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SECRETARY OF THE AIR FORCE**

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Operations

INDIVIDUAL MEDICAL READINESS

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This instruction implements AFPD 10-2, Readiness, October 30, 2006; Title 10, United States Code Sections 136(d) and 671, DoD Directive 5124.02, Under Secretary of Defense for Personnel and Readiness, February 11, 2006, Section 731 of Public Law 108-375, Ronald Reagan National Defense Authorization Act for Fiscal Year 2005, October 28, 2004, DoD Directive 6200.4, Force Health Protection, October 9, 2004, DoD Instruction 6025.19, Individual Medical Readiness, January 3, 2006. This publication requires the collection and or maintenance of information protected by the Privacy Act (PA) of 1974. The authorities to collect and or maintain the records prescribed in this publication are Title 37 United States Code, Section 301a and Executive Order 9397, Numbering Systems for Federal Accounts Relating to Individual Persons, November 22, 1943. Forms affected by the PA have an appropriate PA statement. System of records notice F044 AF SG E Medical Record System (December 9, 2003, 68 FR 68609) applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123 (will convert to AFMAN 33-363), Management of Records, and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at <https://afirms.amc.af.mil/>. Comments and suggested improvements should be forwarded on the AF IMT 847, Recommendation for Change of Publication, to HQ AFMOA/SGPP, 110 Luke Avenue, Suite 405, Bolling AFB DC 20332-7050.

This Air Force Instruction (AFI) establishes responsibilities and guidance to improve and maintain Individual Medical Readiness (IMR). IMR monitoring and reports allow commanders and their medical support providers to monitor the medical readiness status of unit personnel, ensuring a healthy and fit fighting force, medically ready to deploy. This AFI establishes defined, measurable medical elements, criteria and goals for medical readiness that provide unit commanders and higher headquarters the ability to continuously monitor their military personnel for medical readiness and deployability. IMR requirements apply to all Active and Selected Reserve (SELRES) members of the Air Force, including participating inactive ready reserve. It does not apply to those who have not completed initial active duty training and follow-on technical training (AFSC-granting training) and others who are deemed unavailable for deployment, such as Reserve Office Training Corps (ROTC) cadre, students in deferred training status, recruiters, those

assigned to geographically separated units (GSUs), Individual Mobility Augmentee (IMA) and others as identified. Although not reported for DoD IMR compliance statistics, many of these personnel must meet Force Health Protection requirements as noted elsewhere in policy and should be monitored and tracked by their commander and medical support providers.

Once in deployed status, members will no longer be monitored for individual medical readiness purposes and will remain unmonitored for one month post-deployment. Members will continue to be monitored for vaccination status by in-theater medical units for force health protection purposes and deployed unit commanders will take prudent actions to allow members to be vaccinated when the mission allows. Failure to meet vaccination requirements while deployed will not affect home unit individual medical readiness status since deployed members are not monitored for individual medical readiness.

Chapter 1

RESPONSIBILITIES

- 1.1.** US Air Force Chief of Staff (CSAF): Directs implementation of the Individual Medical Readiness (IMR) program.
- 1.2.** AF Surgeon General: The office of primary responsibility (OPR) for IMR policy and procedures.
 - 1.2.1. Identifies requirements and criteria to designate members as medically ready to deploy. See **Chapter 2** for detailed descriptions of IMR elements, requirements for each element and the criteria necessary to be determined “medically ready.”
 - 1.2.2. Monitors and reports Air Force IMR status periodically to the CSAF and the Assistant Secretary of Defense, Health Affairs (ASD(HA)) as directed in DoD Instruction 6025.19, Individual Medical Readiness, January 3, 2006.
 - 1.2.3. Provides the medical information system support necessary to monitor, track and report IMR status and requirements at all levels.
 - 1.2.4. Ensures adequate medical resources are planned, programmed and budgeted to support unit commanders and individuals in achieving and maintaining their individual medical readiness.
 - 1.2.5. Provides Air Force representation to the DoD Force Health Protection Council, which charts the DoD IMR Working Group.
- 1.3.** Assistant Surgeon General for Healthcare Operations (AF/SGO):
 - 1.3.1. Develops AF policy for IMR.
 - 1.3.2. Monitors IMR medical support capabilities and services and works with MAJCOM/SGs to ensure corrective action is taken if necessary.
 - 1.3.3. Ensures Privacy Act and Health Information Protection and Accountability Act (HIPAA) requirements are met for IMR data.
- 1.4.** Air Force Medical Operations Agency (AFMOA).
 - 1.4.1. Manages the execution of the IMR program.
 - 1.4.2. Supports development of AF IMR policy through experience with execution and management of the IMR program and as representatives for the Air Force at DoD and TriService working groups.
 - 1.4.3. Provides representation to the DoD IMR Working Group.
- 1.5.** Air Force Medical Support Agency (AFMSA).
 - 1.5.1. Provides necessary information system support for the Preventive Health Assessment and Individual Medical Readiness (PIMR) application.
 - 1.5.2. Shares IMR data with appropriate agencies (DoD, Health Affairs, Sister Services, etc) when authorized by AF/SGO and the Air Force Surgeon’s General Chief Information Officer.

1.5.3. Shares IMR data with appropriate systems, such as Reserve Component Preventive Health Assessment (RCPHA), Defense Readiness Reporting System (DRRS), AEF Online, Armed Forces Health Longitudinal Technology Application (AHLTA), when authorized by AF/SGO and the Air Force Surgeon's General Chief Information Officer.

1.5.4. Follows all applicable requirements and guidelines for the security and privacy of IMR data, information systems and information sharing.

1.6. AF Deputy Chief of Staff, Air, Space & Information Operations, Plans & Requirements (AF/A3/5): The office of collateral responsibility (OCR) for IMR policy.

1.6.1. Coordinates on IMR policy to ensure it is compatible with AEF construct and current operational readiness reporting policy.

1.6.2. Coordinates on IMR readiness programs to ensure compatibility with current DoD and AF readiness reporting systems.

1.7. MAJCOM/DRU: OPR for organizing, training and equipping forces and installations to meet and maintain IMR requirements.

1.7.1. All MAJCOMS: Incorporate IMR program principles and practices into all officer and enlisted curriculum, as appropriate.

1.7.2. All MAJCOMS: Incorporate IMR program principles, practices, procedures and program support and management training into educational curriculum, as appropriate, including primary care graduate medical education.

1.7.3. Organizations in special situations, such as Headquarters Air Staff or MAJCOM A Staff, may supplement this Instruction to meet their unique organizational IMR management needs.

1.8. AF Reserve Component (ARC):

1.8.1. Provides ARC representation to the DoD IMR Working Group.

1.8.2. Provides analysis and representation of ARC IMR to AF/SG at Performance Improvement Board meetings and at other venues.

1.8.3. (AF Reserve Command only) Liaison with AF/SGO on data transfer issues with RC medical information systems. ANG utilizes the AD PIMR application.

1.9. Installation Commander. OPR for complying with Air Force and MAJCOM guidance to meet IMR requirements.

1.9.1. Establishes a command expectation that unit commanders and individuals will be responsible for meeting and maintaining IMR requirements.

1.9.2. Establishes a forum in which the IMR status of installation units is monitored and discussed at least monthly with installation leadership.

1.9.3. Develops and maintains a standard, installation-wide process by which the Medical Treatment Facility Commander (MTF/CC) or their designee will inform unit commanders or their designated representatives (e.g. First Sergeant, Unit Health Monitor) of their unit member's IMR requirements at least monthly.

1.9.4. Ensures that appropriate action is taken regarding units and members with excessive IMR delinquencies.

1.10. Medical Treatment Facility Commander (MTF/CC), including ANG Medical Group Commander (ANG MDG/CC) and Reserve Medical Unit (RMU) Commanders. OPR for providing medical support and IMR tracking and reporting to the installation for the IMR program. RCPHA is the equivalent IMR management system presently used by the Reserves with active data exchange with PIMR.

1.10.1. Maintains adequate capabilities to ensure the access to and provision of services to allow members who report in a timely fashion to meet their individual medical readiness requirements. Meets TRICARE access standards, where applicable, for necessary services.

1.10.2. Notifies Installation Commander, NAF and MAJCOM/SG immediately when capabilities are not sufficient to keep members from becoming IMR “not ready” simply due to lack of services or access.

1.10.3. Plans, programs, and submits budget requests for funds and procures supplies and equipment to accomplish IMR program requirements.

1.10.4. Monitors IMR status and reports IMR requirements that are Due/Overdue to unit commanders or their designees at least monthly; standard PIMR reports are recommended.

1.10.5. Tracks and reports to unit commanders the names of their members who fail to take action to meet IMR requirements after notifications to the member and unit or who have short-notice cancellations or “no shows” for scheduled services.

1.10.6. Ensures the IMR status of every Service member is checked using PIMR during every health visit unless precluded by the urgent nature of the visit.

1.10.6.1. Ensures that any due or overdue requirement is addressed by the healthcare team at the time of the visit if possible or scheduled for a later time before the member leaves the medical facility.

1.10.6.2. Ensures all IMR-related services rendered to Active Component (AC), ANG, Reserve and IMA members are entered into the PIMR database.

1.10.7. Ensures all locally determined IMR requirements, e.g. deployment or PCS-related immunizations or Hospital Employee Health templates are loaded into PIMR as they are identified.

1.10.8. Ensures the PIMR and related programs are installed, maintained and used properly by trained administrators and users.

1.10.8.1. Provides the necessary support to properly install and operate the PIMR and AFCITA programs in an information environment that meets all applicable requirements for security and privacy.

1.10.8.2. Ensures the provision of training necessary to install, maintain and operate the programs.

1.10.8.3. MTFs with collocated RMUs and/or ANG units will support PIMR/AFCITA applications utilized by these units by providing server space for the associated data files and all necessary training required to access and operate the application on the MTF network.

1.11. Unit Commander. OPR for meeting and maintaining unit and individual medical readiness.

1.11.1. Establishes a command expectation that individuals will be personally responsible for meeting and maintaining IMR requirements.

1.11.2. Ensures unit IMR status is monitored frequently and at least monthly using IMR systems and reports developed for commanders (AEF Online, DRS, DRRS) and by reports generated by MTF/CC or their designee.

1.11.2.1. Designates a primary unit IMR program manager and point of contact (generally the Unit Health Monitor, but can be the Unit Deployment Monitor or First Sergeant).

1.11.2.2. Ensures Unit Health Monitors are provided the necessary resources and authority to effectively manage unit IMR status from day to day (or duty day to duty day for Guard and Reserve personnel).

1.11.3. Ensures unit members are given adequate duty time to meet and maintain IMR requirements. ANG/Reserve personnel may have to accomplish some IMR requirements on their own time such as civilian dental exams or medical evaluations.

1.11.4. Takes action when unit members fail to respond to notifications of Due or Overdue IMR requirements or fail to keep scheduled appointments for IMR. ANG/Reserve members may be separated for noncompliance IAW AFI 36-3209, Separation and Retirement Procedures for ANG and AFR Members.

Chapter 2

INDIVIDUAL MEDICAL READINESS ELEMENTS, CRITERIA AND GOALS

2.1. DoD and Air Force IMR Classification Schema

2.1.1. The DoDI on Individual Medical Readiness (DoDI 6025.19) describes a 4-tiered classification system for reporting individual medical readiness: Fully Medically Ready (GREEN), Partially Medically Ready (YELLOW), Indeterminate (GRAY) and Not Medically Ready (RED). All AF data reported to DoD will be classified using this 4-tiered system. The AFRC also uses these classifications within its RCPHA system for internal AFRC purposes.

2.1.2. The AF Active Component has been using a two-tiered system since 1997, and the ANG since 2001, that provides a clear message to Commanders and members: you are fully medically ready to deploy (GREEN) or you are not medically ready to deploy (RED). A YELLOW classification is used to report IMR elements that are Due but are not yet Overdue or not yet causing a member to be “not medically ready.” This is a management category or tool only. All internal AF and ANG reports, metrics and statistics will continue to use the two-tiered GREEN/RED system. However, as stated in [2.1.1.](#), AF and ANG data can easily be translated to DoD classifications when required and is always reported this way to DoD.

2.2. IMR Elements

2.2.1. Periodic or Preventive Health Assessment (PHA)

2.2.2. Dental Readiness

2.2.3. Immunization Status

2.2.4. Individual Medical Equipment

2.2.5. Medical Readiness Laboratory Studies

2.2.6. Deployment Limiting Conditions

2.3. IMR Criteria by Element

2.3.1. PHA: PHAs will be conducted annually per Health Affairs policy memo 06-006, Periodic Health Assessment Policy for Active Duty and Selected Reserve Members. The AF follows the Periodic Health Assessment policy as required by DoDI and HA policy but does so through the AF Preventive Health Assessment program. Both may be used interchangeably, but the Preventive Health Assessment, with its preventive focus, is preferred by the AF.

2.3.1.1. For reports to DoD and for internal AF IMR reporting purposes, all AF members, including Active Component, Reserves and Air National Guard members will use the DoDI definition for medical readiness for PHA currency. The DoDI definition includes a 90-day grace period beginning the day the PHA is due (366 days after the last PHA) during which time the member will remain “medically ready.” On the day after the grace period expires (366 days + 90 days), the member will be determined “not medically ready” and will count against the unit’s “medically ready” status. Except as noted below, all AF and ANG members will follow these guidelines in scheduling to maintain PHA currency.

2.3.1.2. Flying and Special Duty Operations personnel will follow existing guidance in AFI 48-123, Medical Examinations and Standards, Attachment 2, Table A2.1. for purposes of PHA periodicity and currency for their duty and pay purposes. However, for IMR reporting purposes, the DoD definition of medically ready as defined in 2.3.1.1. will be used. While this could result in a mismatch between PHA IMR readiness and PHA flying currency, the requirements for these two programs are different and this is acceptable.

2.3.1.3. Reserve members and Non Reserve Unit personnel (i.e., Category B and E etc.) will follow AFRC/SG guidance for annual PHA periodicity. ANG members will follow AF guidance as noted above. However, for IMR reporting purposes, the DoD definition of medically ready as defined in 2.3.1.1. will be used.

2.3.1.4. The requirements of a PHA are specified in Health Affairs policy memo 06-006, Periodic Health Assessment Policy for Active Duty and Selected Reserve Members and may be further defined elsewhere in AF policy as they are subject to change. Once the initial requirements of the PHA are met (e.g. once the “assessment” has been made), the PHA should be counted as complete for IMR purposes even though follow-on studies, labs, referrals or additional visits may be pending or planned. Any questions as to deployability or retainability should be addressed through a profile and not by holding up the PHA until the issue is resolved. However, requirements specific to the PHA itself, such as required items for flyer PHAs must be completed prior to the PHA being considered complete.

2.3.1.5. During deployments and for one month following deployment, members will not be monitored for PHA currency. To ensure a balance between the requirement for an annual PHA, the need to send healthy, fully-assessed members on deployments and the burden to the member, unit and health system when the member deploys, especially for lengthy deployments, the following criteria will be followed:

2.3.1.5.1. Prior to deployments of greater than 6 months in length, the member’s PHA must not exceed 18 months of age in the month after return from deployment or the PHA must be re-accomplished prior to deployment.

2.3.1.5.2. Prior to deployments of less than 6 months in length, the member’s PHA must not exceed 15 months of age in the month after return from deployment or the PHA must be re-accomplished prior to deployment.

2.3.2. Dental Readiness

2.3.2.1. Members must have a current dental exam and be either dental class 1 or 2 to be classified as “medically ready.” Dental examination and classification is required annually. Members will be given a grace period beginning the day the dental exam is due (366 days after the last dental exam) during which time the member will still be considered “medically ready.” The grace period will extend through the end of the month following the month the dental exam became due. The first day of the month following the grace period, the member will receive a dental classification of 4 and be determined to be “not medically ready” and will count against the unit’s “medically ready” status.

2.3.2.2. DoD requires a dental examination and classification annually. When reporting dental examination and classification data to DoD, follow DoD definitions and requirements as specified in DoDI 6025.19, Individual Medical Readiness. DoD’s definition of dental readiness differs from the AF in that a 90-day grace period is allowed after the dental exam is due.

2.3.2.3. Members who receive a dental classification of 3 will be considered “not medically ready” and will count against their unit’s “medically ready” status. Dental class 3 is considered a deployment limiting condition (see section 2.3.6.).

2.3.2.4. Reserve members will follow AFRC/SG guidance for annual dental exam periodicity. ANG members will follow AF guidance. For reporting purposes, AF definitions will be used for AF purposes and DoD definitions will be used for DoD purposes if the two differ.

2.3.2.5. The requirements of a dental examination and the specifics of dental readiness classification can be found in AFI 47-101, Managing Air Force Dental Services.

2.3.2.6. Prior to deployments, dental treatment facilities will refer to AFI 47-101 for guidance on whether re-accomplishment of dental exams is necessary based on length of deployment. ANG and Reserve members must only have a current dental exam and be either dental class 1 or 2 to deploy.

2.3.3. Immunizations

2.3.3.1. It is DoD and AF policy to follow the Advisory Committee on Immunization Practice’s (ACIP) vaccination recommendations when published by the Centers for Disease Control and Prevention (CDC) in the Mortality and Morbidity Weekly Report, unless stated otherwise by specific DoD or AF policy. All recommended vaccinations are to be kept current.

2.3.3.1.1. Grace periods, when the shot is Due but not Overdue, are allowed for most immunizations and during those periods, the member will still count as “medically ready.” Grace periods vary by immunization and are programmed into the Air Force Complete Immunization Tracking Application (AFCITA). These grace periods are communicated to PIMR and are reflected in the reports given to unit commanders by MTF/CC or designee.

2.3.3.1.2. There are also “early periods” where some immunizations may be given earlier than the date due. These periods are also programmed into AFCITA as YELLOW flags and are reflected in PIMR and its reports. Care should be taken in giving “due reports” to members and units for immunizations that cannot be given immediately. Immunizations given before this early YELLOW period, even if given for operational reasons by a licensed provider, may not count towards the IMR immunization requirement and may require additional doses. In almost all cases, immunizations should be given within the prescribed time periods.

2.3.3.2. Immunization requirements are noted elsewhere but are almost always reflected in AFCITA, which should generally be the source for determining what immunizations are due and when they should be given. Some immunizations are specific to a deployment, PCS, or TDY location or an occupation and must be loaded as requirements by MTF personnel when these requirements are identified. Once the requirement is loaded, the vaccine(s) will reflect as Due in AFCITA and PIMR.

2.3.3.3. DoD IMR requirements for immunizations differ from internal AF requirements due to the differing functional abilities of the Service’s immunization tracking systems. Therefore, when reporting IMR status to DoD, DoD requirements, and not those internal to the Air Force, will be used.

2.3.3.3.1. Current DoD IMR required vaccinations are: hepatitis A, tetanus, diphtheria (Td or Tdap), MMR (measles, mumps, rubella), IPV (inactivated polio vaccine), hepatitis B (if the series is initiated) and influenza (once per season).

2.3.3.3.2. Vaccines are considered overdue if more than 30 days has elapsed since their due date. Influenza is considered Overdue if not administered by 1 January of each year. The requirement is valid from 1 October (or slightly earlier if vaccine is available) until 30 June of each fiscal year.

2.3.3.3.3. Members with validated administrative or medical exemptions are excluded from these requirements and reporting.

2.3.4. Individual Medical Equipment

2.3.4.1. Some members require special equipment for deployments. The only item required for IMR is one pair of gas mask inserts and only for those who meet certain visual acuity deficiencies. All members must have either a recorded distant visual acuity to determine if they need gas mask inserts or a record in PIMR that they were shipped gas mask inserts from the DoD Spectacle Request Transmission System (SRTS). Each of these requirements is only required once and once documented, will not change unless a new visual acuity measurement is added to PIMR that drives the requirement for a gas mask insert.

2.3.4.2. Once a member is identified as needing a gas mask insert, they will have a 30-day grace period during which the inserts are being ordered and shipped. Most sites have a direct link to SRTS data and will be updated once this data is uploaded into PIMR. After this 30-day grace period, the member will become “not medically ready” until PIMR is either updated automatically by the SRTS system or manually with an issue date by medical personnel.

2.3.5. Medical Readiness Laboratory Studies.

2.3.5.1. AF IMR laboratory requirements include those screening tests required upon accession: Blood type and Rh factor, G6PD, Hgb-S with positive results confirmed by electrophoresis, DNA Specimen Collection and HIV plus any others required from other policies. These requirements are all reflected within PIMR and a source document will be posted to the Knowledge Exchange at <https://kx.afms.mil>.

2.3.5.2. HIV screening is required by DoD every two years for all AF members (Active, ANG and AFRC) and must be current for IMR purposes. Members will be flagged YELLOW and will be reported on Due Lists 90 days in advance of the due date to allow adequate time to meet this requirement without going Overdue.

2.3.5.3. A DNA specimen must be logged and stored at the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR). This site automatically updates PIMR when the specimen has been received and logged. Once logged and updated in PIMR, this requirement is met and never becomes due again. However, specimens that are not received at AFRSSIR or that are received but do not meet standards will not count towards IMR requirements and must be re-accomplished.

2.3.5.4. DoD requirements for IMR laboratory testing are an on-file DNA Specimen and a current HIV test. Therefore, when reporting laboratory testing IMR status to DoD, these requirements, and not those internal to the Air Force, will be used.

2.3.6. Deployment Limiting Conditions.

2.3.6.1. Members must have no deployment limiting condition to be determined “medically ready.” Members on a 4T profile recommending “not worldwide qualified” or “not deployable” or

having a personnel system designator, either an Assignment Limitation Code (ALC)-C (1, 2 or 3) or an Assignment Availability Code (AAC) 81, 37 or 31, signifying a deployment limiting condition, are determined to be “not medically ready.”

2.3.6.2. See AFI 48-123, Physical Exams and Standards and AFI 41-210, Patient Administration Functions, for a description of profiling, Assignment Limitation Codes and Assignment Availability Codes.

2.3.6.3. Members with any deployment limiting condition will show up on Due/Overdue Lists to Unit Commanders in the appropriate descriptive category (4T, ALC-C, AAC-81, etc). Commanders should contact the member’s provider or the Chief, Aeromedical Services for questions regarding the member’s deployability.

2.4. IMR Goals

2.4.1. DoDI 6025.19 states that the overall goal for a fully medically ready force is ideally 100% but a more realistic, minimal target is 75% of the total force. This goal of 75% has been achieved for some time by the Active Component Air Force in aggregate but has not been achieved consistently by all bases or the ARC. To raise the bar and promote consistent achievement of the DoD target goal by those already meeting the minimum goal and promote higher achievement for those not meeting the DoD goal, the target goal for the Air Force is 80%.

2.4.2. There are no goals for each element score. Reports that provide medically ready statistics by element display all personnel who are current or non-current for that element. Personnel may be non-current for more than one element, but will only count against the unit IMR score once. For example, Airman 1 is non-current in 3 elements and Airman 2 is non-current in only 1 element; they both count against the unit IMR score equally and only once. Airman 1 needs to correct 3 items to bring the unit IMR score up, but Airman 2 only needs to correct 1 item to bring the unit IMR score up.

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DCS, Air, Space and Information Operations,
Plans and Requirements

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Title 10, United States Code Sections 136(d) and 671

Section 731 of Public Law 108-375, Ronald Reagan National Defense Authorization Act for Fiscal Year 2005, October 28, 2004

DoD Directive 5124.02, Under Secretary of Defense for Personnel and Readiness, February 11, 2006

DoD Directive 6200.4, Force Health Protection, October 9, 2004

DoD Instruction 6025.19, Individual Medical Readiness, January 3, 2006

AFPD 10-2, Readiness, 1 March, 1997

AFI 36-3209, Separation and Retirement Procedures for ANG and AFR Members, 14 April, 2005

AFI 41-210, Patient Administration Functions, 22 March, 2006

AFI 47-101, Managing Air Force Dental Services, 5 May, 2000.

AFI 48-123, Medical Examinations and Standards, 5 June, 2006

AFI 48-135, Human Immunodeficiency Virus Program, 12 May, 2004

AFJI 48-210, Immunizations and Chemoprophylaxis, 12 May, 2004

Assistant Secretary of Defense, Health Affairs Policy Memo, 06-006, Periodic Health Assessment Policy for Active Duty and Selected Reserve Members, February 16, 2006

Abbreviations and Acronyms

AFCITA—Air Force Complete Immunization Tracking Application

DNA—Deoxyribonucleic Acid. Genetic material used for positive identification of remains.

DRRS—Defense Readiness Reporting System

G6PD—Glucose-6-Phosphate Dehydrogenase. An enzyme critical for certain drug metabolism, e.g. malaria prophylaxis medication.

Hgb-S—Hemoglobin-S. Abnormal hemoglobin linked with sickle trait and sickle cell disease.

IMA—Individual Mobility Augmentee

IMR—Individual Medical Readiness

PHA—Periodic or Preventive Health Assessment

PIMR—Preventive Health Assessment and Individual Medical Readiness application

RCPHA—Reserve Component Preventive Health Assessment application

RMG—Readiness Management Group

UHM—Unit Health Monitor