USCG Aeromedical Technical Bulletins June 2010

References

(a) Coast Guard Aviation Medicine Manual, COMDTINST M6410.3 (series)

(b) Coast Guard Medical Manual, COMDTINST M6000.1 (series)

(c) Personnel Manual, COMDTINST M1000.6 (series)

(d) U. S. Coast Guard Addendum to the United States National Search and Rescue Supplement (NSS) to the International Aeronautical and Maritime Search and Rescue Manual (IAMSAR), COMDTINST M16130.2 (series)

(e) Coast Guard Air Operations Manual, COMDTINST M3710.1 (series)

(f) Quality Improvement and Implementation Guide 8

1. PURPOSE. Aeromedical Technical Bulletins (ATBs) are intended to provide specific guidance on issues related to the clinical and administrative care of Coast Guard (CG) aviators and in support of CG aviation safety medical support. ATBs provide information on some of techniques and procedures necessary to comply with policies set forth in the references sited above, particularly reference (a). ATBs should be considered as extensions of the policies set forth in the sited references and as such carry the same authority. These ATBs are purposefully formatted as web-based documents to enable timely and regular revision. Initiative for change is welcome and encouraged from the field.

2. ACTION. CG Flight Surgeons (FS), Flight Surgeon Trainees (FST), Aviation Medical Officers (AMO), Aeromedical Physician Assistants (APA), other CG health care professionals and Health Services Technicians (HS) are encouraged to use this information whenever providing care to CG aviation personnel, participating in aviation safety programs or in direct support of CG missions.

3. DIRECTIVES AFFECTED. Should the information provided in these ATBs conflict with references (a), (b) and (c), (or other CG Policy), existing policy takes precedence. When conflict is suspected, address comments to: Commandant (CG-11), US Coast Guard, 2100 Second St., SW, Washington, DC 20593.

4. DISCUSSION. ATBs provide guidance for health care professionals who directly support CG operations and provide medical care to CG and other military aviation personnel. Procedures on various medical and operational situations that apply to the aviation community are discussed.

5. RESPONSIBILITIES. In order to standardize procedures, CG Flight Surgeons (FS), Flight

Surgeon Trainees (FST), Aviation Medical Officers (AMO), Aeromedical Physician Assistants (APA), other CG health care professionals and Health Services Technicians (HS) should utilize ATBs whenever providing care to CG aviation personnel or in support of aviation safety activities. Commanders of CG Air Stations and other commanding officers overseeing CG aviation personnel should anticipate that the techniques and procedures outlined in these ATBs will be applied consistently.

6. INPUT. Comments and suggestions from the field are welcome. Address comments to: Commandant (CG-11), US Coast Guard, 2100 Second St., SW, Washington, DC 20593.

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Chapter 1. AVIATION CAREER INCENTIVE PAY (ACIP).

Section A – ACIP General Instructions and Guidelines.

1. ACIP is authorized for designated FS/FSTs contingent on the frequent and regular performance of operational flying duty within a specified billet (DIFOPS), in accordance with Public Health Service Commissioned Corps Personnel Manual CC22.3, Instruction 3. The steps to follow are summarized below:

    a. CG designation letter as a FS or FST is forwarded to Division of Commissioned Personnel (DCP) Compensation Branch (CB) by PHS Liaison (note: member should ensure that PHS Liaison has designation letter and forwards this to PHS). Also a billet description showing DIFOPS status must be furnished to DCP/CB if billet was not previously a DIFOPS billet.

    b. CB will review designation and billet and issue orders designating officer as an FS or FST and establishing the Aviation Service Date (ASD). (Note: Until PHS has processed these orders, the member is not entitled to ACIP. The member should ensure that this paperwork is properly filed or entitlement to ACIP will be delayed.)

    c. CB will process an order to authorize payment of ACIP effective as of the date of designation on PHS orders.

Section B – Requirements for receipt of ACIP.

2. ACIP is not continuous or automatic.

    a. During mission planning, the FS/FST should request that they be entered into ALMIS (see ALMIS Access ATB) as the aircrew Flight Surgeon, not as a passenger (PAX).

    b. Flight hour reports may be generated from ALMIS and must be submitted monthly to the Public Health Service (DCP/CB) even if no hours are flown.

    c. The Public Health Service Commissioned Corps Flight Certificate, PHS-2814 is the form for submitting flight hours to DCP/CB.

    d. The hours must be certified by the command on the (PHS-2814).

    e. All correspondence to DCP/CB should go to the address shown on the (PHS-2814).

CHAPTER 2. AVIATION LOGISTICS MANAGEMENT INFORMATION SYSTEM (ALMIS).

Section A – Definition of ALMIS.

1. The Aviation Logistics Management Information System (ALMIS) enables efficient, flexible, and cost-effective aircraft operations, logistics, and maintenance support.

2. ALMIS supports data entry from the start of a flight operation, recording the flight execution, tracking aircrew events, aircraft aging, aircraft configuration, aircraft maintenance requirements, aircraft part replacements, warehouse activities, procurement actions, financial payments, and reconciliation.

3. A suite of government developed reports and commercial off the shelf business intelligence reporting tools are used to provide information to business managers throughout these related processes for optimal mission performance.

4. ALMIS is a steady-state system, and provides logistical support of 200 CG aircraft at 28 CG Air Stations and at the Aircraft Repair and Supply Center in Elizabeth City, NC.

5. ALMIS has 5000 registered users that include pilots, maintainers, contractors, and senior decision makers at CG Headquarters.

Section B - ALMIS Access and Use.

1. Unit flight surgeons need read access to ALMIS to recover information regarding flight time for themselves and to review flight activities of flight surgeon trainees they may be supervising.

2. The ALMIS website address is: http://cgweb.almis.uscg.mil

3. If you don't have an account, follow the on screen instructions.

4. CG Flight Surgeons should request 'Read Only' access to ALMIS.

Section C – How to Obtain a Flight Record from ALMIS.

1. From the main screen, select Electronic Asset Logbook from the index menu on the left hand side of the screen and then select Mission Records.

2. In the top left hand corner of the screen, enter the date of the flight in the box labeled 'Zulu date' and left mouse click on the adjacent 'Go' button.

3. Select the desired flight record (usually easiest to find by noting the pilot in command).

4. Scroll to the desired flight and left mouse click on the 'View Flight Record' icon in the Type/Model column (the 4th column).

5. You can print the flight record or save a copy.

6. To save a copy, left click on the 'page' icon at the top right corner of the screen and select 'save as'.

Section D – How to Obtain a Cumulative Report of Flight Hours from ALMIS.

1. From the main screen, select Decision Support System from the index menu on the left hand side of the screen and then select the following:

    a. Web Reports

    b. Operations Reports

    c. Crew Reports

    d. Full Crew Logbook

2. On the Full Crew Logbook screen:

    a. Select your unit from the drop down menu

    b. Enter you full SSN

    c. Enter beginning and ending dates for the report period you want

    d. Left mouse click on the 'next' button

3. On the 'Save As' screen:

    a. You may choose to leave the document title as the default or change it

    b. Left mouse click on the 'Finish' button

4. You are now back at the Crew Reports screen.

5. To view your report:

    a. Left mouse click on your ‘news box’ at the top of the index menu on the left hand side of the screen.

    b. Left click to open your document.

    c. You can print and or save the document.

CHAPTER 3. MEDICAL EVACUATION (MEDEVAC) MISSION SUPPORT.

Section A – General Guidelines and Background.

1. Background: As outlined in the Abstract of Operations Reports, COMDTINST 3123.7 (series), Search and Rescue (SAR) is one of the eleven statutorily mandated missions of the CG.

    a. Direction to carry out SAR is found in reference (d). Traditionally, medical evacuation (MEDEVAC) and inter-health care facility transfer (IFT) have been 'lumped' with SAR and approached in a standard fashion.

        (1) Data collected on MEDEVAC and IFT is found in the SAR folder in the Marine Information for Safety and Law Enforcement **(**MISLE**)** system which is used to track all CG missions.

        (2) SAR planners training at the TRACEN Yorktown SAR School are taught to manage MEDEVAC and HHT in the same fashion as SAR.

    b. MEDEVAC and IFT missions are common operations for the CG. Since data has been collected, the number of MEDEVAC and IFT missions that the CG performs annually has been steady at about 1,200.

    c. The CG is authorized by law to assist with SAR, MEDEVAC and IFT, but it is not required to respond (reference (d)). The CG retains discretionary authority and may choose not to respond if there are mitigating circumstances or if the risk exceeds the anticipated gain.

    d. Organizationally, SAR, MEDEVAC and IFT are managed in a similar fashion but from an aeromedical perspective there are important differences.

        (1) **SAR:** These missions typically involve time critical events such as a person in the water (PIW), a sinking vessel or a catastrophic on board event such as a fire. Response time is critical and every effort is made to reach the area as soon as possible. It is unusual for a flight surgeon to be consulted or to participate in SAR missions. The emergent nature of the case does not allow for adequate time to consult and the primary concern is not injuries or illness but otherwise healthy persons in imminent danger. During a SAR mission, injured victims may be recovered. At that moment, the mission may change from SAR to MEDEVAC. The flight surgeon may be consulted to make a recommendation on how soon the victim needs medical care and where they should be taken.

        (2) **MEDEVAC:** These missions entail responding to a request for transport of an injured or ill person in the maritime environment. Typically this is a crewmember or a passenger on a vessel afloat but it can also be a person on an island or in a remote and inaccessible area (deserted beach, cliff face, etc.). Reference (e) authorizes transport

of patients and attendants on an approved medical evacuation (MEDEVAC) flight when the patient's condition has been validated by a CG Flight Surgeon or competent medical authority if a CG Flight Surgeon is not readily available. These individuals may not be transported if either adequate care or a commercial transport service such as an air ambulance is locally available. Sorting out the nature of the problem and deciding whether or not assistance is needed takes time. If a launch recommendation is made, determining what platform to use, the personnel to take and what equipment may be needed understandably delays launch.

(3) **IFT** missions involve moving a patient from one health care facility to another and are guided by the same instructions in reference (e), Ch 5.C.2 that refer to MEDEVAC. Additional clarification and authorization can be found in a Memorandum from CG-094 dated 10NOV2010, 'Legal Authority to Conduct Emergency and Non-Emergency Air Medical Transports Between Facilities'. The unique aspect of HHT is that the person is already receiving some level of care which will almost certainly be lowered during transport. Again, taking the time to carefully examine alternatives and assuring that appropriate personnel and equipment accompany the patient make rapid launch for IFT missions unrealistic.

2. Command and Control: Each of the nine CG districts has mission planners at the district and sector level.

   a. These command centers are staffed at all times with trained Operations Unit Controllers (OUC's), formerly known as SAR Mission Controllers (SMC's) who:

      (1) Receive requests for CG assistance from within their respective geographic area of responsibility (AOR).

      (2) Oversee the process of CG response:

         a. Validate the mission.

         b. Determine best method(s) for assistance and task appropriate operational units.

         c. SAR planners depend on guidance from the regional on call duty flight surgeon During MEDEVAC and IFT mission validation (see Section B below).

   b. Final decision to launch on a mission is at the discretion of the tasked unit's commanding officer and ultimately the platform commander.

Section B – Flight Surgeon Responsibilities in Support of MEDEVAC and IFT missions.

1. Purpose**:** This section describes the primary duties and responsibilities that Flight Surgeons (FS's) and Flight Surgeons in Training (FST's) have regarding support for MEDEVAC missions. In this section, the term FS will be used to include FST's. For more information regarding these designations see Chapter 5 of reference (a).

2. Authorization and Designation: Chapter 5.D.2.d of reference (a) outlines the assignment process for FSs to stand duty as the regional on-call flight surgeon.

3. Logistics: The regional duty FS is contacted when requests come to area District or Sector Command Centers for MEDEVAC or IFT assistance.

    a. The FS is expected to render an opinion on the medical gain (if any) that may result from recovery and transport of an ill or injured person and to make a recommendation for or against mission prosecution.

    b. The FS only makes a recommendation and has no authority for directing action.

    c. For both MEDEVAC and IFT missions, transport should be for emergencies only and the CG shall be the carrier of last resort. Federal regulations prohibit the CG from competing with civilian companies which provide transport services (Chapter 5.C.2.a of reference (e)).

    d. During the initial mission evaluation phase, mission planners should attempt to establish a three way call between the Command Center, the FS and the person requesting assistance. This may be anyone from the medically untrained friend of a victim on a small private vessel to a physician in a remote community hospital.

    e. During these conversations, the FS should refrain from any statements regarding whether or not the CG will attempt to transport.

    f. After collecting as much information as needed, the FS should make sure that person requesting assistance is offline before discussing the case. At this point, the FS should take some time to consult with references or regional specialists if necessary.

Section C – MEDEVAC and IFT Requests.

1. Nature of the caller. The duty FS should never assume that the person requesting assistance will be competent to determine whether or not the CG should transport an ill or injured person.

    a. Most of the time, the person making the request has no medical training or experience. In these cases, it should be anticipated that the information available to the FS will be incomplete, inaccurate or both.

    b. Even when persons on scene have medical training such as the sick bay on a Cruise Ship, they will have very limited understanding of CG capabilities and the inherit risks associated with transport. They may also have a subjective investment in getting the patient transferred and therefore lose some of their objectivity in the decision making process.

c. For HHT requests, the fact that a request for transport is coming from a health care professional should not reduce the FS's diligence and objectivity in evaluating the case and should never be construed as a guarantee for a launch recommendation. The FS should not expect that a health care provider will have collected all the information needed to make a transport recommendation. They may have no training in medical evacuation and are unaware of the hazards of transport, particularly on CG platforms. As stated in Chapter 4.8.3 of reference (d), the referring hospital must be willing to provide appropriately trained medical personnel and CG approved equipment during the transport. All FSs should familiarize themselves with this document.

2. MEDEVAC or IFT request evaluation. A decision to prosecute a MEDEVAC or IFT mission may involve significant risk for the victim, the aircrew and the aircraft. This mandates that the flight surgeon:

   a. Carry out their responsibilities with the utmost diligence.

   b. Make every effort to formulate a cogent and concise recommendation.

   c. NOT modify their recommendation based on real or potential risks that may be involved with the mission.

      (1) In the operational risk management (ORM) process, FSs provide the gain side in the risk versus gain analysis.

      (2) FSs do not normally possess the knowledge, skills and experience needed to evaluate mission risk. NOTE: It is appropriate for the FS to ask questions concerning the environment or method of recovery when it may have medical consequences (e.g. sea swell might make transfer of a heavy litter patient to a small boat ill-advised). When the FS asks questions that might seem mission risk related, they should articulate their medical concerns to the operations personnel.

3. The Five Questions. The best way to assess the gain from a MEDEVAC or IFT mission is by systematically seeking the answers to five important questions:

   1. What does the victim have?

   2. What does the victim need?

   3. Where can they get the needed service?

   4. How soon do they need the service?

   5. Can the time window of opportunity be met?

   1) What does the victim have? Having very few of the tools a physician normally relies upon to make a medical diagnosis can severely compromise this process. However,

since everything that follows depends on the diagnosis, the FS must be conscientious and creative in collecting as much information as possible.

a. For MEDEVAC missions, helpful actions include:

(1) Requesting to speak directly with the victim (when possible). This avoids the natural 'subjective slide' of important information as it is passed from one person to the next.

(2) Talking with several different crewmembers may also help.

(3) Have a crewmember take a digital photograph and send it via email.

b. For IFT missions:

(1) Never hesitate to ask for additional information or consultations.

(2) Make sure that the referring physician has identified an accepting regional hospital and physician.

(3) Consider contacting the accepting physician to discuss treatment options and time constraints.

(4) Make sure that the requesting health care professional understands that you do not have launch authority and for both MEDEVAC and IFT missions never state that the CG will transport the patient.

(5) Operations personnel may decide that conditions dictate that the patient be transported to a different regional facility. The FS may be asked to communicate with the accepting facility to assure that appropriate care can be provided. If a decision to divert is made before the patient is on the CG platform, the referring hospital should also be notified.

2) <u>What does the victim need</u>? MEDEVAC and IFT transports should only be recommended when there is specific and meaningful treatment available that can be reasonably expected to favorably affect outcome. For example:

a. A crewmember with an open fracture needs treatment within 6 hours to reduce the risk for infection, while an uncomplicated closed fracture can wait up to 7 days for treatment.

b. A stroke patient with symptoms greater than 3 hours duration does not require urgent transport from a health care facility (or cruise ship sickbay) since supportive care is the only option.

c. It is not uncommon for isolated community hospitals and cruise ship medical officers to request CG assistance in moving patients because they have limited staff or other agenda. Common examples of this are congestive heart failure and overdose which typically only require supportive care. In these situations, the gain in transport is minimal (or zero) for the victim and does not favor a recommendation for medical evacuation. When in doubt, it can be very helpful to contact the accepting hospital physician to discuss issues of what treatment(s) are needed and how soon. If doubt remains after these discussions, it is recommended that a FS consult with other area specialists before making a launch recommendation.

3) Where can they get the needed service? It is paramount that an accepting facility be identified and queried about their capabilities before recommending a launch. This is normally done by the Command Center personnel, but the FS should be clear in specifically describing what care is needed so that mission planners can contact regional facilities and confirm that the care is available. There have been cases in which great effort and significant risk have transpired in getting a victim to a facility that does not have the ability to provide a time critical treatment.

4) How Soon Do They Need It? For the person requesting MEDEVAC or IFT, there is normally a sense of urgency. However, there may be no value in moving a victim if the care needed cannot be delivered in time. For example:

a. Cardiac ischemia needs thrombolytic therapy within 4 hours of symptom onset. A patient in a hospital on a remote island (or Cruise Ship sickbay) with symptoms greater than 4 hours would likely receive very little benefit from transport.

b. CPR in progress. Unless CG assets are on scene with appropriate equipment (AED, etc.), responding to this situation has no probability of changing a fatal outcome.

(1) Under these circumstances, the FS should provide calm and consistent communication that there is no reason for emergent response. This is the most valuable and important support that the FS can provide because a false sense of extreme urgency generated from a 'CPR in progress' report may result in operational personnel compromising safety procedures.

(2) When there is every indication that a victim is dead (ongoing CPR without pulse), the FS needs to relay to operational personnel that the mission is a request for corpse recovery. There may be humanitarian, legal or political reasons for transport but there is no medical gain for the victim and platform commanders must be prepared and comfortable with a decision to decline the mission.

(3) More specific guidance regarding CPR in progress can be found in the U. S. Coast Guard Addendum to the United States National Search and Rescue

Supplement (NSS) to the International Aeronautical and Maritime Search and Rescue Manual (IAMSAR), COMDTINST M16130.2 (series) Chapter 4.7.8.

5) Can We Meet the Time Window of Opportunity? In determining if time sensitive care can be obtained, it is important to consider mission time constraints. Cardiac symptoms may be less than 2 hours in duration, but getting a CG platform to the scene and transporting to a facility that can provide thrombolytic therapy within the 4 hour window may be impossible. Similarly, amputated digits or limbs need reattachment surgery within 6 hours but the amputated portion must be appropriately preserved or the time window is much shorter.

4. The Medical Recommendation**:** Mission Planners, Operations Officers and Commanders of CG platforms need a concise, logical and specific recommendation from the flight surgeon regarding medical evacuation. They expect the following information:

   a. Will CG assisted medical evacuation result in a life saved, a limb saved or a reduction in human suffering?

   b. How soon does the evacuation need to occur (give as precise an estimate as possible, in hours)?

   c. Does the patient's condition or body habitus require the use of a specific platform?

   d. Is there specific treatment needed during transport that requires special equipment or personnel?

   e. Are there altitude or other restrictions if an aviation platform is to be used (e.g. is the victim ambulatory and can they be safely hoisted in a basket or must they remain in a litter)?

   f. Figure (1) below is a job aid that can assist a duty flight surgeon in making a concise recommendation. Consistent use of this aid will help to standardize what information duty flight surgeons communicate to mission planners and operations personnel and how they say it.

5. MEDEVAC and IFT Mission Execution. FS's should not consider their tasking done after they make a recommendation to the OUC for CG involvement in a MEDEVAC or IFT mission. Once a decision to launch a mission has been made, it is recommended that:

   a. The FS request a conference call between the FS, the OUC and the commander of the platform that will be used. This may be an aircraft commander, the officer in charge of a small boat or the captain of a Coast Guard Cutter. Details about the mission should be discussed and the FS should make every effort to be involved in the ORM process.

   b. These kinds of conversations are greatly facilitated when the FS has a good working knowledge of the platforms and mission operations under consideration. Previous knowledge from visits to small boat stations and experience with hoist operations and

flights in CG aircraft greatly enhance the contribution a flight surgeon can make during mission planning.

c. Having a familiarization with the geography and an understanding of weather dynamics is also beneficial.

d. Depending on the victim's condition and the duration of the transport, the FS should be prepared to go on the mission.

Section D – Flight Surgeon MEDEVAC/IFT Recommendation Job Aid.

1. The following job aid is intended to provide general guidance for the Flight Surgeon when they are processing a request for MEDEVAC/IFT medical recommendation.

2. Use of the job aid is encouraged but not required and it is recognized that the aid does for encompass all aspects of the decision making process.

3. Where possible, Flight Surgeons are encouraged to use the format supplied in the job aid for making a recommendation. By doing so, a 'standard' response format is delivered to the mission planners in a consistent and logical manner.

Flight Surgeon Job Aid MEDEVAC / Communicating with the Operations Unit Controller (OUC)	
Step	**Action**
1	• **Receive call from district/sector command center OUC** • **Obtain basic case information** • **Request conference call with on scene personnel (if needed and available)** • **Request delay in decision recommendation to review references and/or discuss with specialist (if needed)**
2	**Decide:** • **What does the victim have (diagnosis)?** • **What does the victim need (specific medical or surgical intervention)?** • **How soon does the victim need it (be specific in hours, ASAP not acceptable)?** • **Where can they get the required care?** • **What care can be rendered immediately (prior to recovery) and during transit?**
3	**Answer the following questions:** • **Is the victim obviously dead?** ☐ **Yes – No gain go to step 6** ☐ **No - go to Step 4** • **Is it safe for the victim to remain on board?** ☐ **Yes – No gain go to step 6** ☐ **No - go to Step 4** • **Would the process of MEDEVAC gravely worsen or aggravate the condition?** ☐ **Yes – No gain go to step 6** ☐ **No - go to Step 4**
4	• **Is there a time sensitive treatment that has a reasonable probability for improving the victim's outcome (save life, limb, eyesight or reduce suffering)?** ☐ **True – Go to step 5** ☐ **False - go to Step 6**
5	**Say to the district/sector command center OUC:** **"Based on the information I have, I believe that the victim has __(insert diagnosis)___. The victim needs (___type of care ____) in (_ number of hours). If the window of opportunity can be met, then I am recommending MEDEVAC. If a unit will be tasked with this mission, I need to speak with the platform commander prior to launch or as soon as possible thereafter. "** **Go to step 7**
6	**Say to the district/sector command center OUC:** **"Based on the information I have, I believe that the victim has __(insert diagnosis)___. No urgent or emergent treatment will improve the victim's outcome and therefore I am not recommending MEDEVAC. This is a medical recommendation only. There may be legal, political or humanitarian reasons for mission tasking but there is no medical gain. If a unit will be tasked with this mission, I need to speak with the platform commander prior to launch or as soon as possible thereafter."** **Go to step 7**
7	**If the mission is validated and tasked, decide:** • **Are there issues related to victim recovery?** ○ **Basket vs Litter Hoist** ○ **Backboard and/or cervical collar** ○ **Oxygen augmentation** ○ **Altitude restrictions** ○ **Other special considerations** • **Are there operational issues that would make recovery ill advised?** ○ **Prolonged delay in transport (missed window of opportunity)** ○ **Recovery necessitates exposure of victim to adverse conditions** ○ **Other special considerations (transport personnel, hospital, etc.)**
8	**Communicate with the district/sector command center OUC and the platform commander any concerns regarding operational plans.**

Figure (1)

CHAPTER 4. USE OF MEDICAL RECOMMENDATION FOR FLYING DUTY, CG-6020.

Section A – General instructions and guidance.

1. Each item of the Medical Recommendation for Flying Duty, CG-6020 will be completed as directed in Section B below. Three copies of the Medical Recommendation for Flying Duty, CG-6020 will be completed. Copy 1 is placed in the outpatient medical record in chronological order above the physical exams. Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (note: copy 2 applies only to personnel currently on flight status). Copy 3 is given to the examinee.

2. If the examinee is found qualified for flying duty by the local FS/AMO/APA issuance of the Medical Recommendation for Flying Duty, CG-6020 will constitute an aeromedical clearance for flying duty pending final review of the flight physical by the reviewing authority Commander (PSC-PSD-med). The aeromedical clearance will expire when the current flight physical is no longer valid.

3. If a disqualifying medical condition (DQ) is found, a waiver must be granted by the appropriate authority before further flying duties are performed. For minor defects that will not preclude safe and efficient performance of flying duties and will not be aggravated by aviation duty or military mission, the local commander may permit an individual to continue performance of aviation duties pending completion of the formal waiver process and upon favorable recommendation for temporary FFD by the local FS/AMO (note: recommendation for clearance for temporary FFD pending receipt of a waiver may only be made by a CG FS).

4. When used to recommend temporary flying duties, the Remarks section of Medical Recommendation for Flying Duty, CG-6020 will be completed to reflect a limited length of time for which the clearance is issued; example "Temporary FFD, 90 days, pending receipt of waiver." This is the procedure even if the waiver is being requested at the time of the flight physical. If and when the waiver is granted, a Medical Recommendation for Flying Duty, CG-6020 is then annotated for both "flight physical" and "issue of waiver for DQ" and the valid date is the appropriate date per Chapter 2 for an aviation physical exam.

5. The FS/AMO/APA will consult the flight surgeon in Commander (PSC-PSD-med) before issuance of an "FFD" Medical Recommendation for Flying Duty, CG-6020 for cases which do not clearly meet the standards and/or waiver specifications outlined in the USCG Aeromedical Policy Letters (reference (f)).

6. Medical Recommendation for Flying Duty, CG-6020 may be used to extend the validity period of the current flight physical for a period not to exceed 30 days. After expiration of this extension, aviation personnel must complete the flight physical and be medically qualified or be:

    a. Administratively restricted from flying duties if no medical DQ exists and be considered for a nonmedical (administrative) DQ and Flight Examining Board (FEB).

b. Medically restricted from flying duties if an aeromedical DQ exists. In some cases temporary flying duties may be recommended on Medical Recommendation for Flying Duty, CG-6020.

7. Personnel authorized to sign the Medical Recommendation for Flying Duty, CG-6020 are as follows:

   a. Any physician or health care provider may sign Medical Recommendation for Flying Duty, CG-6020 for the purpose of restricting aviation personnel from aviation duties when an aeromedical DQ exists.

   b. Only an FS, AMO or APA may sign the Medical Recommendation for Flying Duty, CG-6020 to return aviation personnel to FFD. Recommended restrictions, if any, will be annotated in the Remarks block of Medical Recommendation for Flying Duty, CG-6020.

   c. A non-FS/AMO physician, an APA or Health Service Technician (HS) under the supervision of an FS may sign the Medical Recommendation for Flying Duty, CG-6020 to recommend returning aviation personnel to FFD when an FS/AMO is not locally available by either:

      (1) Obtaining case-by-case telephonic guidance from an FS/AMO. The name of the consulted FS/AMO will be annotated on Medical Recommendation for Flying Duty, CG-6020, and on a Chronological Record of Medical Care, SF-600 in the patient health record.

      (2) Alternatively, an APA may grant an upchit without the telephonic guidance of an FS provided that an FS reviews the medical record of the encounter and co-signs the Medical Recommendation for Flying Duty, CG-6020 within 72 hours (may occur using fax copies).

8. Forms similar to Medical Recommendation for Flying Duty, CG-6020 of the other branches of the U.S. Armed Services and Host Allied Nations will be accepted by the CG when aeromedical support is provided by those services/nations and Medical Recommendation for Flying Duty, CG-6020 is not available.

Section B - Filling out Medical Recommendation for Flying Duty, CG-6020.

1. Preparing the Medical Recommendation for Flying Duty, CG-6020: The Medical Recommendation for Flying Duty, CG-6020 (located at: http://www.uscg.mil/hq/cg1/cg112/cg1121/aviation_med.asp) is prepared in three copies and distributed as in paragraph 4-A-6 above. The top portion of the form contains a "TO" and "FROM" block. These blocks contain the address/unit designator of the individual's commander that the Medical Recommendation for Flying Duty, CG-6020 is being sent to, and the address/unit designator of the FS/AMO/APA the Medical Recommendation for Flying Duty, CG-6020 is from.

a. Blocks 1-4: The next line contains blocks one through four that contain identifying data about the examinee. Enter the examinee's name in the format: last name, first name and middle initial in Block 1. Enter the examinee's social security number in Block 2, the examinee's grade or rank in Block 3, and the examinee's date of birth in Block 4.

b. Blocks 5-6: Enter the examinee's unit in Block 5. Enter the type of flying duty performed in Block 6. For example: Aviator, flight surgeon, APA, flight mechanic, rescue swimmer.

c. Block 7-10: (Section A- Qualifying Action Recommendation By Medical Authority): Is completed by the FS/AMO/APA. If the examinee is qualified to perform flying duties in accordance with this Bulletin and references (a) and (b). Enter the reason(s) for the medical clearance recommendations in Blocks 7a through 7h (more than one may be checked).

(1) Check 7a. (Termination of Temporary Medical Suspension): if clearance is for return to duty after a temporary disqualifying condition. The "Date Clearance Expires" Block 10 will generally be the expiration date that existed prior to the temporary grounding (usually the date the current flight physical expires).

(2) Check 7b. (Medical Examination): if the reason is for completion of a flight physical. The expiration date generally will be determined as outlined in Chapter 2 of this Manual.

(3) Check 7c. (Reporting to New Duty Station): if the reason for the upchit is reporting to a new duty station. The "Date Clearance Expires" Block 10 will generally be the expiration date that existed at the previous duty station (usually the date the current flight physical expires).

(4) Check 7d. (After Aircraft Mishap): if the member has been in an aviation mishap and is now cleared to resume aviation duties. The "Date Clearance Expires" Block 10 will generally be the expiration date that existed prior to the temporary grounding (usually the date the current flight physical expires).

(5) Check 7e. (Termination of Medical Disqualification): has had a medical disqualification that has now resolved. The "Date Clearance Expires" will generally be the expiration date that existed prior to the temporary grounding (usually the date the current flight physical expires).

(6) Check 7f. (Pending Issue of Waiver for Medical Disqualification): if the member has been noted to have a medical disqualification but is determined to be safe to continue/resume flight duties while awaiting waiver determination from Commander (PSC). Generally the expiration date will be short term (1-3 months), giving a reasonable amount of time for waiver issuance from Commander (PSC).

a) Note that this category is only used when it is reasonably certain (may require consultation with Commander (PSC)) that a waiver will be granted.

b) If the medical disqualification is noted during the flight physical, 7b. may also be checked, but a more restrictive expiration is given as outlined above.

(7) Check 7g. (Issue of Waiver for Medical Disqualification): when Commander (PSC) has issued a waiver for a medical disqualification. The expiration date reverts to expiration of the most recent flight physical unless otherwise determined by the waiver criteria. (E.g. if the waiver requires blood pressure checks every 6-month, then the expiration should be in 6 months). If the waiver request was generated at the time of a flight physical, then the expiration date is determined per Chapter 2 of this Manual (unless restricted by the waiver criteria).

(8) Check 7h. (Other) when the reason is not listed in 7a.-7g. and explain the reasoning in Block 14. "Remarks".

2. Blocks 8-10: Regulations require the examinee's vision to be 20/20 both near and far or corrected to 20/20 by spectacles that are worn when performing flying duties. Check the "No" block in Block 8 if the examinee's vision is 20/20 uncorrected and they do not wear spectacles. Check the "Yes" in Block 8 if the examinee is required to wear spectacles. Enter the effective date of the medical recommendation in Block 9 (usually the date the upchit is being given). Enter the date the medical clearance expires in Block 10 as determined by clearance reason from Block 7.

3. Blocks 11-13 (Section B - Disqualifying Action Recommended by Medical Authority): Is completed when the examinee is found medically unfit for flying duties in accordance with this Manual and references (a) and (c), or is medically disqualified because of a temporary medical problem or medication.

4. Check 11a. (Temporary Medical Suspension): if the member has a "Temporary Medical Suspension".

5. Check 11b. (Temporary Medical Suspension Following A/C Mishap): if this "Temporary Medical Suspension" is due to an aircraft mishap.

6. Check 11c. (Permanent Medical Disqualification): if the medical incapacitation is expected to last more than 365 days and the condition cannot be waivered. Termination from aviation service (permanent medical suspension) is required.

7. Check 11d. (Permanent Medical Disqualification following A/C Mishap): if the permanent medical disqualification is the result of an aircraft mishap.

8. The estimated time the examinee will be grounded is entered in Block 12, and the effective date of medical incapacitation is entered in Block 13. The date of medical incapacitation is

the date the disqualifying medical condition was diagnosed by history, examination, tests, or consultation. It may proceed the date the Medical Recommendation for Flying Duty, CG-6020 was actually completed by the flight surgeon. (E.g. member broke leg on 18 August and you are seeing him on 28 August. The effective date of incapacitation is 18 August, not 28 August).

9. Block 14: Use the "Remarks" section to communicate to the commander about special requirements of the medical recommendations. Use Block 14 for comments such as "FFD, biennial PE completed", or if arriving at a new duty station remarks such as "FFD, current biennial PE on file", or "Temporary FFD 30 days pending completion of biennial physical" or "Temporary FFD 90 days pending evaluation of diet control of cholesterol" for those being followed for high cholesterol. It is appropriate to indicate temporary "DNIF" (Duties Not Including Flying) explanation (Temporary Medical Disqualification) reasons here also. (E.g. "member DNIF; can't clear ears; on medications which will cause drowsiness").

10. Block 15: Specify whether the examinee may perform simulator duties and/or ground run up duties if otherwise grounded for a medical condition. Note: if you place the member "Sick-in-quarters", ground run up and simulator duties would not be allowed. Examples:

    a. If your examinee has a cast, ground run-up duties might not be allowed, but simulator duties might be authorized.

    b. Generally speaking, simulator duties can be authorized for anyone who can safely get into the simulator, such as uncomplicated pregnancy.

    c. Ground run-up duty is specifically authorized when controls can be safely managed despite medical restriction from flying duty.

    d. An aircrew member with a URI on a medication that causes drowsiness: He/she is authorized simulator duties, but because of the effects of the medication, he/she cannot safely control the aircraft in ground run-up duties.

11. Type, print or stamp the name of the FS/AMO/APA signing the Medical Recommendation for Flying Duty, CG-6020 and making the medical recommendation in Block 16. This person then signs in Block 17 and prints the date the Medical Recommendation for Flying Duty, CG-6020 was signed by the FS/AMO/APA in Block 18. This date can be different than the effective date in Block 9 or Block 13, or in Section C.

12. If the Medical Recommendation for Flying Duty, CG-6020 is completed by a medical or dental officer or HS who is not a FS/AMO/APA, the wording "FS/AMO/APA" is to be lined out in Blocks 16 and 17.

13. Note: non-FS/AMO/APA personnel may only issue grounding chits (i.e., only may DNIF aviation personnel) except as noted in 4-A-12.c. of this Chapter.

14. Block 19 (Section C - Certification by Aircrew Member): The examinee completes Section

C when informed of the recommendations contained in Sections A or B of the Medical Recommendation for Flying Duty, CG-6020. The examinee will check the "may" or "may not" block as appropriate, sign and date the form. If the aircrew member is not available, these blocks may be left blank. If the aircrew member refuses to sign, a notation to that effect should be made in Block 14, "Remarks", and his commander notified immediately.

15. The top copy of the Medical Recommendation for Flying Duty, CG-6020 is then filed in the outpatient medical record in chronological order above the physical exams and constitutes the medical recommendation. The individual copy is given to the individual for his/her personal records. If on flight status, the commander's copy is sent to the aircrew member's commander by a distribution system agreed upon by the flight surgeon and commander(s). The most expedient means is usually hand carried by the individual.

16. The examinee's unit commander or official designee will complete (Section D-Action Taken by Commander) by checking either the "Approved" or "Disapproved" in Block 20, typing, printing or stamping name in Block 21 and signing and dating the form in Blocks 22 and 23. The completed form is then forwarded to the flight records officer for inclusion in the member's official flight records for aviation personnel currently on flight status.

17. Extensions. The Medical Recommendation for Flying Duty, CG-6020 may be used by the FS/AMO/APA to extend a currently valid medical examination clearance for a period not to exceed 30 days beyond the end of the birth month for the purpose of completing an examination begun before the end of the birth month. In this case Block 7h., "Other" in Section A will be checked and in Block 14, "Remarks" will appear the statement "FFD, Extended 30 days to complete biennial PE." Block 10 will be dated 30 days later.

18. Exception to the Extension Rule. Medically disqualified aircrew members have 365 days to complete their aviation physical exam and request a waiver to continue flying duties despite the disqualification. Medical termination from aviation service is mandatory if the condition is not waiverable within 365 days or is found to be non-waiverable by Commander (PSC).