

MEDICAL STANDARDS FOR LAW ENFORCEMENT PERSONNEL

1. MINIMUM COMPONENTS OF THE CLINICAL TESTS. A qualified physician or practitioner performs a medical examination to include a thorough history, physical examination (as reported on the standardized ICE forms), and clinical tests, which consist of, but are not limited to, the following components:
 - a. Urinalysis (dipstick).
 - b. TB skin test.
 - c. ECG (resting).
 - d. Complete blood count (CBC)
 - e. Chest x-ray if indicated based on TB skin test or other findings from the history and/or physical examination.

2. HOW TO USE THESE MEDICAL STANDARDS.
 - a. Throughout these standards, unless otherwise stipulated, an employee or applicant with a medical condition listed will NOT meet the medical standard required for an 1811 or 1801 position. This will be determined by either a current diagnosis or a verified past medical history that consistently or intermittently prevents the employee from completing all assignments outlined in the job description.
 - b. If NO medical conditions defined in these standards are present, either currently or in the applicant's or employee's past medical history, the applicant or employee is considered to have met the standards.
 - c. If medical conditions defined in these standards are present, either currently or in the applicant's or employee's past medical history, the applicant or employee is considered to have NOT met the standards.
 - d. If additional medical information is needed beyond the scope of the medical examination in order to determine whether a medical condition defined in these standards is present, either currently or in the past medical history, the applicant or employee is considered to have NOT met the standards until receipt and review of the additional medical documentation.

- e. The ICE waiver process is available for applicants or employees who do NOT meet the standards. The Medical Review Board policy and process is defined elsewhere.
2. ORGANIZATION OF THESE MEDICAL STANDARDS. The medical standards are classified by the general body systems.
- a. HEAD.
 - i. Deformities of the skull, face, or mandible of a degree that shall prevent the individual from the proper wearing of a protective mask or headgear, as required for the position.
 - ii. Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a 25-cent piece.
 - b. EYES.
 - i. Lids.
 - 1. Current symptomatic blepharitis.
 - 2. Current blepharospasm.
 - 3. Current dacryocystitis, acute or chronic.
 - 4. Defect or deformity of the lids or other disorders affecting eyelid function or significant ptosis sufficient to interfere with vision or impair protection of the eye from exposure.
 - ii. Conjunctiva.
 - 1. Current acute or chronic conjunctivitis resulting in excessive mucous production likely to interfere with visual acuity. Seasonal allergic conjunctivitis DOES meet the standard.

2. Current pterygium if condition encroaches on the cornea in excess of 3 millimeters, interferes with vision, is progressive, or a history of recurrence after any prior surgical removal.

iii. Cornea.

Corneal dystrophy or degeneration of any type, including but not limited to keratoconus of any degree.

History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy (RK), astigmatic keratotomy (AK), or corneal implants.

Corneal refractive surgery performed with an excimer laser, including but not limited to photorefractive keratectomy (PRK), laser epithelial keratomileusis (LASEK), and laser-assisted in situ keratomileusis (LASIK) if any of the following conditions are met:

- a. For corneal refractive surgery, at least 180 days recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.
 - b. There have been complications and/or medications or ophthalmic solutions, or any other therapeutic interventions such as sunglasses, are required.
 - c. Post-surgical visual acuity in each eye, if worse than 20/40, must be stable as demonstrated by consistent uncorrected distant vision as compared to any prior distant visual acuity assessment DOES meet the medical standard.
2. Current or recurrent keratitis affecting visual acuity or causing photophobia.
 3. Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision below the standards prescribed in this standard.

4. Current or history of uveitis or iridocyclitis.

iv. Retina.

1. Current or history of any abnormality of the retina, choroid or vitreous resulting in decreased visual acuity or affecting visual fields.

v. Optic Nerve

1. Any current or history of optic nerve disease, including but not limited to optic nerve inflammation, optic nerve swelling, or optic nerve atrophy or any other optic nerve anomaly resulting in decreased visual acuity or loss of visual field.

vi. Lens.

1. Current aphakia, history of lens implant, or current or history of dislocation of a lens.

2. Current or history of opacities of the lens, including cataract.

vii. Ocular Mobility and Motility.

1. Current or recurrent diplopia.

2. Current nystagmus other than physiologic “end-point nystagmus.”

3. Esotropia, exotropia, and hypertropia.

viii. Miscellaneous Defects and Diseases.

1. Current or history of abnormal visual fields due to diseases of the eye or central nervous system, or trauma.

2. Absence of an eye (monocular vision), clinical anophthalmos, unspecified congenital or acquired, or current or history of other disorders of globe.

3. Current unilateral or bilateral exophthalmoses.

4. Current or history of glaucoma, ocular hypertension, pre-glaucoma, or glaucoma suspect. Waivers will be based upon documented control of pressure and no loss of visual acuity or visual fields.
5. Current night blindness.
6. Current or history of intraocular foreign body.
7. Current or history of ocular tumors.
8. Current or history of any abnormality of the eye or adnexa which threatens vision or visual function.

c. VISION.

- i. Use of soft-contact lens (SCL) for 6 months or longer is NOT subject to Successful uncorrected distant-vision standards. Those SCL users with uncorrected distant vision of worse than 20/100 must carry an extra set of SCL during field operations.
- ii. Uncorrected distant visual acuity must meet at least one of the following (corrected distant visual acuity must be 20/20 in each eye and both eyes viewing regardless of uncorrected distant visual acuity):
 1. 20/40 in one eye and no worse than 20/70 in the other eye.
 2. 20/30 in one eye and no worse than 20/100 in the other eye.
 3. 20/20 in one eye and no worse than 20/400 in the other eye.
- iii. Corrected distant visual acuity must be 20/20 in each eye.
- iv. Current near visual acuity must correct to 20/20 in the better eye.
- v. Depth perception must be greater than 100 seconds of arc or 50% or less for Shepard-Fry.

- vi. Peripheral vision must be greater than 120 degrees in each eye.
 - vii. If near visual acuity is 20/30 or better without corrective lenses, then color vision testing should be conducted without corrective lenses. The Hardy, Rand and Rittler (HRR) pseudoisochromatic plate test should be performed at or about 30 inches distance under full-spectrum lighting. Passing score is correct responses on the 6 screening plates. If there is an incorrect response on the screening plates, but correct responses on all subsequent diagnostic plates and on retesting there are no errors on the 6 screening plates, normal color vision is present. Those who fail should have the HRR repeated by an optometrist or an ophthalmologist. Ophthalmologic assessment of their color vision via anomaloscope or Farnsworth-Munsell 100 Hue Test may also be submitted for subsequent consideration
 - viii. Any condition requiring contact lenses for adequate correction of vision, other than refractive errors, such as corneal scars and opacities and irregular astigmatism does not meet the standard.
- d. EARS.
- i. Current atresia of the external ear or severe microtia, congenital or acquired stenosis, chronic otitis externa, or severe external ear deformity that prevents or interferes with the proper wearing of hearing protection.
 - ii. Current or history of Ménière's Syndrome or other chronic diseases of the vestibular system.
 - iii. Current or history of cholesteatoma.
 - iv. History of any inner or middle ear surgery excluding successful tympanoplasty performed during the preceding 180 days.
 - v. Current perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 180 days.

- vi. Chronic Eustachian tube dysfunction as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization (PE) tube within the last 3 years.
- vii. Use of a cochlear implant.

e. HEARING.

- i. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute (ANSI S3.6-2004) (Reference (i)) and shall be used to test the hearing of all individuals.
- ii. For those with assistive hearing devices, hearing aids, testing should be conducted with, and without, such devices.
- iii. Current hearing threshold level in either ear greater than that described in this enclosure does not meet the standard:
 - 1. Average hearing loss at 500, 1000, 2000, and 3000 Hz for each ear of not more than 25 decibels (dB). This is calculated by summing the dB loss at these frequencies, then dividing by 4.
 - 2. Difference in average hearing level between the better and poorer ear of:
 - a. More than 15 dB at 500, 1000 and 2000 Hz, or
 - b. More than 30 dB at 3000, 4000, and 6000 Hz.
 - 3. A waiver will be medically recommended with a Speech Discrimination in Noise Test, also known as a Hearing in Noise Test, of at least 50% accuracy, and if sound localization remains intact.
 - 4. Where a hearing assistive device is required to meet the medical standard then a provision of any waiver should include a requirement to carry extra batteries or an additional device.

f. NOSE, SINUSES, MOUTH, AND LARYNX.

- i. Current cleft lip or palate defects not satisfactorily repaired by surgery or that interfere with use or wear of protective equipment, speech or that prevent drinking from a straw.

- ii. Current ulceration of oral mucosa, including tongue, excluding aphthous ulcers.
- iii. Current chronic conditions of larynx including vocal cord paralysis or history of laryngeal papillomatosis.
- iv. History of non-benign polyps, chronic hoarseness, chronic laryngitis or spasmodic dysphonia.
- v. Current anosmia or parosmia.
- vi. History of recurrent epistaxis with more than one episode per week of bright red blood from the nose occurring over a 3-month period within the last 3 years.
- vii. Current nasal polyp or history of nasal polyps, unless more than 12 months have elapsed since nasal polypectomy and/or sinus surgery, and asymptomatic.
- viii. History of recurrent aerosinusitis not responsive to medical management.
- ix. Current chronic sinusitis as evidenced by chronic purulent discharge, symptoms requiring frequent medical attention, or computed tomography (CT) scan.
- x. Current or history of deformities, or conditions or anomalies of the upper alimentary tract, mouth, tongue, palate, throat, pharynx, larynx, and nose, which interferes with speech, or breathing.

g. NECK.

- i. Current symptomatic cervical ribs.
- ii. Current congenital cyst(s) of branchial cleft origin or those developing from the remnants of the thyroglossal duct.
- iii. Current contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent it interferes with the proper

wearing of appropriate protective equipment or is so disfiguring as to interfere with or prevent satisfactory performance of job functions.

- iv. Chronic degenerative disease resulting in loss of range of motion to less than 90° rotation to each side and/or less than 70° of extension.

h. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM.

- i. Current abnormal elevation of the diaphragm (either side) resulting in difficulty breathing or use of a respirator.
- ii. Chronic abscess of the lung or mediastinum.
- iii. Current or history of recurrent acute infectious processes of the lung, including but not limited to viral pneumonia, pneumococcal pneumonia, bacterial pneumonia, pneumonia due to other specified organism, pneumonia infectious disease classified elsewhere, bronchopneumonia (organism unspecified), and pneumonia (organism unspecified).
- iv. Airway hyper responsiveness including asthma, reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, reliably diagnosed and symptomatic after the 13th birthday.
 - 1. Reliable diagnostic criteria may include any of the following elements: substantiated history of cough, wheeze, chest tightness, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 12 months, prescription of a “rescue inhaler” or use of an inhaler.
 - 2. A waiver is medically recommended if ALL of the following criteria are met:
 - a. No use or prescription of controller or rescue medications (including, but not limited to inhaled corticosteroids, leukotriene receptor antagonists, or short-acting beta agonists).
 - b. No exacerbations requiring acute medical treatment.
 - c. No use of oral steroids.

- xv. Recurrent spontaneous pneumothorax.
 - xvi. History of chest wall surgery, including breast, during the preceding 6 months, or with persistent functional limitations.
 - xvii. Current or history of malignancy.
- i. HEART.
- i. History of valvular repair or replacement.
 - 1. Current or history of the following valvular conditions as defined by the current American College of Cardiology and American Heart Association guidelines:
 - a. Severe pulmonic regurgitation.
 - b. Severe tricuspid regurgitation.
 - c. Moderate pulmonic regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.
 - d. Moderate tricuspid regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.
 - e. Moderate or severe mitral regurgitation.
 - f. Mild, moderate, or severe aortic regurgitation.
 - 2. The following are considered normal variants that meet accession standards:
 - a. Trace or mild pulmonic regurgitation.
 - b. Trace or mild tricuspid regurgitation.
 - c. Trace or mild mitral regurgitation in the absence of mitral valve prolapse.

- d. Trace aortic insufficiency.
- ii. Mitral valve prolapse with normal exercise tolerance not requiring medical therapy DOES meet the standard.
- iii. Bicuspid aortic valve, in the absence of stenosis or regurgitation DOES meet the standard.
- iv. All valvular stenosis, other than as specifically noted in this document.
- v. Current or history of atherosclerotic coronary artery disease.
- vi. Current or history of pacemaker or defibrillator implantation.
- vii. History of supraventricular tachycardia.
- viii. History of recurrent atrial fibrillation or flutter.
- ix. Supraventricular tachycardia associated with an identifiable reversible cause and no recurrence during the preceding 2 years while off all medications DOES meet the standard.
- x. Those with identified atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (such as Wolff-Parkinson-White (WPW) syndrome) who have undergone successful ablative therapy with no recurrence of symptoms after 3 months and with documentation of normal electrocardiograph (ECG) DOES meet the standard.
- xi. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment or result in physical or psychological impairment.
- xii. Abnormal ECG patterns
 - 1. Long QT.
 - 2. Brugada pattern.
 - 3. WPW syndrome pattern unless associated with low-risk accessory pathway by appropriate diagnostic testing.

- xiii. Current or history of ventricular arrhythmias including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions. Occasional asymptomatic unifocal premature ventricular contractions DOES meet the standard.
- xiv. Current or history of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block, and third- degree AV block.
- xv. In the absence of cardiovascular symptoms, the following DOES meet the standard:
 - 1. Sinus arrhythmia.
 - 2. First degree AV block.
 - 3. Left axis deviation of less than -45 degrees.
 - 4. Early repolarization.
 - 5. Incomplete right bundle branch block.
 - 6. Wandering atrial pacemaker or ectopic atrial rhythm.
 - 7. Sinus bradycardia.
 - 8. Mobitz type I second-degree AV block.
- xvi. Current or history of symptomatic conduction disturbances such as left anterior hemiblock, right or left bundle branch block. A normal echocardiogram would be a basis for a waiver.
- xvii. Current or history of cardiomyopathy, cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), dilation, or congestive heart failure.
- xviii. History of angina, endocarditis, myocarditis or pericarditis unless the individual is free of all cardiac symptoms during heavy exertion, does not require medical therapy, and has normal echocardiography for at least 1 year.

- xix. Current persistent tachycardia (as evidenced by average heart rate of 100 beats per minute or greater over a 24-hour period of continuous monitoring).
- xx. Current or history of congenital anomalies of heart and great vessels. The following conditions DO meet the standard with an otherwise normal current (within 6 months) echocardiogram:
 - 1. Dextrocardia with situs inversus without any other anomalies.
 - 2. Ligated or occluded patent ductus arteriosus.
 - 3. Corrected atrial septal defect or patent foramen ovale without residua.
 - 4. Corrected ventricular septal defect without residua.
- xxi. History of recurrent syncope and or near-syncope, including black out, fainting, loss or alteration of level of consciousness (excludes vasovagal reactions with identified trigger such as venipuncture) unless there has been no recurrence during the preceding 2 years while off all medication.
- xxii. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, near-syncope, chest pain, palpitations, and dyspnea on exertion) that impairs a physically active lifestyle.

j. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

i. Esophageal Disease.

- 1. Current or history of esophageal disease, including but not limited to ulceration, stricture, varices, fistula, or achalasia.
- 2. Gastro-Esophageal Reflux Disease (GERD), with complications.
 - a. Stricture or B-ring.
 - b. Dysphagia.

6. History of gastric varices.

iii. Small and Large Intestine.

1. Current or history of inflammatory bowel disease, including but not limited to indeterminate, Crohn's disease, ulcerative colitis, or ulcerative proctitis.

2. Current infectious colitis not otherwise specified.

3. Current or history of intestinal malabsorption syndromes, including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.

4. Current or history of gastrointestinal functional and motility disorders within the past 2 years, including but not limited to pseudo-obstruction, megacolon, history of volvulus, or chronic constipation and or diarrhea, regardless of cause, persisting or symptomatic in the past 2 years.

5. History of gastrointestinal bleeding, including positive occult blood, if the cause has not been corrected. Meckel's diverticulum, if surgically corrected more than 6 months prior DOES meet the standard.

6. Current or history of irritable bowel syndrome of sufficient severity to require frequent intervention or prescription medication or to interfere with normal function and/or activities. If medical management has prevented any relapses or interventions within the past 2 years, a waiver is medically recommended.

7. History of bowel resection with resultant chronic diarrhea.

8. Current or history of symptomatic diverticular disease of the intestine.

iv. Hepatic-Biliary Tract.

1. Current chronic hepatitis with persistence of symptoms after 6 months, or objective evidence of impairment of liver function.
2. Current or history of cirrhosis, hepatic cysts, abscess, or sequelae of chronic liver disease.
3. Current or history of symptomatic cholecystitis, unless successfully surgically corrected; post-cholecystectomy syndrome; or other disorders of the gallbladder and biliary system.
 - a. Cholecystectomy DOES meet the standard if asymptomatic.
 - b. Endoscopic procedure to correct choledocholithiasis, if performed more than 6 months prior to examination and individual remains asymptomatic, DOES meet the standard.
4. History of sphincter of Oddi dysfunction.
5. Choledochocyst.
6. Primary biliary cirrhosis or primary sclerosing cholangitis.
7. Current or history of pancreatitis, acute or chronic.
8. Current or history of metabolic liver disease, including but not limited to hemochromatosis, Wilson's disease, or alpha-1 anti-trypsin deficiency. Gilbert's syndrome DOES meet the standard.
9. Current enlargement of the liver from any cause.

v. Anorectal.

1. Chronic symptomatic anal fissure or anal fistula.
2. Current or history of anal or rectal polyp, prolapse, stricture, or fecal incontinence within the last 2 years. History of removal of juvenile or inflammatory polyp DOES meet the standard.

vi. Abdominal Wall.

1. Current hernia (except for small or asymptomatic umbilical hernias), including but not limited to uncorrected inguinal and other abdominal wall hernias.
2. History of open or laparoscopic abdominal surgery during the preceding 6 months to include cesarean section. Uncomplicated laparoscopic appendectomies meet the standard after 3 months.

vii. Cancer. Current or history of malignant disease of the liver, gall bladder, pancreas, esophagus, stomach, small or large bowel, rectum or anus.

k. FEMALE GENITALIA.

- i. Current dysmenorrhea that is unresponsive to medical therapy and is incapacitating to a degree recurrently requiring absences of more than a few hours from routine activities.
- ii. Symptomatic endometriosis that is unresponsive to medical therapy.
- iii. Persistent, symptomatic, clinically significant ovarian cyst(s).
- iv. Polycystic ovarian syndrome with metabolic complications that adversely affect work performance or interfere with the wearing of required protective equipment.
- v. Pelvic inflammatory disease within the preceding 30 days.
- vi. Chronic pelvic pain or unspecified symptoms associated with female genital organs.
- vii. Symptomatic uterine enlargement due to any cause.
- viii. Current or history of genital infection or ulceration if of sufficient severity to interfere with normal function.
- ix. Current or history of malignant disease of the bladder, kidney, ureter, cervix, ovaries, breasts, etc.

l. MALE GENITALIA.

- i. Current or history of recurrent orchitis or epididymitis resulting in partial or total incapacitation.
- ii. Current or history of genital infection or ulceration if of sufficient severity to interfere with normal function.
- iii. Current acute prostatitis, chronic prostatitis, or chronic pelvic pain syndrome.
- iv. Current hydrocele or spermatocele associated with chronic pain.
- v. Varicocele, if painful or symptomatic.
- vi. Current or history of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs.
- vii. Current or history of malignant disease of the bladder, kidney, ureter, prostate, testicles, etc.

m. URINARY SYSTEM.

- i. Current or history of chronic / recurrent cystitis, interstitial cystitis, or painful bladder syndrome.
- ii. Current urethritis or history of chronic or recurrent urethritis.
- iii. History or treatment of the following voiding symptoms within the previous 12 months:
 1. Urinary frequency or urgency more than every 2 hours on a daily basis.
 2. Incontinence of urine, such as urge or stress.
- iv. History of need for urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

- v. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.
- vi. Current or history of abnormal urinary findings:
 - 1. Gross hematuria.
 - 2. Microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collected urinalyses).
 - 3. Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalyses).
- vii. Current or recurrent urethral or ureteral stricture or fistula involving the urinary tract.
- viii. Conditions associated with the kidneys, including:
 - 1. Current absence of one kidney, congenital or acquired, unless current renal function is normal which DOES meet the standard.
 - 2. Asymmetry in size ~~or function~~ of kidneys.
 - 3. History of renal transplant if on antirejection medications or abnormal renal function.
 - 4. Current chronic or recurrent pyelonephritis or any other unspecified infections of the kidney that temporarily, or permanently, affect renal function.
 - 5. Current or history of polycystic kidney unless current renal function is normal.
 - 6. Current or history of horseshoe kidney.
 - 7. Current hydronephrosis.
 - 8. Current or history of acute nephritis or chronic kidney disease of any type.

9. History of acute, or chronic, kidney injury, or disease, requiring dialysis.
10. Current or history of proteinuria with a protein-to-creatinine ratio greater than 0.2 in a random urine sample more than 48 hours after strenuous activity.
11. Benign orthostatic proteinuria MEETS the standards.
12. Current or history of symptomatic urolithiasis with retained stones.
13. History of stone(s) greater than 4mm in size, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time due to a metabolic disorder.
14. History of urolithiasis requiring surgical treatment or intervention requiring hospitalization.

n. SPINE AND SACROILIAC JOINTS.

- i. Ankylosing spondylitis or other symptomatic inflammatory spondylopathies, or symptomatic spondylosis (degenerative disc disease) persistently limiting strenuous physical activities.
- ii. Current or history of any condition, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:
 1. It prevents the individual from successfully performing strenuous physical activities or is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion persisting over 6 months.
 2. It requires external support.
 3. Any type of device is permanently implanted in order to control pain.
- iii. Current deviation or curvature of spine from normal alignment, structure, or function if:

1. It prevents the individual from performing strenuous physical activities.
 2. It interferes with the proper wearing of appropriate protective equipment.
 3. It is symptomatic for over 6 months.
- iv. History of congenital fusion involving more than two vertebral bodies or any surgical fusion of spinal vertebrae with recurrent or persistent symptoms.
- v. Current or history of fracture or dislocation of the vertebra.
 1. Vertebral fractures that do NOT meet the standard:
 - a. Compression fractures involving more than or equal to 25 percent of a single vertebra, or valid documentation that the selectee is currently symptomatic.
 - b. Compression fractures involving less than 25 percent of a single vertebra occurring within the past 12 months or it is symptomatic.
 - c. Any compression fracture that is symptomatic.
 2. Vertebral fractures that DO MEET the standard:
 - a. Compression fractures involving less than 25 percent of a single vertebra if it occurred more than 1 year before the accession examination and the individual is asymptomatic.
 - b. A history of fractures of the transverse or spinous process IF the individual is asymptomatic.
- vi. History of juvenile epiphysitis with any degree of residual change indicated by X- ray or kyphosis.

- vii. Current herniated nucleus pulposus (or building disc) or history of surgery to correct. A surgically corrected asymptomatic single-level lumbar or thoracic discectomy with full resumption of unrestricted activity DOES meet the standard.
 - viii. Current or history of spina bifida when symptomatic, when there is more than one vertebral level involved, or with dimpling of the overlying skin. History of surgical repair of spina bifida.
 - ix. Current or history of spondylolysis congenital or acquired with symptoms persisting over 6 months.
 - x. Current or history of spondylolisthesis congenital or acquired with symptoms persisting over 6 months.
- o. UPPER EXTREMITIES.
- i. Limitation of Motion. Current active joint ranges of motion less than:
 - 1. Shoulder.
 - a. Forward elevation to 90 degrees.
 - b. Abduction to 90 degrees.
 - 2. Elbow.
 - a. Flexion to 130 degrees.
 - b. Extension to 15 degrees.
 - 3. Wrist. A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.
 - 4. Hand.
 - a. Pronation to 45 degrees.
 - b. Supination to 45 degrees.

5. Fingers and Thumb. Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

ii. Hand and Fingers.

1. Absence of the distal phalanx of either thumb.

2. Absence of any portion of the index finger.

3. Absence of distal and middle phalanx of the middle or ring finger of either hand irrespective of the absence of the little finger.

4. Absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand.

5. Absence of hand or any portion thereof, except for specific absence of fingers as noted in subparagraphs p.ii.1. through 4.

6. Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar, median, or radial nerve, sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

iii. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness or symptoms that prevents satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder, the upper arm, the forearm, and the hand; or chronic joint pain as a late effect of fracture of the upper extremities, as a late effect of sprains without mention of injury, and as late effects of tendon injury.

iv. History of any dislocation, subluxation or instability of the ~~knee or~~ shoulder.

p. LOWER EXTREMITIES.

i. General. General.

1. Current deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, knee, ankle and or foot that have interfered with

function to such a degree as to prevent the individual from following a physically active lifestyle, or that would interfere with walking, running, jumping, climbing, squatting, weight bearing, or the satisfactory completion of training or job performance.

2. Current leg-length discrepancy resulting in a limp.

ii. Limitation of Motion. Current active joint ranges of motion less than:

1. Hip (due to disease or injury).

a. Flexion to 90 degrees.

b. No demonstrable flexion contracture.

c. Extension to 10 degrees (beyond 0 degrees).

d. Abduction to 45 degrees.

e. Rotation of 60 degrees (internal and external combined).

2. Knee (due to disease or injury).

a. Full extension to 0 degrees.

b. Flexion to 110 degrees.

3. Ankle (due to disease, injury, or congenital).

a. Dorsiflexion to 10 degrees.

b. Plantar flexion to 30 degrees.

c. Subtalar eversion and inversion totaling 5 degrees.

iii. Foot and Ankle.

1. Current absence of a foot or any portion thereof. A waiver will be based on a demonstrated ability to stand, walk, run, climb, and jump without impairment.

2. Absence of a single lesser toe or any portion thereof that is asymptomatic and does not impair function DOES meet the standard.
3. Deformity of the toes that prevents the proper wearing of appropriate footwear or impairs walking, running, maintaining balance, or jumping.
4. Symptomatic deformity of the toes (acquired or congenital), including but not limited to conditions such as hallux valgus, hallux varus, hallux rigidus, hammer toe(s), claw toe(s), or overriding toe(s).
5. Clubfoot or pes cavus that prevents the proper wearing of appropriate footwear or causes symptoms when walking, running, or jumping.
6. Rigid or symptomatic pes planus (acquired or congenital).
7. Current or history of recurrent plantar fasciitis not controlled with orthotic inserts or physical therapy.
8. Symptomatic neuroma.

iv. Leg, Knee, Thigh, and Hip.

1. Current loose or foreign body in the knee joint.
2. History of uncorrected anterior or posterior cruciate ligament injury.
3. History of surgical reconstruction of knee ligaments DOES meet the standard if 12 months has elapsed since reconstruction, and the knee is asymptomatic and functionally stable.
4. Recurrent ACL reconstruction.
5. Symptomatic medial or lateral meniscal injury. The following DOES meet the standard if asymptomatic, per current report, and released to full and unrestricted activity:

- a. Meniscal repair, more than 6 months after surgery.
 - b. Partial meniscectomy more than 3 months after surgery.
- 6. Meniscal transplant.
- 7. Symptomatic medial and lateral collateral ligament instability.
- 8. Current or history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Calve-Perthes Disease) or slipped capital femoral epiphysis of the hip.
- 9. Hip dislocation within 2 years preceding examination. Hip dislocation after 2 years DOES meet the standard if asymptomatic and released to full unrestricted activity.
- 10. Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) within the past year.
- 11. Stress fractures, recurrent or single episode during the past year.
- 12. Prosthetic joint.
- 13. History of any dislocation, subluxation or instability of the knee.
- v. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.
- vi. Current history, requiring treatment, of chondromalacia, within the past 6 months, including but not limited to chronic patello- femoral pain syndrome and retro-patellar pain syndrome, osteoarthritis, or traumatic arthritis.
- vii. Current joint dislocation if not reduced, or history of recurrent dislocation, subluxation or instability of the hip, elbow, ankle, or foot.
- viii. History of any dislocation, subluxation or instability of the knee/

- ix. Current history, requiring treatment, of osteoarthritis or traumatic arthritis of isolated joints that has interfered with a physically active lifestyle, or that prevents the satisfactory performance of duty.
- x. Fracture with:
 - 1. Current malunion or non-union (except asymptomatic ulnar styloid process fracture).
 - 2. Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or interferes with proper wearing of appropriate equipment. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.
- xi. Current orthopedic implants or external devices
- xii. Current or history of contusion of bone or joint, an injury of more than a minor nature that shall interfere or prevent performance of duty, or shall require frequent or prolonged treatment, without fracture, nerve injury, open wound, crush, or dislocation, which occurred in the preceding 6 months and recovery has not been sufficiently completed or rehabilitation resolved.
- xiii. Current or history of neuromuscular paralysis, weakness, contracture, or atrophy of sufficient degree to interfere with or prevent satisfactory performance of job duty or requires frequent or prolonged treatment.
- xiv. Current symptomatic osteochondroma or history of multiple osteocartilaginous exostoses.
- xv. Current osteoporosis as demonstrated by a reliable test such as a dual energy x-ray absorptiometry scan (DEXA).
- xvi. Current osteopenia until resolved.
- xvii. Current osteomyelitis or history of recurrent osteomyelitis.
- xviii. Current or history of osteochondral defect, formerly known as osteochondritis dissecans.

- xix. History of cartilage surgery, including but not limited to cartilage debridement, chondroplasty, microfracture, or cartilage transplant procedure.
- xx. Current or history of any post-traumatic or exercise-induced compartment syndrome.
- xxi. Current or history of avascular necrosis of any bone.
- xxii. Current or history of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, or tenosynovitis.

q. VASCULAR SYSTEM:

- i. Current or history of abnormalities of the arteries, including but not limited to aneurysms, arteriovenous malformations, atherosclerosis, or arteritis (such as Kawasaki's disease).
- ii. Current hypertension that is not controlled. Hypertension is defined as systolic pressure greater than 140 mmHg and or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on each of 2 or more consecutive days (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 or more consecutive days). Elevated blood pressure on exam should be referred for blood pressure checks to determine if there is a diagnosis of hypertension.
- iii. Current or history of peripheral vascular disease, including but not limited to diseases such as Raynaud's Disease and vasculidities.
- iv. Current history of venous diseases, including but not limited to recurrent thrombophlebitis, thrombophlebitis during the preceding year, or evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration.
- v. Current or history of recurrent deep venous thrombosis.

- vi. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement.
- vii. History of Marfan's Syndrome.
- r. SKIN AND CELLULAR TISSUES.
 - i. Current diseases of sebaceous glands including severe and or cystic acne, or hidradenitis suppurativa, if extensive involvement of the neck, scalp, axilla, groin, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of equipment.
 - ii. Current or history of atopic dermatitis after the 12th birthday.
 - 1. Atopic Dermatitis. Active or history of residual or recurrent lesions in characteristic areas (face, neck, antecubital and or popliteal fossae, occasionally wrists and hands).
 - 2. Non-specific Dermatitis. Current or history of recurrent or chronic non-specific dermatitis to include contact (irritant or allergic), or dyshidrotic dermatitis requiring more than treatment with over-the-counter medications or interferes with the wear of protective gear.
 - iii. Cysts if:
 - 1. The current cyst (other than pilonidal cyst) is of such a size or location as to interfere with the proper wearing of necessary equipment.
 - 2. The current pilonidal cyst is evidenced by the presence of a tumor mass or a discharging sinus or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative.
 - iv. Current or history of bullous dermatoses, including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa. Resolved bullous impetigo DOES meet the standard.
 - v. Current or chronic lymphedema.

- vi. Current or history of furunculosis or carbuncle if extensive, recurrent, or chronic.
- vii. Current or history of severe hyperhidrosis of hands or feet unless controlled by medications.
- viii. Current or history of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that interfere with function or are exposed to constant irritation.
- ix. Current or history of keloid formation, including but not limited to pseudofolliculitis and keloidalis nuchae if that tendency is marked or interferes with the proper wearing of necessary equipment.
- x. History of photosensitivity, including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus.
- xi. Current or history of scleroderma.
- xii. Current or history of chronic urticaria lasting longer than 6 weeks or recurrent episodes of urticaria within the past 24 months not associated with angioedema, hereditary angioedema, or maintenance therapy for chronic urticaria, even if not symptomatic.
- xiii. Current symptomatic plantar wart(s).
- xiv. Current scars, or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty.
- xv. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with the satisfactory performance of duty due to decreased range of motion, strength, or agility.
- xvi. Current localized types of fungus infections, interfering with the proper wearing of equipment or the performance of duties.

s. BLOOD AND BLOOD-FORMING TISSUES.

- i. Current hereditary or acquired anemia, which has not been corrected with therapy: diagnosed anemia include hereditary hemolytic anemia, sickle cell disease, acquired hemolytic anemia, aplastic anemia, or unspecified anemias requiring hospitalization or cause episodic incapacitation.
- ii. Current or history of coagulation defects, including but not limited to von Willebrand's Disease, idiopathic thrombocytopenia, or Henoch-Schönlein Purpura.
- iii. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia.

t. SYSTEMIC.

- i. Current or history of disorders involving the immune mechanism, including immunodeficiencies and immune suppression due to medications.
- ii. Tuberculosis.
 1. Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years.
 2. Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty.
 3. Individuals with a past history of active tuberculosis more than 2 years before appointment, enlistment, or induction meet the standard if they have received a complete course of standard chemotherapy for tuberculosis.
 4. Individuals with a tuberculin reaction in accordance with ATS and United States Public Health Service (USPHS) guidelines are eligible for employment, provided they have been offered chemoprophylaxis in accordance with ATS and USPHS guidelines.

A negative QuantiFERON®-TB Gold (QFT®-G) with a positive tuberculin skin test DOES meet the standard.

- iii. Current untreated syphilis
- iv. History of anaphylaxis.
 - 1. History of anaphylaxis to stinging insects. A cutaneous only reaction to a stinging insect under the age of 16 DOES meet the standard. Individuals who have been treated for 3-5 years with maintenance venom immunotherapy DO meet the standard.
 - 2. History of systemic allergic reaction to food or food additives within the past 2 years. Systemic allergic reaction may be defined as a temporally related, systemic, often multi-system, reaction to a specific food. The presence of a food-specific immunoglobulin E antibody without a correlated clinical history DOES meet the standard.
 - 3. Hypersensitivity to latex, systemic reaction.
 - 4. Exercise-induced anaphylaxis (with or without food).
 - 5. Idiopathic anaphylaxis.
 - 6. Acute, early, or immediate anaphylactic onset.
- v. Current residual of tropical fevers, including but not limited to fevers, such as malaria and various parasitic or protozoan infestations that prevent the satisfactory performance of duty.
- vi. History of malignant hyperthermia.
- vii. History of industrial solvent or other chemical intoxication with sequelae.
- viii. History of motion sickness resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years.
- ix. History of rheumatic fever.

- x. Current or history of muscular dystrophies or myopathies.
 - xi. Current or history of amyloidosis.
 - xii. Current or history of eosinophilic granuloma and all other forms of histiocytosis. Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, DOES meet the standard
 - xiii. Current or history of polymyositis or dermatomyositis complex with skin involvement.
 - xiv. History of rhabdomyolysis.
 - xv. Current or history of sarcoidosis with signs or symptoms expected to interfere with the performance of the job's duties.
 - xvi. Current systemic fungus infections.
 - xvii. Seasonal or environmental allergies not responding to antihistamine, H1-receptor antagonist, or topical steroid therapy.
- u. ENDOCRINE AND METABOLIC.
- i. Current adrenal dysfunction.
 - ii. Diabetes mellitus disorders, including:
 - 1. Current diabetes mellitus.
 - 2. Current pre-diabetes mellitus defined as fasting plasma glucose 110- 125 milligrams per deciliter (mg/dL) and glycosylated hemoglobin greater than 5.7 percent.
 - 3. Current persistent glycosuria, when associated with impaired glucose tolerance or renal tubular defects.
 - iii. Current or history of pituitary dysfunction, to include history of growth hormone use. Non-functional microadenoma (less than 1cm) DOES meet the standard.

- iv. Current or history of diabetes insipidus.
- v. Current or history of hyperparathyroidism or hypoparathyroidism.
- vi. The following thyroid disorders:
 - 1. Current goiter. Symmetrical simple goiter less than two times normal size with no nodules by ultrasound and normal thyroid function tests DOES meet the standard.
 - 2. Thyroid nodule. A solitary thyroid nodule less than 5mm or less than 3cm with benign histology or cytology DOES meet the standard.
 - 3. Current hypothyroidism. Individuals with two normal thyroid stimulating hormone tests within the preceding 6 months DOES meet the standard.
 - 4. Current or history of hyperthyroidism. In remission off of anti-thyroidal medication with normal thyroid function tests for a minimum of 12 months and without evidence of thyroid associated ophthalmopathy DOES meet the standard.
- vii. Current nutritional deficiency diseases, including but not limited to beriberi, pellagra, and scurvy.
- viii. Current or history of acromegaly, including but not limited to gigantism, or other disorders of pituitary function.
- ix. Current treatment for dyslipidemia. Those on medical management with no medication side effects (such as myositis, myalgias, or transaminitis) for a period of 6 months DO meet the standard.
- x. Metabolic bone disease.
 - 1. Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.
 - 2. Paget's disease.

3. Osteomalacia.

4. Osteogenesis imperfecta.

xi. Current or history of islet-cell tumors, nesideoblastosis, or hypoglycemia.

v. RHEUMATOLOGIC.

i. Current or history of lupus erythematosus or mixed connective tissue disease variant.

ii. Current or history of progressive systemic sclerosis, including calcinosis, Raynaud's disease or phenomenon, esophageal dysmotility, sclerodactyly, telangiectasia (CREST) variant.

iii. Current or history of Reiter's disease.

iv. Current or history of rheumatoid arthritis.

v. Current or history of Sjögren's syndrome.

vi. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions, arteritis, Behçet's, and Wegener's granulomatosis. Henoch- Schönlein Purpura occurring before the age of 19 with 2 years remission and no sequelae DOES meet the standard.

vii. History of congenital fusion involving more than two vertebral bodies or any surgical fusion of spinal vertebrae.

viii. Current or history of gout with recurrent symptoms despite medical management.

ix. Current or history of inflammatory myopathy including polymyositis or dermatomyositis.

x. Current or history of non-inflammatory myopathy to include but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.

- xi. Current or history of fibromyalgia, myofascial pain, or chronic widespread pain with any history of narcotics required for pain management.
- xii. Current or history of chronic fatigue syndrome.
- xiii. Current or history of spondyloarthritis including ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.
- xiv. Current or history of joint hypermobility syndrome.
- xv. Current or history of hereditary connective tissue disorders including but not limited to Marfan's syndrome, Ehlers-Danlos syndrome, and osteogenesis imperfecta.

w. NEUROLOGIC.

- i. Current or history of cerebrovascular conditions, including but not limited to subarachnoid or intracerebral hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation.
- ii. History of congenital or acquired anomalies of the central nervous system or meningocele.
- iii. Current or history of disorders of meninges, including but not limited to cysts. Asymptomatic incidental arachnoid cyst demonstrated to be stable by neurological imaging over a 6-month or greater time period DO meet the standard.
- iv. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.
- v. History of headaches, including but not limited to migraines and tension headaches that:
 - 1. Are severe enough to disrupt normal activities (such as loss of time from school or work) more than twice per year in the past 2 years.

2. Require prescription medications more than twice per year within the last 2 years.
- vi. Migraine or migraine variant associated with neurological deficits other than scotoma.
- vii. Cluster headaches.
- viii. History of head injury if associated with:
 1. Post-traumatic seizure(s) occurring more than 30 minutes after injury.
 2. Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.
 3. Persistent impairment of cognitive function.
 4. Persistent alteration of personality or behavior.
 5. Unconsciousness of 24 hours or more post-injury.
 6. Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.
 7. Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging until resolved and 12 months has elapsed since injury.
 8. Associated abscess or meningitis.
 9. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.
 10. Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.
- ix. History of moderate head injury.

1. Moderate head injuries are defined as:
 - a. Unconsciousness of more than 30 minutes but less than 24 hours, or
 - b. Amnesia, or disorientation of person, place, or time, alone or in combination, more than 24 hours but less than 7 days duration post-injury, or
 - c. Linear skull fracture.
 2. After 12 months post-injury, individuals may be qualified if neurological examination shows no residual dysfunction or complications such as a seizure disorder and if no anti-seizure medications have been prescribed.
- x. History of mild head injury.
1. Mild head injury is defined as:
 - a. Unconsciousness of less than 30 minutes post-injury.
 - b. Amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.
 2. After 1-month post-injury, individuals may be qualified if neurological examination shows no residual dysfunction or complications.
- xi. History of persistent post-concussive symptoms that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.
- xii. Current or history of infectious processes of the central nervous system, including but not limited to meningitis, encephalitis, neurosyphilis, or brain abscess, if occurring within 1 year before examination, required surgical treatment, or if there are residual neurological defects.

- xiii. Current or history of paralysis, weakness, lack of coordination, chronic pain (including but not limited to chronic regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes, including but not limited to Guillain-Barre Syndrome.
 - xiv. Any seizure occurring beyond the 6th birthday. However, if the individual has been free of seizures for a period of 5 years while taking no medication for seizure control, or 10 years if taking medications, and has a normal sleep-deprived electroencephalogram, then it is NOT disqualifying.
 - xv. Chronic nervous system disorders, including but not limited to myasthenia gravis, multiple sclerosis, tremor, and tic disorders (e.g., Tourette's).
 - xvi. Current or history of central nervous system shunts of all kinds.
 - xvii. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope, including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.
- x. SLEEP DISORDERS.
- i. Chronic insomnia within the past year and used medications to promote sleep for more than 3 nights per week, over a period of 3 months.
 - ii. Sleep-related breathing disorders. Current diagnosis or treatment of sleep-related breathing disorders, including, but not limited to sleep apnea for which CPAP is prescribed. No evidence of hypersomnolence or drowsiness during waking hours, and CPAP compliance is 4 or more hours per night over a minimum of 30 days DOES meet the standards.
 - iii. Current or history of narcolepsy, cataplexy, or other hypersomnia disorders.
 - iv. Circadian rhythm disorders requiring treatment.

- v. Current diagnosis or treatment of sleep-related movement disorders to include restless leg syndrome.

y. PSYCHIATRIC DISORDERS

- i. Attention Deficit/Hyperactivity Disorder (ADHD) UNLESS the following criteria are met:
 - 1. The individual has not required an Individualized Education Program or work accommodations since the age of 14.
 - 2. There is no history of comorbid mental disorders.
 - 3. The individual has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.
 - 4. During periods off of medication after the age of 14, the individual has been able to maintain at least a 2.0 grade point average without accommodations.
 - 5. Documentation from the individual's prescribing provider that continued medication is not required for acceptable occupational or work performance.
 - 6. No occupational, functional or academic impairment within the past year.
 - 7. Intact attention, concentration and impulse control.
 - 8. No disqualifying side effects from medication.
- ii. History of specific learning disorders, including but not limited to reading, UNLESS individuals demonstrated passing academic and adequate employment performance.
- iii. Other Neurodevelopmental disorders including autism spectrum disorders, communication and intellectual development disorder.

- iv. Current or previous history of schizophrenia spectrum and other psychotic disorders.
- v. History of depressive disorders, including but not limited to major depression, dysthymic disorder, and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional, or any inpatient treatment in a hospital or residential facility.
- vi. History of bipolar disorder and related disorders.
- vii. Unspecified Depressive Disorder, or unspecified mood disorder, UNLESS:
 - 1. Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional.
 - 2. The individual did not require any inpatient treatment in a hospital or residential facility.
 - 3. DSM V criteria for full remission was met (during the past 2 months, no significant signs or symptoms of the disturbance were present)
 - 4. Depressive episode was not recurring
 - 5. Evidence of treatment compliance
 - 6. No associated evidence of suicidal behavior
 - 7. No psychotic features
- viii. History of a single adjustment disorder within the previous 3 months, or recurrent episodes of disabling symptoms due to an adjustment disorder.
- ix. Current or history of disruptive, impulse-control, conduct and personality disorders.
 - 1. History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other

social groups), interview, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in a law enforcement agency.

2. Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to a potential law enforcement career.
- x. History of suicidal behavior, including gesture(s) or attempt(s) or history of self- mutilation or injury used as a way of dealing with life and emotions.
 - xi. History of obsessive-compulsive and related disorders with history supporting social and/or occupational impairment.
 - xii. Posttraumatic Stress Disorder with current symptoms or history supporting disabling social and/or occupational impairment lasting more than 2 years following the stressor exposure with or without therapy. For a waiver consideration, past medical treatment records must be submitted for review to support a lack of self-reported symptoms over time with therapy. Any medications used for treatment must be consistent and stable without reported side effects supported by the medical treatment records.
 - xiii. History of anxiety disorders including generalized anxiety, panic, specific phobia, social anxiety, substance induced and other specified or unspecified anxiety disorders UNLESS:
 1. The individual did not require any treatment in an inpatient or residential facility.
 2. Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional.
 3. The individual has not required treatment (including medication) for the past 24 continuous months.
 4. There is evidence that the anxiety disorder was successfully treated with full symptoms remission and no reoccurrence.

aa. MISCELLANEOUS

- i. Current parasitic diseases, if symptomatic or carrier state, including but not limited to filariasis, trypanosomiasis, schistosomiasis, hookworm (uncinariasis), or unspecified infectious and parasitic disease.
- ii. Current or history of other disorders that prevent satisfactory performance of duty or require frequent or prolonged treatment.
- iii. Current or history of cold-related disorders, including but not limited to frostbite, chilblain, immersion foot, or cold urticaria.
- iv. Current residual effects of cold-related disorders, including but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache.
- v. History of angioedema.
- vi. History of receiving organ or tissue transplantation.
- vii. History of pulmonary or systemic embolization.
- viii. Thrombotic or embolic disorder for which anti-coagulant therapy is prescribed.
- ix. History of untreated acute or chronic metallic poisoning, including but not limited to lead, arsenic, silver, beryllium, or manganese, or current complications or residual symptoms of such poisoning.
- x. History of heat pyrexia, heatstroke, or sunstroke.
- xi. History of three or more episodes of heat exhaustion.
- xii. Current or history of a predisposition to heat injuries, including disorders of sweat mechanism, combined with a previous serious episode.
- xiii. Current or history of any unresolved sequelae of heat injury, including but not limited to nervous, cardiac, hepatic, or renal systems.

- xiv. Current or history of any condition that, in the opinion of the medical officer, shall significantly interfere with the successful performance of duty or training.
- xv. Any current acute pathological condition, including but not limited to acute communicable diseases, until recovery has occurred without sequelae.

Attachment B

ABBREVIATIONS AND ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
ANSI	American National Standards Institute Affairs
ATS	American Thoracic Society
AV	Atrioventricular
CPT	Current Procedural Terminology
CREST	Calcinosis, Raynaud's phenomenon, Esophageal dysmotility, Sclerodactyly, Telangiectasia
dB	Decibel
ECG/EKG	Electrocardiograph
GERD	Gastro-Esophageal Reflux Disease
DHHS	Department of Health and Human Services
LASEK	Laser epithelial keratomileusis
LASIK	Laser-assisted in situ keratomileusis
LDL	Low-density lipoprotein
LTBI	Latent tuberculosis infection
mg/dl	milligrams per deciliter
mmHg	millimeters of mercury
NHLBI	National Heart, Lung, and Blood
Institute NIH	National Institutes of Health
PRK	Photorefractive keratectomy
QFT®-G	QuantiFERON®-TB Gold
USPHS	United States Public Health Service
WPW	Wolff-Parkinson-White

Attachment C

DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this Instruction.

Anemia: A hemoglobin level of less than 13.5 for males and less than 12 for females.

Equipment: All ICE-issued equipment provided to the employee for purposes of completing his or her job. This is to include: respirators, protective vests, body armor, weapons and protective clothing.

Individual: applicants for a position in the GS-1811 or GS-1801 job series and current employees occupying a position in the GS-1811 or GS-1801 job series.

QFT[®]-G: An in vitro laboratory diagnostic test using a whole blood specimen. It is an indirect test for Mycobacterium tuberculosis-complex (i.e., M. tuberculosis, M. bovis, M. africanum, M. microti, M. canetti) infection, whether tuberculosis disease or latent tuberculosis infection (LTBI). It cannot distinguish between tuberculosis disease and LTBI and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations.

Attachment D

Revisions

Revision 1: March 22, 2018, 2. c. ii, iv, v. Standards added for corrected distant visual acuity, depth perception, and peripheral vision.

Revision 2: October 29, 2018

2.b.iii – Removed pre-surgical refractive criteria. Changed post-surgical refractive criteria to visual acuity criteria.

2.c.i.4 – Added criteria for soft-contact lens use.

2.c.vii – Allowance added for alternate color vision tests for retesting color vision.

2.e.ii.1 – Added clarification on how to calculate the average hearing loss.

2.e.ii.3 – Change “granted” to “medically recommended” and added comment regarding alternate terminology for the Speech Discrimination in Noise Test.

2.h.iv.2. – Changed MET requirement from 15 to 12.

2.z.iii – Added criteria for finding excised tumor without recurrence as not disqualifying.

2.j.vii – Obesity criteria removed; bariatric surgery previously addressed. 2.t.iv.2 – Added requirement for treatment within the past 2 years to be disqualifying.

2.t.iv.4 – Added “systemic reaction” as disqualifying hypersensitivity to latex

2.x.ii – Added CPAP compliance criteria that DOES meet the standards.

Revision 3: February 4, 2019

2.c.vi. – Added “Those who fail should have the HRR repeated by an optometrist or an ophthalmologist. Ophthalmologic assessment of their color vision via anomaloscope or Farnsworth-Munsell 100 Hue Test may also be submitted for subsequent consideration.

2.c.vi. (Same number as above since it re-numbers once deleted) – Removed current refractive error criteria.

Revision 4: April 30, 2019

2.w.xiv. – changed to read “Any seizure occurring after the 6th birthday. However, if the individual has been free of seizures for a period of 5 years while taking no medication for seizure control, or 10 years if taking medications, and has a normal sleep-deprived electroencephalogram, then it is NOT disqualifying.”

2.c.i. – added clarifying language “(Distant visual acuity must be 20/20 in each eye with or without corrective lens)”

2.q.ii. – added highlighted clarifying language “Current hypertension that is not controlled. Hypertension is defined as systolic pressure greater than 140 mmHg and or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on each of 2 or more consecutive days (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 or more consecutive days). Elevated blood pressure on exam should be referred for blood pressure checks to determine if there is a diagnosis of hypertension.

Revision 5

2.p Edited to clarify that prosthetic joints are disqualifying.

2.r.vii. Removed “topical” to allow for management using injectable products.

2.t.xvii Added section on severe seasonal/environmental allergies not controlled with OTC medications.

2.x.ii. Revised to note that a CPAP prescription defines whether sleep apnea is present.