and/or not impede it. Individuals must remain available for appointments and interviews.
c. To return to unit.	Individuals who have been given an employable assessment or who have been upgraded from degree 0 to an employable assessment.	It may be necessary to conduct a workplace assessment.

2. In the case of individuals considered by the board to be unfit for further service, instructions are to be given by means of the form shown in Appendix 10.

PROTECT STAFF (when complete)

APPENDIX 8

Application Form for Permission to Retain an Individual whose JMES has fallen below the Minimum for the Arm/Corps

To: (APC Career Manager for onward transmission to SO2 Discharges, DM(A))

Commanding Officer's Statement

No:		**Rank**		**Surname:**	
Unit:		**Regt/Corps:**		**Forename:**	
CEG:		**EED:**		**PiD:**	

1. The above-named individual is employed as ……... in

this unit. His/her JMES has been lowered from ……..……to……..…….but I

consider that he/she is in every way fit to carry out the duties of…….. in this unit and recommend that he/she may be retained accordingly subject to a formal review (over a period of no greater than 12 months).

2. I have ensured that a current Appendix 9 is attached.

3. Paragraph 5 below certifies that from a medical perspective, the retention of the above-named individual in the employment suggested will not exacerbate their medical condition or place at risk the health and safety of others.

4. The following circumstances and factors support my request for retention of this individual:

Note: A current Appendix 9 must be attached.

Name:		**Rank**		**Signature:**	
Date:		**Appt:**		**Unit:**	

Certificate (to be completed by a RMO/CMP)

5. I certify that the above-named individual, whose

JMES is……., is medically fit to perform the duties of…… in

……..(*Unit*) and that if he/she is retained in this employment, this

will not exacerbate their medical condition or place at risk the health and safety of others.

Name:		**Rank**		**Signature:**	
Date:		**Appt:**		**Unit:**	

APC Career Manager Recommendations

6*. ☐ I do support this application for the following reasons:
☐ I do not support this application for the following reasons:

Name:		**Rank**		**Signature:**	
Date:		**Appt:**		**Unit:**	

APC OH Comments

7. I have the following comments:

Name:		**Rank**		**Signature:**	
Date:		**Appt:**			

DM (A) Approval

8*. ☐ The application for retention is approved:
☐ The application for retention is rejected for the following reasons (see attached):

Name:		**Rank**		**Signature:**	
Date:		**Appt:**		**Unit:**	

*****Tick as applicable

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 read the paragraph below and sign at section 8. A second signed copy should be sent to the unit. It is the units 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 Appx 9, you are still required to complete the DMICP JMES template and 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.

Guidance for Individual You must read this form- 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 board proceedings, ongoing treatment and likely outcome. You will need to sign section 8 to say you have been given a copy and consent to its use.

No:		**Rank:**		**Name:**	
Unit:		**JMES:**	**Date of board:** **MDS:** **MES temp/perm:** **MES:**	**Board Type:** **Review date:**	

1. DEPLOYABILITY/ EMPLOYABILITY ON OPERATIONS

Tick one to indicate suitable operational role limitations:

MND	(Not)	Not deployable on operations	☐
MLD	(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	(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	

Tick if the individual functionally CANNOT:		Assess risk of:			
Take cover / prone position	☐	Incapacitation	☐Low	☐Med	☐ High
Run a short distance (<100m)	☐	Worsening condition	☐Low	☐Med	☐ High
Carry own bergan to transport	☐	Primary care requirement	☐Low	☐Med	☐ High
Walk 3.2 km carrying 15kg	☐	Rehabilitation requirement	☐Low	☐Med	☐ High
Wear body armour (ECBA 4.5 kg)	☐	Secondary care requirement	☐Low	☐Med	☐ High
Wear body armour (OSPREY 10.5 kg)	☐	Emergency aeromed	☐Low	☐Med	☐ High
Stand 2 hours in PPE with weapon	☐	Interference with treatment	☐Low	☐Med	☐ High
Overall risk assessment for deployment:		☐Low ☐Med ☐ High			
Comments:					

2. DEPLOYABILITY/ EMPLOYABILITY ON EXERCISES

Weight-personal kit & equipment	Full trade exercise activities
Infantry activities (Including digging)	Living in field conditions
Travel on foot across rough terrain	Move tactically and adopting fire positions
Comments:	

3. SPECIFIC LIMITATIONS - *complete if appropriate*

Trade restrictions	
Noise Restrictions	
Climatic Restrictions	
Other restrictions	
Requires ongoing primary health care	☐ **Yes** ☐ **No**
Comments:	

4. FUNCTIONAL CAPACITY

Physical Training (Choose one or more options as required)			
The individual should avoid: Upper body PT Lower limb non-impact PT Lower limb Impact PT Contact Sports All Sports	 ☐ ☐ ☐ ☐ ☐	The individual should seek guidance for the Unit QMSI/ PTI staff for a suitable PT programme The individual has been given a rehabilitation PT program The individual is at risk of prolonging the period of recovery if their rehabilitation programme is interrupted	☐ ☐ ☐
PFA		AFT	
Functional Activities (Choose one or more relevant options)			
Walking	Working Hours	Boots	
Standing	Workplace	Clothing	
Sitting	Marching / drill	Combat Body Armour	
Lifting	Guard duties	Helmet	
Comments:			

5. SAFETY CRITICAL TASKS

Driving	Weapons	Working at Heights
Passenger	Ranges	Workplace Assessment
Comments:		

6. MEDICAL REVIEW

Medical review required before commencing MST/ Deployment	☐ **Yes** ☐ **No**
Approval by an ROHT required before commencing MST/ Deployment	☐ **Yes** ☐ **No**
Comments:	

7. COMPLETED BY

Name:		**Date:**	
Rank and Appointment:		**Signature:**	

8. INDIVIDUAL'S ACKNOWLEDGEMENT OF RECEIPT (Sign before giving to line manager)

Name:		**Rank**		**Signature:**	

PROTECT STAFF (when complete)

APPENDIX 10

Instructions Given to Individual Provisionally Considered Unfit for Further Military Service

At a Full Medical Board held at ……on …… You:

No:		**Rank:**		**Name:**	
Nature of Employment:				**Regt/Corps:**	

have been provisionally considered unfit for further service.

---

1. **The Board's Recommendation is Subject to Confirmation by Higher Authority.** The Army Personnel Centre (APC) will notify you of the final decision.

2*. You are to:
- ☐ Remain in Hospital
- ☐ Contact your unit and then proceed on Leave
- ☐ Contact your unit and remain on Leave
- ☐ Return to your Unit

and await APC instructions. Such instructions or an interim notification should be received from the APC within 40 days of the date of the board.

3. Leave address *(if applicable. Any change of leave address must be notified immediately to the Army Personnel Centre, Medical Discharge Wing, MP544, Kentigern House, Brown Street, Glasgow and your unit).*

Address:	
Telephone:	

4*. **"Transition to Civilian Life - A Welfare Guide (AC 66408)"** - has been issued to the individual.

- ☐ Yes
- ☐ No

Signature of President of the Medical Board:	
Name of President of the Medical Board:	
Signature of Individual:	
Date:	

Distribution: CO/OC (Unit)
Col relevant MS Branch
Individual
CO PRU in the individual's unit and/or individual's leave/home location
IERO in the individual's unit's location and individual's leave/home location
APC Medical Discharge Cell, MP 544

***Tick as applicable**

APPENDIX 11

Initial Resettlement Referral Form

To: [IERO] Copy to: [FMB and Individual]

No:		**Rank**		**Name:**	
Unit:			**Regt/Corps:**		

The above named was referred to a Full Medical Board on……

At: …….…….…….…….. *(Insert date and location if known).*

---

1. **PROVISIONAL** assessment of ability to perform occupational functions:
(Please grade using the following scale: 1 - Full Function, 2 - Reduced Function, 3 - Nil Function)

Right shoulder	Right arm	Right hand	Climbing stairs	Climbing ladders	Working at heights
Left shoulder	Left arm	Left hand	Bending	Lifting/Carrying	Prolonged sitting
Walking	Standing	Kneeling	Driving	Exposure to dust and fumes	Outdoor work in all weathers
Relevant mental function	Hearing	Vision	Skin Irritants		

2. Other relevant information:
(insert any relevant functional occupational information, e.g. fit or unfit Group 2 Driving)

3. It has been explained to the above named that this assessment in no way predetermines the findings of the Medical Board.

Signed:		**Name:**	
Date:		**Rank & Appointment**	

PROTECT STAFF (when complete)

APPENDIX 12

Form for Notification of the Result of a Medical Board Recommending Medical Retirement/Discharge

To: (1) Unit (2) IERO (3) Medical Discharge Cell, APC (4) respective MS Branch, APC (5) Individual

No:		**Rank**		**Name:**	
Unit:			**Regt/Corps:**		

The above named was referred for examination by a Medical Board at ……

on …… and given the following assessment: *JMES*……..……

1*. **Recommendation (by Medical Board)** *[To be completed by the Medical Board and copied to unit, IERO (for resettlement action), Med Discharge Cell (APC), respective MS Branch and individual.]*

Medical Board proceedings recommend:

☐ retirement under the "Army Promotions and Appointments Warrant 2009" or

☐ discharge under QR 1975 para 9.386/9.387 or

☐ discharge under TA Regs 1978 Chapter 5 part 6 para 5.199.

☐ The medical condition does not preclude resettlement activity from being completed before discharge.

☐ The medical condition dictates that all resettlement activity may be deferred until after discharge.

☐ The medical condition dictates that resettlement activity may be deferred to spouse.

"Transition to Civilian Life - A Welfare Guide for the Service Leaver (AC66408)" - has been issued to the individual.

☐ Yes

☐ No

Place:		**Signature of Presiding Officer:**	
Date:		**Rank and Appointment:**	

*****Tick as applicable

PROTECT STAFF (when complete)

Assessment of ability to perform occupational functions
(Please grade using the following scale: 1 - Full Function, 2 - Reduced Function, 3 - Nil Function)

Right shoulder	Right arm	Right hand	Climbing stairs	Climbing ladders	Working at heights
Left shoulder	Left arm	Left hand	Bending	Lifting/Carrying	Prolonged sitting
Walking	Standing	Kneeling	Driving	Exposure to dust and fumes	Outdoor work in all weathers
Relevant mental function	Hearing	Vision	Skin Irritants		

2. Other relevant information:
(insert any relevant functional occupational information, e.g. fit or unfit Group 2 Driving)

3. **Authority for Retirement/Discharge.** To be completed by APC copied to P File, unit and IERO for resettlement action:

☐ Retirement authorised under the "Army Promotions and Appointments Warrant 2009"

☐ Discharge authorised under QR 1975 para 9.386 / 9.387

Name of Authorising Officer in APC:	
Signature of Authorising Officer in APC:	
Date:	

*****Tick as applicable

APPENDIX 13

Medical Standards for Unmanned Aircraft Operators

INTRODUCTION

1. **General**. Unmanned aircraft 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 will have to 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**. British military Unmanned Aircraft (UA) are regulated by *JSP 550 Military Aviation Policy Regulations and Directives* under Regulation 320. Under this regulation, UA operator medical standards will be set on a tri-Service basis.

3. **Terminology**. UA refers to the aerial platform itself. Although an older term, Unmanned Aerial Vehicle (UAV) is still commonly used to refer to the vehicle. Unmanned Aerial Systems (UAS) refers to the vehicle and all of the additional equipment necessary to operate it plus the personnel involved.

4. **Definition**. UA 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 unmanned aircraft operation.

5. **Characteristics**. UA 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 UA are entirely autonomous, others follow preset commands from their operators and some are actively flown by the operator. Additionally, larger UA 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. **UA Classification**. The precise definitions of UA types is still the subject of international and NATO discussion. However, the current belief is that they are likely to be divided into 3 categories depending on the size, control system, range and endurance. For medical operator certification purposes, UA are divided into 3 categories:

   a. Category 1. Category 1 UA are otherwise termed ‘Mini‘ and ‘Micro’ UA (MUA). They are small, short range, low endurance UA operating in military restricted areas only.

b. Category 2. Category 2 UA are otherwise termed 'Tactical' UA (TUA). They are medium sized UA 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 will have to manoeuvre platforms in an airfield environment.

c. Category 3. Category 3 UA are otherwise termed 'Operational' or 'Strategic' UA (OUA/SUA). They are medium or large UA operating in both restricted areas and controlled (ICAO) airspace shared with civil manned traffic which will be be operating according to Visual and Instrument Flight Rules. These platforms may be armed.

7. **UA Operator Classification**. Under Regulation 320 of JSP 550 there are 3 types of UAV[1] operator:

a. The UAV System Commander (UAV Sys Cdr) is responsible for the overall command of the entire UA system and its safe and effective operation. He may be responsible for a number of concurrent UAV flights.

b. The UAV Commander (UAV Cdr) is responsible for the conduct and safety of a specific flight and for supervising the person in direct control of the UAV. His duties are equivalent to those of an aircraft commander.

c. The UAV pilot (UAV-p) is the person in direct control of the UAV.

8. **Operator Demands**. UA 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. UA operator standards are related to the category of UA and have been developed to comply with international standards such as the developing NATO STANAG 7192, CAA/EASA and FAA standards. They seek to minimise the risk of UA as the potential hazards related to UA and demands of UA operations increase.

10. Army UA medical standards will be applied in accordance with Tri-Service UA policy. The medical supervision will be the responsibility of the UA operator's parent regiment or corps, 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 DAAvn, the Release to Service Authority for all Army aerial platforms.

11. **PULHHEEMS Profile**. The UA operator medical standards will be applied at entry to UA training. However, in the case of Category 1 UA, if this is at service entry

1. Currently, in Sep 09, JSP 550 Regulation 320 still uses the term UAV so this will be used for abbreviations that are still defined in this way within that document.

any (higher) Army entry standard for the applicants trade will have to be met. The minimum PULHHEEMS profiles for UA operators, by UA category are:

UA Category	P	U	L	H	H	E	E	M	S	CP
1	2	2	2	2	2	8 2	8 3	2	2	4
2	2	2	2	2	2	8 1	8 1	2	2	3
3	2	2	2	1	1	8 1	8 1	2	2	2

12. **Additional Requirements**.

a. Category 2. In addition to the stated requirements in the table, Category 2 UA operators must comply with the TUA operator medical requirements in *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force*[2]. 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 N12 at 100cm.

(3) Hearing. Hearing must comply with the AAC Aircrew retention standard at Appendix 6.

b. Category 3. In addition to the stated requirements in the table, Category 3 operators must comply with the OUA/SUA operator medical requirements in *Air Publication 1269A - Assessment of Medical Fitness in the Royal Air Force*[2]. These include:

(1) Visual Refraction. Spherical correction limits are –7.00D to +8.00D. Cylindrical correction limits are +/- 5.00D.

(2) Phorias. Phorias must not exceed 5D in esophoria, 10D in exophoria, or 1D in hyperphoria

(3) Near Point. The corrected near point must be no worse than N5 at 30-50cm.

(4) Intermediate Vision. The corrected intermediate vision must be no worse than N12 at 100cm.

(5) Convergence. Convergence must be less than 10cm.

2. As at 10 Sep 09, these standards are yet to be included in AP1269A but they and the related SGPL are in preparation and will be published in the near future.

(6) Hearing. Hearing must comply with the AAC Aircrew retention standard at Appendix 6.

(7) ECG. Cat 3 UA operators will 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, Paragraph 9a to coincide with their annual medical examinations in those years. Currently the ECG periodicity is 5 yearly to age 30, 2 yearly from 30-40, annually from age 40 and 6 monthly from age 50.

13. **Aircrew Employment Category.** The JMES of all UA will remain A4, other than those that are already trained aircrew to whom the relevant aircrew standards at Appendix 6, Table 5 or Table 6 will apply. UA operators trained and employed to operate UA from aircraft must achieve the relevant aircrew medical category for that platform/role.

UA OPERATOR RETENTION STANDARDS

14. UA operator retention standards will be those of their trade listed at Tables 5 and 6. However, to remain fit to operate Category 2 & 3 UA, operators must continue to comply with the vision, mental capacity and emotional stability 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 UA operators that fall below H2. If the requirements for vision, hearing, mental capacity and emotional stability are met, UA operators may continue to operate UA at JMES categories of MLD and MND provided that the employment limitations of their other medical conditions are fulfilled.

UA OPERATOR MEDICAL EXAMINATIONS

15. Under Regulation 320 of JSP 550, all UAV Sys Cdr, UAV Cdr and UAV-p must hold a valid medical certificate appropriate to the type of UA operation that they conduct. The medical clearance is to be entered in the operator's logbook as well as recorded in the medical record.

16. **Category 1 UA Operator Medical Certification**. The medical clearance of Category 1 UA operators requires no medical examination procedures in addition to the general requirements of PAP 10. However, operators and medical officers are reminded that even Category 1 operators must not operate UA if they develop an illness making them unfit to do so.

17. **Category 2 and 3 UA Operator Medical Certification**. Category 2 and 3 UA operators must be certified medically fit to conduct UA operating duties. The UA Operator medical examination is to be conducted annually by an Authorised Medical Examiner (AME). An AME is a medical officer authorised by CA Avn Med (Army) (or CA Avn Med (RN) or Command Flight Medical Officer (CFMO) (RAF). The PULHHEEMS/JMES grade is to be entered on DMICP, the FMed 143 and the cover of the FMed4. The annual medical examination is valid until the last day of the month in which it next falls due.

18. **Annual UA Operator Medical Examinations (Cat 2 & 3 UAV Operators)**. 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 AME must also include a statement that the patient remains '*Fit for Category 2* (or 3) *UA operator duties*.'

19. **Administrative Requirements**. At each medical examination the PULHHEEMS/JMES grade is to be recorded on DMICP on a F Med 143 which is to be printed and inserted as an enclosure in the FMed4. The medical category is also to be recorded in the log book of each operator.

APPENDIX 14

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

APPENDIX 15

Information Sheet on your Principal Rights under Access to Medical Reports Act 1988

You should be aware of your rights under the Access to Medial 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 applicant. If the medical practitioner has not heard from you, in writing, within 21 days of the application of the report being made, he/she 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 he/she is 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 he/she 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, he/she 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 6 months after it was supplied.

APPENDIX 16

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, eg infantry soldier]* in the British Army and has been under your care for the treatment of *[insert condition]*.

2. I am responsible for his occupational healthcare and in order that I may advise on his fitness for work, I would be grateful if you could provide me with a medical report outlining his diagnosis, treatment and prognosis for this condition whilst he has 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 his rights under the Access to Medical Reports Act 1988 and has stated that he does not wish to see your report before it is sent to me. A copy of his 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]

APPENDIX 17 A

Consent to Disclosure of Medical and Administrative Records and Information Following a Medical Board including, if appropriate, referral to the Army Employment Board - Data Protection Act 1998 and Access to Medical Reports Act 1988

Information to Patient

1. Following your Medical Board there will be various other external and internal departments / authorities who will be required to assess your individual circumstances and case for the purpose of making various decisions relating to your future employment or eligibility for resettlement, pay, pensions and compensation. These other departments will usually require the release of certain records or information to them in order to enable a full and proper assessment/ decision to be determined. This information that may be requested is *confidential* and cannot be disclosed without your specific consent.

2. For cases which are referred to the Army Employment Board (AEB), members of the AEB will need to be able to assess your individual functional capacity for the purpose of making a decision relating to your possible future employment in the Army. The Board will need to see certain records and information in order to enable a full and proper assessment/decision to be determined. To assist the AEB in making their decision concerning your employment future, it is sometimes helpful for the AEB President of the medical board to divulge limited medical information regarding your case. This is particularly concerned with current and future treatment, your ability to serve in operational and peacetime conditions and your long term prognosis. For those personnel recommended for retention or discharge in a permanent medical category the AEB Secretary will forward, prior to the AEB, a short synopsis of your case to all AEB members.

3. The table below outlines who may require access to your records and what information they may require.

Agency / Authority	**Records that may be required to be disclosed**	**Usual purpose of disclosure**
For all Medical Boards:		
Unit	Revised PULHHEEMS Administrative Pamphlet (PAP 10) Appendix 9	To enable a full & proper assessment of your employability to be determined.
APC OH Branch	Functional capacity from the Medical record	To provide employment advice to APC Career Manager
Defence Analytical Statistics Agency (DASA)	FMed 23.	For statistical recording and analysis.
For cases where medical discharge is recommended:		
Individual Education & Resettlement Officer (IERO)	Appendix 11 to PAP 10.	To enable provision of adequate resettlement advice.
Service Personnel and Veterans Agency Glasgow (SPVA Gl)	All Personal Medical Records.	To enable a full & proper assessment of your eligibility for AFPS (75, 05 & RFPS) Invaliding & Service Attributable benefits to be determined.
Service Personnel and Veterans Agency Norcross (SPVA Nx)	All Personal Medical Records.	To enable a full & proper assessment of your eligibility for War Pension / Armed Forces Compensation Scheme benefits to be determined.
Discretionary Awards Review (DAR) **Discretionary Awards Appeals Review (DAAR)**	All Personal Medical Records. All Personal Medical Records.	To enable a full & proper assessment of your eligibility for AFPS (75,05 & RFPS) invaliding & Service Attributable benefits to be determined if further scrutiny is required in the case of an appeal against SPVA(Gl) decision.
Agency / Authority	**Records that may be required**	**Usual purpose of disclosure**

	to be disclosed	
Med Legal	All Personal Medical Records (F Med 4 & DMICP records) *& any* AEB records held.	To deal effectively with any legal claim that you may have.

For Army Employment Board (AEB) cases:		
AEB	F Med 24. A short synopsis of your case. The AEB Chair may also divulge limited information regarding you with your consent.	To enable a full and proper assessment of your employability to be determined.

4. In some instances this information may be requested again at a later date following initial disclosure at the time of your medical board (for example your condition changes and your pension/ benefits needs to be re-assessed, your case reviewed etc). If you are not medically discharged this information may be required by some departments/authorities after you leave the service if you make a subsequent or further claim. In these circumstances the departments/authorities involved will need to obtain further consent from you before your records are released to them. The consent that you are giving on this form is not continuous, it will only last and be used for the purpose of concluding your attendance at this particular Medical Board.

5. You ***do not have to*** consent to the release of this information or records if you do not wish to and the Medical Board will not disclose it if you have not done so. You must bear in mind the implications that this *may* have on any decision that those departments/authorities are required to make.

Consent

a. I have read and understand the 'Information to Patient' notes 1 – 5 above.

b. **I consent / do not consent** * to the disclosure of the medical and administrative records / information that is, or may be required following my Medical Board, only to those departments / authorities and only for those purposes, as detailed overleaf at paragraph 3 of this form, until expiry of this consent.

c. I understand that if any other records/information is/are required by any other department / authority, or for any other purposes, other than those detailed at paragraph 3 of this form my separate consent will be required.

d. I understand that this consent is not continuous and will automatically expire after 12 calendar months from the date of the Medical Board attended. I understand that I may withdraw my consent at any time and accept that should I do so, it is my responsibility to inform both the Chain of Command and Medical Officer.

* *Delete as required*.

Service No:		**Date of Medical Board:**	
Rank:		**Signature:**	
Name:			

e. I have explained the contents of and requirements for this consent form and have witnessed his / her signature.

Signed by witness:		**Date:**	
Name of witness:		**Rank of witness:**	

APPENDIX 17 B

Consent to Disclosure of Medical Board Report (FMed 23) to Defence Analytical Statistics Agency(DASA)

Information to Patient

1. Following your Medical Board a copy of the report produced (FMed 23) would normally be sent to the Defence Statistical Analysis Agency (DASA). This report will include a summary of your medical history and the recommendations made upon your fitness for work.

2. This information contained in the report is *confidential* and cannot be disclosed without your specific consent.

3. DASA extract data from these reports to produce anonymous databases for using in the analysis of issues relating to health and fitness for work in the Armed Services.

4. You ***do not have to*** consent to the release of this information if you do not wish to and the Medical Board will not disclose it you have not done so.

Consent

a. I have read and understand the 'Information to Patient' notes 1 – 4 above.

b. **I consent / do not consent** * to the disclosure of the Medical Board Report (FMed 23)

* *Delete as required*.

Name:		**Rank:**	
Service No:		**Date of Medical Board**:	
Signed:		**Date:**	

c. I have explained the contents of and requirements for this consent form and have witnessed his/her signature.

Name of witness:		**Rank of witness:**	
Signed by witness:		**Date:**	

PROTECT- STAFF (when complete)

APPENDIX 18

Occupational Report on an Individual for employment purposes (Including Medical Boarding)

Personal Details

No:		**Rank**		**Surname:**	
Unit:		**Regt/Corps:**		**Forename:**	
Branch / Trade:				**Age:**	
Total Full Time Service		**Years**	**Months**		
Type of Enlistment / Commission:				**Marital Status:**	

Consent *(to be signed by the individual prior to submission to Commanding Officer/Officer Commanding).*

I *(Name)* …… *(Rank)* …… *(No)* ……

consent to the completion of this form by my Commanding Officer or Officer Commanding. I also consent to my Commanding Officer or Officer Commanding obtaining the opinion of other individuals (when considered necessary) to aid in the completion of this form. If Temporarily Non-Effective, I consent to the personnel Recovery Unit staff contacting 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 may see a copy of the completed form if I so wish. Should I not consent I understand that advice or a decision will be based on the information available, which may disadvantage me.

Date:		**Signature:**	

Address *(to which completed Appendix 18 will be sent).*

Name and Role of individual requesting report:	
Address:	

PROTECT- STAFF (when complete)

No:		Rank:		Name:	

Notes for Commanding Officer/Officer Commanding

- You should only complete this form if the subject individual has given express consent and you have seen the signed form.
- The **Data Protection Act 1998** allows the subject individual 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 individual's personal file. If the subject individual subsequently asks to see the form this copy should be made available to them. Under DPA 98 the subject individual may make objections to factual inaccuracies that must be corrected by forwarding an amended copy of this form to the original recipient. However, the individual 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 individual 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

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 etc.)*

4. Performance in current or last post

No:		**Rank:**		**Name:**	

5. Individual 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. Has the officer/soldier attempted?

		Result
a. WHT	☐ Yes ☐ No	☐ Pass ☐ Fail
b. ACMT	☐ Yes ☐ No	☐ Pass ☐ Fail
c. Physical MATTs	☐ Yes ☐ No	☐ Pass ☐ Fail
d. Non-physical MATTs	☐ Yes ☐ No	☐ Pass ☐ Fail
e. Unit Exercises	☐ Yes ☐ No	
f. Deployment	☐ Yes ☐ No	

If unable to pass physical MATT, has the Officer / Soldier attempted?

g. Walk 3.2 Km in 60 mins, repeated 24 hours later?	☐ Yes ☐ No	☐ Pass ☐ Fail
h. Walk 3.2 Km in 60 mins with 15 Kg, repeated 24 hours later?	☐ Yes ☐ No	☐ Pass ☐ Fail

Any additional relevant information

PROTECT- STAFF (when complete)

No:		**Rank:**		**Name:**	

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 OH 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.

Occupational report completed by:

Surname & Initials:		**Rank:**	
Regt / Corps:		**Unit:**	
Appointment (CO / OC):			
Signature:		**Date:**	

APPENDIX 19

Appeals Process for Medical Boarding Decisions

Reference:

A. AGAI Vol 2 Chapter 70.

GENERAL

1. Appeals relating to medical boarding decisions must be submitted using the format at Appendix 20. The individual should state why they wish to make the appeal and provide supporting evidence where possible. Not being content with the Board outcome alone is not sufficient grounds for appeal. The grounds for appeal should be based on either additional functional or medical evidence that has not been considered by the Board or a requirement to have the decision making process of the Board which led to the allocation of a PULHHEEMS or JMES grade clarified.

MANAGEMENT OF APPEALS

2. Appeals may reflect a misunderstanding of the process and decision making of medical boards. This can be minimised by adherence to high standards of medical practice at the time of boarding. Full Medical Boards (FMB) and doctors raising One-Member and Two-Member Medical Boards (OMMB and TMMB) should share their opinion with the individual and ensure that the individual understands their recommendation, following discussion with them. Advice on the medical factors affecting their employment must be explained in full to all individuals. Board members should be alert to any signs of disquiet and should tailor their explanation accordingly. FMBs recommending medical discharge must advise the individual on their fitness for further work, tailored to the plans of the individual on leaving the Army. A copy of Appendix 9 is to be given to all individuals attending a medical board, along with a copy of the FMed 23.

POTENTIAL RECRUITS AND POTENTIAL OFFICERS

3. Boarding procedures for recruits, potential recruits, potential officers and officer cadets are the responsibility of the Army Recruiting and Training Division (ARTD). Candidates may appeal against decisions made at the pre-employment medical assessment or during training. HQ ARTD 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. TA appeals should be referred to the Divisional Comd Med, who will seek occupational medicine advice. HQ ARTD are the authority for TA pre-entry medical reviews with advice from AMD.

a. **Appeals Arising at the Pre-Employment Medical Assessment**. The administration of appeals following deferral or rejection at the pre-employment medical assessment is detailed in an ARTD Occupational Medicine Standard

Operating Procedure. 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. Level 1 Appeals are to be conducted to completion by the selection centre SMO.

(2) **Level 2 Appeal**. All avenues of investigation (at Level 1) have confirmed that the standard of P2 has not been met but the candidate continues to contest the guidelines applied to assess against the entry standard. The SMO is to write direct to HQ ARTD Occ Med. This is the final level of appeal for potential applicants and any new medical or functional evidence that subsequently comes to light is to be referred back to SO1 OM ARTD.

RECRUITS AND OFFICER CADETS

4. **Appeals Arising During Training.** A recruit or Officer Cadet under training (Phases 1 & 2) may appeal against the decision of a Medical Board to their CO. The CO may then request the HQ ARTD Occ Med consultant to review the findings of the board. If a further medical assessment is required the Occ Med consultant may convene a FMB to re-assess the individual. If there is a subsequent appeal on medical grounds the case is to be referred to AMD. Those undertaking training out-with ARTD (mainly some elements of TA) should appeal through using the process described for trained personnel.

TRAINED PERSONNEL

5. Appeals 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 individual an opportunity to discuss the boarding process and outcome.

6. If the appeal is not resolved at this stage, the individual is to apply to the Comd Med (TA)/RCD (Regular) via his CO. This appeal is normally to be submitted **within 3 months** of date of the medical board. Later appeals will be considered, but the reasons for delay should be clearly stated. The individual is to complete the form at Appendix 20 when submitting his appeal to his CO.

7. The RCD or Comd Med will act as the non-clinical facilitator of the appeal. Consideration will be made for referral to a medical board at the next higher level (e.g. TMMB for OMMB). Boards which have not involved a Consultant Occupational Physician, should be referred to the Regional OH Team for review by the Regional OM Consultant. The opinion of the consultant adviser in occupational medicine (CAOM) may be sought in more difficult cases to decide the most appropriate route for the appeal case review. In the case of an appeal against a FMB (or other board presided over by an OM Consultant), the case may be referred to a Super board or to AMD for consideration of a MOD(A) Board**.**

8. The MOD(A) Board decision is final. An individual may submit a complaint in accordance with Reference A.

APPENDIX 20

Submission of a Formal Appeal against a Medical Board

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 medical board that took place on ……*(Date)*

at …….*(Medical Centre or other board location)*.

have been provisionally considered unfit for further service.

2. My reason(s) for this appeal is/are:

a.	
b.	

3. I would like the following outcomes:

a.	
b.	

Date:		**Signed:**	

Note - This form should not contain confidential clinical information unless the individual wishes this information to be seen by their Commanding Officer. If the individual does wish to submit medical information confidentially it should be submitted by an appropriately marked, sealed means.

RESTRICTED STAFF (when complete)

APPENDIX 21

Application for Reallocation or Discharge of a Recruit 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 recruit is below medical entry standards for 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 Vol 2 Chap 48.
(2) If recruit is below medical entry standards for any Corps this form is to be forwarded to ARTD SO1 Occ Med.
(3) Appendix 18 to PAP 10 is to be completed by the Unit in all cases and attached to this form.

1*. I can confirm that:

☐ a. The trainee is below medical entry standards for his present Corps but is within entry standards for another Corps.

☐ b. The trainee is below medical entry standards for any Corps.

2. The trainee has been fully briefed on the implications of the RECU process.

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)

☐ 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 RECU process and understand its possible outcomes.

Name:		**Signature:**	
Rank:		**Date:**	

Section C - To be completed by the SPSO (where a recruit is medically fit for transfer)

Notes:
(4) This section is not completed where the individual is unfit for transfer to a different Arm or Service.
(5) If the SPSO considers the individual suitable for transfer, the Appendix 21 should be returned to the unit CO for transfer action to be initiated.

5*. I can confirm that:

☐ a. This soldier is within medical entry standards for reallocation to another Corps but is not suitable for the following reasons:

☐ b. This soldier is within medical entry standard for reallocation to another Corps but is not willing to be reallocated.

☐ c. This soldier is within medical entry standard for reallocation to another Corps and is willing to be reallocated.

6. The individual is considered suitable for employment as:

Name:		**Signature:**	
Appointment:		**Date:**	

Section D - To be completed by the UMO

Notes:
(6) Where possible the UMO should be involved in conducting the Medical Board. The UMO is responsible for ensuring that sufficient information is provided to ARTD Occ Med to allow an employability or discharge decision to be made. Only the UMO or his delegated representative should sign Section D.
(7) An appropriately qualified Medical Officer should make comments below where medical condition has changed since the Medical Board has been conducted.

---

7. A Medical Board was conducted on …… to consider the employability of the soldier listed and the individual is permanently graded (JMES) as: ……

*****Tick as applicable

RESTRICTED STAFF (when complete)

8. 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[1]:**	
Appointment:		**Date:**	

Section E - Attachments

9. The following documents should be attached to this form before forwarding to HQ ARTD Occ Med. Any documents classified as 'Medical in Confidence' should be placed in a sealed envelope which should only be opened by HQ ARTD Occ Med. Appendix 17 must be completed to allow ARTD SO1 Occ Med access to medical records.

- ☐ PAP 10 Appendix 18 (completed and attached by CO)
- ☐ FMed 23 (UMO)
- ☐ PAP 10 Appendix 9 (UMO)
- ☐ PAP 10 Appendix 17 (UMO)
- ☐ FMED 133 and full DMICP Printout
- ☐ Additional documents as listed:

Section F - To be completed by ARTD SO1 Occ Med

To the CO[2] …… *(Unit)*

10. Discharge is recommended under the terms of QRs 75 Para ……

11. I have following additional comments[3]:

Name:		**Signature:**	
Appointment:		**Date:**	

[1] See Note (6)
[2] For officers in probationary commission, Appx 21 is to be sent to the Army Commissions Board for ratification at Section F.
[3] ARTD SO1 Occ Med may wish to make comment regarding the appropriateness of re-enlistment.

PART 2 - To be completed by Unit CO

Notes:

(8) Recommendation for discharge under QRs 9.385 is to be authorised by the CO on an AFB 130 after ratification by ARTD SO1 Occ Med. This form is then to be sent with a completed AFB 130 to APC SO1 OH for authorisation and forwarding to APC MS Occurrences Medical Discharge Cell.

(9) Recommendation for discharge under QRs 9.414 is to be submitted to DM(A) on AFB 130A.

(10) Recommendation for discharge under QRs 9.381 is to be sent to APC MS Occurrences Terminations with a completed AFB 130.

---

12. Discharge is hereby authorised under the terms of QRs 75 Para ……

Name:		**Signature:**	
Appointment:		**Date:**	

RESTRICTED STAFF (when complete)

APPENDIX 22

Application for Reallocation or Discharge of a Soldier Medically Unfit for Employment within Current Arm or Service

The RECU process is initiated at unit level where an individual is deemed unfit for normal employment within current CEG or Arm or Service. This appendix is for trained soldiers and officers of Captain rank and below only.

Section A - To be completed by Unit CO

Notes:
(1) After completing Section A,B & C this form is to be sent to Unit Medical Officer for Formal Assessment.

No:		**Rank:**	
Surname:		**Unit:**	
Regt/Corps:		**Forename:**	
CEG:		**Date of Commission / Enlistment:**	
Marital Status:		**TOS:**	

1. The individual listed above is currently employed within my unit as ……

2*. I have attached Appendix 18 to PAP 10 providing details of the limits of his/her employment. (This is mandatory).

☐ Yes ☐ No

3. I am aware that should such a transfer be unavailable this may result in the individual's discharge/retirement from the Army and :

Either*: It is my assessment is that he / she is no longer employable within his current CEG, unit or Arm/Service and I recommend that consideration be give to transfer to a different cap badge (I am aware that should such a transfer be unavailable this may result in the individual's discharge from the Army).

Or: I have submitted an Appendix 8 requesting the retention of this individual within his/her unit but this application for retention has been rejected.

4*. I certify that the individual has been fully briefed on this process and its possible financial, welfare and career implications.

☐ Yes ☐ No

Name:		**Signature:**	
Rank:		**Date:**	

Section B - To be completed by the Adjt / RCMO (in consultation with APC Career Manager if appropriate)

5*. I can confirm that all internal transfer opportunities have been explored and that the individual listed above is no longer employable within their current CEG unit or Arm/Service.

☐ Yes ☐ No

6. The individual has potential for transfer to or employment in the following Corps:

a. ……

b. ……

c. …… *****Tick as applicable

7. The individual is not recommended for transfer for the following reasons:

Name:		**Signature:**	
Appointment:		**Date:**	
Tel no:			

Section C - To be completed by Individual

8. I am fully aware of the implications of the RECU process and I have been briefed on the career, financial and welfare implications of any decisions I might make.

9*. I understand that should the Army find suitable employment through transfer to a different Arm or Service I will be unlikely to be considered for discharge/retirement on medical grounds if I reject this offer.

☐ Yes ☐ No

10. I would be interested in transferring to another cap badge within the Army and have discussed these options with my Career Manager:

☐ Yes ☐ No

If yes, I wish to be considered for the following cap badges

a. ……

b. ……

c. ……

11. I am not willing to be considered for transfer to another cap badge for the following reasons:

Name:		**Signature:**	
Appointment:		**Date:**	

*****Tick as applicable
Notes:

(2) In order to be considered for a discharge/retirement on medical grounds, an individual must be a volunteer for transfer.
(3) Transfer to RN / RAF is only considered under extant inter-Service transfer policies and processes and is separate to PAP 10.

Section D - To be completed by the Unit Medical Officer

Notes:
(4) Medical assessment should be conducted by a minimum of a Two Member Medical Board presided over by an OM Consultant. Any assessment not meeting these medical board criteria will not be considered by APC SO1 OH and will be returned to unit for further action.

12. A Medical Board has been conducted to consider the employability of the individual listed and the individual is permanently graded as: ……

13. I have read Appendix 18 completed by the Chain of Command and can make the following comments on the individual's employability: (no medical in confidence information should be included on this form).:

14. The following documents should be attached to this form before forwarding to SO1 OH, MP 544, APC, Kentigern House, 65 Brown Street, GLASGOW, G2 8EX . Any documents classified as 'Medical in Confidence' should be placed in a sealed envelope which should only be opened by APC SO1 OH. Appendix 17 must be completed to allow APC SO1 OH access to medical records.

- ☐ PAP 10 Appendix 18 (completed and attached by CO)
- ☐ F Med 4 (SMO)
- ☐ PAP 10 Appendix 17 (SMO)
- ☐ F Med 143 (optional)
- ☐ Additional documents as listed:
- ☐ FMed 23 (SMO)
- ☐ PAP 10 Appendix 9 (SMO)
- ☐ Full DMICP Printout
- ☐ Individual's Personal Statement

Name:		**Signature of Medical Officer:**	
Date:		**Date of Medical Board:**	

Section E - To be completed by APC Career Manager

15*. I can confirm that no suitable employment is available for the soldier named in Section A in his / her present cap badge.

☐ Yes ☐ No

16. The individual is assessed as suitable for transfer to or employment in the following cap badge:

a. ……

b. ……

c. ……

17. I would like to make the following comments:

18. After consultation with other Arms or Services the following employment or transfer options (with attached illustrative career plan) have been identified:

a. ……

b. ……

Name:		**Signature:**	
Appointment:		**Date:**	

*****Tick as applicable

Notes:
(5) If transfer or employment options are identified at this stage Appendix 22 should be returned to unit for an offer to be made to the individual. Individuals unwilling to transfer will not normally be considered for invaliding from service but can be retired or discharged under QRs Para 9.414 if they are unwilling to accept the transfer or employment offer.
(6) If the employment or transfer offer is rejected, Appendix 22 is to be returned to APC SO1 OH and Appendix 25 initiated.

Section F - To be completed by APC SO1 OH

19. I can confirm that no suitable transfer opportunities or employment are available for the individual named in Section A in his/her present cap badge.

20. Discharge is recommended under the terms of P&PW or QRs 75 para 9.381/9.385/9.414 for the following reasons:

Name:		**Signature:**	
Appointment:		**Date:**	

PART 2 - To be completed by Unit CO

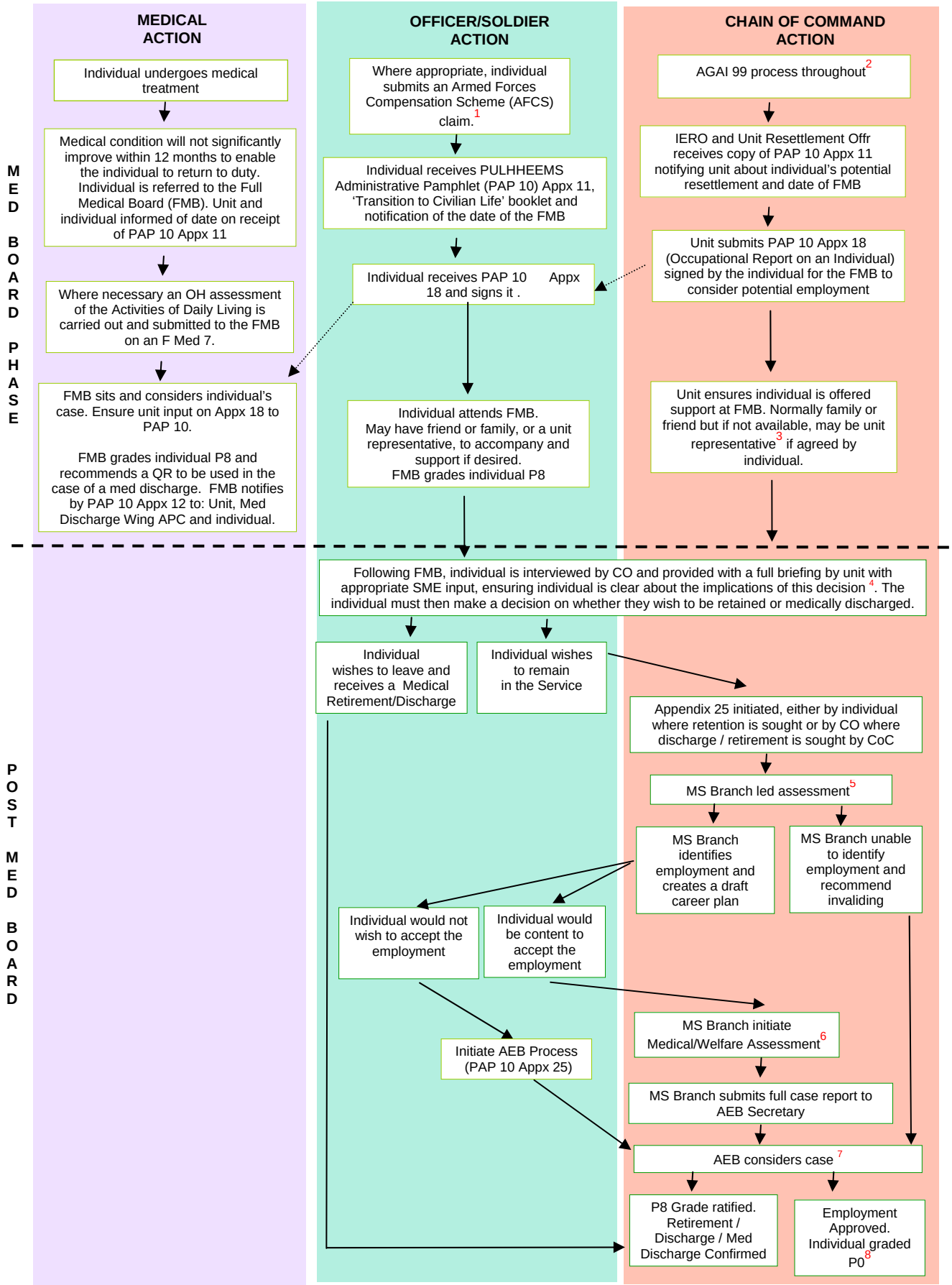
Notes:
(7) This Part is only used when a soldiers is not a volunteer for transfer.
(8) Recommendation for discharge under QRs 9.414 is submitted to DM(A) on AFB 130A, together with this form.

21. Discharge is hereby authorised under the terms of P&PW or QRs 75 Para ……

Name:		**Signature:**	
Appointment:		**Date:**	

APPENDIX 23

Aide Memoire for Army Personnel graded L5 E5 MND Perm (P8) Who Wish to be Retained



Notes:

1. AFCS information and claim forms can be obtained from the Service Personnel and Veterans Agency website at www.veterans-uk.info**,** 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 on or after 6 April 2005. Applications can be submitted at any stage up to 5 years after the injury/event.

2. This will normally be applied as soon as an individual is downgraded. AGAI Vol 3 Ch 99 (Command and Care of Wounded, Injured and Sick).

3. Role of unit representative is to support the individual, 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 1009).

5. MS Branch should consult with A&SDs prior to the formulation of employment plans. Should also include further Occ Health assessments where necessary.

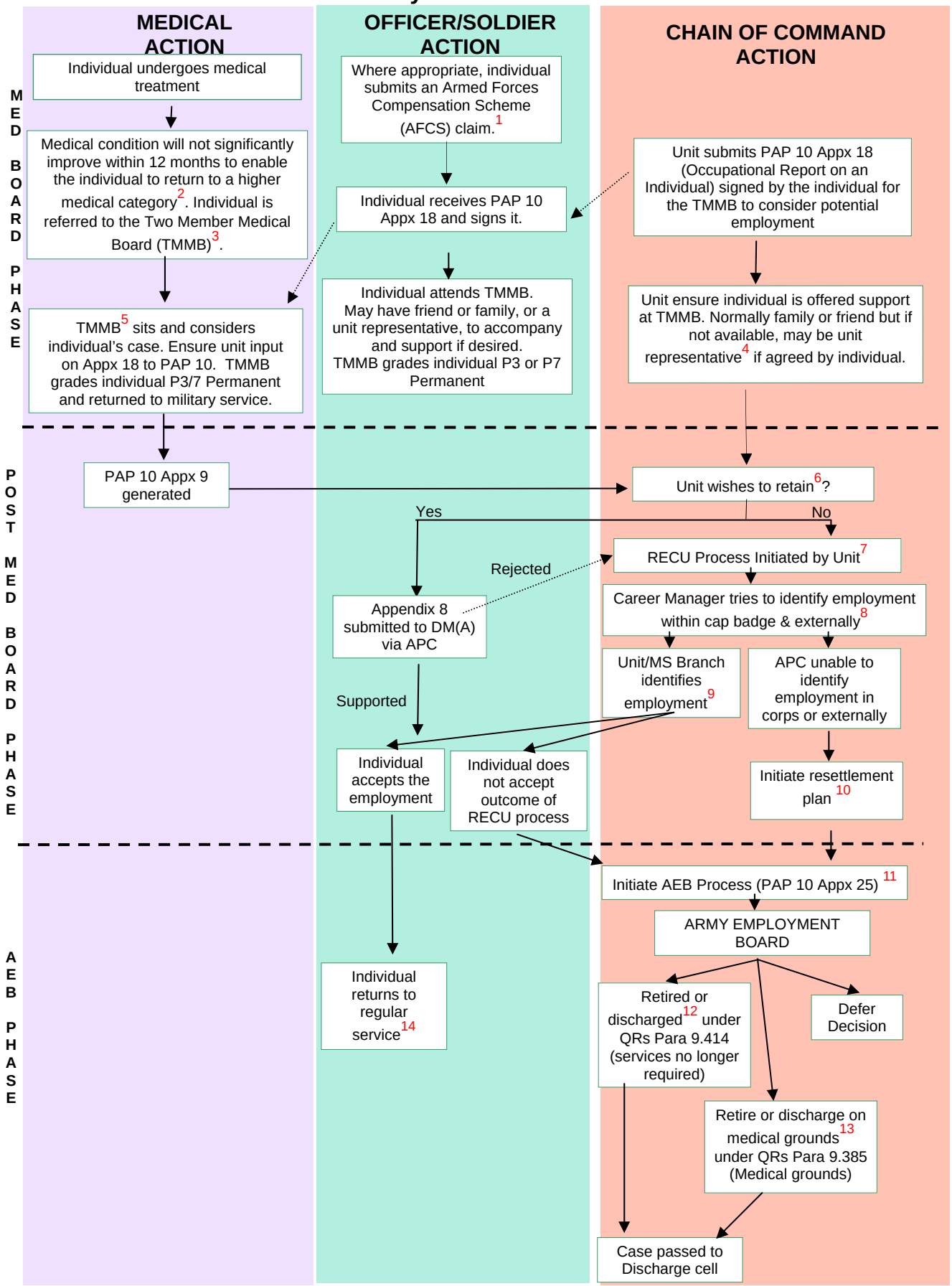
6. Assessments to be carried out by AWS Casualty Key Workers or Army Welfare Workers as appropriate. A report is to be produced for the Employment Board that covers all medical and welfare issues linked to continued employment. Issues such as costs for SFA / SLA and workplace modifications for activities of daily living; estimated future medical/welfare costs, additional necessary leave for attending appointments/convalescence and to include likely additional T&S bill etc.

7. Employment Board will consider Medical Board recommendation, CO's comments, a personal statement by the individual, the potential Career Plan, Medical / Welfare Report and Retirement / Discharge / Retention options (see Chapter 12).

8. Individuals approved for continued employment may be graded P0 and subject to 6 monthly review by the APC. Additionally, individuals unable to maintain employment may apply through their CO to the APC (SO1 OM/OH) for medical discharge. The APC will decide on the most appropriate course of action to facilitate this.

APPENDIX 24

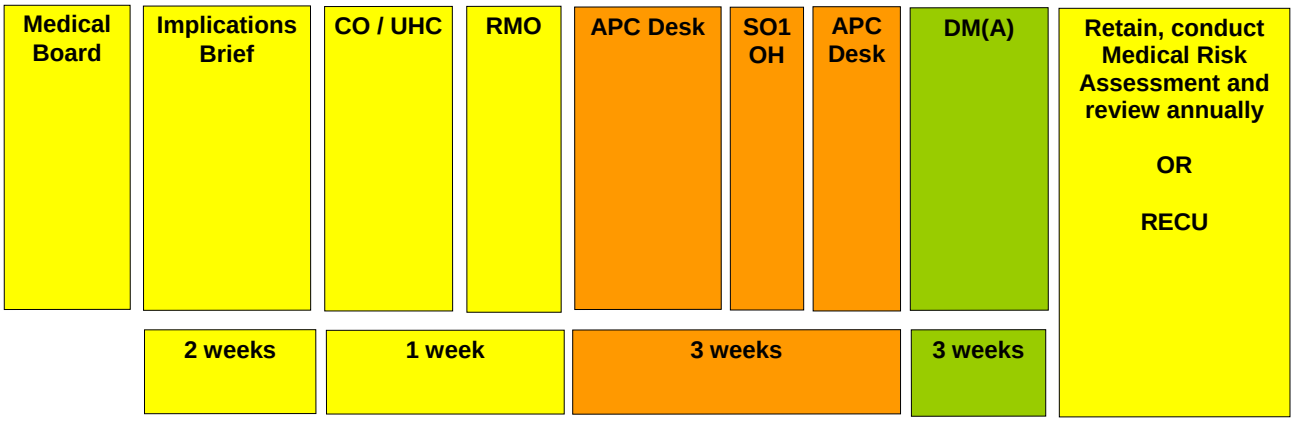
Aide Memoire for Army Personnel Graded MND Permanently or Exceptionally MLD Permanently Who Wish to be Retained



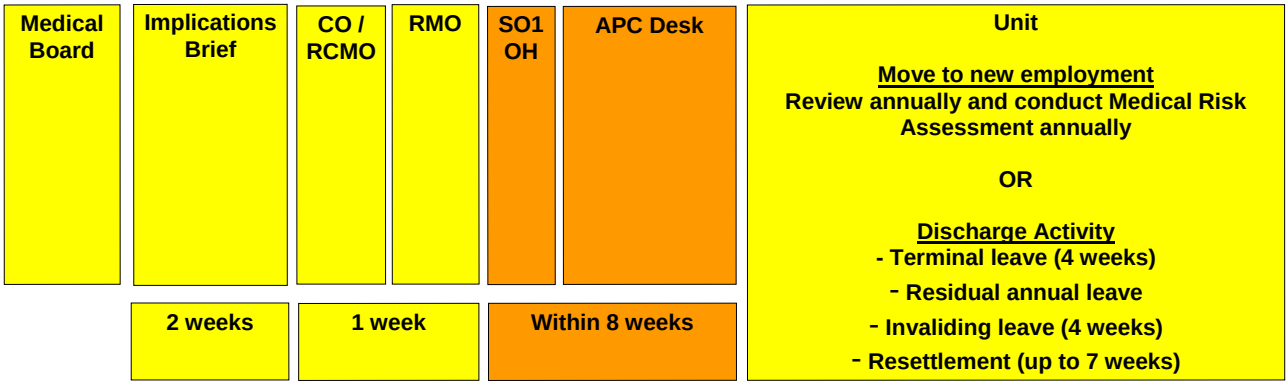
Timings:

The following timelines are to be adhered to for submission and management of the Appendix 8 and RECU process.

Appendix 8



RECU/Appendix 22



Notes:

1. AFCS information and claim forms can be obtained from the Service Personnel and Veterans Agency website at www.veterans-uk.info**,** 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 on or after 6 April 2005. Applications can be submitted at any stage up to 5 years after the injury/event.

2. Timelines laid down in AGAI Vol 3 Ch 99 (Commend and Care of the Wounded, Injured and Sick).

3. TMMB details in PAP 10 Appx 3. Supported by DGAMS PL 06/07.

4. Role of unit representative is to support the individual, not to influence the board.

5. A TMMB with an Occupational Medicine Consultant presiding is required for all board which are likely to result in RECU.

6. With A&SD and APC Career Manager advice.

7. Majors and above should write to their Career Manager requesting retention and either transfer of Corps or employment.

8. Where required MS Branches should consult with A&SD.

9. Should include additional Occ Health reports as necessary

10. Once Appendix 22 has been submitted to APC, the unit should initiate a resettlement plan, including booking Career Transition Workshops, in order to enable resettlement to be conducted concurrently with the RECU process. This will enable the individual to be prepared for discharge/retirement on medical grounds.

11. Where retention is sought by the individual, Appendix 25 is initiated by the individual. Where discharge or retirement is sought by the CoC, Appendix 25 is to be initiated by the CO.

12. This may include a decision to delay discharge to a specified date.

13. This may include a decision to delay discharge to a specified date.

14. Unit to complete Appendix 8 as appropriate.

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APPENDIX 25

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 individual named above has signed **PAP 10 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 only**, the individual 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 or discharge, the Commanding Officer is to give reasons why this is deemed appropriate 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 individual, the wishes of the unit, welfare considerations and presentation issues)

Name:		**Signature:**		**Date:**	

*****Tick as applicable

PROTECT STAFF (when complete)

5*. The following information is to be submitted with all applications by the unit:

	Documents	JMES	Action	Remarks
☐	F Med 4, 23 & 24	L5 E5 perm L3 L4	FMB automatic to APC SO1 OH request from MC	
☐	Appendix 8 to PAP 10	L5 E5 perm	Unit	Retention cases only, submit to SO1 OH cc to DM(A)
☐	Appendix 22 to PAP 10 (if appropriate)	L3 L4	Unit	SO1 OH POC to advise on completion of documentation
☐	Appendix 12 to PAP 10	L5 E5 perm	FMB Automatic	
☐	Appendix 17 to PAP 10	L5 E5 perm L3 L4	FMB Automatic SO1 OH request from MC	AEB Consent form in addition through SO1 OH
☐	Appendix 18 to PAP 10	L5 E5 perm L3 L4	FMB automatic SO1 OH request from unit	
☐	Appendix 20 to PAP 10 (Appeal cases only)	L5 E5 perm	Individual	Appeal through unit CO to AEB.
☐	Personal statement from individual	L5 E5 perm L3 L4	FMB automatic SO2 OH request from individual	In addition to F Med 24
☐	Interview record with individual 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 (signed by individual)	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 C of C, MS Branches and other key organisations (ie AWS, SPVA etc) as to who is responsible for providing the information.

***Tick as applicable

PROTECT STAFF (when complete)

6. **SO1 OH comments:**

Name:		**Signature:**	
Appointment:		**Date:**	

7. **For SO1 OH Action.** The following additional documents were considered by the FMB and are attached to this application:

Name:		**Signature:**	
Appointment:		**Date:**	

8. **Decisions of AEB and Reasons:**

Name:		**Signature:**	
Appointment:		**Date:**	

PROTECT - STAFF (when complete)

APPENDIX 26

Deployment Medical Risk Assessment Form

This form is the obligatory risk assessment which must be completed for individuals graded Medically Limited Deployability (MLD commencing Mission Specified Training (MST) for a specific operational tour. The form is to be used to provide a risk assessment for an individuals MST and subsequent deployment against a specified role in accordance with **PAP 2010 Para 0512**. It must be completed in conjunction with PAP 10 Appendix 9.

The assessment requires careful consideration of all information available to the unit on the individual's limitations and the risk they represent. The validity of the Deployment Medical Risk Assessment (DMRA) will be enhanced by discussion at the Unit Health Committee (UHC) with the Regimental Medical Officer (RMO) or designated Unit Medical Officer (UMO) present. The form is not be completed by the medical chain and must be signed by the Commanding Officer. A signed copy of the form is to be held in the individual's personnel file and one provided to the individual and their commander on operations. The individual must have the outcome of the risk assessment explained to them.

Personnel graded MND are by definition not deployable on operations but will require a MRA for exercises.

No:		**Rank**		**Surname:**	
Unit:		**Regt/Corps:**		**Forename:**	
Branch / Trade:				**Age:**	

To be completed by OC

1. Details of activities - complete all headings (Use Appendix 4 to Annex I of Land Mounting Instructions):

Operation / MST Dates: Tour length:

Locations:

Deployed role[1]:

Physical demands of role:

Weapon systems:

Body armour type:

Vehicles:

Other considerations:

2. Other considerations has the individual worked in this/or similar role before, have they deployed either successfully or unsuccessfully to this/or a similar theatre before? (Detail - length of time in role, previous exercises, previous CASEVAC).

Previous deployments as MLD- dates/length/location:

Recent exercise performance:

Other factors:

3. Medical facilities and threats, in theatre medical facilities as described in Mounting Instructions or from unit recce report and local disease prevalence. For PJHQ CAT 1 deployments to MOB only on established operations it is sufficient to detail the location in theatre where the individual will be based:

Location based during MST:

Location based during Tour:

[1] Job Spec to be attached where available

PROTECT - STAFF (when complete)

No:		**Rank:**		**Name:**	

Use the individual's in date **Appendix 9** to complete 4 and 5:

4. Review Appx 9 section 6. Is a medical review required before commencing MST/Deployment? .

No ☐ Current Appendix 9 attached to this form. (**Go to 5**)

Yes ☐ After the review, attach any new appendix 9 generated. (**Then go to 5**)

5. Review Appendix 9 section 6- Does the individual require approval by a Regional Occupational Health Team (ROHT) prior to deployment?

Yes ☐ (RMO/UMO to arrange this review. After the review attach the new Appendix 9 (**Go to 6**)
No ☐ (**Go to 7**)

6. The ROHT risk assessment for this specific deployment as detailed on the Appendix 9 should be read and if the deployment is approved the implications assessed as follows:

Summary of ROHT advice on how individual's deployment should be managed:
Can this can be achieved:
What additional resources, if any are required:

7. All risk assessments should be discussed at UHC prior to commencing MST:

Date of UHC:
Record any decisions:
Record advice of RMO/UMO provided:

8. Any employment restrictions required should be documented (e.g. no patrols, no heavy lifting, warm working environment). This section should be used to demonstrate unit awareness of Appendix 9:

Restrictions placed to ensure sustainable deployment:

9. Recommendation to CO of risk of employing/deploying the individual in the specified role:

Accept ☐
Decline ☐
Decline ☐ (recommend alternative role considered, a new Appendix 26 must be initiated for this role)

10. If recommendation is to accept risk, indicate PJHQ operational role limitations:

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	☐

11. Assessment completed by:

Name:		**Rank:**		**Post:**	
Signature:		**Dated:**		**Contact No:**	

No:		**Rank:**		**Name:**	

12. Commanding Officers decision on risk of deploying individual in specified role

Deployment in proposed role - Accepted ☐
Deployment in proposed role - Refused ☐

Comments

13. Completed by:

Name:		**Rank:**		**Post:**	
Signature:		**Dated:**		**Contact No:**	

Copy to:
Individual
Sub Unit Comd
Adjt

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APPENDIX 27
Example of a Unit Implications Brief

1. **Introduction**. Immediately on receipt of an Appendix 9 to PAP 10 from the RMO confirming a permanent medical grading MND Perm or MLD Perm, this brief must be given to the individual by his/her OC or an appropriate alternative, which may include WIS staff[1]. It is to be completed before a decision has been made on retention or RECU and should be reviewed annually where the individual is retained.

2. **Personal Details**.

Number	Rank	Name	Sub-unit	JMES[2]	Remarks

3. **OC Interview**.

a. Does the individual wish to be retained? YES / NO
b. Is the individual a volunteer to transfer for alternative employment? YES / NO
c. Outline the implications of the individual's JMES Grading and the PAP 10 process.

OC Comments

Signed:

4. **Adjt/RCMO Interview**. The Adjt/RCMO should give initial career advice on the implications of being classed MND (Perm) or MLD (Perm), including the implications on the individual's career, including prospects of promotion. He/she should outline:

Adjt/RCMO Comments including:

- The potential outcomes of the RECU process, if undertaken.
- Retirement/discharge through RECU or as a result of being graded L5 E5 Perm (P8) both constitute retirement/discharge on medical grounds (not administrative).
- The financial implications of rejecting an employment offer.
- An explanation of the AEB and appeals processes.
- The individual should also be given resettlement entitlement advice and support, including outline planning and booking of initial resettlement interviews/workshops (if applicable).

Signed:

[1] 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. It is also the PRO or Unit WIS officer who, at the UHC, makes the recommendation to the CO on retention or RECU.

[2] Either MND Perm or MLD Perm.

5. **RAO Interview**. The RAO should give broad financial advice, based on potential career options implications, including pay, pensions, and compensations and 'signpost' the individual 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 also submitting a request for information on pension entitlements from SPVA.

RAO Comments   **Signed:**

6. **Welfare Interview (If Applicable)**. The UWO should outline additional welfare support if applicable.

UWO Comments   **Signed:**

7. **Medical Advice.** The RMO should provide additional medical advice and support if required by the individual.

RMO advice (if requested) **Signed:**

9. **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 his inclusion on the soldier's P-File.

OC Signature…… **Date**……..

Individual Signature…… **Date**……..

Adjt/RCMO Signature…… **Date**……..