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FSG 100-02
Aircrew Medicals

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References:

A. CFP 154 *Medical Standards for the Canadian Forces*
B. A-GA-005-000/AG-001 Chap 7 *Medical Standards for Canadian Forces Aircrew*
C. AMA Directive 100-01 *Medical Standards for CAF Aircrew*
D. PD 4000-16 *Periodic Health Assessment – Aircrew*
E. Instruction 4000-01 *Periodic Health Assessments*
F. FSG 100-01 *Aircrew Medical Selection*
G. 1 Cdn Air Div Order 1-748 *Air Reserve – Enrolment of Skilled Applicants and the Enrolment Review/Medical Employment Limitations*
H. 1 Cdn Air Div Order 1-737 Air Reserve – *Career Review/Medical Employment Limitations*

Record of Amendments:

yyyy-mm-dd	Amendment
2020-03-17	New Edition with Substantial Changes Effective Immediately – Check out Para 10 onwards and the Annexes

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INTRODUCTION

1. The medical standards for the CF, CF aircrew, and requirements for aircrew periodic health examinations (PHE) are at refs A, B, and C. The content, schedule, and periods of validity of aircrew PHEs in aircrew are at refs D and E. The main purposes of the aircrew PHE are to:

a. Provide an opportunity for the aircrew member to bring health concerns to the attention of a FSurg;

b. Identify diseases and conditions that are affecting or have the potential to affect the health of the aircrew member;

c. Provide screening for medical conditions known to be associated with occupational exposure in the CF environment;

d. Assess lifestyle habits and provide positive health recommendations (e.g. regarding diet, physical activity, drinking, and smoking);

e. Institute appropriate counseling, therapy, and follow-up to address identified or potential health concerns;

f. Verify and update immunization status; and

g. Reaffirm or amend the medical category.

2. In a broad sense, the aircrew PHE is intended for prevention and/or early detection of illness in aircrew personnel, in an effort to provide timely positive intervention. The goal is to maintain high individual productivity over a full career in

the CF. The aircrew PHE is not intended to search out aircrew members to ground but, rather, to avoid the need to ground aircrew at all. It is, therefore, extremely important that the PHE be taken very seriously and that it be accurate, appropriate, and complete. This FSG contains guidelines that FSurgs/BAvMed providers are expected to follow when completing a PHE.

3. This FSG also applies when Aircrew are assessed for any other medical reason outside the normal PHE schedule.

COMPLETION OF THE AIRCREW MEDICAL

4. It is imperative that the FSurg/BAvMed provider be meticulous when completing PHA notes on CFHIS and /or filling out forms CF 2088 and CF 2017 (Medical Examination for Release). Information such as “Reason for Examination”, “Examination Unit”, “Enrolment Date”, and “Total Flying Time/Total Past Year” can be extremely valuable to the ASCS/CFEME/DMedPol reviewer. An aircrew member who has accumulated 3000 hours of flying experience over a 15-year career with the CF is vastly different from a new pilot. All of this information helps reviewers understand what decision they are being asked to make and about whom they are making it. A good example of an identification statement is “37 year-old male pilot WFSO. Currently holds flying position (CF-18), 3300 hours total flying time, almost all in fighters.” A thorough identification statement goes a long way towards helping the reviewer form a mental picture of the aircrew member he/she is reviewing.

5. A complete physical examination is required in all cases where permanent Medical Employment Limitations (MELs) are being assigned or where temporary MELs are being removed. A targeted physical examination, aimed at the medical condition(s) in question, is acceptable where temporary MELs are being assigned and/or extended provided that PHE requirements (e.g. visual and auditory acuity, etc.) and the results of all pertinent ancillary investigations are still valid. ***In all cases, a ‘paper board’ (i.e. no physical examination) is not acceptable***.

6. All concerns identified on the forms DND 2552 Periodic Health Assessment Questionnaire and DND 2452 Aircrew and Diver Health Examination must be noted and commented upon by the examining FSurg/BAvMed provider.

7. FSurgs/BAvMed providers should also include either a short narrative in the PHA note (see Annex B) and clearly include their recommendation for fitness to fly or other disposition (e.g. “Fit full flying duties” or “Recommend A3T6 with or as co-pilot”).

8. Please note that the only difference between the CF 2033 *Medical Examination Record* and CF 2017 *Medical Examination for Release* is Part 4 of the CF 2017 that the aircrew member completes and signs. The FSurg/BAvMed provider must comment at Part 5 on any medical problems noted in Parts 2 and 4 of the CF 2017

along with the usual identification statement, medications and allergies, past medical and surgical history, family, social, and work history, functional inquiry, and any other pertinent findings.

AEROMEDICAL INFORMATION

10. The decision to restrict an aircrew member's occupation must always be based on sound logic and appropriate review of each individual case. This includes examining the medical condition, the individual's response to the condition, the aerospace environment, and the CF mission requirements. There are times when this complex interaction may jeopardize flight safety, mission completion, or the aircrew member's personal health.

11. All decisions to let someone fly are risk management decisions and every case has subtle features that may not be apparent at first glance. It is imperative that FSurgs/BAvMed providers be extremely thorough when making a recommendation for the continued employment (or grounding) of aircrew. CFHIS PHA notes relating to MELs and Air Factors must include sufficient aeromedical information to support robust aeromedical decision-making. This allows a FSurg/BAvMed Provider to systematically work through a case without missing key information and assists reviewing FSurgs to look at the aerospace environment the aircrew member works in, or could potentially work in, and determine whether or not a particular medical condition is compatible with that environment.

12. Annex B provides an information template for the FSurg/BAvMed provider to use when completing an aircrew medical assessment.

RECORDING OF AIRCREW MEDICAL ASSESSMENTS IN CFHIS

13. All Aircrew PHAs should be recorded in CFHIS using the relevant PHA template. Any assessment that results in a TCAT or PCAT recommendation should be recorded using the same template. ASCS and DMedPol will record decisions in the same section of CFHIS.

ASCS REVIEW REQUIREMENTS

14. ASCS is responsible for Air Factors and related MELs; DMedPol is responsible for G and O factor reviews. Most aircrew medicals necessitating a change in air factor and/or related MELs greater than 3 months and permanent changes must be reviewed by ASCS at 1 Cdn Air Div. Exceptions are:

a. Initial and second A7 TCATs (i.e. grounding) totalling 12 months or less may be approved locally by any reviewing B/W Surg who is a FSurg;

b. Uncomplicated pregnancy A3 TCATs to 12 months may be approved locally by any reviewing B/W Surg who is a FSurg; and

c. Where the changes are within the scope of a specific B/W Surg's delegated ASCS review authority (see para 18 below).

15. When the reviewing B/W Surg locally approves an A7 TCAT, the originating 2088 entry should state `A7 TCAT not exceeding 12 months - ASCS review not required` and the ASCS portion of the form be struck through.

16. All other files involving returns to flying status ('ungrounding'), changes in A3 MELs, TCATs greater than 12 months total, or PCATs are to be forwarded to ASCS unless the aeromedical disposition falls within the scope of a specific B/W Surg's delegated ASCS authority (See para 18 below).

17. See Annex A for further details and flowchart.

DELEGATION OF ASCS APPROVAL AUTHORITY

18. Limited ASCS review authority may be delegated in writing to individual B/W Surgs by the 1 Cdn Air Div Surg. The scope and limits of the individual's delegation will be clearly stated. ASCS review authority will only be granted to those FSurgs who have demonstrated the appropriate level of aerospace medical knowledge and decision-making ability to safely discharge the responsibilities of ASCS. The delegation is to include a period of validity which will normally be while the B/W Surg is employed in that position.

19. When reviewing on behalf of ASCS, delegates are to record their disposition using the ASCS review template in CFHIS, and are to sign and annotate the CF2088 block normally used by ASCS for disposition 'for ASCS'.

ASCS FILE REVIEW PROCESS

20. All ASCS processing of aircrew files is done electronically via CFHIS. CF H Svcs Cs are asked to follow the process outlined below:

a. The FSurg/BAvMed provider will complete the CF 2088 with an aeromedical summary **and aeromedical recommendation** in the CFHIS PHA note and forward for review and countersignature by another qualified FSurg (usually the B/W Surg) IAW local procedures;

b. Clinic health records personnel will scan the signed copies of the CF 2088 into the member's electronic health record and ensure that all supporting clinical documentation relevant to the medical category change are available in CFHIS, including: DND 1737/2452, test results, consult notes, generic/MOSID-Specific Task Statements, etc; and

c. Clinic health records personnel shall forward the CF2088 via CFHIS message to the 'Aeromedical Standards – 2088' CFHIS inbox.

21. ASCS FSurg will approve or apply an Air Factor and/or restrictions when appropriate. The completed CF2088 will be scanned into CFHIS at 1 Cdn Air Div and a notification message sent back to the originating unit via CFHIS.

22. Where DMedPol review or approval is required (e.g. 3rd and subsequent TCATs, PCATs etc), ASCS will then send the file and CF2088 to the relevant DMedPol CFHIS inbox for action as well as to the originating unit for information. DMedPol will return the final disposition to the originating Unit via CHFIS when completed.

FILE PROCESSING FOR THE AIR RESERVE

23. For Air Reserve aircrew files for component transfer and direct enrolment of skilled applicants who are undergoing an Air Reserve Enrolment Review due to Medical Employment Limitations (ER/MEL), D Air Res will send a message to the Base/Wing Surgeon requesting the following documents be sent to ASCS via the Aeromedical Standards inbox IAW Refs G and H:

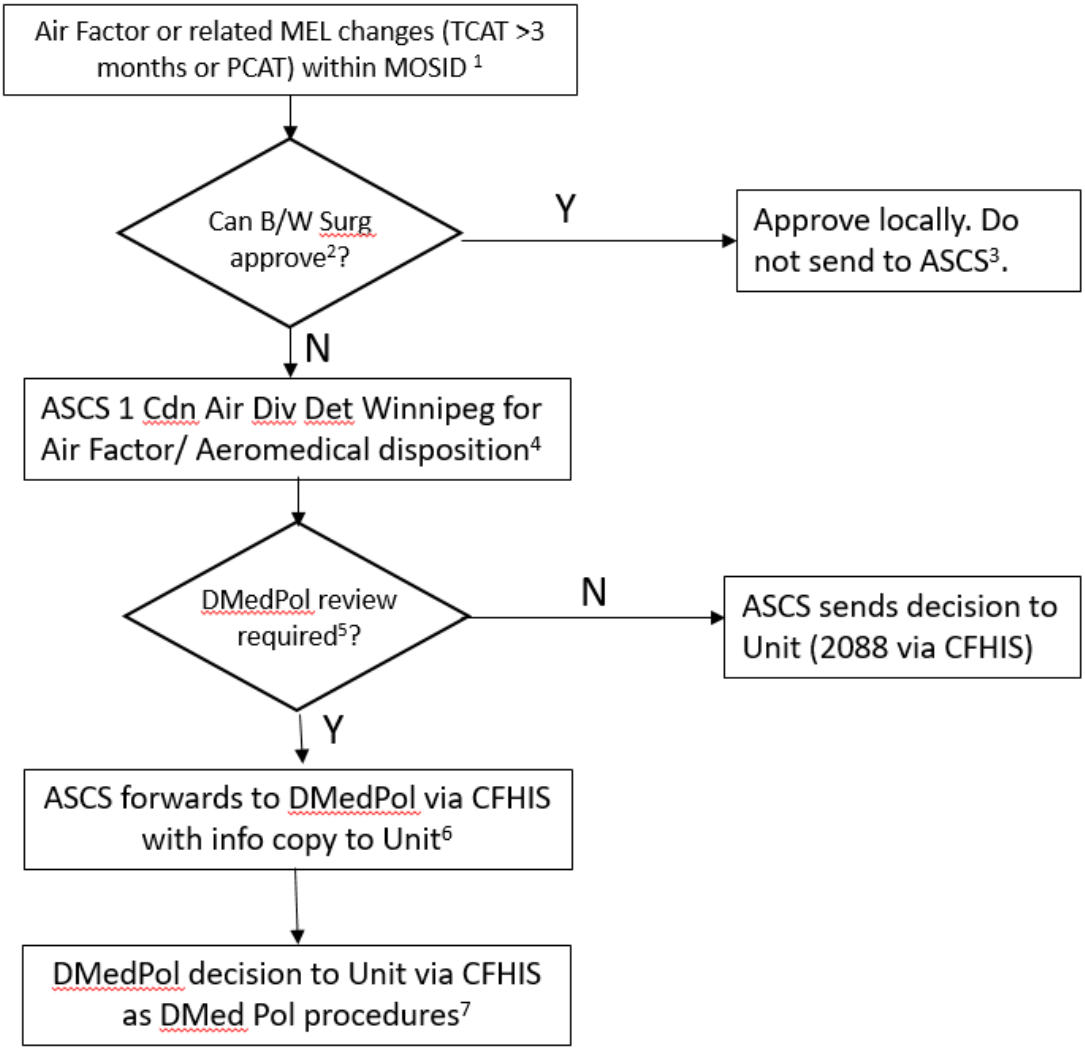
a. CF 2034;
b. any previous Release Medicals;
c. any previous AR/MEL decisions; and
d. Task Statements (Generic and MOS) from Ref A.

24. ASCS FSurg will review the ER/MEL files and the medical documents and make a medical statement with recommendations to D Air Res. No further medical review is required. A copy of the ER/MEL and all remaining medical documentation will be returned to the member's medical clinic via CFHIS.

INITIAL AIRCREW APPLICANTS AND AIRCREW MOSID CHANGES

25. Reference F contains instructions for initial aircrew selection candidates contains requirements for initial aircrew applicants and aircrew MOSID changes, which are evaluated and given an air factor at CFEME. ASCS does not review these files and they should not be sent to ASCS.

ANNEX A – PROCESSING AIRCREW MEDICALS



Notes:

1. All Initial Aircrew and Aircrew MOSID Occupational Transfers go directly to CFEME. See FSG 100-01 Aircrew Medical Selection.
2. Initial and second A7 TCATs up to 12 months total and uncomplicated pregnancy TCATs (ie T12) may be approved locally by any B/W Surg. (See Para 14). Additional ASCS delegated authority may be granted to named individuals (see Para 18).
3. Contact ASCS for advice if required.
4. See Paras 20-22 and Annex B for details of required information and transmission procedure to ASCS using 2088 via CFHIS.
5. Refer to DMedPol policy for further direction relating to G and O factor recommendations for PCATs and TCATs over 12 months.
6. ASCS will forward to DMedPol after Air Factor/MEL review. Units do not need to send copies of these aircrew files to DMedPol.
7. Refer to DMedPol policy and procedures or notifications for timing, decision transmission to unit, and instructions for expedited reviews etc.

ANNEX B – AEROMEDICAL INFORMATION TO BE INCLUDED IN CFHIS PHA FOR B/W SURG OR ASCS REVIEW

Note: This information can be included with a routine PHA where applicable.

Introduction: eg `29 M instructor pilot, 10 years in CF, 2500 flying hours rotary wing`/`43 F AEC posted AWACS OUTCAN, 21 years CF, 2600 flying hours`/`24 M student pilot phase 1 training`. Include an aircraft type i.e. Hercules, Griffon, CF-18 etc.

If routine PHA: All concerns identified on the forms DND 2552 Periodic Health Assessment Questionnaire and DND 2452 Aircrew and Diver Health Examination must be noted and commented upon by the examining FSurg.

History of Present Illness: Summarize as usual but as briefly as possible.

- What the relevant condition is (eg `New onset DMII`/`Head injury with concussion`/`Nephrolithiasis`/`Major depressive episode` etc) – list if multiple.
- First restricted/grounded for this problem on date (if applicable) – (eg `Third TCAT, initially grounded Feb 2017`).
- Progression of case and prognosis (eg `Steady improvement with lifestyle and diet, good prognosis`/`No improvement despite intensive therapy with poor prognosis`).

Physical Examination: Targeted to the specific issues related to the MELs/TCAT/PCAT with relevant positives and negatives.

Labs: Relevant with date done and results (eg HBA1c 8.1 Feb 2018, 7.0 Mar 2019).

Consultant Reports: Brief summary, diagnosis and follow-up recommended. (eg `Ortho consult 2018-06-05 reduced ROM, chronic pain, poor prognosis, surgery recommended`/ `Urology consult 2019-08-17 single 3mm non-obstructing stone pelvis of L kidney, annual US recommended`).

Past Hx: Brief and relevant (eg `MDE 2012, medicated 12 months, discharged from treatment mid 2014 with full recovery`/`MVA multiple rib fractures and pneumothorax 2018`).

Social Hx: Brief and relevant (eg `Previous alcohol abuse, abstinent since 2015, relapsed once in 2016`).

Meds: Type(s) and dose(s) relevant to the MEL/TCAT/PCAT recommendation.

Aeromedical Issues and Air Factor Discussion: List relevant issues and recommendation as fit to fly/not fit to fly or appropriate restrictions (eg `able to safely operate all flying controls, perform emergency drills or egress aircraft`/`Complete recovery with no residual deficits, normal exam`/'remains symptomatic, unable to cope with stresses of flight' etc).

Make a clear and reasoned recommendation for Air Factor, eg:

- Recommend A7T6 unfit flying duties
- Recommend A3T6 with or as co-pilot qualified on type
- Recommend A3T6 Unfit AWACs fit live controlling
- Recommend A4 fit SAR duties… etc

Do NOT just write `To ASCS for review`.

Finally, add `to ASCS then DMEdPol` if this is applicable.

ANNEX C – TIPS FOR COMPLETING/APPROVING AIRCREW MEDICALS

Examining FSurg/BAvMed Provider Post-Check:

- Are all Aircrew PHE requirements up to date (i.e. Cardiovascular Risk Evaluation, Ophthalmological examination, bloodwork etc.)?
- Have I addressed all medical issues that could impact the Air Factor (e.g. visual acuity, hearing loss, obesity, hypertension, hyperlipidemia, mental health, etc.)?
- Have I completed each section with sufficient detail?
- **Have I included my aeromedical recommendation**?
- Is my recommended category correct?
- Will the Approving FSurg have sufficient information at hand to concur with my recommended category (e.g. vision/hearing results, specialist reports etc)?
- Is there a change in the medical category from previous? Is a CF 2088 required?
- Signed and dated?

Approving FSurg Post-Check:

- Has the Examining FSurg/BAvMed Provider Post-Check (above) been completed?
- Does the category, in general, reflect the description, history, physical, and laboratory findings for this patient?
- Is a medical specialist opinion required/desirable?
- Have all medical issues that could impact the Air Factor been addressed?
- Write a CFHIS review note in the PHA section, “concur” on 2088, then sign and date.