



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR RESERVE PERSONNEL CENTER

10 Jan 2003

MEMORANDUM FOR All Individual Mobilization Augmentees

FROM: HQ ARPC/CC
6760 E Irvington Pl #1000
Denver CO 80280-7200

SUBJECT: Reserve Component Physical and Dental Exams

1. Effective 1 Oct 01, the physical and dental exams became an annual requirement for all members of the Air Force Reserve, replacing the traditional 5-year physical. Our records indicate you are due for a physical and/or dental evaluation. This is your notice to promptly schedule and complete the required exams. The accompanying documents are intended to guide you through the process of scheduling, completing and returning the physical and dental examination paperwork to HQ ARPC/SGP.
2. Current RCPHA information is essential to ensure a fit force. Your safety and ability to complete your military mission are dependent in part on this screening process. Failure to comply with this annual requirement significantly impacts the safeguards intended to protect you and the Air Force mission.
3. HQ ARPC/SGP tracks this requirement, and provides information to Program Managers on the currency of their assigned IMAs. If you believe this notice is in error you are encouraged to query HQ ARPC/SGP at the address/email/phone numbers identified in your packet.
4. Failure to accomplish the required examination(s) by 1 May 03 will affect participation, result in restriction of pay and points for all training, and your ability to complete a satisfactory year. Failure to accomplish required examinations will not prevent mobilization.
5. Your prompt compliance is appreciated, as is your service to the US Air Force and your country.


K.C. McCLAIN, Colonel, USAF
Commander

- 4 Attachments:
1. HQ ARPC/SGP letter
 2. RCPHA Form
 3. SF 600 Overprint
 4. DD Fm 2813



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR RESERVE PERSONNEL CENTER

10 Jan 03

MEMORANDUM FOR All Individual Mobilization Augmentees (IMA) and Participating Individual Ready Reservists (PIRR)/Category E Reservists

FROM: HQ ARPC/SGP
6760 E Irvington Pl #7200
Denver CO 80280-7200

SUBJECT: Annual Requirement for Physical and Dental Examinations for Individual Mobilization Augmentees (IMA), Participating Individual Ready Reservists (PIRR)/Category E Reservists.

1. Effective 1 Oct 01, you are required to have an annual physical assessment and dental examination. Also known as the Reserve Component Periodic Health Assessment, the RCPHA must be completed once every year. The RCPHA consists of a Reserve Component Health Risk Assessment (RCHRA), a SF 600 overprint tailored to gender, age and flying status, a dental examination, and an immunization record review. The RCHRA and SF 600 overprint must be completed by a military provider. The dental examination can be completed by a military dentist using the SF 603A, Health Record – Dental Continuation, or a civilian dentist using DD Form 2813, Department of Defense Reserve Forces Dental Examination, respectively. You can download the forms from our web site at http://arpc.afrc.af.mil/sgp/forms_pubs.htm. This letter is your authorization to obtain the required military exam(s) at an Active Duty Air Force Medical Treatment Facility.
2. You are strongly encouraged to complete your RCPHA during your Annual Tour or Inactive Duty Training (IDT). In order to do this during your Annual Tour, you will need to contact the Medical Treatment Facility Physical Exams Section well in advance (at least 30 days prior) to schedule an appointment for a physical assessment and/or dental examination. If the MTF does not have a Physical Exams section ask to be connected with Force Health Management, the facility RCPHA Project manager, or as a last resort the facility patient advocate. If you are unable to complete these during your scheduled duty periods, an AF Form 40a, Record of Individual Inactive Duty Training, may be submitted for one non-paid point upon completion of the exam(s).
3. If you have recently completed your annual physical and dental requirements, please send HQ ARPC/SGP a copy of the documentation. An RCPHA, to include both a physical and dental exam, is only current up to one year (365 days) from the date of the older of either the physical or dental exam.
4. If you fail to complete a physical and/or dental examination, you may be placed on a “no pay-no points” status IAW AFM 36-8001 para 1.6 *Reserve Personnel Participation and Training Procedures* and AFI 48-123 *Medical Examinations and Standards*. Eligibility for pay and points may be restored upon completion and receipt of documentation by HQ ARPC/SGP of all required examinations.
5. To accomplish your required examinations and assessments:
 - a. Using local protocol, schedule your appointment(s) by contacting the Medical Treatment Facility (MTF) at your base of assignment or attachment. References for Authority to Conduct Medical Exams of IMAs are available at http://arpc.afrc.af.mil/sgp/imamed_ex.doc.
 - b. Contact your active duty supervisor regarding the date and time of your exam.

c. HQ ARPC/SGP must be notified of the appointment(s) date(s) and location. E-mail to arpc.sgpdl@arpc.denver.af.mil, or complete the form at the bottom of this letter and fax to 303-676-7589 or DSN 926-7589. If SGP is notified 10 days prior to your appointment, a copy of your last physical examination can be faxed to the MTF in advance for the provider to look at during your assessment.

d. Download blank forms at http://arpc.afrc.af.mil/sgp/forms_pubs.htm. Prior to your appointment, fill out the 4-page Reserve Component Health Risk Assessment (RCHRA). Please bring the RCHRA, the blank SF 600 and your PHS 731 (Shot Record) to your appointment. If you have any medical conditions, please bring copies of medical records or supporting documentation with you as well.

e. Upon completion of the exam(s), the forms will need to be sent to HQ ARPC/SGP. Although the MTF may do so, ultimately it is your responsibility to ensure that the original documentation is sent to and received by ARPC/SGP. You are strongly encouraged to obtain and keep a copy of all completed medical documentation.

6. For dental exams only: You may have your civilian dentist complete the DD Form 2813 Reserve Forces Dental Examination two years out of three. You must receive a dental examination at a DoD medical facility at least once every three years.

7. Helpful web sites: If you are unable to schedule your appointments at an Active Duty Air Force MTF, search www.afcrossroads.com/html/dodinstall/index.htm for the DoD facility nearest you. For additional information about Physical Standards requirements and other items of interest, our web site address is <http://arpc.afrc.af.mil/sg/index.htm>.

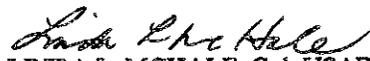
8. If you have questions about scheduling your appointments or are having difficulty completing the annual requirement, please contact your active duty supervisor, or your Base Individual Mobilization Augmentee Administrator (for a listing, visit <http://arpc.afrc.af.mil/bimaas.htm>), or your MAJCOM Program Manager (<http://arpc.afrc.af.mil/Program%20Manager%20Listings.doc> is the website).

To contact ARPC/SGP:

Our E-mail is arpc.sgpdl@arpc.denver.af.mil Our fax number is 303-676-7589 (DSN 926-7589).

Our address is: HQ ARPC/SGP, 6760 E. Irvington Place, #7200, Denver, CO 80280.

Our phone numbers are: 1-800-525-0102 x71236/71235 or DSN 926-7236/7237.


LINDA L. MCHALE, Col, USAF, NC
Director, Health Services
Individual Reserve Programs

Name and SSN _____

Location, date and time of appointment(s) _____

Type of Appointment: Physical Exam Dental Exam (circle one or both)

MTF POC and phone number _____

Fax or mail back to ARPC/SGP at the number or address listed above.

Reserve Component Health Risk Assessment (RCHRA)
(This form is subject to the privacy Act of 1974 - Use Blanket PAS - DD Form 2005)

AUTHORITY: 10 U.S.C., 8013, as implemented by Air Force Instruction 48-123.

PURPOSE: To collect personal information from military Reserve Component (RC) personnel to assess their ability to perform routine fitness testing, their individual deployment readiness, and overall RC deployment readiness.

ROUTINE USE(S): To assess the safety of your performing routine fitness testing. To screen for conditions that may interfere with your ability to deploy and meet mission requirements. To collate data on overall RC capability to deploy and meet mission requirements. In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside DoD as a routine use pursuant to 5 USC 552a(b)(3) as follows: The Department of the Air Force "Blanket Routine Uses" set forth at the beginning of the Air Force's compilation of systems of records notices apply to this system. This information will be kept in your medical record and summary results will be provided to you upon completion of the Reserve Component Periodic Health Assessment (RCPHA).

DISCLOSURE: Disclosure of this information is required by Title 10, Chapter 51, Section 1004 of the United States Code. Giving false information concerning current health status is a punishable offense and can result in administrative action. IAW AFI 48-123, paragraph 14.4.2, each member is responsible for promptly reporting a disease, injury, operative procedure or hospitalization not previously reported to his or her commander or supervisor.

Personnel Data

Name/Rank		SSN	Age	Date of Birth	Gender
Home Street Address		City	State	Zip Code	
Unit	Duty Section	Base		Duty AFSC	ASC
Primary Email Address			Home Phone	Duty Phone	

Civilian Occupation

Active (AGR) Guard/Reserve	Traditional Reservist/Guardsman	Individual (IMA) Mobilization Augmentee	Air Reserve Technician	Other Specify
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Traditional ARC: How many days have you performed military duty this year (excluding IDT)? Days

Are you a family member of an active duty military member entitled to care through military channels? Yes No

Racial Background

American Indian/Alaska Native	Asian/Oriental	Black, Hispanic
Black, Non-Hispanic	Pacific Islander	White Hispanic
White, Non-Hispanic	Other (Specify)	

Health Status Questionnaire- Instructions

Mark the appropriate response to each number question and sign the form after reading it carefully. Continue on the reverse side or attach comments or documentation if necessary. Positive responses which are not fully explained or which may effect your medical qualifications for continued military duty will require an interview and further documentation. You may also be required to provide supporting civilian medical and dental documentation for inclusion in your medical records.

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. Overall Self-Assessment of Health is Excellent Very Good Good Fair Poor

2. Are you on a renewable flying or worldwide duty waiver for any medical reason? Yes No

3. Do you have any allergies to medications, foods, or airborne substances? Yes No

List all known allergies:

4. (a) Do you regularly take any prescription medication(s)?										Yes	No		
(b) Do you regularly take any over the counter medication(s)?										Yes	No		
(c) Do you regularly take any dietary supplement(s)?										Yes	No		
Medication(s) Name and why taken													
5. During the last year have you taken medication or seen a health care provider for any of the following conditions?													
Chest pain/angina		Yes	No	Shortness of breath		Yes	No	Anxiety/depression		Yes	No		
Inflammatory bowel disease			Yes	No	Seizure Disorder			Yes	No				
If you require medications for any of the above, have the medications been listed in block # 5.										Yes	No		
Does the use of these medications control your symptoms? (If No please explain below)										N/A	Yes	No	
6. During the last year have you been told that you have high blood pressure?												Yes	No
7. Since your last AF Form 895, RCPHA, or Physical Examination have you had chest pains, pressure, or discomfort either with physical activity or when at rest?										Yes	No		
8. Have you ever had irregular heartbeats that have concerned you?										Yes	No		
9. Have you ever had a heart attack?										Yes	No		
10. Have you had a heart operation (bypass, angioplasty, etc.)?										Yes	No		
11. Is there a family history of heart attack in a parent, sibling, aunt or uncle before the age of 55?										Yes	No		
12. Have you been told you have high blood sugar or /diabetes?										Yes	No		
How is it controlled? (✓all that apply):			None of the following		Insulin		Diet/Exercise control		Oral Medication				
13. Have you been told you have problems with blood cholesterol?										Yes	No		
14. Do you use any tobacco products? If no, skip to question 15.										Yes	No		
Type- (check all that apply):		Pipe		Cigar		Smokeless		Cigarettes					
How many packs of cigarettes per day?				Less than one		One		Two		Three or more			
How many years have you been using tobacco products?				Less than one		One-Five		Six-Ten		More than Ten			

RCPHA Test Form, 20010501

Date	Name/Rank	SSN										
15. Do you ever experience shortness of breath at rest, walking or with only moderate exertion?			Yes	No								
16. Have you ever been told you have asthma, bronchospasm, or reactive airway disease?			Yes	No								
17. Do you engage in a program of regular aerobic physical fitness 20 minutes 3 times per week?			Yes	No								
<table border="1"> <tr> <td>Light Exercise</td> <td>Moderate Exercise</td> <td>Heavy Exercise</td> </tr> </table>			Light Exercise	Moderate Exercise	Heavy Exercise							
Light Exercise	Moderate Exercise	Heavy Exercise										
18. Do you have a physical condition that precludes brisk walking or running for 1 to 3 miles?			Yes	No								
19. Has your treating physician placed you on restricted activity?			Yes	No								
If yes, explain (include length of time and time of year restrictions apply if known)												
20. Do you have any orthopedic problems that prevent regular exercise or become bothersome during exercise?			Yes	No								
21. Do you consume alcoholic beverages? If no, skip to question 26			Yes	No								
22. Have you ever felt you ought to cut down on your drinking?			Yes	No								
23. Have people annoyed you by criticizing your drinking?			Yes	No								
24. Have you ever felt bad or guilty about your drinking?			Yes	No								
25. Have you ever had a drink first thing in the morning (eye opener) to steady your nerves or get rid of a hangover?			Yes	No								
26. Are you on any medications for depression, ADD/ADHD or any other psychiatric condition?			Yes	No								
27. Do you have any problems with your eyes, vision or prescription glasses (check all that apply)?			Yes	No								
<table border="1"> <tr> <td>Blurred Vision</td> <td>Double Vision</td> <td>Blind Spots</td> <td>Night Blindness</td> </tr> <tr> <td>Glare</td> <td>Glaucoma</td> <td colspan="2">Glasses more than 2 years old</td> </tr> </table>			Blurred Vision	Double Vision	Blind Spots	Night Blindness	Glare	Glaucoma	Glasses more than 2 years old			
Blurred Vision	Double Vision	Blind Spots	Night Blindness									
Glare	Glaucoma	Glasses more than 2 years old										
28. Have you had any of the following types of eye surgery (check all that apply)?			Yes	No								
<table border="1"> <tr> <td>RK</td> <td>PRK</td> <td>LASIK</td> <td>Implants</td> <td>Other Specify:</td> </tr> </table>			RK	PRK	LASIK	Implants	Other Specify:					
RK	PRK	LASIK	Implants	Other Specify:								
29. Have you gained or lost more than 15 pounds in the past year that cannot be explained by change in diet and exercise?			Yes	No								
30. Have you noticed blood in your stool or significant changes in your bowel habits?			Yes	No								
31. Have you been advised to eat a special diet?			Yes	No								
32. During the past year have you missed more than 7 days from work due to illness or injury?			Yes	No								
33. Do you have a non-military job or hobby which exposes you to loud noise?			Yes	No								
34. Do you have a non-military job or hobby which exposes you to hazardous chemicals?			Yes	No								

RCPHA Test Form, 20010501

Name and/or type of chemical(s)?					
35. Do you use hearing aid(s)?				Yes	No
36. Do you routinely forget to wear proper protective gear for sports, hobbies, or work (e.g., helmets, goggles, ear plugs, gloves, etc.)?				Yes	No
37. Do you routinely forget to fasten your seat belt?				Yes	No
38. Have you seen a health care provider during this past year?				Yes	No
If yes how many visits:		One - Two	Three - Six	Seven - Ten	More than Ten
39. Excluding pregnancy have you been a patient in the hospital overnight/or had any outpatient surgical procedure or been administered intravenous medication in the hospital during the past year?				Yes	No
40. Have you been treated for any other medical conditions since you completed your last RCPHA or AF Form 895? Please list conditions below.				Yes	No
Females Only Complete Blocks 41 - 45.					
41. Are you pregnant?				Yes	No
42. Was your last PAP Smear abnormal?				Yes	No
43. Have you ever had an abnormal breast lump or mammogram?				Yes	No
44. Do you perform self-breast examination (SBE) at least monthly?				Yes	No
45. If no longer having menstrual periods or if having had a history of a total hysterectomy, have you been advised regarding osteoporosis prevention?				Yes	No
I understand that disclosure of this information is required by Title 10, Chapter 51, Section 1004 of the United States Code. Giving false information concerning current health status is a punishable offense and can result in administrative action. IAW AFI 48-123, paragraph 14.4.2, each member is responsible for promptly reporting a disease, injury, operative procedure or hospitalization not previously reported to his or her commander or supervisor.					
Typed or Printed Name Examinee			Signature		Date
Notes:					
Typed or Printed Name Physician or Examiner			Signature		Date

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**DEPARTMENT OF DEFENSE
RESERVE FORCES DENTAL EXAMINATION**

*Form Approved
OMB No. 0720-0022
Expires Dec 31, 2002*

The public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0022), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 105-85, Sec. 765; DoD Directive 6490.2; E.O. 9397.

ROUTINE USE(S): None.

PRINCIPAL PURPOSE(S): An assessment by a dentist of the state of your dental health for the next 12 months is needed to determine your fitness for prolonged duty without ready access to dental care.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service.

1. SERVICE MEMBER'S NAME (Last, First, Middle Initial)

2. SOCIAL SECURITY NUMBER

3. BRANCH OF SERVICE

4. UNIT OF ASSIGNMENT

5. UNIT ADDRESS

6. EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is a Guard/Reserve member of the United States Armed Forces. This member needs your assessment of his/her dental health for worldwide duty. Please mark (X) the block that best describes the condition of the member, using as a suggested minimum a clinical examination with mirror and probe, and bite wing radiographs. This form is meant to determine fitness for prolonged duty without ready access to dental care and is not intended to address the member's comprehensive dental needs.

(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.

(2) Patient has some oral conditions, but you do not expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).

(3) Patient has oral conditions that you do expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: (X the applicable block or specify in the space provided)

(a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.

(b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.

(c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.

(d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.

(e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.

(f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

(4) If you selected Block (3) above, please circle the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below:

(5) Were X-rays consulted?

YES

NO

IF YES, DATE X-RAY WAS TAKEN (YYYYMMDD)

7. DENTIST'S NAME (Last, First, Middle Initial)

8. DENTIST'S ADDRESS (Include ZIP Code)

9. DENTIST'S TELEPHONE NUMBER (Include Area Code)

10. DENTIST'S SIGNATURE

11. DATE OF EXAMINATION (YYYYMMDD)

FLYER CLINICAL TESTING REQUIREMENTS

TESTING REQUIREMENT	AGE																						
	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
AF form 895/RC/HRA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Near and Distant Visual Acuity	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Distant Stereopsis ¹	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Electrocardiogram																							
Cholesterol and HDL ²		X			X			X			X			X			X			X			X
Dental ³	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Audiogram	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Amsler Grid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Glaucoma									X					X						X			X
Skin Exam for Cancer/Surgical Scars									X					X			X			X			X
Breast Exam ⁴		X			X			X			X			X			X			X			X
PAP ⁵		X			X			X			X			X			X			X			X
Mammogram ⁶								X			X			X			X			X			X
HIV		X			X			X			X			X			X			X			X
Gas Mask Inserts ⁷	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PHAM Visit ⁷	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

FLYER CLINICAL TESTING REQUIREMENTS

TESTING REQUIREMENT	AGE																								
	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
AF form 895/RC/HRA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Near and Distant Visual Acuity	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Distant Stereopsis ¹	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Electrocardiogram			X			X			X			X			X			X			X			X	
Cholesterol and HDL ²			X			X			X			X			X			X			X			X	
Dental ³	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Audiogram	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Amsler Grid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Glaucoma	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Skin Exam for Cancer/Surgical Scars			X			X			X			X			X			X			X			X	
Breast Exam ⁴			X			X			X			X			X			X			X			X	
PAP ⁵			X			X			X			X			X			X			X			X	
Mammogram ⁶			X			X			X			X			X			X			X			X	
HIV			X			X			X			X			X			X			X			X	
Fecal Occult Blood ⁷											X				X			X			X			X	
Gas Mask Inserts ⁷	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PHAM Visit ⁷	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

1. For rated aircrew, boom operators, and rotary wing enlisted aircrew only.
2. Test includes total serum cholesterol and HDL cholesterol. Those who have a total cholesterol >200 and a HDL <35 should be referred to their private physician for follow-up.
3. Dental exams will be done per applicable RC Headquarters guidance.
4. Females considered at high risk should be referred to their personal medical provider for guidance on more frequent PAP, Mammogram or breast examinations (See Clinician's Handbook of Preventive Services, 2nd Ed.).
5. Individuals that have had a sigmoidoscopy or a rectal exam as part of another examination may submit the report instead of having an occult blood screen.
6. Gas Mask Inserts may be ordered at any time when there is a change in prescription, as documented by the RC MDS or individual's private vision care provider.
7. PHAM visit must be a flight surgeon.

NON-FLYER CLINICAL TESTING REQUIREMENTS

TESTING REQUIREMENT	AGE																						
	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
AF form 895/RCHRA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure		X			X			X			X			X			X			X			X
Height and Weight		X			X			X			X			X			X			X			X
Cholesterol and HDL																							
Dental	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Glaucoma															X							X	
Skin Exam for Cancer/Surgical Scars									X														X
Breast Exam			X		X			X			X			X			X			X			X
PAP		X			X			X			X			X			X			X			X
Mammogram																						X	X
HIV		X			X			X			X			X			X			X			X
Gas Mask Inserts		X			X			X			X			X			X			X			X
PHAM Visit		X			X			X			X			X			X			X			X

Attachment

NON-FLYER CLINICAL TESTING REQUIREMENTS

TESTING REQUIREMENT	AGE																								
	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
AF form 895/RCHRA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure			X			X			X			X			X			X			X			X	
Height and Weight			X			X			X			X			X			X			X			X	
Cholesterol and HDL			X			X			X			X			X			X			X			X	
Dental	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Glaucoma						X			X			X			X			X			X			X	
Skin Exam for Cancer/Surgical Scars			X			X			X			X			X			X			X			X	
Breast Exam			X			X			X			X			X			X			X			X	
PAP			X			X			X			X			X			X			X			X	
Mammogram			X			X			X			X			X			X			X			X	
HIV			X			X			X			X			X			X			X			X	
Fecal Occult Blood												X			X			X			X			X	
Gas Mask Inserts			X			X			X			X			X			X			X			X	
PHAM Visit			X			X			X			X			X			X			X			X	

- BP testing may be done during the member's periodic dental examinations. Personnel on medication for hypertension must have annual BP check or submit documentation that BP is adequately controlled.
- Test includes total serum cholesterol and HDL cholesterol. Individuals who have a total cholesterol >200 or a HDL <15 should be referred to their private physician for follow-up.
- Dental exams will be done per applicable RC Headquarters guidance.
- Consider referring African Americans or those with a family history of glaucoma to their personal vision care provider for advice on more frequent screening.
- Females considered at high risk should be referred to their personal medical provider for guidance on more frequent PAP, Mammogram, or breast examinations (See Clinician's Handbook of Preventive Services, 2nd Ed.).
- Individuals that have had a sigmoidoscopy or a rectal exam as part of another examination may submit the report instead of having an occult blood screen.
- Gas Mask Inserts may be ordered at any time when there is a change in prescription, as documented by the RC MDS or individual's private vision care provider.