This instruction implements Air Force Policy Directive (AFPD) 10-2, Readiness, 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, DoD Directive 6200.04, Force Health Protection, DoD Instruction 6025.19, Individual Medical Readiness. This Air Force Instruction (AFI) establishes defined, measurable medical elements, criteria and goals for medical readiness for Active and Selected Reserve (SELRES) members of the Air Force (AF), and participating individual ready reservists. It does not apply to those who have not completed initial active duty training and follow-on technical training (Air Force Specialty Code-granting training) and others who are deemed unavailable for deployment, such as Reserve Officer Training Corps (ROTC) cadre, students in deferred training status, recruiters, those assigned to geographically separated units (GSUs), and others as identified. This publication requires the collection and or maintenance of information protected by the Privacy Act 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 (SSN) as amended by Executive Order 13478, Amendments to Executive Order 9397 Relating to Federal Agency Use of Social Security Numbers, November 18, 2008. Forms affected by the Privacy Act must have an appropriate Privacy Act 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 (IAW) Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of IAW Air Force Records Disposition Schedule (RDS) located in the Air Force Records Information Management System (AFRIMS). Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, Recommendation for Change of Publication; route AF Forms 847 from the field through the appropriate functional chain of
command. This publication may be supplemented at any level, but all direct supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

**SUMMARY OF CHANGES**

This document has been substantially revised and must be completely reviewed. Major changes include the use of the Aeromedical Services Information Management System (ASIMS) Web application module in place of the Preventive Health Assessment and Individual Medical Readiness (PIMR) and Air Force Complete Immunization Tracking Application (AFCITA) programs. The publication has been revised to include instructions for identifying Tier waiver authorities as approved by the Inspector General Advisory Board (IGAB). Administrative changes have also been incorporated.
Chapter 1

ROLES AND RESPONSIBILITIES

1.1. US Air Force Chief of Staff (CSAF). Directs implementation of the Individual Medical Readiness (IMR) program.

1.2. AF Surgeon General (AF/SG). 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 AF 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.

   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 AF representation to the Defense Health Agency, which charters the DoD IMR Working Group.

1.3. Assistant Surgeon General for Healthcare Operations (AF/SG3).

   1.3.1. Develops AF policy for IMR.

   1.3.2. Monitors IMR medical support capabilities and services and works with Major Command Surgeon (MAJCOM/SG) 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): Will support development of AF IMR policy through experience with execution and management of the IMR program.

1.5. Defense Health Agency, Health Information Technology (DHA/HIT).

   1.5.1. Provides necessary information system support for the ASIMS Web application.

   1.5.2. Shares IMR data with appropriate agencies (DoD, Health Affairs, Sister Services, etc.) when authorized by AF/SG.

   1.5.3. Shares IMR data with appropriate systems, such as Defense Readiness Reporting System (DRRS), AEF Online, and Armed Forces Health Longitudinal Technology Application (AHLTA), when authorized by AF/SG3.

   1.5.4. Follows all applicable requirements and guidelines for the security and privacy of IMR data, information systems and information sharing.
1.5.5. In collaboration with Air Reserve Component (ARC)/A1 and ARC/SG, develops, executes, and maintains business rules to assure SELRES members of the AF who are deemed unavailable for deployment are excluded from IMR criteria and compliance rate.

1.6. **Deputy Chief of Staff (DCS) of the Air Force for Operations, Plans, and 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 programs to ensure compatibility with current DoD and AF readiness reporting systems.

1.7. **Major Command/Direct Reporting Unit (MAJCOM/DRU).** OPR for organizing, training and equipping forces and installations to meet and maintain IMR requirements.

   1.7.1. Will coordinate with MAJCOM Inspector General (MAJCOM/IG) or Wing Inspection Team (WIT) in incorporating IMR unit compliance rates and reporting into Unit Effectiveness Inspections (UEI).

   1.7.2. Ensures all locally determined medical readiness requirements (e.g. deployment or PCS-related immunizations) are loaded into ASIMS Web as they are identified.

1.8. **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.


   1.9.1. Establishes a command expectation that unit commanders and individuals will be responsible for meeting and maintaining IMR requirements. (T-1).

   1.9.2. Establishes a forum in which the IMR status of installation units is monitored and discussed at least monthly with installation leadership. (T-2).

   1.9.3. Designates ASIMS Web as the standard, installation-wide process for unit commanders or their designated representatives (e.g. First Sergeant, Unit Health Monitor) to access their unit member’s IMR requirements real-time. (T-2).

   1.9.4. Ensures that appropriate action is taken regarding units and members with excessive IMR delinquencies. (T-1).

1.10. **Medical Treatment Facility Commander (MTF/CC):** Including Air National Guard, Guard Medical Unit (GMU) and Reserve Medical Unit (RMU) Commanders. OPR for IMR tracking and reporting to the installation for the IMR program. (T-1).

   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. (T-1).
1.10.2. Notifies Installation Commander, Numbered Air Force (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. (T-1).

1.10.3. Plans, programs, and submits budget requests for funds and procures supplies and equipment to accomplish IMR program requirements. (T-1).

1.10.4. Ensures the IMR status of every Service Member is checked using ASIMS Web (if operational) during every visit to Primary Care Manager (PCM) unless precluded by the urgent nature of the visit. (T-1).

1.10.4.1. Ensures that any due or overdue requirement is addressed by the healthcare team at the time of the visit or scheduled for a later time before the member leaves the medical facility, unless precluded by the urgent nature of the visit. (T-1).

1.10.4.2. Ensures all IMR-related services rendered to Active Component (AC) and ARC members are entered into ASIMS Web and AHLTA, if available. (T-1).

1.10.5. Ensures programs related to accessing ASIMS Web are installed, maintained and used properly by trained administrators and users. (T-1).

1.10.5.1. Provides the necessary support to properly install AHLTA programs and operate ASIMS Web in an information environment that meets all applicable requirements for security and privacy. (T-1).

1.11. Force Health Management (or ARC equivalent).

1.11.1. Monitors IMR status and grants account access for ASIMS Web to unit commanders and their designees (e.g. unit health monitor). (T-2).

1.11.2. Provides periodic notifications/web links to the unit monitors. (T-2).

1.11.3. Reports as necessary 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. (T-2).

1.12. Unit Commander. OPR for meeting and maintaining unit IMR.

1.12.1. Establishes a command expectation that individuals will be personally responsible for meeting and maintaining IMR requirements. (T-0: requirements IAW Ronald Reagan National Defense Authorization Act of 2005 Subtitle D, and DoDI 6025.19).

1.12.2. Ensures unit IMR status is monitored frequently and at least monthly using IMR systems and reports (i.e. ASIMS Web, DRS, DRRS). (T-1).

1.12.2.1. Designates, in writing, a primary unit IMR manager (generally the Unit Health Monitor [UHM], but can be the Unit Deployment Monitor [UDM] or First Sergeant). (T-2).

1.12.2.2. Ensures primary unit IMR managers are provided the necessary resources and authority to effectively manage unit IMR status from day to day (or duty day to duty day for ARC personnel). (T-2).
1.12.3. Ensures unit members are given adequate duty time to meet and maintain IMR requirements. ARC personnel may have to accomplish some IMR requirements on their own time such as civilian dental exams or medical evaluations. (T-1).

1.12.4. Takes action when unit members fail to respond to notifications of Due or Overdue IMR requirements or fail to keep scheduled appointments for IMR. **Note:** Reservists overdue for IMR requirements will be referred to their CCs IAW AFI 36-2254 Vol. 1, *Reserve Personnel Participation*, and processed IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members* or involuntarily transferred to the Individual Ready Reserve in accordance with AFI 36-2115, *Assignments Within the Reserve Components*. (T-1).

1.12.5. Ensures the unit IMR standards are met and maintained at the Air Force medical readiness target goal of 80%. (T-1).

1.13. **UHM/UDM.**

1.13.1. Notifies Airmen of due/overdue IMR requirements, and Deployment-Related Health Assessments (DRHA) completion. (T-2).


1.13.3. Assists Airmen with the coordination of follow-up IMR requirements. (T-2).

1.14. **Individual Airman.**

1.2.11.1. Will monitor and maintain currency of his/her IMR requirements. IMR status can be monitored using MyIMR at [https://imr.afms.mil/imr/myIMR.aspx](https://imr.afms.mil/imr/myIMR.aspx) (ARC may also use ARCNet). (T-2).
Chapter 2

INDIVIDUAL MEDICAL READINESS ELEMENTS, CRITERIA AND GOALS

2.1. DoD and Air Force IMR Classification Schema.

2.1.1. 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. (T-0).

2.1.2. The AF Active Component and ARC use a two-tiered system that provides a clear message to Commanders and members: Fully Mission Capable (GREEN) or Not Mission Capable (RED). The classification Partially Mission Capable (YELLOW) is used to report IMR elements that are Due (e.g. unmet IMR requirements that can generally be resolved within 30 days) 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 ARC reports, metrics and statistics will continue to use the two-tiered GREEN/RED system. However, as stated in 2.1.1., AF data can easily be translated to DoD classifications when required and is always reported this way to DoD. (T-1).

2.2. DoD Instruction 6025.19. IMR Elements:

2.2.1. Periodic/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 Tests.

2.2.6. Deployment Limiting Conditions.

2.3. IMR Criteria by Element.

2.3.1. PHA: PHAs will be conducted annually per AFI 44-170, Preventive Health Assessment. (T-0).

2.3.1.1. For reports to DoD and for internal AF IMR reporting purposes, all AF members, including Active Component and ARC members will use the DoDI 6025.19 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 (i.e., the PHA is green for 365 days; turns yellow (due) on day 366, and turns red (overdue) 90 days later on day 456). Except as noted below, all AF and ARC members will follow these guidelines in scheduling to maintain PHA currency. (T-0).

2.3.1.2. Flying and Special Duty Operations personnel will follow existing guidance in AFI 44-170. Required examinations for these personnel are in sync with current PHA and IMR reporting business rules. (T-1).
2.3.1.3. Reserve members and Non-Unit Reserve Personnel (i.e., Category B and E) 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. (T-1).

2.3.1.4. During deployments and for three months following deployment, members will not be monitored for PHA currency. PHAs do not need to be accomplished on deploying Airmen as long as the PHA is current (within 365 days of the last recorded PHA) on the projected Required Delivery Date. Note: For further guidance, refer to AFI 44-170. (T-1).

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.” For Active Component members, the grace period will extend through the end of the month following the month the dental exam became due. For ARC members, IAW DoDI 6025.19, the grace period will extend for 3 months after the dental exam is 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. (T-0).

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. The DoDI allows a 90-day grace period after the dental exam is due. (T-0).

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). (T-0).

2.3.2.4. 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. (T-3).

2.3.2.5. During deployments and for three months following deployment, members will not be monitored for dental examination currency IAW AFI 47-101. Dental examinations do not need to be accomplished on deploying Airmen as long as the dental examination is current (within 365 days of the last documented dental examination) on the projected Required Delivery Date and the member is Dental Class 1 or 2. (T-2).

2.3.3. Immunizations.

2.3.3.1. It is DoD and AF policy to follow the Advisory Committee on Immunization Practices (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. (T-0).

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 exclusively into ASIMS Web. (T-2).

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 ASIMS Web as YELLOW flags and are reflected in its reports. 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. (T-3).

2.3.3.2. Immunization requirements are noted elsewhere but are reflected in ASIMS Web, 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 MAJCOM personnel in coordination with the DHA/HIT Solution Delivery Division when these requirements are identified. Once the requirement is loaded, the vaccine(s) will reflect as Due in ASIMS Web. (T-1).

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. (T-1).

2.3.3.3.1. Current DoD IMR required vaccinations IAW DoD Instruction 6025.19, Individual Medical Readiness and AFJI 48-110, Immunizations and Chemoprophylaxis, 29 Sep 2006: 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). (T-0).

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 influenza requirement is valid from 1 October (or slightly earlier if vaccine is available) until 30 June of each fiscal year based on DoDI 6025.19. (T-0).

2.3.3.3.3. Once in deployed status, members will no longer be monitored for individual medical readiness purposes and will remain unmonitored for three months 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. (T-1).

2.3.3.3.4. Members with validated administrative or medical exemptions are excluded from these requirements and reporting. (T-2).

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 ASIMS Web 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 ASIMS Web that drives the requirement for a gas mask insert. (T-2).

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 ASIMS Web. After this 30-day grace period, the member will become “not medically ready” until ASIMS Web is either updated automatically by the SRTS system or manually with an issue date by medical personnel. (T-2).

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 ASIMS Web and a source document will be posted to the Knowledge Exchange at https://kx2.afms.mil. (T-1).

2.3.5.2. Except for pre-deployment HIV screening, all AF and ARC personnel are screened for serological evidence of HIV infection every 24 months. Members will be flagged YELLOW at 24 months and will remain yellow for 90 days to allow synchronization with the members PHA appointment. (T-1).

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 ASIMS Web when the specimen has been received and logged. Once logged and updated in ASIMS Web, 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. (T-1).

2.3.5.4. DoDI 6025.19 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. (T-0).

2.3.6. Deployment Limiting Conditions. (T-1).

2.3.6.1. Members must have no deployment limiting condition to be determined “medically ready.” Members on a AF Form 469 duty limiting condition, code 31, 37, 81 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.” (T-1).

2.3.6.2. Commanders should reference ASIMS Web, contact the member’s provider, or the Chief, Aeromedical Services for questions regarding the member’s deployability. **Note:** See AFI 48-123, Medical Examinations and Standards, AFI 10-203, Duty Limiting
Conditions, AFI 36-2110, Assignments (Table 2.1 and 2.2), and AFI 41-210, Patient Administration Functions, for a description of profiling, Assignment Limitation Codes and Assignment Availability Codes. (T-1).

2.4. IMR Goals. (T-1).

2.4.1. The AF goal for IMR is 80%. Note: the AF goal of 80% reflects those Service members that are considered “Fully Medically Ready.” Refer to DoDI 6025.19, Individual Medical Readiness, for DoD current goal and category requirements. (T-1).

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 Airmen 2 only needs to correct 1 item to bring the unit IMR score up.

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DCS, Operations, Plans and Requirements
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References
Title 10, United States Code Sections 136(d) and 671
*Fiscal Year 2005, October 28, 2004
DoD Instruction 6025.19, Individual Medical Readiness, October 2, 2013
DoD Directive 6200.04, Force Health Protection, October 9, 2004
AFJI 48-110, Immunizations and Chemoprophylaxis, 29 September 2006
AFI 36-3209, Separation and Retirement Procedures for ANG and AFR Members, 14 April, 2005
AFI 41-210, Tricare Operations and Patient Administration Functions, 6 June, 2012
AFI 44-170, Preventive Health Assessment, 22 February 2012
AFI 47-101, Managing Air Force Dental Services, 1 June 2009
AFI 48-123, Medical Examinations and Standards, 24 September, 2009
AFI 48-135, Human Immunodeficiency Virus Program, 13 May, 2010
AFI36-2110, Assignments, 22 September, 2009
AFPD 10-2, Readiness, 6 November 2012
Assistant Secretary of Defense, Health Affairs Policy Memo, 06-006, Periodic Health
Assessment Policy for Active Duty and Selected Reserve Members, February 16, 2006

Prescribed Forms
None

Adopted Forms
AF Form 847, Recommendation for Change of Publication

Abbreviations and Acronyms
AD—Active Duty
AF—Air Force
AFI—Air Force Instruction
AFMAN—Air Force Manual
AFMOA—Air Force Medical Operations Agency
AFPAM—Air Force Pamphlet
AFPD—Air Force Policy Directive
AFRC—Air Force Reserve Command
AHLTA—Armed Forces Health Longitudinal Technology Application, the DoD Electronic Medical Record
ANG—Air National Guard
ARC—Air Reserve Component
ASIMS—Aeromedical Services Information Management System
CC—Commander
DHA/HIT—Defense Health Agency/Health Information Technology
DLC—Duty Limiting Conditions
DNA—Deoxyribonucleic Acid. Genetic material used for positive identification of remains.
DoD—Department of Defense
DoDI—Department of Defense Instruction
DRHA—Deployment-Related Health Assessment
DRRS—Defense Readiness Reporting System
DRU—Direct Reporting Unit
G6PD—Glucose-6-Phosphate Dehydrogenase. An enzyme critical for certain drug metabolism, e.g. malaria prophylaxis medication.
GMU—Guard Medical Unit
GSU—Geographically Separated Unit
Hgb-S—Hemoglobin-S. Abnormal hemoglobin linked with sickle trait and sickle cell disease.
HQ—Headquarters
IAW—in accordance with
IMA—Individual Mobility Augmentee
IMR—Individual Medical Readiness
KX—Air Force Medical Service Knowledge Exchange
MAJCOM—Major Command
MDG—Medical Group
MTF—Medical Treatment Facility
OPR—Office of Primary Responsibility
PA—Privacy Act
PCS—Permanent Change of Station
PHA—Preventive or Periodic Health Assessment
PRP—Personnel Reliability Program
RCPHA—Reserve Component Preventive Health Assessment application
RMU—Reserve Medical Unit
SG—Surgeon General
SGH—Chief of the Medical Staff
SGP—Chief of Aerospace Medicine
TDY—Temporary Duty
UHM—Unit Health Monitor
Web HA—Web-based Health Assessment