Headquarters
New Zealand Defence Force
Defence House
Private Bag 39997
Wellington Mail Centre
Lower Hutt 5045
New Zealand

OIA-2025-5255

19th February 2025

[redacted]

Dear [redacted]

I refer to your email of 22 January 2025 requesting, under the Official Information Act 1982 (OIA), *all policy and or guidelines from NZDF* concerning the matters listed below.

ADHD

The New Zealand Defence Force (NZDF) direction to medical practitioners on neurodevelopmental disorders including Attention Deficit Hyperactivity Disorder is outlined at Defence Health Rules 31, Part 3, Chapter 6. A copy is provided at Enclosure 1.

Depression and or anxiety

The NZDF has a systematic approach to managing mental health conditions and does not have policy or guidelines explicitly targeting depression or anxiety. Conditions are managed clinically as per New Zealand national best practice. This part of your request is therefore declined in accordance with section 18(e) of OIA, as the information requested does not exist.

Medical exemptions for recruits/candidates
Medical exemptions for recruits/candidates with Depression and or anxiety.
Recruitment medical appeal process.
Policy relating to recruiting those with Depression and or anxiety.

NZDF medical processes are outlined in Defence Health Rules 11 NZDF Personnel: Health Provisions. A copy is provided at Enclosure 2.

You have the right, under section 28(3) of the OIA, to ask an Ombudsman to review this response to your request. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that responses to official information requests are proactively released where possible. This response to your request will be published shortly on the NZDF website, with your personal information removed.

Yours sincerely

GA Motley
Brigadier
Chief of Staff HQNZDF

Enclosures:
1. Defence Health Rules 31, Part 3, Chapter 6
2. Defence Health Rules 11

Chapter 6 - The management of neurodevelopmental disorders in Regular Force members of the Armed Forces

Purpose of rule

The purpose of this rule is to provide direction to New Zealand Defence Force (NZDF) medical practitioners on neurodevelopmental disorders (ND), specifically autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), as they relate to Regular Force members of the Armed Forces.

Application

a. This rule applies to NZDF—

(1) medical practitioners (Defence Health and other medical practitioners under the technical control of the Surgeon General); and

(2) Regular Force members of the Armed Forces.

b. This rule does not apply to Territorial Force members of the Armed Forces. Territorial Force members are to be assessed on a case-by-case basis and are to be referred to the Principal Medical Officer (PMO) or Chief Medical Officer (CMO) for assessment. Any decisions on the management of Territorial Force personnel are to be based on operational and/or occupational requirements.

c. As this rule relates specifically to ASD and ADHD, other NDs are to be addressed on a case-by-case basis.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the CMO.

c. The Regulatory Custodian for this rule is the CMO.

d. The Custodian for this rule is the Director Defence Health Policy (DDHP).

31.3.6.1 Background

Due to growing public awareness of neurodivergence, there has been an increase in the number of Regular Force members presenting with concerns about ASD or ADHD in themselves. Individuals are approaching NZDF healthcare professionals for diagnoses, driven by a desire to better understand their cognitive and behavioural patterns. This trend underscores the importance of having transparent and robust practices for the diagnosis, treatment and management of NDs and their occupational implications.

31.3.6.2 Neurodiversity and neurodevelopmental disorders

It is important to distinguish neurodiversity from neurodevelopmental disorders. Neurodiversity refers to the broad spectrum of variations in human cognition and behaviour, which includes a wide range of traits and characteristics that are not necessarily linked to any diagnosable condition or disorder. In contrast, NDs such as ASD and ADHD are clinically recognised and diagnosable conditions.

31.3.6.3 Neurodevelopmental disorders

a. NDs encompass a range of diagnoses including intellectual disabilities and specific learning disorders. NDs are behavioural and cognitive conditions present throughout life, involving significant challenges in specific cognitive, motor, language and social functions. While many mental health issues show behavioural and cognitive deficits early on (eg schizophrenia or bipolar disorder), only those with core neurodevelopmental features fall into this category.

b. By definition, NDs significantly impact personal, family, social, educational, occupational and/or other important functions and are typically evident across multiple settings, though impact may differ according to context and individual adaptation.

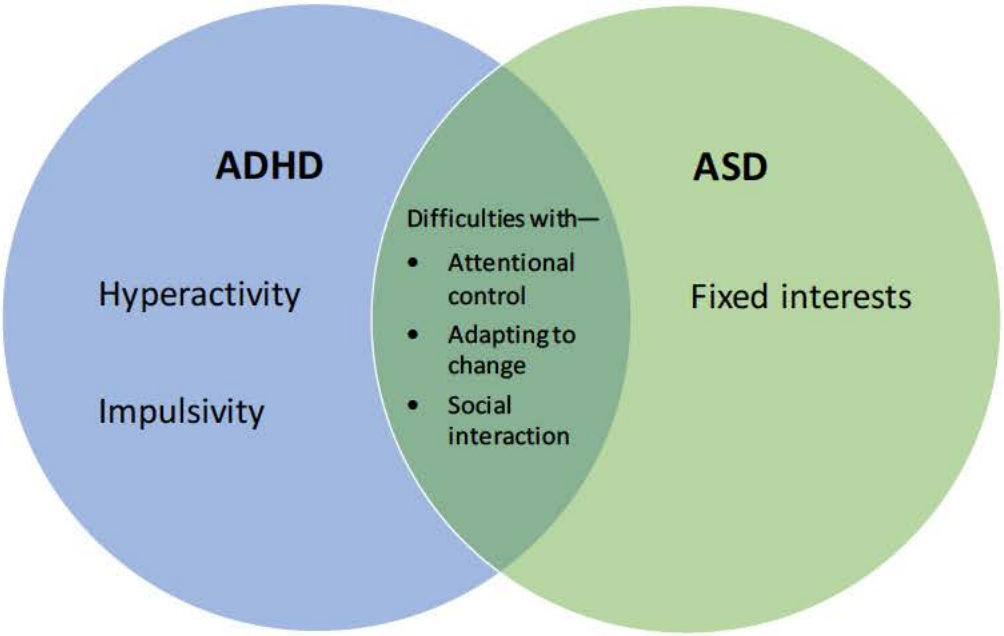
c. NDs usually onset during the toddler, child or adolescent stage of development. Symptoms may be 'outgrown' during childhood or adolescence, or they may persist into adulthood. In some cases, symptoms may not be detected or diagnosed during these stages, and a person may go undiagnosed until adulthood.

d. ASD and ADHD both present on a continuum, are highly heterogeneous and their functional impact can vary depending on context and demands on the individual. They have high comorbidity and share several common features, as shown in Figure 31.3.6.1 *Challenges typically experienced by those with ADHD and ASD*.

e. While ASD and ADHD can present unique challenges, they also come with distinct strengths (eg attention to detail and creativity), which can be harnessed effectively with appropriate support and intervention.

f. This policy specifically addresses the needs, diagnosis and management of Regular Force members presenting with ASD and ADHD (referred to in this policy as NDs). It does not encompass broader neurodivergent traits that do not fall within these medical diagnoses. The responsibility of understanding, supporting and leading individuals with broader neurodivergent traits falls under the purview of command and management, who are to ensure that diverse cognitive and behavioural patterns are accommodated appropriately within the Armed Forces' operational and occupational framework.

Figure 31.3.6.1 – Challenges typically experienced by those with ADHD and ASD



31.3.6.4 Recruit medical standards

The intent of recruit medical standards is to ensure that personnel accepted for service in the NZDF will not face health challenges that will be exacerbated by, or cannot be supported during, their service. The recruit medical standards are specified in DHR 11 *NZDF Personnel: Health Provisions*, Part 1, Chapter 1 *Recruit Medical Standards*. Due to the nature of Aircrew roles, and other considerations such as Civil Aviation Authority rules, separate recruitment standards apply to Aircrew (refer to DHR 11, Part 1, Chapter 4 *Aircrew Recruitment*).

Note: Aircrew recruitment standards apply both when individuals are recruited ab initio and when Regular Force members transfer from another Service.

31.3.6.5 New presentation or diagnosis in serving members

a. ND traits can interact with military duties in both beneficial and undesirable ways. ND traits may be beneficial in the military context in the following ways—

   (1) Intense focus, strong adherence to routines and attention to detail traits may benefit technical or analysis roles, where an ability to concentrate deeply on specific tasks and identify patterns can enhance operational efficiency and accuracy.

   (2) High energy levels may enable an individual to succeed in roles that are reactive or require non-linear thinking.

b. However, there are also potential challenges associated with NDs in a military context, which may include the following—

   (1) Difficulties with social communication and interaction may impact the ability to work effectively in team-based environments.

(2) The structured and hierarchical nature of military life, while beneficial in some respects, can pose difficulties for some individuals with NDs if abrupt changes or deviations from expected routines occur.

(3) Having fixed interests and difficulty adapting to change may prove a challenge in roles that require rapid, dynamic decision-making and adaptability.

(4) Any sensory sensitivities might be exacerbated by the intense and often unpredictable stimuli encountered during military operations, potentially leading to heightened stress or anxiety.

(5) While individuals may be able to complete initial trade training, learning challenges may be identified through increasing academic requirements associated with career progression.

31.3.6.6 Identification, diagnosis and prognosis

a. NDs may be challenging to identify due to their heterogeneity, high comorbidity with mental health conditions and symptoms/signs that may mask or mimic other disorders. This complexity can significantly impact the process of diagnosis, prognosis, and treatment, necessitating comprehensive assessments to ensure an accurate diagnosis.

b. In the case of a Regular Force member, the possibility of a ND may be recognised due to concerns raised (eg by the member themselves). This may be precipitated by a change in duties/activities (eg a move from an operational/field role to a staff role or with change in requirements as an individual progresses in rank) or signs of a mental health condition (eg persistent anxiety or mood difficulties).

c. Where the possibility of a ND is identified (whether that be by the individual, their command/management or by health elements), the individual is to be assessed by an NZDF medical practitioner. If the medical practitioner decides further investigation/ assessment is required, and there is potential for impact on the employment or deployment of the individual, an external specialist assessment may be funded (refer to Health Instruction (HI) 012/15 *Authority for Private Treatment at Public (NZDF) Expense*).

d. An ND diagnosis must be made only by an external specialist who is to provide supporting documentation that should include face-to-face assessment, thorough history and collateral information. Any diagnosis must meet the International Classification of Diseases (ICD) 11: *Classification of Mental and Behavioural Disorders diagnostic criteria*. Self-diagnosis by an individual (eg via an online survey) will not be accepted as a diagnosis (although this may contribute to initial clinical hypothesis prompting an assessment).

e. Prognosis can vary widely depending on the unique combination of context, symptoms and co-occurring conditions, often requiring personalised treatment plans. Moreover, this variability underscores the importance of ongoing monitoring and adjustment of treatment strategies, which may include tailored therapeutic interventions and medication management, to effectively support the individual in both their personal and professional lives.

f. Regular Force members whose neurodivergent traits do not meet the ND diagnostic threshold may be connected with services outside the health system. These may include adult learning tutors, organisational psychologists and other professionals providing tailored guidance to enhance their functioning in both interpersonal and professional domains.

31.3.6.7 Medications

a. Medications may be useful in the treatment of NDs (eg methylphenidate can help those with ADHD manage hyperactivity, agitation and inattentiveness).

b. These medications may be prescribed by—

(1) a treating external psychiatrist;

(2) a treating external paediatrician; or

(3) an NZDF medical practitioner with—

(a) specialist approval; and

(b) a PHARMAC Special Authority Number.

c. As with any medication, ND medications are associated with side effects, which may include, but are not limited to—

(1) rebound effect (a short period of fatigue, increased activity or a bad mood as the medication wears off);

(2) anxiety;

(3) tics;

(4) upset stomach;

(5) changes in blood pressure or heart rate;

(6) decreased appetite; and

(7) difficulty sleeping.

d. When medications are prescribed, the following implications must be determined—

(1) the effects (including side effects) of the prescribed medication on the individual's employability;

(2) international travel restrictions (due country-specific drug regulations and the requirement for a guaranteed supply of medication); and

(3) implications of stopping any medication, such as the effects of withdrawal.

e. Due to the issues in rules 31.3.6.7 b and c, caution is to be exercised by NZDF medical practitioners in the prescribing of medications for the treatment of NDs for Regular Force members. If medications are prescribed in accordance with rule 31.3.6.7.b, the implications on occupational medical grading and restrictions are to be considered (refer to rules 31.3.6.9 *Occupational medical grading and restrictions: Aircrew* and 31.3.6.10 *Occupational medical grading and restrictions: Regular Force members non-Aircrew*).

31.3.6.8 Other treatments

Other treatment options for NDs include, but are not limited to—

(1) behavioural therapy, including—

(a) cognitive behavioural therapy;

(b) specific skills coaching (eg interpersonal skills); and

(c) applied behavioural analysis; and

(2) wellness options, including—

(a) nutrition; and

(b) exercise.

31.3.6.9 Occupational medical grading and restrictions: Aircrew

a. As per rule 31.3.6.4 *Recruit medical standards*, the ND standards for Aircrew are stipulated in the *NZDF Aircrew Medical Standards*. In general, applicants with diagnosed NDs are to be deemed Unfit Aircrew Selection. However, an Aircrew applicant with a previously diagnosed ND who has had no medications or symptoms for at least 2 years may be considered (to be assessed on a case-by-case basis).

b. Aircrew diagnosed with an ND while in service are to be assigned an individual occupational medical grading and appropriate restrictions, as approved by the Officer Commanding the Aviation Medicine Unit.

31.3.6.10 Occupational medical grading and restrictions: Regular Force members non-Aircrew

a. Where a diagnosis is made by an external specialist, the following occupational medical grade and restrictions are to apply—

(1) Where the condition and/or medication prescribed for treatment of the condition significantly impact(s) day-to-day functioning—

(a) Air: A4.

(b) General: G4.

(c) Zone (deployability): Z4 or Z5.

(d) Review period: R3 (or shorter, as clinically appropriate).

(e) Unfit deployment.

(2) Where the condition and/or medication prescribed for treatment of the condition does not have a significant impact on day-to-day functioning for a minimum period of six months—

(a) Air: A4.

(b) General: G3.

(c) Zone (deployability): Z2.

(d) Review period: R12, noting comorbidity of mental health conditions.

(e) Waiver required for deployments (subject to prescription medicine supply).

31.3.6.11 Medical review of service

The medical review of service policy must be applied to permanent medical downgrades on the basis of identified health issues that affect the employability or deployability of an individual so that a balanced review of service and/or trade can be considered (refer to DHR 11, Part 2, Chapter 3 *Medical Review of Service Process*).

Defence Health Rules 11 NZDF Personnel: Health Provisions

Defence Health Directorate
Headquarters New Zealand Defence Force
WELLINGTON

AUTHORITY ORDER

Defence Health Rules 11
NZDF Personnel: Health Provisions

Issued by the Surgeon General
Defence Health Directorate, Headquarters New Zealand Defence Force

Authority

1. Defence Health Rules (DHR) 11 *NZDF Personnel: Health Provisions* is issued and promulgated under the delegated authority of the Chief of Defence Force (CDF) to the Surgeon General, Defence Health Directorate, pursuant to s 30(2) of the Defence Act 1990, to regulate and administer specified functions and activities, and to issue publications within the New Zealand Defence Force (NZDF).

2. Every order, rule, instruction and procedure contained in this publication is to be considered applicable to all whom it may concern and is to be complied with when relevant to a particular function or area of responsibility and accountability.

Conflict

3. Nothing in this publication is to be construed as prevailing over any relevant Act of Parliament or Regulations made under it, or Defence Force Orders issued and promulgated by the CDF or under a delegated authority.

4. Any conflict between the mandatory requirements stated in this publication and any other policy, order, rule or procedure issued within the NZDF is to be reported to the Custodian without delay.

CM TATE
Colonel
Surgeon General

07 November 2022

CONTENTS

PRELIMINARY PROVISIONS

Purpose of Defence Health Rules 11

1. The purpose of Defence Health Rules (DHR) 11 *NZDF Personnel: Health Provisions* is to prescribe the regulatory management processes required to ensure the safe and legal provision of health services to New Zealand Defence Force (NZDF) personnel in order to—

   a. minimise the potential for patient harm;

   b. support operational outputs; and

   c. meet health and logistics regulation compliance.

2. Acceptable Means of Compliance (AMC) and Guidance Material (GM) are included in this DHR (DHR 11). The AMC are supplementary information, and they are not mandatory unless they are referenced as the means of compliance within the content of this DHR. GM are supporting information and not mandatory.

   Note: Throughout the period of transition to compliance with DHR 11, this publication will be continually updated. Some hyperlinks may not function as intended, and readers may find themselves directed to this front page. If unable to find the material you are looking for, contact DHDPolicy@nzdf.mil.nz.

Application

3. This is a general order to all members of the Armed Forces pursuant to s 30 of the Defence Act 1990 and instructions to members of the Civil Staff.

4. All members of the NZDF must comply with the rules stipulated in this publication.

5. The rules in DHR 11 apply equally to contractors and consultants, persons seconded to the NZDF from external employers, contractors, sub-contractors and their respective employees working in NZDF areas or organisations engaged for NZDF purposes. It is the responsibility of the member of the NZDF engaging any contractor, consultant or other person not a member of the NZDF to make them aware of these requirements and to include such requirements in their contracts.

6. Non-compliance with these rules may result in disciplinary action being taken in accordance with the Armed Forces Discipline Act 1971 or may result in possible sanctions in accordance with the NZDF *Civil Staff Code of Conduct*.

7. Non-compliance by persons seconded to the NZDF from external employers, contractors, sub-contractors and their respective employees could lead to a contract or secondment being terminated.

Effective date

8. This publication is effective from the date of promulgation (Version 1.00) and any ensuing amendments to the publication version.

Authorising Authority, Approving Authority and Custodian

9. The Authorising Authority for DHR 11 is the Surgeon General.

10. The Approving Authority for DHR 11 is the Surgeon General.

11. The Custodian for DHR 11 is the Director Defence Health Policy.

Amendments

12. A person submitting a proposed rule or amendment is to—

    a. send the proposed rule or amendment to the DHR 11 Custodian;

    b. include the text or substance of the rule or amendment proposed or the rule that the petitioner seeks to have repealed;

    c. state which interested persons have contributed to the development of the draft rule or amendment; and

    d. include recommendation and supporting details for the technical consideration.

13. Revision bars will identify only changes made at the current amendment status.

14. Amendments to this publication are documented in the Record of Change in the end matter.

Meanings of terms

15. Terms used in DHR 11 and not explained elsewhere are defined in the NZDF Glossary.

    Note: Terms that have a definition are indicated by underlined, blue text and are hyperlinked to their entry in the NZDF Glossary.

Authoritative version of DHR 11

16. The online copy of DHR 11 promulgated in the NZDF information environment is the authoritative version. Any printed copy or any other electronic copy is deemed uncontrolled and is to be used for guidance only. Users should check the DHR online to ensure they are using the current release.

Legislation and Related Publications applicable to DHR 11

17. Any legislation and related publications applicable to each Part of DHR 11 will be specified within each part.

PART 1 - RECRUIT STANDARDS AND PROCESSES

Chapter 1 - Recruit Medical Standards

Purpose of rule

The purpose of this rule is to specify the health standards to be applied in the assessment of the suitability of applicants for recruitment into the New Zealand Defence Force (NZDF).

Application

a. This rule applies to the health standards for the recruitment process for NZDF personnel only.

b. This rule does not apply to the ongoing management of NZDF personnel.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulating Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.1.1.1 Personnel responsibilities

Defence Health medical practitioners in the recruitment process are responsible for application of the medical standards to the recruit applicants in the assessment of suitability for service.

11.1.1.2 NZDF health standards

The NZDF health standards are derived from the Australian Defence Force medical standards.

11.1.1.3 Authority

a. Medical practitioners assessing applicant suitability are to apply these health standards in the assessment process.

b. Recruiting medical practitioners are not to change these medical standards. Where a requirement for change is identified, the medical practitioner concerned is to notify the Director of Health Policy to initiate a change management process.

11.1.1.4 Requirement for health standards

It is an inherent requirement of employment in the NZDF for all members to be operationally deployable. The enlisted member or officer is in general primarily a combatant and secondarily a specialist tradesperson. NZDF members must be able to deploy at short notice and this is reflected in specific conditions of service and health standards that must be fulfilled. Enlistees (both Regular and Reserve) must be medically fit to deploy at the time they enter the NZDF.

11.1.1.5 Meaning of recruiting health classification terms

a. NZDF Recruiting Health Classifications—

(1) **Class 1**. At the Initial Health Check stage, this candidate may proceed to a full health assessment (MD911 *NZDF Medical Examination Record*). If Class 1 classification is confirmed following the MD911 NZDF medical examination, this candidate is 'recommended' as medically fit for enlistment.

(2) **Class 3R (Report)**. This class denotes 'further information required'. A report must be obtained from a healthcare provider about a medical condition or clinical finding. Once the diagnosis has been made, and the prognosis and requirement for healthcare has been determined, the case is to be reviewed. The applicant may then be allocated a health classification (usually Class 1 or 4).

(3) **Class 3T (Temporary)**. This class denotes that the condition or clinical finding is remediable and likely to resolve within 12 months. The applicant is 'temporarily not recommended' but may be made Class 1 when they provide a letter from an appropriate healthcare provider stating that the condition has fully resolved and that the risk of sequelae or likelihood of recurrence is small.

(4) **Class 4**—

(a) This class denotes that the applicant is 'permanently not recommended'. This means permanently medically unfit for military service (Class 4). 'Permanently', for the purposes of this classification, denotes longer than 12 months. An explanation of the reason the condition is not compatible with service in the NZDF is included in the Medical Recruit Standards Specifications.

(b) An applicant may decide to appeal this decision, but in this case all costs associated with obtaining a second or subsequent medical opinion is the responsibility of the applicant. In some cases, applicants will be Class 4 based on current or historical symptoms, but if symptoms remit, or become absent for a period of time as prescribed, the applicants may be reassessed later as suitable for recruitment.

b. For these codes to be applied, there is a requirement for the health classification codes to be mapped to the NZDF terms used in the recruitment process. The comparative meaning of the terms is stated in Table 11.1.1.1.

Table 11.1.1.1—Mapping of Recruit Classifications

NZDF Recruit Classification	Description	Recruit Health Classification
Recommended	Fit for entry	Class 1
Further Information Required	Decision pending further information	Class 3R
Temporarily Unfit	Not recommended temporary or specialist assessment required	Class 3T
Not Recommended	Declined permanently as medically unfit	Class 4

11.1.1.6 Classification of applicants

a. It is most important that applicants meet strict health requirements at the medical assessment stage of recruitment. It is not possible to include all conditions in this Standard, but the vast majority of conditions that will affect an applicant's suitability for military service are listed in the NZDF Recruit Medical Standards Specifications.

b. Each condition listed in the NZDF Recruit Medical Standards Specifications is assigned a recruiting health classification. The Recruiting Medical Practitioner is to assign a NZDF Recruit classification to each applicant for enlistment based on their suitability for service within NZDF. Entrants will be allocated a medical employment standard on entry to the NZDF.

c. Where there is no listing for a particular condition, the case must be taken on its merits with regard to potential short- and long-term impact. Military and clinical medical expert advice should be sought in these cases. In allocating a classification for conditions not listed, medical practitioners are to consider the factors addressed in rule 11.1.1.5 *Meaning of recruiting health classification terms*. Where any doubt or uncertainty exists, the case is to be discussed with the Principle Medical Officer (PMO).

11.1.1.7 Factors for consideration

a. The following factors are to be considered when determining the operational deployability of an individual. These underlie the health standards that applicants are screened against—

(1) **Function**. The ability of the individual to perform the physical and intellectual tasks required.

(2) **General living conditions**. The applicant must be capable of operating efficiently and effectively in all types of living and operating conditions, including occupational and domiciliary accommodation.

(3) **Clothing and equipment.** The applicant must be able to wear and use all standard issue specific clothing and equipment, including personal protective equipment.

(4) **Climate.** Individuals are expected to be capable of prolonged physical activity in extremes of environmental conditions and for extended periods of time.

11.1.1.8 Rejection of applicants

a. This rule defines the health conditions that may render an applicant permanently medically unfit for recruitment. Those applicants who do not satisfy the health standards in this rule are to be 'Class 4' in the first instance, once all available clinical information has been reviewed.

b. Recruiting officers are not to advise applicants of their unsuitability until medical administrative responsibilities have been satisfied. For those applicants who are rejected on medical grounds, it is important, for both legal and ethical reasons, that the reasons for rejection are communicated to them fully and in an easily understood manner.

c. If a rejected applicant has a condition requiring further investigation or treatment, they must be informed in writing to consult their general practitioner regarding this condition. Therefore, medical practitioners must critically assess the Medical History Questionnaire (Initial Health Check) and the MD911 to confirm the applicant's suitability for Service life. Accurate recording of findings are also essential.

11.1.1.9 Doubtful applicants

a. Where doubt exists, expert advice should be sought from military and clinical medical specialists as appropriate. When possible, applicants should be referred to a specialist with NZDF experience. Medical specialists or healthcare providers undertaking examination of NZDF applicants should not provide an opinion on fitness for NZDF entry. The report should provide advice on the diagnosis, the treatment required and the prognosis.

b. Opinions regarding the medical fitness for specialist occupations are to be referred as follows—

(1) **Divers**. The Dive Medicine Certifying Authority. Prior to referring a diver applicant classified as Class 3 for specialist opinion or a medical report, the case should be discussed with the Dive Medical Certifying Authority to confirm the requirement.

(2) **Aviation-based occupations.** The Officer Commanding the Aviation Medicine Unit (OC AMU).

11.1.1.9A Command Medical Waivers

a. Where a candidate does not meet the minimum recruit medical standard for employment, but the Defence Recruiting Medical Officer (DRMO) believes that the candidate may be employable in some roles, the DRMO is to inform Trade Command or Defence Recruiting operations (DROPS). If Trade Command or DROPS desire to recruit the candidate, a Command Medical Waiver may be raised by DROPS.

b. The Command Medical Waiver is to be presented to a DRMO. The DRMO is to gather and consider all available information. Considerations include (but are not limited to)—

(1) the consensus opinion of other DRMOs and/or NZDF medical practitioners, as appropriate to the issue;

(2) the consensus opinion of single Service subject matter experts, as appropriate to the issue;

(3) evidence from external expert opinion; and

(4) available clinical literature.

c. The DRMO then forwards the Command Medical Waiver, with supporting information and advice, to the PMO.

d. The PMO is to then review the information and has the authority to decide the medical risk advice that is given to Trade Command/DROPS with regard to the appropriateness of the Command Medical Waiver application.

e. In the presence of a conflict of interest, in the absence of the PMO, or if the justification for a Command Medical Waiver is unclear or disputed, the Chief Medical Officer (CMO) will consider the Command Medical Waiver and provide medical risk advice to Trade Command/DROPS.

f. The Command Medical Waiver will be presented to the relevant Trade Command for progression.

g. Any decision regarding a Command Medical Waiver of a recruit medical standard is to be raised with the appropriate Single Service Career Manager by the Defence Recruiting Case Engagement Facilitator. In this case, health make the recommendation; however, the relevant Single Service Deputy Chief has final approval authority.

11.1.1.9B Candidate appeals

a. Candidates may appeal a medical assessment decision.

b. The candidate may appeal the decision on the basis of new evidence provided in support of the application, supporting either a Command Medical Waiver of the recruit medical standards or the candidate’s compliance with the recruit medical standards.

c. Appeals are considered by the DRMO in the first instance. The DRMO is to consider all available evidence, including (but not limited to)—

(1) the consensus opinion of other DRMO and/or NZDF medical practitioners, as appropriate to the issue;

(2) the consensus opinion of Single Service subject matter experts, as appropriate to the issue;

(3) evidence from external expert opinion; and

(4) available clinical literature.

d. The DRMO, based on the consideration of evidence, may uphold the candidate's appeal if the information renders the candidate compliant with the recruit medical standards.

e. If, after consideration of the evidence, the DRMO considers that the candidate still does not meet the recruit medical standards, the candidate will again be declined. If the candidate appeals a second time and still does not meet the recruit medical standards, the candidate's appeal is to be referred to a Medical Review Board (MRB). This may also occur—

(1) if there is a conflict of interest;

(2) in the absence of the DRMO; and/or

(3) if the justification for appeal is unclear or disputed.

f. If an MRB is not able to be completed in the required time, the PMO may consider the appeal and provide a decision.

g. Where the decision of the DRMO, PMO or MRB is disputed or appealed, the CMO is responsible for making a decision. This decision is final and cannot be appealed within Defence Health.

11.1.1.9C Medical Review Boards

a. MRBs will be convened where—

(1) an appeal has not resulted in a clearly acceptable or unacceptable candidate;

(2) in complex cases where the recruit medical standards do not clearly apply;

(3) where a candidate does not meet the minimum recruit medical standard for employment and a DRMO believes that the candidate is fit for service, despite the identified condition; and/or

(4) in any case where a previously declined appeal has been re-submitted.

b. The MRB is to be convened with a minimum of three experienced NZDF medical practitioners. One of the members of the MRB must be either the Senior DRMO or the PMO. MRBs may be conducted either in-person or virtually. In addition, it is preferred for tri-service representation to be present where practicable. The meetings are to be held quarterly, or as required by Defence Recruiting outputs.

c. In addition to the considerations in rules 11.1.1.9A.b and 11.1.1.9B.c, MRB members are to consider—

(1) the expected progression of the condition;

(2) whether military service will exacerbate symptoms or hasten the progression of the condition;

(3) features of the condition that may affect service and deployability (for example, restrictions on physical activity or a need for monitoring);

(4) the trade of the candidate and the trade exposures relevant to the condition (some trades' business as usual tasks may be less likely to exacerbate a condition); and

(5) Service demand for the candidate trade and any unique skills the candidate possesses that are desirable to the service.

d. All candidates accepted for enlistment at MRB review must—

(1) enter service with a deployable grading (minimum A4 G3 Z1);

(2) be expected to complete Basic/Initial training without concern from the reviewed condition(s); and

(3) be reasonably expected to be able to serve without restriction from that condition(s) for at least 5 years.

e. If these specifications are not met, then the candidate may either be referred for a Command Medical Waiver, if appropriate, or will be made permanently unfit and may appeal only through the Surgeon General.

11.1.1.9D Significant cases

Clinical cases or clinical governance issues that pose a potential risk to Defence, either reputational or functional, should be reported to the CMO by the DRMO. This must include any requirement for significant policy deviations or evidence of policy deficiencies.

11.1.1.10 Transfers

NZDF personnel applying for transfer to a specialist occupation stream or trade change are to meet the standards of this rule for the occupation stream/trade to which they are transferring.

11.1.1.11 Height standards

A minimum height of 152 cm is required for entry into all three services. There is no maximum height limit, although for applicants who are over 196 cm tall, consultation with the appropriate Trade Sponsor (through recruiting co-ordinator) may be required to identify any potential issues.

11.1.1.12 Medications

a. In general, any applicant who requires regular or long-term medication to control a medical condition (contraception excluded) will normally be unfit service. This is because it may be difficult to re-supply medications in the deployed situation, medications may be destroyed, degraded (heat/wet), lost or denied for periods of time.

b. Should a candidate taking a regular medication be considered for enlistment, a designated recruiting medical officer must authorise the enlistment considering the impact of the medication on deployability.

11.1.1.13 Vision and colour vision entry standards

a. Applicants must have adequate visual acuity to perform highly skilled and complex tasks, often in conditions of limited visibility. Members may be unable to wear visual aids under certain conditions, especially in an emergency. During training and action, there is always the risk of damage or loss of spectacles or contact lenses with no facility for quick replacement. The ability to see targets at a distance and distinguish signals is vitally important for individual and collective safety.

b. Vision Assessment General. All applicants who wear glasses and applicants with an uncorrected visual acuity of 6/9 or below, in either eye, are to be assessed by an optometrist and the results recorded on an MD913 *NZDF Recruit Visual Assessment*.

c. Refractive errors of −7D or worse in any meridian (sphere plus cylinder) will render the candidate unfit for service.

d. The conditions that are a cause for rejection are contained in NZDF Recruit Medical Standards Specifications, Chapter 17 *Visual Systems.* These include, but are not limited to—

(1) keratoconus;

(2) amblyopia (outside the specified visual entry standard);

(3) monocularity (defined as one eye with normal vision and the second eye having a best corrected vision falling below 6/24), ;

(4) squint with refraction outside the entry visual standards for trade or squint with amblyopia or monocularity; and

(5) abnormal field of vision.

e. Applicants who do not meet the visual entry standard and wish to consider photorefractive surgery should be advised of the criteria detailed in the Annex Q of the Medical Recruit Annexes.

11.1.1.14 Individual Service standards

a. **Navy entry visual acuity criteria**. Navy has two entry visual standards that apply to specific branches and trades (NZDF Vision, colour perception, hearing standards tables)—

(1) VS1: Unaided 6/36 / 6/36—

(a) Aided: 6/6 / 6/9, both eyes 6/6; and

(b) Heterophoria: must not exceed Exophoria or Esophoria 6 dioptres or Hyper/Hypophoria of 1 prism diopter.

(2) VS2: Unaided 6/60 / 6/60—

(a) Aided: 6/6 / 6/12, both eyes 6/9; and

(b) Heterophoria: no limits.

b. **Army entry visual acuity criteria**. Refer to NZDF Vision, colour perception, hearing standards tables.

c. **Air Force entry visual acuity criteria**—

(1) For ground branches and trades, the applicant is fit for enlistment provided they meet the entry standard detailed in the table of Visual and Hearing Standards.

(2) Aircrew standards are issued separately by OC AMU.

11.1.1.15 Colour Perception standards

a. For many branches and trades, normal colour perception is essential for interpreting signals using coloured lights. These signals may relate to aircraft flight safety and landing guidelines, map reading and/or marine navigation. Some individuals with colour vision deficiency (CVD) may have difficulty interpreting signals, acting as lookouts or using equipment that requires specific colour discrimination. Thus, Colour Perception (CP) is classified as follows—

(1) Colour Perception A (CPA)—

(a) Ground trades: Successfully identifies all plates correctly on Titmus vision tester or 13 out of the 15 Ishihara pseudo-isochromatic plate edition.

(b) Aircrew and Special Forces: Require to pass the Ishihara 24 (two failures allowed) or 38 (three failures allowed) plate edition.

(2) Colour Perception B (CPB)—

(a) Red/Green colour safe.

(b) Unable to meet the standard for CPA but passes the Farnsworth Dichotomous D15 test.

(c) Aircrew and Special Forces candidates may be referred for further specialist testing to elucidate their level of CVD.

(3) Colour Perception C (CPC)—

(a) Severe CVD and red/green unsafe.

(b) Fail on Ishihara plates and fail on the Farnsworth D15 test.

b. Notes—

(1) The use of colour correcting lenses to meet the standard is unacceptable.

(2) Trade-specific colour vision standards are detailed in NZDF Vision, colour perception, hearing standards tables.

(3) For Navy, most trades need to be colour safe to ensure that members can perform duties such as bridge watch-keeping and marine navigation.

(4) The following trades (Navy) will require a specific trade test for colour vision if they are graded CPB—

(a) Electrical Technician.

(b) Marine Technician.

(c) Weapons Technician.

(d) Marine Engineering Officer.

(e) Weapons Engineering Officer.

11.1.1.16 Hearing entry standards

a. Service members require acceptable levels of hearing to ensure that communication and commands are heard clearly and unambiguously. Although NZDF makes every effort to protect hearing, it is unacceptable to enlist an applicant with a hearing deficit where further reduction (due to inadvertent noise exposure) could lead to a significant functional hearing loss.

b. The use of hearing aids or cochlear implants to meet the standard is not accepted. This is because the hearing aids could be damaged in austere/wet conditions.

c. The criteria for hearing standards 1–4 are as listed in Table 11.1.1.2.

Table 11.1.1.2—Criteria for Hearing Standards 1-4

	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
HS1	25	25	25	25	30	30	30
HS2	30	30	30	30	40	40	40
HS3	35	35	35	35	>15 dB change	>15 dB change	>15 dB change
HS4	>35	>35	>35	>35	>55	>55	>55

d. Trade-specific entry hearing standards for all three services are detailed in NZDF Vision, colour perception, hearing standards tables.

e. Notes—

(1) The required minimum hearing standard must be met in each ear independently.

(2) For Air Force, the entry standard is H1, but for some trades this can waivered to H2 with a supportive Ear, Nose and Throat (ENT) specialist report.

Chapter 2 - Recruit Candidate Immunisation Standards

Purpose of rule

The purpose of this rule is to specify the immunisation standards to be applied in the assessment of candidates for recruitment into the New Zealand Defence Force (NZDF). This will ensure that—

(1) all candidates are at the same standard when enlisted;

(2) all candidates are protected against diseases they may otherwise be susceptible to during initial training;

(3) efficient expenditure of NZDF resources during enlistment processes; and

(4) all relevant documents are available when creating care plans on the Defence Health Information System (Profile) to ensure compliance with future operational vaccination requirements.

Application

a. This rule applies to the vaccination standards for the recruitment process for NZDF Service personnel only (Regular and Territorial Force). This includes, but is not limited to—

(1) ab-initio recruits (no previous military service);

(2) lateral recruits (previous military experience);

(3) overseas applicants;

(4) band members; and

(5) re-enlisting personnel.

b. This policy does not detail the requirements or process for creating vaccination care plans when a candidate is enlisted.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.1.2.1 Personnel responsibilities

a. NZDF Recruit Vaccination Coordinators are to be registered nurses who have undergone vaccination administration training. The Recruiting Senior Medical Practitioner is responsible for approving NZDF Recruit Vaccination Coordinators.

b. The NZDF Recruit Vaccination Coordinators are responsible for assessing the evidence provided by the candidate and determining what further evidence or vaccines are required in order to continue a candidate's enlistment.

c. NZDF Recruit Vaccination Coordinators are not responsible for planning any catch-up vaccinations identified. This is a responsibility of the candidate's own healthcare provider.

d. NZDF Recruit Vaccination Coordinators have access to the health information system used by recruiting.

11.1.2.2 NZDF candidate Immunisation standard

a. The minimum NZDF Immunisation standard for candidates reflects the Ministry of Health's funded Primary Immunisation requirements for adults, plus some additional designated vaccines, such as the COVID-19 vaccine.

b. The NZDF does not require the completion of the course for human papillomavirus (HPV) vaccine (aged 26 years and under) but recommends candidates to consider or continue with this course of vaccination.

c. Some of the vaccines offered on the National Immunisation Schedule are for diseases common only in childhood and have changed over time. A candidate's vaccination history needs to be assessed based on what is currently required for the NZDF Baseline and not the National Immunisation Schedule at the time of the candidate's childhood.

d. Candidates will be considered to be at NZDF Recruit Immunisation Standard and marked as 'complete' when there is evidence of them having received the minimum vaccine doses detailed in the *NZDF Candidate Immunisation Standard*.

e. Candidates born prior to the introduction of the measles vaccine in1969 are considered immune to measles, as circulating virus and disease were highly prevalent at that time. Therefore, the MMR vaccination is not required as part of the Baseline Immunisation Standard if born prior to 1969. This should be noted in the candidate's medical notes.

f. Candidates must have had a tetanus booster within the previous 10 years.

g. The following points should be considered when assessing a candidate's tetanus vaccination status—

   (1) Some candidates will have received a tetanus booster after this time.

   (2) The date of the last administration of tetanus must be recorded to enable scheduling of subsequent vaccination.

h. Homeopathic vaccinations are not acceptable. A decision not to be vaccinated makes the candidate unfit for military service.

11.1.2.3 Requirement for Baseline Immunisation standards

a. All NZDF service personnel are required to be vaccinated to NZDF Baseline Immunisation standard.

b. All candidates (both Regular and Territorial Force) must have reached the National Immunisation Schedule primary immunisation requirements prior to enlistment.

c. If the candidate is unable to reach these vaccination standards, either by choice or for medical reasons, then they may be classified as unfit for military service.

11.1.2.4 Catch-up programmes prior to enlistment

a. Catch-up programmes for unimmunised or partially immunised children or adults are designed to provide a complete course of vaccinations in order to provide protection against specified diseases.

b. Some candidates are aged 17; they are still considered as children for the purposes of vaccination. Therefore, any of these candidates requiring 'catch-up' vaccines are entitled to free vaccinations listed in the National Immunisation Schedule.

c. Candidates aged 18 and older can be offered catch-up programmes to ensure they have been vaccinated. If a full primary course has not been received, candidates are to be instructed to complete these courses via their primary healthcare provider, at their own cost.

d. Enlistment into the NZDF is not an indication for an accelerated dosing schedule for hepatitis B vaccine.

11.1.2.5 Candidates from overseas

a. Candidates born overseas are required to provide evidence of completion of the primary courses above.

b. Accepted evidence can include—

(1) a childhood vaccination book or equivalent record;

(2) a vaccination record from their General Practitioner in their country of birth; or

(3) a printout from a government immunisation register where applicable (eg Australia has state-based registers).

c. The evidence needs to be in English or have abbreviations that are easily identifiable. If the evidence is in another language and not identifiable, the candidate is responsible for providing a certified official translation with the original document.

d. If no evidence is available, the candidate will need to be re-vaccinated in New Zealand as per the primary immunisation requirements for adults, including hepatitis B vaccination, by their primary care healthcare provider.

11.1.2.6 Acceptable evidence

a. The MD1187 *NZDF Recruit Vaccination History* form requires a copy of the candidate's vaccination record from their General Practitioner or their early childhood book (eg Well Child Tamariki Ora My Health Book) as evidence.

b. Evidence of any additional vaccines, including those for travel, are also to be provided as this may prevent these vaccines being given again after enlistment.

c. Serology will not be accepted as evidence of vaccination. The current immunisation handbook does not recommend serology as proof of vaccination, and this will not be accepted as evidence.

d. If a General Practitioner/Immunisation Status report is provided, it must have—

(1) the candidate's name;

(2) the candidate's National Hospital Identification number;

(3) the date printed; and

(4) the dates the vaccines were given (not only due dates).

e. If a childhood vaccination book (eg Well Child Tamariki Ora My Health Book) is provided, it must show (prior to submission to a registered nurse)—

(1) the page with dates and doses of vaccinations given; and

(2) the candidate's name written at the top of the page, or a note from a healthcare provider (signed and stamped) stating they have sighted it and to whom it refers.

f. A Candidate Engagement Facilitator at NZDF Recruiting—

(1) must ensure that all vaccination data is entered into the recruiting database;

(2) is responsible for the collection of information, not its analysis; and

(3) must acquire this information as soon as possible because the need for further vaccinations may delay a candidate's enlistment date.

g. The Health Data Manager at NZDF Recruiting is responsible for transferring vaccination data from the recruiting database to NZDF electronic health record before a candidate attends training. Practice Nurses at Defence Health Centres (DHCs) load the vaccination episode details into the individual's care plan on Profile.

h. Immunisation certificates are not acceptable without the above evidence, as accuracy relies on the reader knowing the National Immunisation Schedule at the time of the candidates' birth and are not a complete record.

i. The NZDF Recruit Vaccination Coordinator assessing the evidence is to consider—

(1) the dates of vaccination on the record; and

(2) if a particular vaccine was on the National Immunisation Schedule at that time.

j. If the information submitted is unclear, the NZDF Recruit Vaccination Coordinator may request further evidence to ensure the standard is reached. Only clearly documented doses should be considered as evidence.

11.1.2.7 Hepatitis B vaccination

a. Candidates born in New Zealand after 1990, if vaccinated in line with the National Immunisation Schedule, have had doses of hepatitis B vaccine at the ages of 6 weeks, 3 months and 5 months.

b. If catch up hepatitis B vaccines are required prior to enlistment, the recommended schedule of 0, 1, then 6 months should be applied.

c. However, a schedule of 0, 1, then 2 months is recommended in the National Immunisation Handbook and may also be acceptable in exceptional circumstances.

d. Exception to the recommended schedule should be discussed with an NZDF Recruit Vaccination Coordinator.

11.1.2.8 COVID-19 vaccination

a. Candidates should receive COVID-19 vaccines as part of the national vaccination rollout at public vaccination clinics prior to enlistment.

b. Candidates are required to be fully immunised against COVID-19 when they arrive for ab initio training and are to bring evidence to initial training of having received COVID-19 vaccines.

11.1.2.9 NZDF catch-up programme

DHCs may provide catch-up vaccinations to candidates on enlistment if candidates are unable to be vaccinated or are unable to receive a full vaccine schedule prior to enlistment. Acceptance of a candidate in these situations is at the discretion of Recruit Medical Practitioners.

11.1.2.10 Human papillomavirus vaccination

a. A complete course of human papillomavirus vaccination is not required to complete the NZDF Baseline schedule. Therefore, candidates do not have to complete this prior to recruit course.

b. A human papillomavirus vaccine course can be commenced or completed after enlistment, subject to the Ministry of Health criteria for funded human papillomavirus vaccine.

c. If candidates have received human papillomavirus vaccine dose(s), evidence of this is also to be submitted.

Chapter 3 - Recruitment Asthma

Purpose of rule

The purpose of this rule is to provide the New Zealand Defence Force (NZDF) recruit entry requirements for candidates with a history of asthma.

Application

This rule applies to the management of recruitment candidates for entry into the NZDF.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.1.3.1 Fit for entry

a. Applicants who record ‘no’ to a history of asthma symptoms or treatment in the last three years on initial screening are fit for entry recruiting.

b. Asthma is an exclusion criteria for some employment roles, including, but not limited to—

(1) Aircrew;

(2) Divers; and

(3) Special Forces.

11.1.3.2 Exclusion criteria

a. Applicants with any of the following are to be graded as P8 and excluded—

(1) Admission to hospital for asthma after age 15.

(2) Requirement for Step 3 asthma management in the last 3 months, eg—

(a) use of budesonide/formoterol, 200/6, two activations twice daily, or

(b) inhaled steroid greater than 250mcg daily.

(3) Use of oral corticosteroid.

11.1.3.3 Applicants with asthma in last three years (with no exclusion criteria)

a. Spirometry (via general practitioner or respiratory laboratory) is to be conducted on applicants who respond 'yes' to symptoms of asthma within the last three years in order to measure respiratory function.

b. Forced Expiratory Volume 1 (FEV1) is a proxy indicator of asthma severity. The best of three attempts is to be recorded. FEV1 results are to be interpreted as follows—

(1) FEV1 less than 80 per cent of predicted—

(a) Applicant is graded P8 and excluded as medically unfit for NZDF entry. The applicant is to be—

(i) advised to see their general practitioner for review of asthma management if clinically indicated; and

(ii) provided with guidance on the requirements for NZDF entry.

(2) If FEV1 80 per cent or greater of predicted, the applicant is to be referred to a respiratory laboratory for bronchial provocation testing (BPT).

11.1.3.4 Exercise-induced asthma

Applicants with a history of exercise-induced asthma with normal FEV1 at rest and normal BPT may be required to undertake suitable additional testing at the discretion of the Recruiting Medical Practitioner.

11.1.3.5 Bronchial provocation testing

a. Mannitol and hypertonic saline are the acceptable methods of BPT.

b. Fit for Entry—

(1) Normal BPT, on no treatment, with no symptoms (this is considered to be low risk, and applicant is fit for entry).

(2) Normal BPT, on medication, with mild persistent and intermittent asthma—

(a) On standard maintenance dose of budesonide/formoterol, 200/6, two activations twice daily or inhaled steroid greater than 250 mcg daily (or equivalent).

(b) If treated with no more than 250 mcg of fluticasone (or equivalent) per day.

(c) This is considered to be a low risk, and the applicant is fit for entry with limitations.

c. Currently Unfit for Entry—

(1) Positive BPT—

(a) The applicant is to be graded as P8 and excluded but may see their general practitioner for further assessment and stabilisation of their asthma on no more than budesonide/formoterol, 200/6, two activations twice daily or inhaled steroid greater than 250 mcg daily, if clinically appropriate.

(b) This is to be maintained for a minimum of three months and then confirmed with a negative BPT prior to re-application.

(2) Negative BPT on medication regime with more than budesonide/formoterol, 200/6, two activations twice daily or inhaled steroid greater than 250 mcg daily—

(a) The applicant is to be excluded as P8 unfit for entry.

(b) The applicant may attend their general practitioner for assessment and, if clinically appropriate, back titration of their asthma medication to no more than budesonide/formoterol, 200/6, two activations twice daily or inhaled steroid greater than 250 mcg daily.

(c) This is to be maintained for a minimum of three months and then confirmed with a negative BPT prior to re-application.

11.1.3.6 Prior to entry

All candidates with a confirmed diagnosis of asthma that have been deemed fit for entry are to obtain via their general practitioner—

(1) an appropriate documented asthma action plan;

(2) education regarding the management of their asthma and the correct use of medications (this is to be documented by their general practitioner); and

(3) one month’s supply of asthma medication on entry to the NZDF.

11.1.3.7 Medical record

All documentation, including test results, related to the applicant’s asthma history is to be scanned into the patient’s clinical record.

Chapter 4 - Aircrew Recruitment

Purpose of rule

The purpose of this rule is to specify the management processes for medically assessing applicants for suitability for aircrew recruitment.

Application

This rule applies to the processing of applicants wishing to join the New Zealand Defence Force (NZDF) as aircrew. Applicants are to be assessed by NZDF medical practitioners trained in aviation medicine and approved by the Officer Commanding the Aviation Medicine Unit (CO AMU) (or Senior Aviation Medical Officer).

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.1.4.1 Intent

Application of the Defence Health Aircrew Medical Standards is to determine the medical suitability of an individual to become an aircrew member in the NZDF. It ensures that the applicant is fit for trade. This, in turn, maximises the likelihood that an individual will complete their training and reduces the risk of medical disqualification through the individual's career.

11.1.4.2 Direct entry applicants

a. It is most important that aircrew applicants meet strict health requirements at the medical assessment stage of recruitment. These requirements are specified in Part 2 *Medical Standards*, Chapter 4 *Aircrew Medical Standards*.

b. It is not possible to include all conditions in the rule, but the vast majority of conditions that will affect an applicant's suitability for aircrew training and military service are listed in the NZDF Aircrew Medical Standards.

c. The Recruiting Aviation Medical Practitioner is to determine whether a candidate is—

(1) fit to proceed;

(2) to be deferred for further investigation or gathering of reports;

(3) to be classified as temporarily unfit; or

(4) to be classified as permanently unfit for aircrew duties.

d. An aircrew medical grade or a medical employment standard will normally be awarded only following an Initial Aircrew Medical Examination, held at a personnel selection board (PERSEL). Initial Aircrew Medical Examinations may be undertaken outside a PERSEL only with authority from the Senior Aviation Medical Officer.

e. The grade/standard is to be confirmed by the Senior Aviation Medical Officer or other delegated Aviation Medical Officer.

11.1.4.3 In-Service applicants

a. When a Serviceperson applies for aircrew training (prior to the Initial Aircrew Medical Examination), applicants are to have their Defence Health Information System (Profile) medical record (including hard copy medical documents) reviewed by the Senior Aviation Medical Officer or other delegated Aviation Medical Officer as part of the selection screening process.

b. The results of this review are to be recorded as specified in RNZAF 1370 Transit Cover *Application for Officer/NCO Aircrew Selection - Transit Cover*.

c. This is to be undertaken no later than seven days before the date of the PERSEL.

11.1.4.4 University applicants

University applicants, on completion of their studies, require an MD914 *NZDF Medical Re-examination Record* aircrew medical performed in the previous twelve months prior to commencing Initial Officer training. The MD914 medical is to be performed by a Royal New Zealand Air Force (RNZAF) Aviation Medicine trained medical practitioner.

11.1.4.5 Factors for consideration

a. The following factors are to be considered when determining the suitability and fitness of an individual to operate in the aviation environment. These underlie the aircrew medical standards that applicants are screened against—

(1) **Function**. The ability of the individual to perform the physical and intellectual tasks required. This includes an anthropometric assessment.

(2) **General living conditions**. The applicant must be capable of operating efficiently and effectively in all types of living and operating conditions, including austere field conditions.

(3) **Clothing and Aircrew Life Support Equipment** (ALSE). The aircrew applicant must be able to wear and use all standard issue specific clothing and ALSE, including personal protective equipment.

(4) **Environment.** Individuals are expected to be capable of prolonged physical activity in extremes of environmental conditions and for extended periods of time. This includes the aviation environment.

b. Aircrew optometry examinations are to be conducted only by approved aviation optometrists or ophthalmologists (list available on NZCAA Website). Reports are to be provided on an MD913 *NZDF Recruit Visual Assessment*.

11.1.4.6 Rejection of aircrew applicants

a. Part 2, Chapter 4 defines the medical conditions that may render an aircrew applicant permanently medically unfit for recruitment.

b. Recruiting Aviation Medical Officers are not to advise applicants of their unsuitability until medical administrative responsibilities have been satisfied.

c. Once medical administrative responsibilities have been satisfied, it is important for those applicants who are rejected on medical grounds that the reasons for rejection are communicated to them fully and in an easily understood manner.

d. If a rejected applicant has a condition requiring further investigation or treatment, they must be informed in writing to consult their general practitioner regarding this condition. Therefore, medical practitioners should critically assess the Medical History Questionnaire (Initial Health Check) and the MD1232 *Initial Aircrew Medical Examination* to confirm the applicant's suitability for Service life as aircrew. Accurate recording of findings are also essential.

e. Candidates may not appeal against a decision made on the basis of a medical standard. However, they may appeal if they consider their health to have been misrepresented on their application or if new medical evidence that may support their fitness for flying is available.

11.1.4.7 Doubtful applicants

a. Where doubt exists regarding an aircrew application, expert advice should be sought from the Senior Aviation Medical Officer as appropriate.

b. When possible, applicants should be referred to a specialist with NZDF experience. External medical specialists or healthcare providers undertaking examination of NZDF aircrew applicants should not provide an opinion on fitness for NZDF aircrew training. The external provider's report should provide advice on the diagnosis, treatment required, prognosis and any adjustments required for daily living, exercise and work.

Chapter 5 - Territorial Force to Regular Force Transfers and Lateral Recruits (Including Re-enlistments)

Purpose of rule

a. The purpose of this rule is to specify the medical processes for assessing the suitability of applicants with previous military experience (New Zealand Defence Force (NZDF) Regular Force/Territorial Force and/or Foreign Defence Force) for recruitment/ enlistment/re-enlistment into the NZDF Regular Force.

b. An accurate assessment and understanding of the current health status of personnel who are to undertake tasks and duties as a serviceperson is critical to ensure both—

(1) the health and safety of the individual to conduct the tasks expected as part of their role; and

(2) that the NZDF does not take on undue resource liability that is out of proportion to the expected contribution of an enlisted workforce.

c. The onus is on all applicants to truthfully declare their health conditions and concerns. The integrity of applicants is assumed to be demonstrated in full and frank disclosure of health issues during the enlistment/re-enlistment process.

Application

a. This rule applies to the medical assessment processes applied by medical practitioners for recruitment/enlistment/re-enlistment into the NZDF Regular Force of applicants with previous NZDF Regular Force or Territorial Force service or previous enlistment with foreign militaries.

b. This policy does not apply to the ongoing management of re-enlisted NZDF personnel.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.1.5.1 Territorial Force to Regular Force transfers and lateral recruits

a. Territorial Force to Regular Force transfers are applicants to the NZDF Regular Force who are currently serving in the Territorial Force.

b. Lateral recruits are applicants to the NZDF Regular Force with either previous NZDF (Regular Force or Territorial Force) service (for re-enlistment) or qualifying foreign military service (for enlistment) who are not currently serving in the Territorial Force.

11.1.5.2 Exclusions to re-enlistment

a. Personnel who have previously been assessed as MED1 (unfit any military tasks/duties) as part of a MD715 Medical Review of Service process cannot re-enlist into the NZDF.

b. Personnel who have been assessed and assigned a Medical Employment Standard (MES) of G5 (unfit any military tasks/duties) at any point in the assessment process cannot re-enlist into the NZDF.

11.1.5.3 Territorial Force to Regular Force transfers

a. Currently serving Territorial Force personnel may be engaged in the Regular Force.

b. Applicants to the NZDF Regular Force who are currently serving in the NZDF Territorial Force are to follow the same process (refer to *Flowchart: Medical process for enlisting/ re-enlisting NZDF personnel with previous NZDF service*)—

(1) The individual must—

(a) submit a current health information summary from their external primary healthcare provider (summary of General Practitioner notes, medications, allergies etc) to their nearest Defence Health Centre;

(b) disclose and supply other relevant information as required/directed (eg a specialist letter); and

(c) undergo a medical examination at their local Defence Health Centre where the examining medical practitioner is to complete an MD914 *Medical Re-Examination Record*.

(2) The examining medical practitioner is to use their findings in conjunction with the individual's healthcare summary and NZDF health record to assign the individual an appropriate MES.

(3) The minimum MES for transfer to the Regular Force is A4G3Z1; if the individual is assessed as not meeting this standard, Career Managers may initiate a Command Medical Waiver.

11.1.5.4 Lateral recruits with previous NZDF service

a. Applicants to the NZDF Regular Force who are not currently serving in the NZDF Territorial Force but have previous NZDF service are assessed against different standards depending on whether or not—

(1) the length of time since their previous NZDF service is more than 3 years;

(2) they have previously served in the Regular Force;

(3) they are changing trade; and/or

(4) they are changing Service.

b. For those with previous Regular Force service who are re-enlisting within 3 years of their previous NZDF service into the same Service and trade, the process is as follows (refer to *Flowchart: Medical process for enlisting/re-enlisting NZDF personnel with previous NZDF service*)—

(1) The individual must provide Defence Recruiting with—

(a) a current health information summary from their external primary healthcare provider (summary of General Practitioner notes, medications, allergies etc);

(b) other relevant information as required/directed (eg a specialist letter); and

(c) an accurately completed self-declaration MD1205 *Health Declaration: Pre-Overseas/Re-Entry/Reserve Service* that discloses all health issues or conditions.

(2) The Defence Recruiting Medical Officer (DRMO) is to review the individual's application and prior NZDF health records, assess their case and assign them an MES.

(3) If the individual is assessed as not meeting the minimum MES (ie A4G3Z1), Career Managers may initiate a command medical waiver.

c. For those who did not previously serve in the Regular Force, left the NZDF more than 3 years prior to re-applying, are changing Service and/or are changing trade, the process is as follows (refer to *Flowchart: Medical process for enlisting/re-enlisting NZDF personnel with previous NZDF service*)—

(1) The individual is to go through the ab initio recruiting process and be assessed against ab initio standards as specified in Chapter 1 *Recruit Medical Standards*.

(2) If they fail to meet the ab initio standards, Career Managers may initiate a Command Medical Waiver, dependent upon the needs of the single Service or the NZDF.

11.1.5.5 Lateral recruits with previous service in a foreign military

a. For lateral recruits who are currently serving in an American/British/Canadian/Australian/New Zealand (ABCANZ) military, the process is as follows—

(1) These applicants are to provide their current MES/medical grade and copy of their medical record for review by the DRMO.

(2) The DRMO is to review the individual's application, assess their case and assign them an NZDF MES. ABCANZ applicants with a fully operational MES/medical grade in their current military will generally be allocated an equivalent NZDF MES.

(3) Applicants who are assessed as not meeting the minimum MES (ie A4G3Z1) will not normally be accepted; however, if such applicants possess a highly sought after skill set, a command medical waiver may be initiated.

b. Lateral recruits who are currently serving in a non-ABCANZ military or who previously served in any foreign military are to be assessed against NZDF ab initio enlistment standards. Applicants who fail to meet these standards will not normally be accepted; however, if such applicants possess a highly sought after skill set, Defence Recruiting may consider raising a command medical waiver.

PART 2 - MEDICAL STANDARDS

Chapter 1 - Blood Grouping/G6PD

Purpose of rule

The purpose of this rule is to specify the management of ABO blood group, Rhesus Factor D (and other clinically relevant blood transfusion information) and Glucose-6-Phosphate Dehydrogenase (G6PD) status information for New Zealand Defence Force (NZDF) members of the Armed Forces.

Application

a. This rule covers the information management requirements for NZDF members of the Armed Forces with respect to their ABO blood group, Rhesus Factor D (and other clinically relevant blood transfusion information) and their G6PD status only.

b. This rule applies to Regular Force and Reserve Force NZDF members of the Armed Forces.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for this rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.1.1 ABO blood group, Resus Factor D and other clinically relevant blood transfusion information

a. An individual's ABO blood group and Rhesus Factor D (and other clinically relevant blood transfusion information) status is tested for the purpose of the identification of compatible blood in the event of a blood transfusion being required.

b. Other clinically relevant blood transfusion information may include, but is not limited to—

(1) clinically relevant blood transfusion antibodies;

(2) any additional blood group testing results; and,

(3) high haemolysin titres.

11.2.1.2 G6PD

An individual's G6PD status is tested for the purpose of identifying any potential adverse reactions, primarily to primaquine. G6PD deficiency can also lead to cell breakdown of donated blood.

11.2.1.3 Documentation/recording

a. All Regular Force members of the Armed Forces are to have their ABO blood group, Rhesus Factor D and G6PD status tested on Basic training.

b. All members of the Armed Forces, when operational requirements indicate, are to have additional testing and checks of national health records to identify such blood antibodies and additional antigens as clinically relevant for blood transfusion, in accordance with policy, procedure or directive for a military activity.

c. Results of testing are to be recorded in the individual's clinical record on Profile.

d. Results are also to be recorded on their identity disk (refer to DFO 3 *NZDF Human Resource Manual,* paragraph 14.1.33).

Chapter 2 - Medical Grading Processes (on issue)

To be issued.

Chapter 3 - Medical Review of Service Process

Purpose of rule

The purpose of this rule is to specify the Defence Health processes associated with the review of Regular Force personnel's service and/or trade in relation to identified health issues.

Application

a. This rule applies to New Zealand Defence Force (NZDF) medical practitioners involved in the Defence Health components of the review of service and/or trade process.

b. This rule applies to NZDF personnel undergoing a review of service and/or trade for health reasons.

c. This rule does not relate to command/management/administrative processes outside of Part A and Part B of the MD715 *NZDF Record of Procedure: Medical Review of Service*.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.3.1 General

a. The complete review of service and/or trade process (Defence Health and others) is detailed in and conducted in accordance with DFO 3 *New Zealand Defence Force Human Resource Manual*, Part 11, Chapter 8 *Departing the NZDF (Military)*.

b. The review of service and/or trade process on medical grounds is conducted and coordinated using an MD715.

c. The MD715, details the complete process (Defence Health and others) involved in the health review of service and/or trade process.

d. When the MD715 is initiated, relevant Defence Health medical practitioners are to complete Parts A and B of the process. Parts A and B provide the health information to command/management in order for the full review to be completed.

e. The MD715 process is a review of service and/or trade on the basis of identified health issues that affect the employability or deployability of an individual. It is a command/ management process with health input in initially identifying health issues and as to the most appropriate employability of the individual. It can involve a review of service of the individual or enable a change in trade/role.

11.2.3.2 Part A: Medical practitioner

a. The MD715 process should be initiated following, but not exclusive to the following—

(1) Recommendation of a 'new' permanent medical downgrade, where the change in health grading results from a significant impact on performance of employment or deployment requirements.

(2) Extended temporary downgrade exceeding twelve months (excluding pregnancy), post Principle Medical Officer review, or post twenty four months in total, where the change in medical status results from a significant impact on performance of employment or deployment requirements.

(3) Sick leave in excess of 91 days (these days are not required to be contiguous but must be for one health issue and/or issues that stem from that health issue).

(4) Cases that may present a significant risk to an individual's welfare or to the organisation or present a security risk.

(5) At the request of Command.

b. If an MD914 *Medical Re-examination Record* medical board has been completed in the preceding three months, the medical practitioner responsible for an individual's healthcare is to raise the MD715, Part A, following the completion of an MD906 *NZDF Medical Grading Review* and interview.

c. If an MD914 has not been completed in the preceding three months, an MD914 is required prior to completion of the MD715.

d. If written consent for the disclosure of clinical information has been given by the individual, medical information may be provided to the Medical Review Board and commander/manager.

e. If the individual does not give their consent for the disclosure of clinical information, then medical-in-confidence information is given to the Medical Review Board clinical members only. Command/management is to be provided with—

(1) limitations of service; and

(2) medical fitness for alternative service.

f. The medical practitioner is to notify the Principal Medical Officer (President of the Medical Review Board) of the requirement for the individual to be reviewed.

11.2.3.3 Part B: Principal Medical Officer and Medical Review Board

a. The Principal Medical Officer (or Board delegate) is to receive all MD715 forms, once Part A has been completed, and conduct an initial file review of the individual.

b. The Principal Medical Officer (or Board delegate) is to decide if the case is straight forward or complex.

c. If the case is deemed to be straightforward, the Principal Medical Officer is to complete Part B of the MD715 form and then forward the form to the individual's commander/ manager.

d. If the case is complex, or there is any doubt, the Principal Medical Officer is to consult with the Chief Medical Officer. The Chief Medical Officer is to be consulted for direction if there is—

(1) a conflict of interest for the Principal Medical Officer; and/or

(2) significant organisational risk.

e. The Chief Medical Officer will direct if a full Medical Review Board review is required (refer to DHR 31 *Applied Clinical Practice - Medical*, Part 1 *Medical Oversight Systems*, Chapter 1 *Medical Review Board*).

f. If a full Medical Review Board is required, the Chief Medical Officer has the authority to direct whether the Medical Review Board is to conduct a file review or the case is to be reviewed by convening a sitting Medical Review.

g. If a full Medical Review Board meeting is required, the Medical Review Board members are to undertake a file review prior to a review meeting. In either event, the Medical Review Board are to—

(1) review the case;

(2) determine the medical grading;

(3) make a recommendation;

(4) comment if appropriate;

(5) complete Part B of the MD715 form; and

(6) forward the form to the individual's commander/manager.

h. All cases where medical discharge is recommended are to be referred to a Complex Care Coordinator and a Multidisciplinary Team referral considered.

i. Medical discharge categories—

(1) **MED1**—

(a) Unfit Military Service.

(b) Unfit re-enlistment.

(c) Continued service is likely to—

(i) exacerbate the member's health condition(s);

(ii) pose an organisational risk; and/or

(iii) result in the member's condition(s) being unable to be appropriately managed within NZDF health support means/eligibility.

(2) **MED2**—

(a) Health condition(s) resulting in significant limitations to employment or deployment that are likely to persist for at least another 12 months. Continued service is subject to medical restrictions due to health condition(s).

(b) If the member is retained, medical restrictions will be applied, and continued service is unlikely to—

(i) exacerbate the member's health condition(s); or

(ii) pose an organisational risk.

(c) In addition, the member's condition(s) can be appropriately managed within NZDF health support means/eligibility.

(d) The individual will remain undeployable without specific command waiver. Retention to be based on NZDF requirement. Individuals may be considered for future re-enlistment where they make a functional recovery and meet recruit medical standards.

Note: Both MED1 and MED2 recommendation categories fulfil the criteria for discharge on medical grounds.

Chapter 4 - Aircrew Medical Standards

Purpose of rule

The purpose of this rule is to specify the medical standards for aircrew.

Application

This rule applies to the medical standards management of aircrew only.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.4.1 Aircrew medical standards specifications

The aircrew medical standards are detailed in Aircrew Medical Standards Specifications.

Chapter 5 - Aircrew Medical Examinations

Purpose of rule

The purpose of this rule is to specify the conduct and level of medical examination required for the assessment of aircrew applicants and serving aircrew and the administration of aircrew medicals.

Application

This rule applies to the aircrew medical standards process for NZDF personnel only.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.5.1 Personnel responsibilities

Only Defence Health medical practitioners with recognised training in aviation medicine and approved by Defence Health Directorate are authorised to conduct aircrew medicals.

11.2.5.2 NZDF aircrew medical standards

The NZDF aircrew medical standards are set by the Aviation Medicine Professional Reference Group with reference to the Five Eyes Air Force Interoperability Council (AFIC) partner medical standards as well as civilian aviation medical standards (when indicated). These are to be adhered to when conducting aircrew medical examinations.

11.2.5.3 Requirement for aircrew medical standards

Aircrew medical standards provide a layer of protection for the individual and the organisation by ensuring that all aircrew are medically, physically and mentally fit to operate in the aviation environment. This contributes to flight safety.

11.2.5.4 Requirements for aviation medical practitioners

a. Aviation medical practitioners assessing aircrew applicant suitability must apply these medical standards in the assessment process.

b. Where a requirement for change is identified, the medical practitioner concerned is to notify the Aviation Medicine Professional Reference Group to initiate a change management process.

11.2.5.5 Types of aircrew medical classification checks

There are four types of aircrew medical check—

(1) Initial Health Check (including trade/Service change);

(2) Initial Aircrew Medical;

(3) Periodic Aircrew Medical; and

(4) Annual Health Declaration.

11.2.5.6 Management of aircrew applicants

a. Suitability for aircrew training will be assessed against published aircrew medical standards.

b. Refer to Part 1, Chapter 4 *Aircrew Recruitment* for process details.

11.2.5.7 NZDF aircrew medical classification

a. Flying medical categories indicate medical fitness to perform flying duties within the current standards. They are recorded as follows—

(1) A—

(a) A1: no limitations.

(b) A2: to wear corrective lenses (ie corrective flying spectacles or contact lenses – as specified) or hearing protection required.

(c) A3: fit to fly with a limitation (these may be role or aircraft specific) or an Aviation Medical Officer (AvMO) endorsement.

(d) A4: unfit flying duties, passenger flying only.

(e) A5: unfit any form of military flying.

(2) G: (as routine).

(3) Z: (as routine).

(4) R 12: All aircrew require 12 monthly health assessments (with annual medical examination for pilot, observer (new term), Loadmaster and Air Engineer. Five yearly medical examination for other aircrew unless specified).

b. A number of potential limitations are available to advise Command how aircrew can operate safely, and manage health-related risks, in the event of a physical, psychological or medical condition that may impact on performance or flight safety but does not disqualify the individual from flying duties.

11.2.5.8 Initial Aircrew Medical examination

a. All potential NZDF aircrew are to undergo a full medical examination prior to being considered for aircrew training.

b. Normally, all potential aircrew will undergo an Initial Aircrew Medical examination at Royal New Zealand Air Force (RNZAF) Base Auckland at the time of Officer and Aircrew Selection Board. Only in exceptional circumstances, and subject to approval by the Officer Commanding Aviation Medical Unit (OC AMU), will initial medical examinations be conducted outside of Auckland.

c. The medical examination of aircrew candidates and personnel is to be carried out in accordance with the procedures laid down in Aircrew Medical Examinations: Table 1.

d. The following apply—

(1) Anthropometry—

(a) Refer to Chapter 7 *Aircrew Anthropometry*.

(2) Blood pressure—

(a) At each Periodic Medical Examination (PME) or as clinically indicated.

(3) Blood tests—

(a) The following are to be undertaken—

(i) Full blood count.

(ii) G6PD.

(iii) HbA1c.

(iv) Lipids (random).

(v) Others as clinically indicated.

(4) Cardiac risk assessment—

(a) From age 36, or if clinically indicated.

(5) Urine tests—

(a) Dipstick only.

(b) Other tests as clinically indicated.

(6) Electrocardiograph (ECG)—

(a) An ECG is required for all aircrew candidates at Officer and Aircrew Selection Board, Aircrew Medical Board.

(7) Audiometry—

(a) Full audiometry.

(8) Vision—

(a) Pilot, Observer (new term) and Helicopter Load Master (HLM) to have full optometry assessment (including colour vision and contrast vision assessment, if clinically indicated).

(b) All other aircrew to have Snellen and Titmus assessments (to include N5 near vision testing) and colour vision assessments.

(c) Refer to NZDF Recruit Medical Standards Specifications, Chapter 17 *Visual Systems*.

(9) Spirometry—

(a) Required for all aircrew.

(b) Establish baseline results for FVC, FEV1 FEV1/FVC and PEFR.

(10) Chest X-ray—

(11) Chest X-rays are required only on clinical grounds.

(12) Dental—

(a) Dental standards are Dental entry standards. In cases of doubt, an NZDF dental practitioner's opinion is to be obtained.

(13) DNA typing—

(a) DNA typing provides a useful addition to other methods of identification in fatal aircraft accidents.

(b) Refer to Part 3, Chapter 1 *Collection of DNA from NZDF Personnel* for full detail.

(14) Other investigations as clinically indicated.

11.2.5.9 Medical practitioners authorised to perform and confirm Initial Aircrew Medical examinations

a. Initial medical examinations of aircrew will only be performed by a medical practitioner who is approved by the OC AMU, who—

(1) hold the Diploma/Masters course in Aviation Medicine; or

(2) has completed the aviation medicine course for Royal Australian Air Force (RAAF) Medical Officers or equivalent.

b. Confirmation is to be undertaken by the OC AMU or delegated AvMO.

11.2.5.10 Recording of Initial Aircrew Medical examination

a. Detailed findings of the Initial Aircrew Medical Examination and its result are to be entered onto MD1232 *NZDF Initial Aircrew Examination* with original signatures of examining AvMO, candidate and confirming AvMO recorded.

b. Medical practitioners are to ensure that the current flying medical category is forwarded to the confirming medical practitioner on MD906 *Medical Grading Review*.

11.2.5.11 Trained aircrew: Health assessments for aircrew

All aircrew require an annual health assessment, by either annual health declaration alone or by annual health declaration and annual medical examination. The health assessments of aircrew personnel are to be carried out in accordance with the procedures laid down in this rule. The detailed findings of the examination are to be documented on an MD914 *Medical Re-Examination Record* and a Profile aircrew template. The following apply—

(1) Periodic Medical Examination (PME)—

(a) Pilots, Observers (new term), HLMs, Air Load Masters (ALM), and Flight Engineers require an annual Medical Examination conducted by an AvMO.

(b) Air Warfare Officers (AWO), Air Warfare Specialists (AWS), Air Ordnance personnel and Flight Stewards require a five yearly periodic medical examination. In addition to this an annual health assessment is to be conducted at the time of annual audiometry, means of providing an Annual Aircrew Statement of Health Declaration, which may subsequently require a medical examination depending on any highlighted medical issues.

(c) Single Pilot Operations (including Instructors) - over age 55 are to have six monthly PMEs.

(d) Aircrew undertaking annual aircrew medicals will complete the MD914 process.

(2) Personnel undertaking five yearly PMEs will complete the MD1585 *Aircrew Annual Statement of Health* declarations (except when completing their PME (MD914 then applies). The following process applies—

(a) **No medical issues raised**. Checked by health staff. R60 remains extant.

(b) **Medical issue raised**. Health statement of health to be reviewed by AvMO. AvMO is to determine the requirement for a medical examination. If medical examination is carried out, the AvMO is to generate an MD906 for a second AvMO to confirm; if downgrade recommended, this is to be confirmed by OC AMU or other delegated AvMO, in OC AMU's absence.

(c) Refer to Aircrew Medical Examinations: Periodic Table for required occupational health investigations (eg audiometry).

(3) Aircrew Medical Grade. The following process applies—

(a) Pilots, Observers (new term), HLM, ALM, and Flight Engineers will be graded R12.

(b) AWO, AWS, Air Ordnance personnel and Flight Stewards (FSTWD) will be graded R60.

(c) If 3 years elapse before starting flying training, re-examination by Initial Aircrew Medical examination is mandatory.

(d) Aircrew appointed to general service or staff duties are to keep their flying medical category in-date. If they are three or more years out-of-date, they are to be referred to OC AMU prior to re-commencing flying.

(e) Aircrew who are unlikely to return to flying duties may elect to revert to A4 medical category or maintain an aircrew medical grade by regular AvMO medical assessments.

(f) Annual aircrew medical grades are normally to be valid for one or five years, as applicable, from the date of the last medical; however, if undertaken up to 60 days before the expiry of the previous medical, the validity is to run for one or five years as applicable, from the expiry date of that medical.

(4) Anthropometry (including height and weight)—

(a) All aircrew—

(i) at aircrew medical, Basic (stature; waist circumference; weight); or

(ii) as directed by AvMO/Senior Physiologist.

(b) When a serving Pilot is identified for Flying Instructor Course (FIC), T6C conversion or other high performance/ejection seat type aircraft, they are to be referred to AvMO or OC AMU for a decision on suitability for role. Additional anthropometric assessment may be required depending on anthropometric history.

(c) Medical practitioners are to take special note of the unclothed weight. Advice on weight reduction is to be given where there are occupational implications, as required.

(d) If assessed as overweight, a careful assessment is to be made of cardiovascular risk factors, physical fitness and physical ability to conduct their duties (including emergency escape from the aircraft). Concerns in these areas may necessitate the award of a temporarily reduced medical category or immediate referral to OC AMU; otherwise, they will be given six months in which to reduce weight, under supervision, after which their case is to be referred to OC AMU if they still exceed the required weight.

(e) Medical practitioners examining aircrew flying in aircraft with ejection seats are to be conversant with the unclothed weight limits for the seats.

(5) Blood pressure—

(a) At each PME, or as clinically indicated.

(6) Blood tests—

(a) At age 40, Full Blood Count (FBC) and Thyroid Stimulating Hormone (TSH) (See Cardiac risk assessment in paragraph 11.2.5.11a.(7)). Others as clinically indicated.

(7) Cardiac risk assessment—

(a) At age 36, 2 yearly from age 40, and annually from age 60.

(b) Refer to Aircrew Medical Examinations: Periodic Table (AWO, AWS and FLTSTWDS five yearly).

(8) Urine tests—

(a) Dipstick only.

(b) Other tests as clinically indicated.

(9) ECG—

(a) ECG for aircrew is to be undertaken according to the schedule in Aircrew Medical Examinations: Periodic Table.

(b) ECGs reported as having potentially significant abnormalities are to be referred to a cardiologist for interpretation; further specialist cardiovascular evaluation, which may entail further investigations, may be required.

(c) Pilots, Observers, ALM/HLM and Air Engineer twice yearly from age 30, then annually from age 50.

(d) Screening ECGs that are reported as ‘otherwise normal’ or ‘borderline’ may be acceptable subject to satisfactory clinical assessment of the aircrew member and the following—

(i) Marked sinus bradycardia; accept only if rate > 40 bpm.

(ii) Minimal or moderate voltage criteria for left ventricular hypertrophy (LVH), may be normal variant; accept only if: physically fit; no hypertension; no murmur.

(iii) No abnormalities noted on examining the rhythm strip.

(iv) Sinus arrhythmia.

(v) First degree heart block if PR interval shortens to 200 ms or less after simple exercise; accept only if under age 40.

(vi) Isolated premature ventricular contractions (PVC).

(vii) Early repolarisation; accept only if under age 40.

(e) In assessing 'otherwise normal' or 'borderline' screening ECGs, it is helpful to compare the ECG with previous ECGs if available. ECG should be referred for specialist evaluation if any doubt remains. If pilot fitness is in doubt, the aircrew member should be grounded pending discussion with an approved cardiologist and/or referral if indicated. All otherwise abnormal ECGs are to be sent for cardiology reporting.

(10) Stress echocardiography (including ECG)—

(a) All aircrew aged 60 or over require stress (exercise) echocardiography to identify those with an increased risk of sudden cardiac incapacitation.

(b) Target personnel should be referred for testing in advance of their PME to ensure results are available at the time of the medical. There is no need to ground or downgrade aircrew pending results of the investigation, which should be completed in any case within one month of the PME.

(c) This policy includes aircrew operating under a Civil Aviation Authority (CAA) Class 1 waiver; this is an additional requirement over and above CAA regulations. Subsequent testing is dependent on CRA (over 10%) or on specialist advice. CRA and test valid 1 year or as advised by cardiologist.

(11) Spirometry—

(a) Pilot, Observer and HLM aircrew are required to undergo lung function testing during every five years at PMEs.

(b) Other aircrew at age 45 and age 55 if they have ever smoked or if clinically indicated. The FEV1 should be ≥80%, the FEV1/FVC should be ≥75% and the PEFR should be ≥80% of the calculated normal for age, sex and height.

(12) Chest X-ray—

(a) Chest X-rays are required only on clinical grounds.

(13) Vision—

(a) Visual standards are in accordance with NZDF Recruit Medical Standards Specifications, Chapter 17 *Visual Systems*.

(14) Audiometry—

(a) Audiometry is based on risk. Those personnel with highest exposure to noise and hence highest risk will require at least annual audiometry. Audiometry is specified in the table below. Aircrew whose hearing standard, determined audiometrically, has fallen from the previously recorded H category are to be re-tested after at least 24 hours in a noise-free environment and, if still below standard, are then to be referred to a ENT specialist/otologist either directly or via OC AMU.

(15) Dental—

(a) Annual assessments required. The dental grade is to be determined prior to the assessment. In cases of doubt, an NZDF dental practitioner's opinion is to be obtained.

(16) DNA typing—

(a) DNA typing provides a useful addition to other methods of identification in fatal aircraft accidents; see JSOP: NZDF Collection of Samples for DNA Forensic Identification for full detail.

(17) Other investigations as clinically indicated.

11.2.5.12 Medical practitioners authorised to perform Periodic Medical Examinations of aircrew and confirm aircrew medical grades

a. PMEs of aircrew will be performed only by a medical practitioner, approved by OC AMU, who—

(1) holds the Diploma/Masters course in Aviation Medicine; or

(2) has completed the aviation medicine course for RAAF Medical Officers or equivalent.

b. Where the medical grade remains unchanged, the confirmation can be undertaken by any aviation medicine trained medical officer (as defined in paragraph 11.2.5.12.a).

c. Confirmation of aircrew who are being upgraded or downgraded is only to be undertaken by OC AMU or specifically delegated AvMO. Upgraded personnel are fit only following confirmation. Downgraded personnel immediately assume the grading (ie immediately unfit to fly if A4).

11.2.5.13 Recording of Annual Aircrew Medicals

a. Detailed findings of the PME and its result are to be entered onto an MD914 or a Profile aircrew template.

b. Medical practitioners are to ensure that the current flying medical category is forwarded to the confirming medical practitioner on an MD906.

c. Medical practitioners are to inform Squadron Commanding Officers, or the appropriate responsible officer, of any change in the medical category of their aircrew, whether of a temporary or permanent nature. In addition to entering the notation in Profile, eg if a pilot develops a need for spectacles his category would be changed from A1 to A2 (to wear corrective flying spectacles), this should be reported by email or minute or by forwarding a copy of the MD906 at the time of the medical and copied to the individual.

d. For unchanged medical grades, the medical grade is to be considered extant from the time of grading by the primary AvMO and the associated MD906 can be used as interim authority to fly.

Note: It is subject to change by the confirming authority. Any subsequent changes are to be immediately relayed to the individual and their chain of command.

e. There is an imperative for AvMOs to provide proof of fitness to fly if the time taken to append/update the details to FEMs is going to render the individual out of date. Confirmation should routinely be undertaken within five working days. If the medical is likely to expire, the confirming Av MO should be contacted in order to hasten the process.

11.2.5.14 Active Reserves medical examination

Refer to Chapter 6 *Aircrew (Pilot) Medical Examinations: Active Reservists*.

11.2.5.15 Sickness of aircrew personnel

a. Medical practitioners concerned with the temporary grounding of aircrew must ensure the category is reviewed at least every three months. If temporary grounding is still necessary after six months, the matter is to be referred to OC AMU.

b. All aircrew returning from sick leave or hospital inpatient stay are to be assessed by an AvMO to determine their fitness to return to flying, correct medical grade and whether limitations are required.

11.2.5.16 Permanent alterations to the Flying Medical Category

OC AMU is the only authority to allocate a permanent alteration of an A3/A4 flying medical category to aircrew. This may be undertaken by confirmation on Profile following recommendation of the examining AvMO or following appointment with OC AMU. They should bring their Flying Logbook with them.

11.2.5.17 Reconsideration of permanent Flying Medical Categories

a. A flying medical category of A4 is given only after a full investigation when it is considered that the individual is medically unfit for further flying duties.

b. If, on the expiration of at least 12 months from the allocation of an A4 category (or other downgrading), an Officer or other rank considers that they have recovered completely from their disability, they may submit to their Commanding Officer that their return to flying duties be considered. If, in the opinion of the Commanding Officer, the submission is justified, the application is to be forwarded to OC AMU for review.

11.2.5.18 Secondment, exchange or loan service

Following a period of duty with foreign or Commonwealth armed forces, the medical documents of aircrew personnel must be scrutinised by an AvMO to ensure that no new medical conditions of aeromedical significance are missed. The responsibility for forwarding the documents to the AvMO rests with the Unit/establishment to which aircrew personnel are re-appointed on return from secondment, exchange or loan service.

11.2.5.19 Helicopter Underwater Escape Training and Emergency Breathing Systems Underwater Escape Module Training

Aircrew and others who are required to undertake Helicopter Underwater Escape Training (HUET), Emergency Breathing Systems (EBS) or Underwater Escape Module (UEM) training in a HUET Unit have a very small risk of Cerebral Arterial Gas Embolism (CAGE). Specific consideration is required in order to assess their fitness to train at the time of PME. Guidance for medical staff may be obtainable from OC AMU or a diving medicine trained medical practitioner.

Chapter 6 - Aircrew (Pilot) Medical Examinations: Active Reservists

Purpose of rule

The purpose of this rule is to specify the annual medical examination requirements for Active Reservist (Pilot) Aircrew.

Application

a. This rule applies to the aircrew medical examinations for Active Reservist (Pilot) Aircrew that fly non-ejection seat aircraft.

b. This rule does not cover aircrew medical examinations for aircrew recruitment, Regular Force aircrew, non-Pilot aircrew or for Active Reservist aircrew that fly ejection seat aircraft.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.6.1 Waiver annual medical examination

Annual military aircrew medical examinations may be waived for Active Reservist (Pilot) Aircrew flying non-ejection seat aircraft. To meet this requirement, the individual must—

(1) have had an initial aircrew medical in the NZDF;

(2) hold a current aircrew licence and Class 1 medical certificate issued under Civil Aviation Authority (CAA) NZ Regulations; and

(3) provide a—

(a) CAA Medical Examiner (ME) stamped copy of CAA 24067/001 V7.0 Mar 17 (Application for a CAA NZ Medical Certificate);

(b) MD1585 *Aircrew Annual Statement of Health*; and

(c) letter from the individual's general practitioner confirming any visits or treatments received in the previous 15 months.

11.2.6.2 Waiver approval process

a. Active Reservist (Pilot) Aircrew are to apply for waivers from their Base RNZAF AvMO prior to expiry of the current medical grading. The AvMO is to determine requirements for additional examinations or clinical investigations as clinically indicated based on the supplied documentation above.

b. The waiver is subject to approval by OC AMU. Any new medical limitations on the CAA licence or medical certificate are to be cleared by OC AMU before confirming aircrew medical category.

c. The OC AMU may direct that there is a requirement for—

(1) an AvMO full or limited medical examination;

(2) further clinical investigations; and

(3) an appropriate limitation to be applied to the military medical category.

11.2.6.3 Health record entry

a. The individual's health record is to be annotated with 'CAA Waiver'.

b. The expiry date of the medical category is—

(1) not to be more than one year from the date of the waiver; and

(2) no later than the expiry date of the CAA medical certificate.

11.2.6.4 Deployments

Active Reservist (Pilot) Aircrew being deployed overseas are to undergo a full pre-deployment medical examination, even if granted an annual medical examination waiver (as above). This is due to the additional military and deployability considerations that are not addressed in a CAA medical examination process.

11.2.6.5 Helmets check

Those Active Reservists (Pilot) Aircrew flying with a helmet are required to have it checked in accordance with Standard Operating Procedures by appropriately qualified personnel.

11.2.6.6 Dental requirements

Active Reservists (Pilot) Aircrew are to be in date with regard to dental fitness.

Chapter 7 - Aircrew Anthropometry

Purpose of rule

The purpose of this rule is to specify the anthropometric accommodation standards for each New Zealand Defence Force (NZDF) aircraft to optimise flight safety and performance.

Application

This rule applies to—

(1) pilots flying NZDF aircraft with design limitations that enforce anthropometric restrictions to operate safely;

(2) passengers in a T-6C Texan;

(3) qualified flying instructors, medical staff and Chain of Command assessing and approving the anthropometric fit of an individual classified as borderline (ie anthropometric dimensions are on the range of the limits) for an aircraft (this process is the Functional Cockpit Assessment (FCA)); and

(4) any aircrew member or passenger that possesses an anthropometric characteristic that may cause a safety or performance issue (eg obese or extremely tall or short sitting height).

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.7.1 Aircraft requiring anthropometric restrictions

a. Currently, only the T-6C Texan, A109 Light Utility Helicopter and King Air 350 require anthropometric standards. All other aircraft, to the Aviation Medicine Unit (AMU)'s awareness, are accommodating to a large range of body shapes and sizes.

b. The anthropometric restrictions for the T-6C Texan, A109 Light Utility Helicopter and King Air 350 are outlined in the *Anthropometric Accommodation Restrictions Table*.

11.2.7.2 Anthropometric assessment

a. Anthropometric measurement of aircrew and passengers must be performed by personnel with an International Society for the Advancement of Kinanthropometry (ISAK) Level 1 certification or who have been trained by the AMU Physiologist.

b. Techniques for measuring anthropometric dimensions must be in accordance with AMU-TR-2401 *A Basic Guide to Predictive Anthropometric Accommodation Modelling for New Zealand Defence Force Aircraft*.

c. The AMU must maintain a database of all aircrew anthropometric measurements.

11.2.7.3 Anthropometric fitness

a. Aircrew anthropometric measurements are compared with standards which differ between aircraft.

b. Aircraft with anthropometric accommodation limitations possess anthropometric restrictions for a combination of body mass, standing height, sitting height, buttock-to-knee length, sitting knee height, combo-leg length and/or body mass index.

c. Each relevant anthropometric dimension has a fit, unfit and borderline range, with the exception of anthropometric dimensions that do not explicitly cause a safety or performance issue (ie these possess only a borderline range).

d. All measurements must be checked by the AMU Physiologist or the Officer Commanding (OC) AMU to determine anthropometric fitness and if an FCA is required.

11.2.7.4 Frequency of anthropometric assessment

The following anthropometric assessments are to be conducted—

(1) **Selection anthropometric assessments**. At selection, pilots must have the following anthropometric dimensions measured—

(a) Body mass.

(b) Standing height.

(c) Sitting height.

(d) Sitting buttock-to-knee length.

(e) Sitting knee height.

(f) Combo-leg length.

(g) Body mass index.

(2) **Anthropometric assessments of serving pilots**. Serving pilots are to have these assessments conducted—

(a) at 5 years following initial measurement, if the initial measurement occurred when the individual was <23 years old;

(b) every 10 years; and

(c) if their body mass has increased or decreased by >10%.

(3) **Special circumstances anthropometric assessments**. Anthropometric assessments are also to be conducted on pilots or passengers in the following situations—

(a) Pilots are to undergo an anthropometric assessment prior to their being posted to fly one of the three aircraft possessing anthropometric standards.

(b) Pilots who have been identified for the Flight Instructor course or T-6C Texan conversion must be referred to the OC AMU or an Aviation Medical Officer (AvMO) to determine if an anthropometric assessment is required.

(c) Potential passengers (refer to Chapter 8 *Passenger Fitness to Fly*), including one-off aircrew flights for the T-6C Texan, are to undergo an anthropometric assessment. If a passenger is classified as borderline, this will be deemed as anthropometrically unfit, as an FCA is not appropriate. The required anthropometric measurements for these potential passengers include—

(i) body mass;

(ii) sitting height; and

(iii) sitting buttock-to-knee length.

11.2.7.5 Anthropometric accommodation reports

a. Anthropometric accommodation reports are to be provided by the AMU and must include the anthropometric measurements, accommodation classification for aircraft with anthropometric standards and requirements for FCAs.

b. All reports must be reviewed by the AMU Physiologist or OC AMU.

c. AMU must store all reports in a protected location.

d. Reports must be loaded onto Profile (patient's electronic medical notes).

e. The OC AMU, or a senior AvMO, must view reports for existing aircrew that alter their anthropometric accommodation to assess whether this influences their medical grading.

11.2.7.6 Aircrew body mass

a. Routine Defence Health Standards apply for all aircrew with regard to a minimum and maximum body mass and body mass index (BMI). A BMI of ≤18.5 or ≥30 may have implications for short- and long-term health, in addition to the safety of their role.

b. Specific body mass restrictions for the T-6C Texan are based on the ejection seat limitations. Due to the additional equipment assembly configurations required for flight (eg G-suit), the boarding weight may supersede nude body mass restrictions but only with Command approval and their full awareness of the potential safety and health risks.

c. Currently, there are no body mass restrictions determined by the fit of aircrew clothing and equipment (eg G-suit); however, a high BMI (≥30) may cause fit issues.

d. The Officer Commanding of the flying unit/squadron is to be immediately made aware when one of their serving aircrew has a body mass outside the minimum or maximum limits.

e. Aircrew with a high body mass for their height (ie BMI) may be restricted in their movement within the aircraft and limit the movement of flight controls. Nonetheless, pilots with a high BMI (≥30) do not automatically classify as anthropometrically unfit, rather as borderline and requiring an FCA (for pilots).

f. Large changes in body mass can affect anthropometric dimensions (ie sitting height and sitting buttock-to-knee length); therefore, any aircrew gaining or losing >10% of their body mass must have a full anthropometric assessment. An AvMO should also consider these body mass changes within the personnel's medical assessment.

g. Any aircrew deemed to have a low or high BMI (ie ≤18.5 or ≥30) must be supported (by medical staff, personal training instructor, dietitian or nutritionist, as required) to achieve a target body mass determined by an AvMO in partnership with the aircrew member.

11.2.7.7 Functional Cockpit Assessment

a. An FCA for an aircraft is required to confirm the fitness (or unfitness) of aircrew with anthropometric dimensions in the borderline range for that aircraft.

b. An FCA may also be required when the functional ability of an aircrew member is doubted (eg during or following injury) or when integrating new equipment that may cause functional issues.

c. FCAs must be completed using MD1565 *Functional Cockpit Assessment*.

d. FCAs must be conducted by a qualified flying instructor (QFI) for the aircraft type with the support of skilled medical staff (eg AvMO or AMU Physiologist knowledgeable in aircraft anthropometric accommodation). The QFI is responsible for ensuring that flight tasks are completed efficiently and safely, and the medical staff is responsible for identifying potential medical or anthropometric issues (eg poor posture) and for validating the judgement of the QFI—

   (1) A QFI may conduct an FCA without the support of medical staff if given approval by OC AMU.

   (2) Completed MD1565 forms must be sent to the OC AMU for assessment and final sign off, after which they are to be stored within the aircrew member's medical records.

Chapter 8 - Passenger Fitness to Fly

Purpose of rule

The purpose of this rule is to specify the medical requirements for passengers flying on New Zealand Defence Force (NZDF) aircraft.

Application

a. This rule applies to all personnel flying in positions normally used by aircrew (eg seats with aircraft controls, such as T-6C Texan II, AWO positions in P-3K2 Orion and Observer position in SH-2G Seasprite).

b. This rule does not apply to routine passenger carriage in aircraft seats designated for that purpose (eg main cabins of the C130H and NH90), or for patients during an aeromedical evacuation flight.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.8.1 Personnel responsibilities

a. **Aviation Medicine trained Medical Officer (AvMO)**. Providing aviation medicine instruction, anthropometric measurements and passenger medical assessments as required. Providing support to Squadron personnel undertaking aviation medicine instruction and anthropometric measurements.

b. **Aircraft Captain**. Checking that passengers have received appropriate instruction in aviation medicine and flight safety, that they have been checked as being within weight and anthropometric limits for the aircraft and ejection seat (as applicable) and are physically fit to undertake the flight as planned (by checking for an absence of positive responses on the Health Questionnaire).

c. **Passengers**. All passengers have a responsibility to provide full disclosure on the medical conditions and to comply with the requirements of this Standard.

11.2.8.2 Fitness determination

a. Passenger assessments are required to determine—

(1) medical fitness for the flight environment;

(2) anthropometric fitness for the aircraft used; and

(3) any physical or medical impairments relating to flight in ejection seat aircraft.

b. Current aircrew holding a valid aircrew medical category may fly as passengers without additional medical examination subject to anthropometric clearance as required. Consideration must be given to the relevance of their aviation medicine knowledge to their intended flight.

c. Passenger flights in RNZAF aircraft may be divided into three categories depending on actual or simulated flight conditions as detailed below—

(1) **Category 1**. Exceeding 4G, Rate of Climb or Rate of Descent greater than 10,000 ft/min, and cabin alt exceeding 10,000 ft.

(2) **Category 2**. All flights in ejection seat aircraft that will not exceed Category 1 limits.

(3) **Category 3**. Flights in normal passenger-carrying aircraft, helicopters and in such aircraft as P-3K2 Orion and C-130H.

d. The medical assessment and level of aviation medicine training required from all other passengers in RNZAF aircraft is related to the category and frequency of flight as detailed in Table 11.2.8.1.

Table 11.2.8.1—Passenger Medical Assessments

Category	Medical Examination and Anthropometry	Aviation Medicine Instruction
Cat 1: (Service and Civilian)	AvMO	AMU (or delegated to local AvMO)
Cat 2: (Service and Civilian)	At SQN level – anthropometry[1], complete health declaration.	By SQN (or delegated to local AvMO)
Cat 3: Frequent (Service and Civilian)	See AVOs. Medical examination required if passenger's fitness is in doubt.	The MO is to brief the flying executive on medical and physical limitations appropriate to the unit's aircraft.

1 Texan T6C-II Boarding weight min = 63 kg, max = 120 kg. Nude weight min = 53 kg, max = 105 kg . Sitting height min = 83 cm, max = 102 cm. Buttock–knee min = 54 cm, max = 71 cm. Assess as temporarily unfit if within 5 mm of max buttock–knee length pending cockpit assessment or re-measurement on a calibrated rig.

11.2.8.3 Medical Assessment Category 1

a. It is advised that fitness for passenger flying be assessed by an AvMO who is familiar with the aircraft in which flights are to occur. The AvMO is to take account of the intended flight conditions and is to certify that the passenger—

(1) is medically fit,

(2) meets the anthropometric requirements of the aircraft concerned, and

(3) has received appropriate aviation medicine instruction.

b. The information is to be recorded on an MD1225 *Fitness to Fly: Passenger Medical Assessment Questionnaire* and on an MD1211 *Fitness to Fly: Passenger Medical Confirmation*.

c. Elderly candidates—

(1) Great care is to be exercised when assessing elderly candidates. It is impossible to give a finite age beyond which an individual is unfit to undertake a Category 1 passenger flight. However, cerebrovascular, coronary and orthopaedic fitness must be considered, as must the increased incidence of osteoporosis in older people, particularly post-menopausal females.

(2) If the AvMO has any doubts, they are to seek advice from the OC AMU.

d. Requirement to warn—

(1) AvMOs are to warn the Squadron executive of problems that may occur when flying civilian passengers.

11.2.8.4 Medical Assessment Category 2

a. Squadron personnel can assess the fitness of passengers in Category 2 flights using this process. The following is advised—

(1) A health declaration is to be completed on an MD1225. This has four components—

(a) a full health questionnaire;

(b) passenger declaration;

(c) anthropometry and medical assessment; and

(d) squadron level and AvMO level approval.

b. If there are any positive responses within the questionnaire that indicate a potential health problem, then it is advised that the passenger be referred to an AvMO to complete the assessment.

c. The completed questionnaire is to be passed to Base Medical in all circumstances for a review to ensure that correct procedures are being followed.

d. Only personnel who have been trained to a suitable level by AMU staff may undertake anthropometric measurements. Measurements are to be recorded and retained with the health questionnaire. These are then to be sent to Base Medical for review and filing. Passengers are to meet the anthropometric requirements of the aircraft concerned.

e. Great care is to be exercised when assessing the suitability of potential passengers. Where concerns on fitness still remain, despite no issues declared on the health declaration, Squadron personnel are to seek further advice from an AvMO.

11.2.8.5 Medical Assessment Category 3

a. For Category 3, frequent civilian flyers, the individual is to be requested to supply a synopsis of their medical history from their general practitioner in order to comply with current Aviation Orders (AVOs).

b. The NZDF will not bear the cost of such a report.

c. A medical examination is required if a passenger's fitness is in doubt. This may be completed on an MD1170 *Defence Health Directorate Medical Clearance of Civilians Participating in NZDF Activities* form.

11.2.8.6 Medical examination

a. A passenger who requires a medical examination is to be medically examined as near to the time of the flight as possible, but not more than four weeks before. Ideally, the examination and the pre-flight confirmation of fitness should be done together.

b. The examination is to include consideration of past medical history. Where no documentation is available the passenger is to be asked about their medical history.

11.2.8.7 Patient records

a. The AvMO is to record a comprehensive past medical history on an MD1225, which is to be retained in the medical notes—

(1) Service personnel. Scanned into the patient's record in Profile.

(2) Civilians. Filed in the Casual Patient records or scanned into Profile as a casual patient.

(3) The hardcopy is to be retained in the examining medical centre for at least 10 years.

b. In the event of any abnormal findings during the examination of a civilian, a report is to be sent, with the patient's consent, to the patient's general practitioner.

11.2.8.8 Anthropometry

a. Only personnel (Squadron or medical) who have been trained by AMU personnel in anthropometry (ie weight, seated height etc) are to conduct pre-flight passenger anthropometric assessments.

b. Anthropometry is to be recorded for all Category 1 and 2 passengers.

11.2.8.9 Anthropometric limitations

a. Each variable is to be measured at least twice and should not vary by more than 1% during the measuring process. If variation is greater than 1% an additional measure is to be taken.

b. In cases of doubt, or when within the 5 mm of the buttock-to-heel limit, the passenger is to be assessed as unfit. Furthermore, the flying executive is to be notified if a passenger falls outside the indicative nude weight limit for the aircraft's ejection seat.

11.2.8.10 Final decision

a. In all cases, the Captain of the aircraft is responsible for checking that passengers—

(1) have received appropriate instruction in aviation medicine and flight safety related matters that are relevant to the flight;

(2) have been checked as being within weight and anthropometric limits for the aircraft and ejection seat; and

(3) are physically fit to undertake the flight as planned (by checking for an absence of positive responses on MD1225 and/or MD1211).

b. It is recommended that section 6 *Squadron Level Approval* in the MD1225 form be completed for all flights and signed off by the aircraft Captain.

11.2.8.11 AvMO training

Aviation medicine training for AvMO is to be undertaken only at courses approved for this purpose by the senior AvMO.

11.2.8.12 Passenger medicine instruction

a. Squadron Level—

(1) Passengers are to receive appropriate aviation medicine instruction in addition to a medical assessment, as passengers undertaking an occasional flight will normally have a very limited understanding of the flight environment. Consequently, their aviation medicine instruction is to be directed towards the practical aspects of the flight and is to be easily understood. Instruction is to focus on safety and enjoyment, and it is recommended that it include—

(a) the need for communication with the pilot;

(b) the cause and prevention of air sickness;

(c) the effects of pressure change (in particular, the effect on ears, sinuses and gut should be discussed) and ways of overcoming the associated problems;

(d) information about hypoxia and hyperventilation;

(e) the implications of pre-flight diet, alcohol and medication;

(f) practical aspects of aircrew equipment assemblies, such as G-trousers, protective clothing, helmet and oxygen system, which will be worn during flight;

(g) the ejection sequence and the procedures to be followed in the event of an ejection; and

(h) acceleration, G Force Loss of Consciousness and the Anti G Strain manoeuvre.

b. The method of instruction is at the discretion of the examining AvMO and or Pilot; however, the issue of a written brief or the showing of a video is considered insufficient in themselves.

c. No matter what method of instruction is employed, the examining AvMO and/or pilot is to test the passenger's understanding to ensure their level of knowledge is appropriate for safety.

11.2.8.13 Pre-flight check

a. All passengers undertaking Category 1 or Category 2 flights are to have their fitness confirmed and ears checked within the day prior to the flight.

b. For Category 1 flights, this check is to be conducted by the AvMO at the unit where the flight is to take place, irrespective of when and where the original examination took place.

c. For Category 2 flights, the pilot is to assess the need for a medical review based on discussion with the passenger. If there has been any change in their fitness since the original assessment, then advice is to be sought from an AvMO.

d. An MD1211 is to be issued, indicating medical and anthropometric fitness is suitably endorsed with any additional limitations if appropriate. Copies are to be held by the medical centre and the squadron.

e. It is the AvMO's responsibility to notify a passenger's medical fitness or unfitness; the decision to fly a passenger remains an executive responsibility.

11.2.8.14 Frequent flyers

Advice is to be sought from an AvMO regarding the need for a more formal medical examination and aviation medicine training requirements for personnel who are frequent Category 1 or Category 2 passengers. An aircrew medical examination and Aircrew Medical Grading may be appropriate.

Chapter 9 - Medical Requirements for Military Parachutists

Purpose of rule

The purpose of this rule is to specify the medical requirements for the selection and periodic examination of personnel for parachuting operations.

Application

a. This rule applies to all New Zealand Defence Force (NZDF) personnel employed in military duties requiring planned parachute descents, including familiarisation.

b. This rule also applies to any civilian personnel undertaking parachute descents with the NZDF.

c. This rule does not apply to parachuting descents by aircrew in emergency situations.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.9.1 Personnel responsibilities

The following responsibilities apply—

(1) Aviation Medicine Unit (AMU)—

(a) To provide aviation medicine instruction, anthropometric measurements and medical assessments as required.

(2) All NZDF and civilian parachutists to comply with—

(a) the medical criteria specified in this rule; and

(b) DAR 105 *Parachuting - Organisational Certification, Operating Rules, and Personnel Licences and Ratings*.

11.2.9.2 Physical standards

The following standards apply to military parachuting—

(1) Height—

(a) There are no absolute minima or maxima for parachuting in the NZDF. Each student is assessed for harness fit by a qualified Parachute Jump Instructor (PJI).

(2) Weight—

(a) Weight limits for parachutists will vary depending on the type of activity or parachute being used. Notwithstanding that the Original Equipment Manufacturer (OEM) Maximum All Up Weight (MAUW) limits are to be complied with, medical practitioners will confirm suitability with Parachute Training and Support Unit (PTSU) if the individual's weight is outside the parameters of 60–120 kgs.

(b) Irrespective of body weight, each candidate will be treated on a 'case-by-case' basis with any medical issues being highlighted during the pre-descent medical assessment.

(c) Final authorisation to complete a parachute descent will be in accordance with AVOs and based on assessment of the situation, such as aircraft type to be used (eg large military aircraft with a ramp as opposed to small civil aircraft).

(d) Tandem master candidates are required to demonstrate functional aspects of operating the tandem parachute system, such as accessing the deployment handles, and carrying various sized passengers and combat equipment. Those with previous shoulder or back injuries may not be suitable for tandem operations due the increased loads encountered.

(3) Functional reach—

(a) All applicants for solo parachuting will be assessed for functional reach by a PTSU PJI to ensure their ability to operate all equipment, including reserve chutes.

(4) Colour Perception—

(a) Colour Perception B is required for all professional parachutists.

(b) Colour Perception C (CPC) is an acceptable level for all others.

11.2.9.3 Medical standards

Parachutists require a high standard of physical fitness and must be deemed fit in accordance with single Service fitness criteria. Due to the corresponding risk of metabolic and cardiovascular disease, their BMI must not be greater than 34.

11.2.9.4 Conditions

The conditions stated in Table 11.2.9.1 below are usually incompatible with military parachuting. This list is not exhaustive. In cases where fitness is in doubt, a military AvMO or aviation medicine specialist's opinion is to be sought. Some discretion in the application of these standards may be appropriate for tandem descents.

Table 11.2.9.1—Conditions usually incompatible with military parachuting

System	Condition
Abdomen	Hernias; organomegaly; abdominal aortic aneurysm (AAA); acute bloating; tumours
Endocrine system	Insulin dependent diabetes mellitus; any other untreated endocrine disorder
Musculoskeletal system	Poor functional results from fractures, or from recurrent sprains or dislocations; spinal injury or significant back pain; brittle bones; significant osteoarthritis of weight bearing joints
Mental health	Significant active psychiatric disorder or alcohol/drug abuse; use of medication with sedative or psychotropic side-effects
Neurological	Conditions that could result in impaired consciousness or impaired concentration; epilepsy (treated or otherwise) with the exception of infantile febrile convulsion; any other condition affecting strength or co-ordination
ENT system	Recurrent or repaired perforated tympanic membrane; active vestibular disease; eustachian tube dysfunction; sinusitis or otitis media/externa; previous sinus and otitic barotrauma to be considered carefully
Respiratory system	Active respiratory conditions affecting functional capacity; history of spontaneous pneumothorax
Visual system	Poor visual acuity (binocular vision worse than 6/60 uncorrected and 6/9 after correction – for operational military parachutists, spectacles are not considered safe for jumping) and functionally significant field defects. Qualified parachutists: monocular vision may be acceptable provided that the good eye has a full field and the individual has adapted. Corneal refractive surgery is permissible on the advice of the ophthalmic surgeon, not before three months after surgery and vision is stable and corrected
Other	Pregnancy

11.2.9.5 Military parachute courses

a. Initial NZDF parachute descent courses include—

(1) Basic Static Line;

(2) Ram Air Static Line;

(3) Military Freefall; and/or

(4) Basic Freefall.

b. Students are deemed suitable for parachute training if they—

(1) hold a minimum medical grade of A4 G3 Z1; and

(2) undergo a medical record review by their unit medical practitioner.

c. An AvMO may be consulted regarding any uncertainty.

d. Following satisfactory medical record review (and medical examination, if required), an MD917 *NZDF Medical Board Personal Advice to Serviceman* stating 'Fit Parachute Training' is to be filed in the individual's medical records. A copy is to accompany the candidate when parading at the PTSU.

e. The MD917 is valid for 3 months from the date of issue if the parachutist's medical grading remains unchanged.

f. Qualified Military Parachutists conducting infrequent parachute descents are required to complete an MD440D *Parachutist: Physiological Fitness for Flight*.

11.2.9.6 Professional parachutists

a. Professional parachutists include PJI, Tandem Masters and Special Operations Forces (SOF) parachutists.

b. Because of the importance of colour vision, especially at night, all professional parachutists are to have a colour perception no worse than Colour Perception B.

11.2.9.7 Parachute Jump Instructors and Tandem Masters

a. Personnel selected for PJI, or tandem duties, are to undergo a full MD914 medical examination by an AvMO before acceptance for training. Thereafter, they will require full medical examinations every five years, with an MD1585 *Aircrew Annual Statement of Health* to be completed by the individual annually in between.

b. PJIs and Tandem Masters are to hold a minimum aircrew medical category of A3 G3 Z1, 'Fit Parachute Jump Instructor duties' or 'Fit Tandem Master duties', respectively.

11.2.9.8 Special Operations Forces

a. All operational SOF personnel, and those applying to attend SOF selection, must be specifically assessed for fitness to parachute. A grading annotation of 'Fit all duties' in the Special Forces indicates fitness to parachute.

b. All SOF military parachutists undergoing currency or continuation training at PTSU will be deemed suitable for parachute duties if they, for each training episode (ie any single or block of training days)—

(1) hold a medical grade of A4 G2 Z1; and

(2) complete an MD440D.

c. For those holding a medical grade of A4 G3 Z1 or below, fitness for parachute duties require a discussion with their Unit Medical Officer/medical practitioner. A medical examination may be required. The Unit Medical Officer/medical practitioner will then issue an MD917 stating 'FIT parachuting', which must be presented by the parachutist to PTSU. The MD917 expires one month after date of issue.

d. SOF personnel, when deploying overseas for exercises with allied forces, will need to provide confirmation from AMU of the following—

(1) They are medically cleared for High Altitude Parachute (HAP) operations (defined as parachute jumps above 13,000 ft Above Mean Sea Level).

(2) They have completed the appropriate Aviation Medicine (AvMed) training, in accordance with the Air Force Interoperability Council (AFIC, Five Eyes) policy. A certificate is issued each time on completion of the initial AvMed course and subsequent refreshers.

11.2.9.9 High Altitude Parachute descents

a. HAP descents include—

(1) High Altitude High Opening (HAHO) descents; and

(2) High Altitude Low Opening (HALO) descents.

b. HAP qualified personnel are to undergo a full MD914 medical examination by their Unit Medical Officer/medical practitioner, with confirmation by the AMU before acceptance, and annually thereafter whilst they continue to perform HAP descents.

c. Prior to conducting operations above 13,000 ft altitude, all professional parachutists must undergo specific high altitude training at the AMU, with refreshers every five years thereafter while still employed in this environment.

d. All personnel conducting HAP operations are to have 'Fit high altitude parachute operations' annotated in their MD906.

11.2.9.10 Infrequent military parachutists

a. Any uniformed personnel wishing to make a military tandem passenger descent are to complete an MD440C *Tandem Parachute Jump Medical Screening* form.

b. An assessment by their Unit Medical Officer/medical practitioner will be necessary if any medical condition is declared on the MD440C.

c. Qualified military parachutists undergoing re-currency training, or descents into water, must complete an MD440D.

11.2.9.11 Civilian parachutists: Tandem

Civilian parachutists (without a medical grade) jumping in tandem under military auspices, will require an—

(1) MD440B *Deed of Waiver of Liability for Tandem Parachute Descent and Passage in RNZAF Aircraft*; and

(2) MD440C, signed by their regular general practitioner if medical condition indicated.

Chapter 10 - Remote Piloted Aircraft Systems Medical Standards

Purpose of rule

The purpose of this rule is to specify the assessment process to determine the medical grading of New Zealand Defence Force (NZDF) Remotely Piloted Aircraft Systems (RPAS) remote pilots in order to determine their medical fitness to be able to safely operate RPAS.

Application

a. This rule applies to the assessment of NZDF RPAS NATO Class I remote pilots both within New Zealand and abroad.

b. The NZDF currently operates only NATO Class I RPAS. Therefore, the medical standards for Class II and Class III RPAS are considered out of scope and will not be covered by this health standard.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.2.10.1 General

The NZDF has ratified Air and Space Interoperability Council: Air Standard ASMG 6005 Ed 1 v 1: UAS Operator Medical Standards.

11.2.10.2 Uniformed personnel

a. All uniformed remote pilots are to be in date with Health Checks required for deploying serving personnel.

b. Uniformed remote pilots must obtain a minimum health grading of A4 G3 in order to be permitted to operate an RPAS.

11.2.10.3 Civilian personnel

a. The minimum fitness requirement for civilian remote pilots, flying RPAS outside of NZDF deployed operations, is the medical fitness to hold a Class I New Zealand drivers licence.

b. Civilians do not need to meet the deployable dental or physical fitness standards for the role of remote pilot within New Zealand.

c. If deployed, civilian remote pilots must then meet the specified deployment standard of fitness, as per NZDF health processes for deploying civilian personnel.

PART 3 - OVERSEAS ACTIVITIES: HEALTH CONSIDERATIONS

Chapter 1 - Collection of DNA from NZDF Personnel

Purpose of rule

The purpose of this rule is to specify the collection and management of New Zealand Defence Force (NZDF) personnel DNA samples.

Application

This rule covers the collection of DNA from at risk personnel for the purpose of forensic identification purposes only. It applies to—

(1) deploying personnel;

(2) personnel posted to high risk occupations including, but not limited to—

(a) Special Forces/Explosive Ordnance Disposal team;

(b) Aircrew (includes all aircrew, such as medical personnel and others, who fly frequently or on high risk activities); and

(c) Divers.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.3.1.1 Introduction

a. At times, NZDF personnel perform their duties in places and activities that place them at personal risk. As a responsible employer, the NZDF has an obligation to care for personnel and their families. The use of DNA in forensic identification can reduce the uncertainty of identity and decrease the stress placed on families and colleagues. This helps to meet the organisational duty of care obligation.

b. DNA is unique to each individual and hence can be used for identification purposes. In the event of an individual's death, a DNA reference sample can be matched with samples from a body or body part in order to positively identify that individual.

11.3.1.2 Voluntary sampling

a. The provision of a DNA sample is voluntary; therefore, an informed consent process is to be used.

b. Ideally, the DNA identification process requires two separate samples for legal identification of the individual. The NZDF process requests an individual to provide information identifying biological family members who share their DNA in order to provide the second reference sample if required. The intent is that this information will be used only for the purpose of forensic identification and is not to be retained.

11.3.1.3 Informed consent

a. Personnel responsible for the DNA collection are to ensure that the potential donors are informed of the—

   (1) reason for DNA collection;

   (2) the voluntary nature of the collection;

   (3) collection process;

   (4) reason for the request for identification of biological family members; and

   (5) storage and destruction management of the DNA samples.

b. The potential donors are to be informed that the process is voluntary but is considered 'best practice' by many armed forces.

c. Personnel who agree to donate a DNA sample are to be given an MD1523 *Defence Health Directorate Individual Reference DNA Collection Form* to read, complete and sign before the sample is collected.

d. It should be noted that the consent process does not prohibit the sample from being used for other lawful purposes under very specific legal exceptions. The clear intent of NZDF however is that access to the sample is for forensic identification purposes only.

11.3.1.4 DNA collection process

a. Health personnel managing the collection process are to follow the procedure specified in the Joint Support Group (JSG) - Health Standard Operating Procedure *NZDF Collection of Samples for DNA Forensic Identification*.

b. Personnel in high risk occupations are to have one DNA sample taken on posting into a role. That DNA sample is to be stored in accordance with JSG - Health Standard Operating Procedure *NZDF Collection of Samples for DNA Forensic Identification* and destroyed or collected when the individual posts out of that role.

c. If there is any possibility that the swab has been contaminated, then the swab is to be re-taken.

11.3.1.5 Access to DNA samples

DNA samples should be accessed only—

(1) as a reference sample for forensic identification processes (this access requires written permission from the Surgeon General); or

(2) for the purpose of destruction of the sample.

11.3.1.6 Storage of DNA samples

DNA samples are to be stored at the Defence Health Centre in accordance with JSG -Health Standard Operating Procedure *NZDF Collection of Samples for DNA Forensic Identification*.

11.3.1.7 Record of DNA samples

a. All personnel who have contributed a DNA sample are to have an entry made in their electronic medical record (Profile).

b. The signed consent form is to be retained with the DNA sample and is to be returned with the DNA sample to the donor.

11.3.1.8 Destruction of DNA samples

a. All DNA samples are to be destroyed post deployment, on leaving the NZDF or on posting from a high-risk occupation.

b. If the sample is not collected by the donor, then destruction is to be by incineration at an approved facility in accordance with controlled waste management as specified in DHR 30 *Applied Healthcare: Health and Disability Services*.

Chapter 2 - Medical and Dental Certification of Foreign Military Sales Program Course Attendees and Authorised Accompanying Dependants

Purpose of rule

The purpose of this rule is to specify the requirements for the issuing of a medical and dental certificate to New Zealand Defence Force (NZDF) personnel, otherwise known as International Military Students, attending a training course in the United States of America (USA). This is funded under the USA Foreign Military Sales program.

Application

This rule applies to the pre-departure medical and dental management of—

(1) International Military Students proceeding on Foreign Military Sales funded courses in the USA, and

(2) authorised accompanying dependants.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.3.2.1 Background

a. International Military Students attending Foreign Military Sales funded courses in the USA, and their authorised accompanying dependants, are to be free of communicable diseases and physical or mental disorders that may pose a threat to the safety of themselves or others.

b. Students and their dependants must complete the required pre-departure medical and dental examinations prior to the issuance of an invitational travel order.

11.3.2.2 Timing

Students and their dependants must complete the required medical and dental assessments within ninety days preceding the course start date.

11.3.2.3 Student management: Initial information

The appropriate health facility is to provide the student with the following before undergoing the required medical and dental assessments—

(1) A blood test form to take to the laboratory for checking—

(a) a full blood count;

(b) varicella immunity (if not previously recorded as positive or no evidence of vaccination);

(c) blood group; and

(d) G6PD status (if not recorded).

(2) Form for the provision of an Interferon Gamma Release Assay Test (Quantiferon Gold). If the IGRA test result is positive or not appropriate, a form for the provision of a chest X-ray is to be supplied as well.

Note: The student must complete an Interferon Gamma Release Assay test, if available, to identify the presence of latent tuberculosis.

(3) If the Interferon Gamma Release Assay test result is positive for latent or active tuberculosis, or the student does not have the option to take the Interferon Gamma Release Assay test, then the student must have a chest X-ray performed to identify/confirm any presence of active tuberculosis.

(4) If the Interferon Gamma Release Assay test result is negative for tuberculosis, a chest X-ray is not required, unless the student will be attending high-risk training that specifically requires the X-ray.

(5) The results of the chest X-ray and/or the Interferon Gamma Release Assay test are to be included on form DD 2808 *Report of Medical Examination.*

(6) If an individual travels to the USA for training more than once in a twelve-month period and the chest X-ray prior to the initial training period is documented as negative for active disease, a repeat chest X-ray is not required unless the individual has symptoms of, or a clinical examination finds or suspects, a pulmonary problem.

(7) Before the medical and dental assessment appointments, the student is required to—

(a) complete form DD 2807-1 *Report of Medical History*;

(b) complete the initial component of DD 2808, as directed in the associated instructions;

(c) have had the blood tests; and

(d) have had a chest X-ray (if the Interferon Gamma Release Assay test result is positive).

11.3.2.4 Student management: Vaccination

a. The student is required to be current with the NZDF Vaccination Schedule Baseline Programme and, as a minimum, be current with the following vaccinations—

(1) Measles, Mumps, and Rubella;

(2) Polio;

(3) Tetanus and diphtheria toxoids, and acellular pertussis (if indicated Td/Tdap);

(4) Varicella (chickenpox);

(5) Yellow fever (if travelling through an infected area);

(6) Hepatitis A; and

(7) Hepatitis B.

b. Students who have received one or both COVID-19 vaccinations are to note the following details on DD 2808 (block 44)—

(1) name of the COVID vaccine;

(2) COVID-19 vaccine batch number; and

(3) the date(s) the vaccine dose(s) were administered.

c. Students are required to take a copy of their vaccination record with them to the United States.

11.3.2.5 Student management: Medical examination

a. An examining medical practitioner is to—

(1) medically examine the student and complete DD 2808; and

(2) complete the student's DD 2807-1.

b. For female students aged between 18 and 44 years, the examination must include a pregnancy test. Test results are recorded in block 73 of DD 2808. If the test result is positive, the student will require a medical waiver through the USA embassy.

c. USA Federal regulations and policies exist to prevent the spread of communicable disease. Students and dependants are to be free of the diseases listed in 11.3.2.5d. below. Note that there is no requirement to test for the listed diseases unless it is clinically indicated to do so.

d. The current communicable disease list contains—

(1) Chancoid;

(2) Cholera or suspected cholera;

(3) Gonorrhoea;

(4) Granuloma inguinale;

(5) Hansen's disease (leprosy), infectious;

(6) Human immunodeficiency virus (HIV);

(7) Lymphogranuloma venereum;

(8) Plague;

(9) Severe acute respiratory syndrome (SARS);

(10) Suspected viral haemorrhagic fevers (Lassa, Marburg, Ebola, Congo-Crimean, and others not yet isolated or named);

(11) Suspected smallpox;

(12) Syphilis, infectious state; and

(13) Yellow fever.

e. Although Human Immunodeficiency Virus was removed from the list of communicable diseases for access into the USA, a Human Immunodeficiency Virus waiver must still be requested. For some training, a waiver would not be permitted, depending on the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome level. The physical exam and laboratory work must be attached to the waiver.

11.3.2.6 Student management: Medical certificate

The examining medical practitioner must—

(1) complete all appropriate fields in DD 2808; and

(2) sign the certificate of FMS Certificate of Medical Examination Compliance form to signify that the named individual—

(a) is fit for military training;

(b) is free of communicable disease; and

(c) has completed the recommended vaccinations.

11.3.2.7 Student management: Medical waivers

Medical waivers will not be granted for listed communicable diseases. Some communicable diseases (eg Hepatitis A, Hepatitis B, and Hepatitis C) are not included in the list. Medical waivers will be considered on a case-by-case basis for individuals testing positive for non-listed diseases, but found not to be at risk to the general population.

11.3.2.8 Student management: Waiver process

a. Where the elements assessed on the DD 2808 are outside of the normal range, the examining medical practitioner is to use their clinical judgement to determine if the student is fit for the course. If appropriate, an FMS Medical Waiver Request form is to be completed by the examining medical practitioner and submitted to the Office of Defence Cooperation, USA Embassy, via the NZDF Foreign Military Sales Coordinator. Any costs incurred as a result of unexpected developments of known conditions will be covered by the NZDF.

b. The medical waiver requests is to include the details of—

(1) the student work control number and program type student case identification;

(2) scheduled training, date and location; and

(3) copies of the pertinent laboratory results.

11.3.2.9 Student management: Defence Health overseas healthcare processes

a. The Foreign Military Sales assessment processes (summarised in *Foreign Military Sales Course – Medical Assessment Process*) should be conducted parallel to the Defence health overseas healthcare processes.

b. Where appropriate, the examining medical practitioner should complete an—

(1) MD914 *NZDF Medical Re-examination Record*, and/or

(2) MD906 *NZDF Medical Grading Review*.

11.3.2.10 Dependants management: Initial information

a. A completed DD 2807-1 and DD 2808 are required for each dependant.

b. Additionally each dependant must complete/possess—

(1) screening for tuberculosis;

(2) Human Immunodeficiency Virus serology;

(3) a letter regarding their current state of health from their general practitioner; and

(4) an immunisation record (recommended).

c. Before the medical and dental assessment appointments, the dependant is required to—

(1) complete form DD 2807-1;

(2) complete the initial component of DD 2808, as directed in the associated instructions; and

(3) have had the relevant blood tests and a chest X-ray or Interferon Gamma Release Assay test.

d. If the dependant is required to be screened for tuberculosis, the dependant must complete an Interferon Gamma Assay test to identify the presence of latent tuberculosis, if available. If the Interferon Gamma Release Assay is positive for latent or active tuberculosis, or if the dependant does not have the option to take the Interferon Gamma Release Assay test, they must have a chest X-ray performed to identify/confirm the presence of active tuberculosis.

e. The results of the chest X-ray and/or the Interferon Gamma Release Assay test are to be included on form DD 2808, block 73.

f. If the dependant is under the age of 15 years, then tuberculosis and Human Immunodeficiency Virus screening is not required unless—

(1) the dependant has symptoms that are consistent with tuberculosis or Human Immunodeficiency Virus;

(2) the dependant was in contact with a person infected with tuberculosis or Human Immunodeficiency Virus; or

(3) there is reason to believe the dependant has been exposed to tuberculosis or Human Immunodeficiency Virus.

11.3.2.11 Dependants management: Vaccination

a. Dependants who have received one or both COVID-19 vaccinations are to note the following details on DD 2808 (block 44)—

(1) name of the COVID-19 vaccine;

(2) COVID-19 vaccine batch number; and

(3) the date(s) the vaccine dose(s) were administered.

b. Dependants are to take a copy of their vaccination record with them to the USA.

c. Authorised accompanying dependants under 18 years of age are recommended to—

(1) be current for age with the New Zealand Immunisation Schedule; and

(2) have Hepatitis A Junior and Varicella vaccinations (if attending school or daycare).

11.3.2.12 Dependants management: Medical examination

a. The examining medical practitioner is to—

(1) medically examine the dependant and complete the appropriate fields in DD 2808; and

(2) complete the student's DD 2807-1.

b. A pregnancy test for each authorised female dependant over the age of 18 is required. If an authorised dependant is pregnant, the Office of Defense Cooperation will be required to submit a request for a health policy waiver.

c. Pregnant dependants will not be authorised on the Invitational Travel Order or to accompany the student until after the birth of the baby unless—

(1) NZDF agrees to pay for the healthcare, including delivery of the baby; or

(2) it is evident that health insurance covers the pregnancy, delivery of the baby, and any after care.

d. It is important to note that not all entry fields in the forms DD 2807-1 and DD 2808 are applicable to young children. In such cases, it is recommended that the examining medical practitioner refers to the following documents for further guidance—

(1) Instructions DD 2807-1 Report of Medical History; and

(2) Instructions DD 2808 Report of Medical Examination.

e. The examining medical practitioner must—

(1) complete all appropriate fields in DD 2808; and

(2) sign the certificate of FMS Certificate of Medical Examination Compliance to signify that the named individual—

(a) is free of communicable disease; and

(b) has complied with the recommended vaccinations.

11.3.2.13 Dependants management: Defence Health overseas healthcare processes

a. The Foreign Military Sales assessment processes (summarised in *Foreign Military Sales Course – Medical Assessment Process*) are to be conducted parallel to the Defence Health overseas healthcare processes.

b. The NZDF Medical Practitioner is required to complete an MD1231 *Overseas Accompanying Dependants: Medical Health and Wellness Risk Assessment and Notification to the Posting Authority* after the examining practitioner has completed the dependant's DD 2808.

11.3.2.14 Dental examination: Students

As part of the *Foreign Military Sales Course: Dental Assessment Process*, an NZDF dental practitioner is required to—

(1) complete the student's dental examination; and

(2) sign DD 2808, block 84, signifying that no care is required for cavities, infection or oral disease.

11.3.2.15 Dental examination: Dependants

a. As part of the *Foreign Military Sales Course: Dental Assessment Process*, the dependant's dental practitioner is required to—

(1) complete the dental examination; and

(2) sign DD 2808, block 84, signifying that no care is required for cavities, infection or oral disease.

b. As part of the *Foreign Military Sales Course: Dental Assessment Process*, an NZDF dental practitioner is to—

(1) review the relevant, completed fields in DD 2808; and

(2) complete an MD1571 *Overseas Accompanying Dependants: Oral Health Risk Assessment and Notification to the Posting Authority*.

11.3.2.16 Certification of dental compliance

An NZDF dental practitioner must complete an *FMS Certificate of Dental Examination Compliance* form (see Foreign Military Sales Course: Dental Assessment Process) if the student and associated dependants—

(1) have received all dental treatment requirements; and

(2) have no significant dental issues that would preclude the attendance on a Foreign Military Sales course or entry into the USA.

11.3.2.17 Students already posted to the USA

a. The student and their dependants, who are at the end of their posting to the USA and transition to a Foreign Military Sales funded course are to complete the Foreign Military Sales medical requirements.

b. Students who are posted to the United States and attend a Foreign Military Sales funded course during their posting are not required to complete the Foreign Military Sales medical process.

11.3.2.18 Explosion Ordnance Disposal Course

a. Attendance at the United States Navy Explosive Ordinance Disposal (USN EOD) Course has the following additional medical requirements—

(1) chest X-ray (PA and lateral);

(2) 12-lead electrocardiogram;

(3) audiogram;

(4) type 2 dental exam;

(5) basic refractive analysis;

(6) colour vision;

(7) depth perception;

(8) complete blood count;

(9) fasting blood glucose;

(10) urinalysis with microscopic examination;

(11) hepatitis C screening; and

(12) tuberculosis skin test or gold test results.

b. Test results are to be provided to the Office of Defense Cooperation to forward to the schoolhouse for review at least 45 days prior to the student departing New Zealand.

c. Students will not be accepted if on daily medication – regardless of the daily medication.

11.3.2.19 Combat Survival Training

Attendance on the United States Air Force Combat Survival Training (SERE) course has the following additional medical requirements. The student must take copies of the following to the USA—

(1) DD 2766 - Adult Preventive and Chronic Care Flowsheet; and

(2) SF600 - SERE Medical/Psychological Pre-Clearance form.

11.3.2.20 Carriage of documents: Pre-departure

a. For all courses, a copy of the student's and dependant's competed FMS Certificate of Medical Examination Compliance form and the FMS Certificate of Dental Examination Compliance form must be forwarded to the Foreign Military Sales Coordinator.

b. As per the additional requirements of the Explosive Ordnance Disposal course and the Combat Survival Training course, a copy of the student's completed documents must be forwarded to the Foreign Military Sales Coordinator. These include the—

(1) DD 2807-1;

(2) DD 2808;

(3) FMS Certificate of Dental Examination Compliance form; and

(4) FMS Certificate of Medical Examination Compliance form.

11.3.2.21 Carriage of documents: Upon arrival

The student is required to receive and forward/hand carry copies of their medical exam, medical history and any relevant medical test results for delivery to their medical treatment facility upon arrival in the USA.

Chapter 3 - Overseas Healthcare Processes for Members of the NZDF on Tours of Duty and Non-Operational Postings (Temporary and Permanent) and their Dependants

Purpose of rule

This rule details the processes required to meet the Defence Health responsibilities detailed in DFI 18.1 *Health Services*, Part 4 *Healthcare Delivery Framework*, Chapter 5 *Non-operational Overseas Travel Health Assistance* for the management of healthcare for New Zealand Defence Force (NZDF) personnel overseas.

Application

This rule applies to the Defence Health management of the care for members of the NZDF on a tour of duty overseas, or posted overseas on a temporary or permanent non-operational posting, and their accompanying dependants.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.3.3.1 Health cover specifications

a. Defence Health management of the care for members of the NZDF on a tour of duty overseas, or posted overseas on a temporary or permanent non-operational posting, and their accompanying dependants includes—

(1) health checks and any restrictions identification prior to departure;

(2) approval processes for non-urgent, non-routine care; and

(3) health management for cases with security issues.

b. The NZDF will generally meet routine healthcare requirements. Specialist and or surgery requirements will be based on the individual case. For non-routine care, the Chief Medical Officer and Chief Oral Health Officer (or relevant delegate), as applicable, will advise command of the most appropriate option. This may include provision of care in-country or on return to New Zealand. Provision of care that falls outside the parameters of what is available under the New Zealand public healthcare system will not normally be met by the NZDF.

c. Any funding of medical care is based on the New Zealand public health care provisions including Accident Compensation Corporation (ACC) entitlements. Any additional expenses incurred outside direct healthcare are not funded by the NZDF. These are included in entitlements and allowances provided to NZDF personnel posted overseas (eg location and expatriate allowances).

d. Dental care is based on equivalent New Zealand private oral health care.

Note: Within New Zealand, dental care is not provided at public expense but is at individual expense. The exception is for those aged under 18 years old who are eligible for free care based on the school dental benefits.

11.3.3.2 Service member: Pre-departure processes

a. A Service member who has received notification of duty travel overseas is, if so directed, required to gain health clearance within one month of the Overseas Posting Instruction being issued. Particular attention is to be paid to the nature and duration of the posting/tour of duty (risks, health threats, repatriation ability etc).

b. This comprises the following—

(1) Medical—

(a) If a non-operational posting of greater than six months in duration—

(i) MD914 (if an MD914 check has not occurred within the previous six months) and file review to determine if any health provider outside of medical has entered relevant health information.

(ii) File review (if an MD914 check has occurred within the previous six months) to determine if an MD914 assessment or additional physical medical review needs to be conducted.

(b) If a non-operational tour of duty of less than six months in duration—

(i) File review to determine if an MD914 assessment or additional physical medical review needs to be conducted.

(ii) If the file review indicates any risk based on clinical findings, and taking into account the nature and duration of the tour of duty, an MD914 is to be completed.

(2) Oral Health/Dental—

(a) A check by a dental practitioner at a Defence Dental Centre.

c. The processes described above form the NZDF health assessment of a Service member proceeding overseas. Healthcare professionals are also to be aware of the requirements of the receiving country/unit and the health situation in that country. In addition, there may be specific forms/investigations/vaccination requirements (separate to NZDF requirements), such as the Foreign Military Sales processes for Service members attending courses in the USA (refer to Part 3, Chapter 2 *Medical and Dental Certification of Foreign Military Sales Program Course Attendees and Authorised Accompanying Dependants.*

11.3.3.3 Service member: Risk assessment

On completion of the health checks, the healthcare professional responsible for completing the assessment is to identify any health issues that could affect the Service member's suitability for the posting. This includes an assessment of the impact of any issue associated with a dependant. The assessment should include—

(1) the risks associated with the issue(s);

(2) the restrictions these impose on the individuals; and

(3) an assessment of possible costs.

11.3.3.4 Service member: Notification to posting authority

a. The results of this impact analysis are to be sent to the posting authority that is responsible for the decision on the Service members posting. The information must be provided in accordance with the specifications of DHR 36 *Healthcare Management Systems*, Part 2 *Healthcare Delivery Systems*, Chapter 2 *Sharing Health Information*.

b. Both the service members risk assessment and notification to the posting authority are to be recorded as follows—

(1) **Medical**. Use an MD1593 *NZDF Serviceperson Overseas Posting (Medical Risk Assessment and Notification to the Posting Authority)*.

(2) **Oral Health**. Use an MD1592 *NZDF Serviceperson Overseas Posting (Oral Health Risk Assessment and Notification to the Posting Authority)*.

c. The assessing medical/dental practitioner is to complete Parts 1 and 2 (of the relevant form)—

(1) If no risk is identified, they are to forward the form to the relevant posting authority.

(2) If risk is identified, the assessing medical/dental practitioner is to forward the relevant form to the Principal Medical Officer/Senior Technical Advisor Oral Health (or delegate).

d. The relevant posting authority must be determined by the provider in order to correctly send the MD1592 or MD1593.

11.3.3.5 Dependants/accompanying family

a. Service member dependants/accompanying family members can include individuals who are—

(1) a partner or dependant family member under 18 years of age;

(2) a dependant family member over 18 years of age if they are still in year 13 of school; or

(3) a family member over 18 years of age who has been approved/funded to accompany by the relevant posting authority.

b. Where the Service member dependants/accompanying family members are accompanying them on a posting, the dependant/family members are to undergo a health assessment by their own health providers at NZDF expense.

c. The required assessments for each dependant are—

(1) **Medical Health/Wellness**. MD1230 *Dependants Medical Health and Wellness Examination Record* (dependant's self-declaration and dependant's general practitioner assessment).

(2) **Oral Health**. MD1570 *Oral Health Examination and Treatment Record* (dependant's dentist assessments and treatments).

d. NZDF funding covers the medical and dental examination and X-rays only.

e. A copy of the completed forms is to be supplied to the Defence Health Centre/Dental Centre. The information is to be recorded in a separate electronic health record created in each individual's name.

f. Duplication of electronic health records creates risk because previous health information for the individual that may be important for their care is not available to their current healthcare provider. An individual may have an existing electronic health record from current Territorial Force service, previous NZDF service, or previous posting. To avoid creating duplicate electronic health records, any person creating a new health record in a Defence Health Information System (Profile or Titanium) must check to see if the individual already has an electronic health record before creating a new one. Particular attention is to be paid when creating a new health record for accompanying dependants and for other civilians. If an existing electronic health record for the individual is found, that record is to be reactivated (if necessary) and the new health information added to it. Any identified duplicate electronic health records are to be reported to the Defence Health Information System team.

11.3.3.6 Dependants: Risk assessment

a. On completion of the oral health/health and wellness checks, the healthcare professional responsible for completing the assessment is to identify any health issues that could impact on the dependant's suitability to accompany the Service member on the posting. The assessment should include—

(1) the risks associated with the issue(s);

(2) the restrictions these impose on the individuals; and

(3) an assessment of possible costs.

b. The oral health risk assessment is to be completed by the confirming NZDF dental practitioner utilising an MD1571, in conjunction with the information supplied in an MD1570.

c. The medical health and wellness risk assessment is to be completed by the confirming NZDF medical practitioner utilising an MD1231 *Overseas Accompanying Dependants: Medical Health and Wellness Risk Assessment and Notification to the Posting Authority,* in conjunction with the information supplied in an MD1230 (dependant's self-declaration and dependant's general practitioner assessment).

11.3.3.7 Dependants: Notification to posting authority

a. If a dependant is risk assessed as being FIT (for either oral health or medical health and wellness assessments), the confirming practitioner is to forward the relevant risk assessment form to the appropriate posting authority.

b. If a dependant is risk assessed as being either AT RISK or UNFIT (for oral health or medical health and wellness assessments), the confirming practitioner is to forward the relevant form for further review.

c. Oral health risk assessments are to be forwarded to the Senior Technical Advisor Oral Health (or delegate). Medical health and wellness risk assessments are to be forwarded to the Principal Medical Officer (or delegate).

d. The Principal Medical Officer (or delegate)/Senior Technical Advisor Oral Health (or delegate) is to assess the information provided and complete the relevant form (MD1571 or MD1231). Once this is completed, the form is to be forwarded to the relevant posting authority.

e. Should any further assessment be required, the Chief Medical Officer or Chief Oral Health Officer are to be involved.

f. The information must be provided in accordance with the specifications of DHR 36 *Healthcare Management Systems*, Part 2 *Healthcare Delivery Systems*, Chapter 2 *Sharing Health Information*.

11.3.3.8 Information provision

All personnel departing overseas are to be briefed by their posting authority on the service provided by International SOS (iSOS) and access given to the online information resources. Refer to Accessing Health Care Guide.

11.3.3.9 Health issues overseas: Emergency care

In the event of a health emergency, the person should access immediate care. iSOS should be contacted to provide advice and facilitation of that care. iSOS will notify the NZDF of any associated requirements. The NZDF covers the costs.

11.3.3.10 Health issues overseas: Routine healthcare

Routine healthcare is to be provided by primary care healthcare professionals in country at NZDF cost, without any requirement for prior authorisation from the NZDF. Administration for this is to be done through the local administration unit and funded by the posting authority. The iSOS assistance centre can help with advice, if required. ISOS will not normally be engaged to manage the case unless exceptional circumstances exist in order to manage contractual costs.

11.3.3.11 Health issues overseas: Non-urgent, non-routine healthcare requirements

a. For healthcare that includes specialist referral and treatment and/or hospital-based care, the individual is to contact the iSOS assistance centre and provide the relevant details regarding the condition. The iSOS will then contact the NZDF duty Medical Officer at Overseas.Med.Dent.Requests@nzdf.mil.nz with the relevant details, the proposed treatment, and the anticipated costs.

b. The Duty Medical Officer is to refer the request to—

   (1) the Chief Oral Health Officer for oral care conditions; or

   (2) the relevant technical authority if the request concerned is not medical or oral health.

c. The Duty Medical Officer/Chief Oral Health Officer is to consider—

   (1) the nature of the condition;

   (2) the urgency of the requirement;

   (3) whether the NZDF will fund the care in accordance with—

      (a) the criteria specified in Part 3, Chapter 3, paragraph 11.3.3.1 *Health cover specifications*; or

      (b) the *Overseas Health Care Funding Schedules*;

(4) the cost of providing the care in situ compared with the cost of providing care within New Zealand; and

(5) the implications of not providing the care.

d. The Duty Medical Officer/Chief Oral Health Officer is then to recommend a course of action to the posting authority regarding the funding of the care. This must be approved by the posting authority before iSOS facilitates the recommended course of action.

e. Full notes are to be maintained in the person's electronic health record.

f. Where the care provision is not funded but the Service member elects to fund the care personally, a copy of the case notes is to be sent back for inclusion in the Service member's record. This is not required for dependants.

11.3.3.12 Health issues with security implications

Where the health issue concerned has potential security issues for the NZDF, the Service member should contact the Duty Medical Officer directly without involving International SOS.

11.3.3.13 Schedules of healthcare provision for overseas persons

The *Overseas Health Care Funding Schedules* are to be reviewed annually by the Principal Medical Officer and the Senior Technical Advisor Oral Health.

11.3.3.14 Quality assurance processes

a. The Practice Governance Board has delegated responsibility for the auditing of overseas personnel funding decisions in order to ensure that an equitable service is being provided to all posted personnel and that NZDF funding criteria are being met.

b. Any issues identified in the management of overseas personnel care provision are to be reported to the Practice Governance Board to determine the appropriate action.

Chapter 4 - Vaccination Requirements for Overseas Postings

Purpose of rule

The purpose of this rule is to specify the management of the vaccination requirements for New Zealand Defence Force (NZDF) personnel and their families for overseas postings.

Application

a. This rule applies to all NZDF personnel and their families who are posted to overseas locations in urban housing for a duration of greater than 12 months.

b. For postings of less than 12 months, current New Zealand travel advice applies.

c. This rule does not apply when additional requirements beyond the NZDF Vaccination Schedule Enhanced Programme are indicated. These cases are to be managed on a case-by-case basis through the Defence Health Centre Manager and Medical Officer Lead, in consultation with the Principal Medical Officer.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.3.4.1 Personnel responsibilities

a. The Principal Medical Officer is responsible for the development and maintenance of the vaccination recommendations.

b. Defence Health Centre and Regional Managers are responsible for ensuring that their staff comply with this policy.

11.3.4.2 Vaccination requirements for overseas postings

a. Non-operational overseas postings may require vaccination of deploying personnel, including accompanying dependants, above that provided in the NZDF Vaccination Schedules or civilian equivalent.

b. Vaccination requirements for these postings depend on a variety of factors—

(1) geographical location;

(2) length of stay;

(3) season and climatic conditions;

(4) type of accommodation; and

(5) activities being undertaken.

c. The NZDF Vaccination Schedules are designed to meet international and operational requirements necessary for Regular Force personnel to be rapidly deployed, often at short notice, into a wide variety of environmental settings.

d. In contrast, families accompanying service personnel on overseas non-operational postings are sent to a specific location for a defined period of time. This means that the family members may not require the same vaccinations as the military person.

11.3.4.3 NZDF personnel

a. Overseas posted Service personnel are to be current with the NZDF Vaccination Schedule Baseline Programme as described in the DHR 31 *Applied Clinical Practice - Medical,* Part 4 *Applied Care: Nursing/Medic*, Chapter 1 *NZDF Vaccination*.

b. Additional vaccines from the enhanced NZDF vaccination schedule that may be required for common postings are described in Joint Standard Operational Procedure (JSOP): *Vaccination Schedule for Overseas Postings*, Annex A.

11.3.4.4 Authorised partners and dependants

a. Partners or dependants (under 18 years of age, or over 18 years of age but who are year 13 students) who accompany Service personnel on postings should be current with the New Zealand Immunisation Schedule and any NZDF identified additional vaccines, as above.

b. For children who will be attending childcare facilities or local schools in the posting location, there may be additional vaccines required prior to commencement at these facilities.

c. The administration of vaccines is to be managed in accordance with DHR 31, Part 4, Chapter 2 *Vaccine Administration.*

11.3.4.5 Course completions/boosters

Additional or booster doses of vaccines for posted personnel and accompanying family, required to complete recommended courses, can be obtained during the posting, through a local healthcare provider in the country of posting. These should be paid for at the time and a claim submitted to the Posting Authority in accordance with other healthcare costs during the posting. Those who require additional or booster vaccinations are to be advised prior to leaving New Zealand.

11.3.4.6 Vaccine recommendations list

a. JSOP: *Vaccination Schedule for Overseas Postings* describes the process for delivery of vaccines to personnel on non-operational postings.

b. The Principal Medical Officer must maintain the schedule of vaccine recommendations for non-operational postings contained within JSOP: *Vaccination Schedule for Overseas Postings*, Annex A.

c. The schedule is to be distributed to all Defence Health Clinics and be made available for NZDF personnel as required.

11.3.4.7 Vaccination refusal

a. Any partners, dependants or Service personnel who are being posted overseas and who are unvaccinated or have refused previous vaccination should be referred to the medical practitioner, in accordance with section Right to Refuse Medical Treatment in DHR 30 *Applied Healthcare: Health and Disability Services,* Part 1 *Health and Disability Services*, Chapter 2 *Informed Consent for Healthcare Treatment*.

b. Recommendations to Command on further action should be treated on a case-by-case basis and based on a risk assessment, according to the posting location.

11.3.4.8 Vaccines for personal travel

Vaccinations required for personal travel are to be managed in accordance with DHR 31, Part 4, Chapter 1.

Chapter 5 - Medical Warning Discs

Purpose of rule

The purpose of this rule is to provide direction on the provision of medical warning discs for New Zealand Defence Force (NZDF) uniformed personnel with potentially life-threatening medical conditions.

Application

This rule covers only the criteria for provision of medical warning discs for NZDF military personnel with potentially life-threatening medical conditions.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.3.5.1 Medical warning discs

a. Medical warning discs allow medical health responders, both military and civilian, to identify potentially life-threatening medical conditions at times when the serviceperson is unable to communicate.

b. The issue of a medical warning disc is at the discretion of the medical practitioner, and the cost of such discs is to be covered by the serviceperson's unit.

c. Medical warning discs are to be red with a red silencer and may be worn on the same chain as the identity discs.

d. Personnel issued with a medical warning disc are to be encouraged to wear them at all times, unless instructed not to.

e. All personnel deploying/posting or travelling overseas are to check if they have a medical requirement for a medical warning disc with Defence Health.

11.3.5.2 Medical conditions

A range of conditions may warrant the issue of a Medical Warning Disc, including (but are not limited to)—

(1) allergy to medications, including antibiotics and anaesthetics;

(2) use of a regular medication, such as an anticoagulant or anticonvulsant;

(3) sensitivity to—

(a) biological products, such as eggs and seafood; and/or

(b) immunising agents, when severe; and/or

(4) any other relevant condition, at the discretion of the medical practitioner.

11.3.5.3 Provision

Personnel with conditions that warrant the issue of a medical warning disc are to be provided with a completed *Identity and Medical Warning Disc Request Form* to request the issue through Defence Shared Services. This is an administrative function that is raised by the attending medical practitioner and administered through the Defence Health Centre.

11.3.5.4 Record

The issue of the medical warning disc is to be recorded in the individual's medical record by the attending medical practitioner.

11.3.5.5 Other medical warning systems

Personnel may request the provision of other medical warning systems. This process may be facilitated as the care provider, but it is not to be funded by the NZDF.

PART 4 - HEALTH SUPPORT

Chapter 1 - Optometrical Provision

Purpose of rule

The purpose of this rule is to specify optometrical provisions for New Zealand Defence Force (NZDF) personnel.

Application

a. This rule applies to—

(1) Regular Force personnel;

(2) Reservist personnel on operational duties; and

(3) Non-Regular Force and civilians, where there is a specific safety requirement for visual acuity.

b. Special provisions apply for—

(1) occupational groups with specific requirements for eyewear; and

(2) personnel on operational service.

c. NZDF employees who are exposed to the risk of eye injury by the nature of their work are to be supplied with appropriate protective eyewear, such as safety glasses or goggles, at employment unit cost. The management of this provision is outside the scope of this policy.

d. Where a medical practitioner identifies a need for a clinical treatment of the eye, the cost is to be borne in accordance with the provision of clinical care and is outside the provisions of this policy.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.4.1.1 Rules of eligibility

All Regular Force personnel, regardless of role, are eligible for $300 biennially for the provision of optometrical assessment and eyewear funded through Defence Health. Any costs incurred over and above the $300 limit are to be at the cost of the individual.

11.4.1.2 Sunglasses/tinted lenses/anti-glare coating

Prescription sunglasses/tinted lenses and anti-glare tinting may be provided within the biennial allowance if required for performance in the individual's role or clinically indicated. In these instances, any cost above the biennial allowance is to be borne by the individual.

11.4.1.3 Safety

a. For all NZDF personnel, including Civil Staff, in a role where there are visual requirements specified in the role description or a visual safety risk, optometrical assessment and any required eyewear to the value of $300 is to be provided at employment unit cost. Any costs incurred over and above the $300 limit are to be at the cost of the individual.

b. Role description must specify actual vision requirements for the role – not implied requirements (eg 'must have driver's licence' implies a vision requirement, but it does not specify vision requirements).

c. Examples of visual safety risk include bomb disposal, air traffic control, avionics repair and tasks where there is a risk of significant task error with poor eyesight.

d. This provision is intended to cover the situations where high visual acuity is required in the task performance so that the safety of others or self is not put at risk. This is for safety-critical roles and is not intended to include generic tasks that do not have a direct impact on safety and may be undertaken by personnel in a multiplicity of areas.

11.4.1.4 Operational service

a. Individuals proceeding on operational deployments, including sea service and overseas postings, are to carry two pairs of spectacles with their current (within the last five years) prescription. This is to ensure the individual's effectiveness and safety in the military environment and to reduce costs and risks to the NZDF.

b. Individuals who have only one pair of spectacles at the time they are notified of their deployment or posting are entitled to an additional amount to obtain a second pair of prescription spectacles with standard lenses as a 'spare'. Any costs associated with the extra provisions are to be costed to the specific mission/operation/posting authority.

11.4.1.5 Aircrew in flying roles

Aircrew in a flying role only with a grading restriction of unfit to fly without visual correction are to have two pairs of spectacles for use in flight. Provision for aircrew covers—

(1) Lenses—

(a) The total cost of corrective lenses will be covered with the exception of transitions lenses and bifocal lenses, unless prior approval has been granted.

(2) Frames—

(a) Frames specified for use in the individual's specific aviation working environment will be funded. Considerations include requirement to wear—

(i) a helmet while flying;

(ii) a headset while flying; or

(iii) night vision goggles while flying.

(b) Exclusions include fashion frames over and above the basic frame requirement. If an individual chooses two different types of frames, the funding will cover twice the cost of the lesser priced frames.

(3) Contact lenses—

(a) Aircrew may wear soft contact lenses with approval from an Aviation Medical Officer. NZDF will fund one pair of glasses and contacts for a full year. Contacts are funded on a pro-rata basis. If the member is on operational deployment, then they are required to have two pair of glasses as well as the contacts.

(4) Lens coatings—

(a) Lenses with coatings that are polarised, scratch resistant or any other requirement must have prior approval.

(b) Costs are to be restricted to what is deemed fair and reasonable.

(5) Aircrew are eligible for funding as required by a prescription change.

(6) Normal funding applies to aircrew in a ground role.

11.4.1.6 Payment/reimbursement

a. For Defence Health reimbursement, payment/reimbursement will be made on submission of an itemised invoice/receipt for the total transaction including examination and corrective lenses, to a maximum value of $300 every two years. Any exceptions are to be authorised by the Principal Medical Officer.

b. Only goods/services provided by a New Zealand registered optometrist are eligible for NZDF reimbursement. Products sourced overseas through the internet or any other suppliers are the responsibility of the individual buyer.

c. The requirements for personnel posted overseas are specified in Part 3, Chapter 3 *Overseas Healthcare Processes for Members of the NZDF on Tours of Duty and Non-Operational Postings (Temporary and Permanent) and their Dependants*.

d. Claims are to be prepared on an MD975 *NZDF Invoice Authorisation Form* or an MD990 *NZDF Personal/Travel Expense Claim* form (for reimbursement) supported by the particulars of the service or charges provided and 'Certified Correct' by the appropriate cost-centre authority.

11.4.1.7 Records

a. A copy of the optometrist's prescription and NZDF costs is to be entered into the individual's electronic health record.

b. Eyewear is to be recorded in the electronic health record as a care pathway for routine management. This should generate automatic recalls to be sent to the individual for action.

11.4.1.8 Loss or damage

Spectacles lost or damaged in the course of duty may be eligible for replacement at NZDF cost, depending on the circumstances and Command authorisation. The total expenditure by the NZDF in such circumstances is not to exceed $300 and is at employment unit cost.

Chapter 2 - Hearing Aid Provision

Purpose of rule

The purpose of this rule is to specify the requirements for the provision of hearing aids within the New Zealand Defence Force (NZDF).

Application

a. This rule applies to—

(1) Regular Force personnel (includes Reserve Force on Regular Force engagement); and

(2) NZDF Civil Staff members, where there is a specific safety requirement for hearing provision.

b. Family/whānau of NZDF servicepeople, NZDF Civil Staff (where there is no specific safety requirement for hearing provision), ex-serving members and Territorial Force personnel are not eligible for the funding of hearing aids by Defence Health Centres and are therefore not included in this policy.

c. Cochlear implants are not provided for by Defence Health.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.4.2.1 General

a. A hearing aid is an electronic device designed to process and amplify sound in order to compensate for a hearing deficit.

b. A serviceperson may require either a single hearing aid or a set of (bilateral) hearing aids.

c. All assessments for hearing aids and subsequent technical follow up must be completed by a qualified Audiologist or (only if required) an Ear, Nose and Throat Specialist.

d. Any recommendation for hearing aids must be approved by an NZDF medical practitioner. Medical practitioners are to ensure that there is a clinical requirement (usually H3 or H4) and occupational justification.

e. Defence Health are responsible for providing assessment, referrals and testing required for Regular Force servicepersons with a hearing difficulty. In situations where funding is not already covered by the Accident Compensation Corporation (ACC)/Accredited Employer Program (AEP), Defence Health may assist with funding for hearing aids.

11.4.2.2 Assessment

a. Audiology assessment external referrals are to be completed using the approval processes described in Health Instruction: 012/15 *Authority for Private Healthcare at Public (NZDF) Expense.*

b. The written report and summary of results must be provided to Defence Health by the external assessor. The external assessor must also include details as to why they are recommending a specific hearing aid.

11.4.2.2A Hearing loss claims

a. Where the hearing loss is deemed to be occupational and may meet the ACC threshold, the medical practitioner is to lodge an ACC45 claim with the NZDF AEP.

b. The medical practitioner is to inquire if the individual has qualifying operational service as defined under the Veterans' Support Act 2014. If they do, they should encourage the individual to lodge a claim with Veterans Affairs New Zealand (VANZ). If the individual needs support for this, it can be provided by a complex care coordinator.

11.4.2.3 NZDF hearing aid provision (including fitting and trial)

a. Regular Force servicepersons may be funded for hearing aids through the following sources—

(1) **ACC/AEP**. If they have a hearing loss claim accepted by the ACC/AEP, this will be the only/main source of funding.

(2) **Defence Health**. If they do not have a hearing loss claim accepted by the ACC/AEP, in cases where there is both a clinical requirement and occupational justification (ie duties of trade; refer to Health Instruction: 012/15), Defence Health will fund hearing aid provision as detailed in paragraph 11.4.2.3.

(3) **VANZ**. Those who did not receive hearing aid funding through the ACC/AEP or Defence Health may be funded by VANZ if they are a veteran with qualifying operational service as defined under the Veterans' Support Act 2014 and meet the VANZ criteria for hearing aids (refer to Veterans Affairs New Zealand: Policy: Hearing Aids and Appliances: Version 5.0: October 2020).

b. In addition, the Ministry of Health contributes towards the cost of hearing aids for every New Zealander. This contribution is available every six years. It should already be applied by the provider where applicable and will appear as a discount on the invoice.

c. Defence Health may fund up to $6,000.00 (including GST) towards the cost of bilateral hearing aids and up to $3,000.00 (including GST) towards the cost of one hearing aid. This cost includes—

(1) assessment;

(2) hearing aid(s); and

(3) fitting and trial.

d. A serviceperson may purchase hearing aids in excess of this funding. However, the serviceperson is to pay the difference between the $3,000.00 (including GST)/$6,000.00 (including GST) that Defence Health will fund and the cost of the hearing aid(s) they purchase.

e. If the above provisions are met and a serviceperson is eligible for assistance with the funding of hearing aids through ACC/AEP, Defence Health will consider paying the difference (if any) between that funding and the maximum Defence Health funded amount ($3,000.00 (including GST)/$6,000.00 (including GST)) on a case-by-case basis.

f. However, if ACC/AEP/VANZ funding is used, Defence Health will not fund the full Defence Health amount of $6,000.00 (including GST) in addition to this other funding. For example, if ACC/AEP provides $4,000 toward bilateral hearing aids, Defence Health may pay up to $2,000 (including GST).

g. Defence Health may fund the above cost for hearing aids to servicepersons no less than every six years since the first-time provision of the hearing aid(s) or since the date of the last replacement, until termination of their service, as long as the above provisions remain extant.

h. If the serviceperson requires a new hearing aid or set of hearing aids caused by the loss or damage of the hearing aid(s) before the six-year timeframe, Defence Health will not fund the cost again, until such time as the serviceperson becomes re-eligible. This includes, whether the cause of the loss or damage of the hearing aid(s) is, or is not, related to the NZDF whilst the serviceperson is performing their duties. If this occurs, the serviceperson or their Unit may pay for replacement.

11.4.2.4 NZDF Civil Staff

a. For all NZDF Civil Staff, in a role where there are hearing provision requirements specified in the role description or where there is a hearing provision safety risk, hearing assessment, hearing aids and associated fitting and trial may be provided at employment unit cost—

(1) Role description must specify actual hearing requirements for the role – not implied requirements.

(2) Hearing provision safety risk examples include communications, air traffic control and tasks where there is a risk of significant task error with poor hearing.

b. This provision is intended to cover the situations where hearing provision requirements are required in the performance of tasks so that the safety of others or self is not put at risk. This is for safety-critical roles and is not intended to include generic tasks that do not have a direct impact on safety and may be undertaken by personnel in a multiplicity of areas.

11.4.2.5 Hearing aid provision exception to policy

The Director Defence Health, in conjunction with the Principal Medical Officer, may authorise the funding or part funding of the provision of hearing aids as an exemption. This will occur only in exceptional circumstances. Funding decision factors include those specified as part of Health Instruction: 012/15.

11.4.2.6 Grading

a. Regular Force Service personnel who require hearing aids are to be medically graded accordingly.

b. Personnel who require hearing aids are to be graded H7.

c. AGZ grading is dependent on the level/nature of functional impairment and could be assessed as 431/432 or 442 with appropriate restrictions. Restrictions may include, but are not limited to, the following—

(1) Unfit Operational Deployment.

(2) Unfit Austere.

(3) Unfit Humanitarian Aid and Disaster Relief.

d. R grading is to be set at 12.

e. They are also to have an annual audiogram performed.

f. A medical review of service process should be considered on an individual basis (refer to Part 2, Chapter 3 *Medical Review of Service Process*).

11.4.2.7 Operational service

Servicepeople who require hearing aid(s) and are to be deployed overseas on operational duties (graded deployable or have been given a waiver to deploy) require a spare hearing aid(s). This is due to difficulties in obtaining further hearing aids in theatre. In this case, the relevant deploying authority (not Defence Health) is to fund the spare.

11.4.2.8 Security considerations

a. Many modern hearing aids have the ability to connect to other devices, are blue tooth enabled and/or may be able to connect to Wi-Fi.

b. For servicepersons that work in secure Sensitive Compartmented Information Facility areas, devices with the above abilities are not permitted due to Information System Security (INFOSEC) requirements.

c. As such, healthcare professionals assessing a serviceperson for hearing aid provision are to take INFOSEC requirements into account when considering the type of hearing aid to be provided.

11.4.2.9 Battery provision

a. Modern hearing aids are usually rechargeable devices. The provision of batteries in these cases is therefore not required.

b. In the event that a serviceperson has hearing aids that require batteries, Defence Health will fund the ongoing provision of those batteries.

11.4.2.10 Accessories provision

Defence Health will not fund the provision of hearing aid accessories.

11.4.2.11 Documentation

a. Details of hearing aids and investigations by the specialists attending the serviceperson are to be entered into the individual's electronic health record (Profile).

b. Hearing loss/difficulty and the provision/requirement for hearing aids are to be recorded in Profile as a care pathway for routine management. This should generate automatic recalls that will be sent to the individual for action.

Chapter 3 - NZDF4U Wellbeing Support Service

Purpose of rule

The purpose of this rule is to specify the support available for New Zealand Defence Force (NZDF) personnel and the broader Defence Community provided by the NZDF4U Wellbeing Support service (includes the Wellbeing Telehealth service and Employee Assistance Programme [EAP]).

Application

a. The NZDF4U Wellbeing Support service (external, confidential, free, 24 hours a day, 7 days a week (24/7)) is available to individuals 18 years of age and over who are—

(1) Regular Force (RF) members (this group includes Territorial Force [TF] members under Regular Force employment);

(2) family/whānau of RF members, who, for the purposes of this rule, are defined as any person who—

(a) is related by—

(i) blood;

(ii) marriage;

(iii) adoption;

(iv) guardianship; or

(v) belongs to the same family/whānau or other culturally recognised group;

(b) would be a relative if the partners in a recognised relationship were legally married; and/or

(c) is nominated by an RF member of the NZDF with whom they have a financial or emotional tie;

(3) partners of RF members, who, for the purposes of this rule, are defined as those identified as being in a formal relationship (eg married, de-facto, civil union) with an RF member;

(4) NZDF Civil Staff;

(5) TF members not under RF employment; or

(6) transitioning ex-serving members who have left the NZDF within the last two years.

b. NZDF4U Wellbeing Support includes support for a range of mental wellbeing issues including: general stress, depression, anxiety, relationship issues, financial concerns, post-deployment problems and transitioning out of the NZDF. Support for physical health concerns is not provided through this service.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Director Integrated Wellness.

c. The Regulatory Custodian for this rule is the Director Integrated Wellness.

d. The Custodian for this rule is the Director Defence Health Policy.

11.4.3.1 Authority

The NZDF4U Wellbeing Support service is delegated by the Chief of Defence Force to the Surgeon General and managed through Defence Health (Integrated Wellness).

11.4.3.2 Roles and responsibilities

The Director Integrated Wellness is responsible for the provision of the NZDF4U Wellbeing Support.

11.4.3.3 Budget

The NZDF4U Wellbeing Support service is funded through Defence Health.

11.4.3.4 Context and provision

a. NZDF Strategic Guidance (*NZDF Strategic Plan 2019–2025: Operationalising Strategy25*) prioritises a focus on developing people to ensure the NZDF has the right mix of people, with the right skills and experience to excel in modern military operations; and to develop a flexible, resilient and affordable workforce.

b. The provision of wellbeing support directly supports the strategic objectives of People25 (*People25: Strategy to 2025*) to protect and support our people through their career journey and to develop highly trained warriors and leaders for integrating military effects.

c. Provision of the NZDF4U Wellbeing Support service falls within the theme of enduring wellness within the Defence Health Strategy (*Defence Health Strategy 2025: A Better, Stronger, Healthier NZDF*). The NZDF4U Wellbeing Support service also falls under the NZDF Mental Health Strategy (*The NZDF Mental Health Strategy: Enhancing Force Strength through Comprehensive Mental Health*), which includes 'Access to Care'. This strategy specifies that accessibility is central to the successful application of the NZDF Model for Mental Health and that personnel will be provided with a range of user friendly options to enable early, effective access to mental health information and support.

d. NZDF4U provides EAP support for Civil Staff.

e. Internal NZDF health services remain the primary source of health and wellbeing support for Regular Force members; however, serving personnel may still access NZDF4U services if needed (eg for after-hours support).

11.4.3.5 Service providers

The NZDF4U Wellbeing Support service is provided by Whakarongorau and Vitae under an integrated contract.

11.4.3.6 Wellbeing Telehealth support

a. Whakarongorau deliver the 24/7, external, confidential NZDF4U Wellbeing Telehealth aspect of the service. All the groups listed in *Application* subparagraphs a.(1)–(6) may access this support. Whakarongorau delivers this support by—

(1) providing trained, experienced mental health professionals to answer NZDF4U calls, emails or text messages and provide support; and

(2) referring eligible individuals as per Table 11.4.3.1 to Vitae for EAP counselling services and/or internal or external support services.

b. If the individual is assessed as being 'in crisis', Whakarongorau will arrange for a Crisis Team or other emergency services to respond.

11.4.3.7 EAP counselling

a. Vitae provides the NZDF EAP counselling as part of the NZDF4U Wellbeing Support service.

b. Vitae will provide counselling sessions to members of the groups listed in Table 11.4.3.1 only; counselling sessions will not be provided to individuals outside of these groups. Additionally, counselling access varies by service user type, as detailed in Table 11.4.3.1.

c. Vitae provides its service by—

(1) managing direct contacts made to them from individuals who are self-referring; or

(2) accepting referrals from Whakarongorau; and

(3) assigning eligible individuals to their contracted counselling providers.

Table 11.4.3.1—NZDF EAP Counselling Access by Service User Type

Service User Type	EAP Counselling
RF	Yes (for any reason and also includes relationship counselling together with their partner)
Partners of RF	Yes (for any reason and also includes relationship counselling together with their partner)
Civil staff	Yes (for any reason)
Family/whānau (excluding partners) of RF members	Yes (only if the issue is NZDF-related)
TF	Yes (only if the issue is NZDF-related)
Ex-serving members who have left the NZDF within the last two years	Yes (only if the issue is NZDF-related)
Ex-serving members who left the NZDF more than two years ago	No
Qualifying Veterans registered with Veterans' Affairs	No

11.4.3.8 Counselling session numbers

a. Individuals who are eligible for counselling sessions (see Table 11.4.3.1) may access up to six counselling sessions in one calendar year.

b. Under normal circumstances, those requiring additional support beyond six counselling sessions are to be encouraged to access it through external community health services, other veteran support services or, in the case of Regular Force personnel, through internal NZDF Health Centres.

c. Access to additional sessions within the calendar year entitlement period may be requested where the issues are NZDF related and/or impacting on wellbeing at work. These will be considered on a case-by-case basis.

d. Any request for counselling to extend beyond six sessions (for anyone) is to be made through the EAP provider to the Director of Integrated Wellness via email. Requests for extensions for Regular Force will be directed to the Chief Medical Officer. The EAP request for extension must include—

(1) a summary of the course of sessions to date, including—

(a) the overarching goals;

(b) the focus of sessions completed to date; and

(c) the outcomes of these sessions;

(2) the rationale for any extension;

(3) a plan for the extra sessions; and

(4) a plan for transiting support as required.

e. It is expected the EAP provider will proactively link the individual to resources and tools, including options for ongoing support, that will include—

(1) NZDF health support for RF members; or

(2) Veterans Affairs' for ex-serving members with qualifying service; and/or

(3) community support services for all other groups.

f. NZDF Commanders/managers may also agree to fund additional sessions separately from their cost centres.

11.4.3.9 Intent

The intent of this section is to describe the contextual and specific processes that are in place for each service user type.

11.4.3.10 Context and specific processes for RF members

a. The primary healthcare provider for RF members of the NZDF is Defence Health, and RF members who would benefit from wellbeing support will be encouraged to seek this support through Defence Health in the first instance. However, the NZDF4U Wellbeing Support service can be accessed by RF members who want after-hours care or have difficulty accessing internal support for any reason. Whakarongorau and Vitae have a list of the support services available across Camps and Bases.

b. 'In crisis' situation—

(1) If the RF member contacting the Wellbeing Telehealth Support service (Whakarongorau) is assessed as being 'in crisis', Whakarongorau will arrange for a Crisis Team or other emergency services to respond and will notify the Principal Medical Officer, Chief Medical Officer or Chief Mental Health Officer.

(2) Additionally, an NZDF4U advisory report is to be sent to the individual's Defence Health Centre.

c. **Record of support**—

(1) In cases where RF members access the NZDF4U Wellbeing Support service but do not require urgent care, they will be encouraged to agree to a record of the support provided being shared with NZDF Defence Health so further support can be arranged.

(2) Where RF members are unable to access Defence Health support, or feel they may benefit from initially contacting NZDF4U, they may still access up to six sessions of EAP counselling support.

(3) For both of the above scenarios, records of the provided support should be handled as follows—

(a) In cases where the individual's consent is gained, an NZDF4U advisory report is to be sent to their Defence Health Centre and the information entered onto the NZDF Patient Management System (Profile) for potential follow-up action (consent to be noted by provider). The reporting procedures that are to occur are detailed in Joint Standard Operating Procedure: *Management of NZDF4U Advisory Reports*.

(b) In cases where no consent is given, the record of provided support is not to be shared with Defence Health unless there are safety concerns. However, anonymised data about the provided support included as part of reporting will still be shared.

d. **Contacts from overseas**. RF members contacting the NZDF4U Wellbeing Support service from overseas (including members at sea in New Zealand waters) can call, email or text message the Wellbeing Telehealth Support service (if calling, they can do so by calling 'collect' from overseas at NZDF expense). In cases where the individual is on deployment—

(1) Whakarongorau is to notify the Medical Officer J1 Health Branch that the individual has contacted the service; and

(2) an NZDF4U advisory report is to be sent to the Medical Officer J1 Health Branch.

e. **Relationship counselling**. RF members may also access up to six relationship counselling sessions together with their partners through contacting the Wellbeing Telehealth Support service and being referred to Vitae by Whakarongorau or by contacting Vitae directly.

f. **Extensions to counselling session numbers**. Requests for extensions beyond the initial six sessions for RF members (using the processes detailed in rule 11.4.3.8) will be referred to the Chief Medical Officer by the Director of Integrated Wellness, who will review the request and make a decision on extending the counselling sessions. For extensions to be granted, the individual will need to consent to their identity being made known to the Chief Medical Officer.

11.4.3.11 Context and specific processes for partners of RF members

a. NZDF Defence Health are not the primary care providers for partners of RF members of the NZDF. As such, partners of RF members who access support from the NZDF4U Wellbeing Support service and do not require urgent care, but would benefit from wellbeing support, will be encouraged to seek this support through community health support services or their primary health organisation in the first instance.

b. **Record of support**. There is no requirement for NZDF4U advisory reports to be transferred to Defence Health (although anonymised data included as part of reporting will still be shared). NZDF4U advisory reports may be provided to the individual's General Practitioner or primary health organisation when consent to do so is given by the individual.

c. **Extensions to counselling session numbers**—

(1) The cost for any additional sessions beyond the initial six will normally need to be met by the individual; however, in some circumstances, an extension to the numbers of sessions may be approved and funded through the NZDF.

(2) Requests for extensions beyond the initial six sessions for partners of RF members (using the processes detailed in rule 11.4.3.8) will be referred to the Director of Integrated Wellness, who will review the request and make a decision on extending the counselling sessions.

(3) Circumstances where funding for an extension may be approved may include, but are not limited to, those where additional issues have presented that are negatively impacting on an individual's recovery journey and where there is a clear NZDF-related impact.

11.4.3.12 Context and specific processes for NZDF Civil Staff

a. NZDF Civil Staff are to be encouraged to utilise the NZDF4U Wellbeing Support service for both workplace and/or personal issues, including (but not limited to) stress, anxiety or depression.

b. NZDF Defence Health are not the primary care providers for NZDF Civil Staff. As such, NZDF Civil Staff who access support from the NZDF4U Wellbeing Support service and require external health and/or wellness support outside of EAP will be referred to community health support services or their primary health organisation.

c. **Record of support**. There is no requirement for NZDF4U advisory reports to be completed and transferred to Defence Health (although anonymised data included as part of reporting will still be shared). NZDF4U advisory reports may be provided to the individual's General Practitioner or primary health organisation when consent to do so is given by the individual.

d. **Extensions to counselling session numbers**—

(1) The cost for any additional sessions beyond the initial six will normally need to be met by the individual; however, in some circumstances, an extension to the numbers of sessions may be approved and funded through the NZDF.

(2) Requests for extensions beyond the initial six sessions for Civil Staff (using the processes detailed in rule 11.4.3.8) will be referred to the Director of Integrated Wellness, who will review the request and make a decision on extending the counselling sessions.

(3) Circumstances where funding for an extension may be approved may include, but are not limited to, those where additional issues have presented that are negatively impacting on an individual's recovery journey and where there is a clear NZDF-related impact.

11.4.3.13 Context and specific process for TF, family/whānau (excluding partners) of RF members, and ex-serving members (who have left the NZDF within the last two years)

a. NZDF Defence Health are not the primary care providers for TF, family/whānau (excluding partners) of RF members, or ex-serving members. As such, any of these individuals who access support from the NZDF4U Wellbeing Support service and do not require urgent care, but would benefit from wellbeing support, will be encouraged to seek this support through community health support services, veteran community services or their primary health organisation in the first instance.

b. **Access criteria**—

(1) TF members not under RF employment, family/whānau (excluding partners) of RF members, and ex-serving members (who have left the NZDF within the last two years) may be referred to Vitae by Whakarongorau, or may be directly accepted by Vitae, for counselling sessions only if the issue relates to the NZDF environment.

(2) Access is encouraged because of the nature of NZDF-related work, which can place unique demands on the Defence Community and which may have a direct or indirect impact on NZDF outputs. Examples of issues that are considered to relate to the NZDF environment include, but are not limited to, deployments, operations, exercises or postings.

(3) If the issue is not related to the NZDF environment, then advice will be provided regarding connection to local community services, their primary health organisation and other options.

(4) Ex-serving individuals should also be encouraged to check the Veterans' Affairs website or contact Veterans' Affairs in order to determine eligibility requirements for support from Veterans' Affairs.

c. **Record of support**—

(1) **TF**. Where TF (not under RF employment) access EAP counselling, they will be encouraged to agree to a record of the support provided being shared with NZDF Defence Health (NZDF4U advisory report).

(2) **Family/whānau (excluding partners) of RF members and ex-serving members**. There is no requirement for NZDF4U advisory reports to be completed and transferred to Defence Health (although anonymised data included as part of reporting will still be shared). NZDF4U advisory reports may be provided to the individual's General Practitioner or primary health organisation when consent to do so is given by the individual.

d. **Extensions to counselling session numbers**—

(1) The cost for any additional sessions beyond the initial six will normally need to be met by the individual; however, in some circumstances, an extension to the numbers of sessions may be approved and funded through the NZDF.

(2) Requests for extensions beyond the initial six sessions for TF, family/whānau (excluding partners) of RF members, and ex-serving members (who have left the NZDF within the last two years), made using the processes detailed in rule 11.4.3.8, will be referred to the Director of Integrated Wellness, who will review the request and make a decision on extending the counselling sessions.

(3) Circumstances where funding for an extension may be approved may include, but are not limited to, those where additional issues have presented that are negatively impacting on an individual's recovery journey and where there is a clear NZDF-related impact.

11.4.3.14 Standard operating procedures

Procedural management of the NZDF4U Wellbeing Support service information that is supplied to the NZDF is promulgated in Joint Standard Operating Procedure: *Management of NZDF4U Advisory Reports*.

11.4.3.15 Reporting

a. Whakarongorau and Vitae are to provide monthly reports to the Director Integrated Wellness (or their delegate). Whakarongorau/Vitae Monthly Reporting Requirements details the contents of these reports.

b. Whakarongorau and Vitae reporting data will be analysed to determine—

(1) any trends;

(2) demand on the service; and

(3) the nature of presenting issues across the NZDF Community in order to inform future arrangements for the service.

11.4.3.16 Privacy and health information sharing

a. Privacy of the health information gathered in the course of providing the NZDF4U Wellbeing Support Service is paramount. NZDF, Whakarongorau and Vitae will maintain privacy and follow information sharing processes in line with their individual organisational policies, the Privacy Act 2020 and the Health Information Privacy Code 2020.

b. If Whakarongorau or Vitae believes that an individual may be a danger to themselves or others and is not safe (taking into account contextual NZDF factors)—

(1) the provider is to contact the appropriate services and the NZDF (as required) in order to intervene; and

(2) it may be necessary to share relevant information with the attending services (and, for RF members, with the NZDF via Whakarongorau/Vitae contacting the Principal Medical Officer, Chief Medical Officer or Chief Mental Health Officer) without the individual's consent being given.

Chapter 4 - Provision of Maternity and Post-Partum Care

Purpose of rule

The purpose of this rule is to specify the—

(1) processes relating to the provision of maternity care in the New Zealand Defence Force (NZDF);

(2) processes relating to the provision of post-partum care; and

(3) processes relating to the provision of healthcare to breastfeeding personnel.

Application

This rule—

(1) covers the funding and processes relating to the provision of maternity care to NZDF servicepeople both within New Zealand and overseas;

(2) specifies the requirements for the medical grading assessment of operational fitness for pregnant NZDF personnel (applies to all NZDF medical practitioners who perform or confirm operational gradings);

(3) specifies the requirements for the medical grading assessment of operational fitness for NZDF personnel who have rehabilitated post-partum but are still breastfeeding; and

(4) provides guidance on physical fitness testing, maintenance and rehabilitation services to pregnant and post-partum NZDF personnel.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.4.4.1 Domestic

a. This rule applies in the domestic setting to NZDF personnel for whom NZDF health (Defence Health and other NZDF health elements under the technical control of Defence Health) are their primary healthcare provider. This includes—

(1) Regular Force personnel; and

(2) Territorial Force personnel on Short Term Regular Force Engagements.

b. For domestic maternity and post-partum care, the term Regular Force will be used.

11.4.4.2 Overseas: Non-operational

This rule applies in the non-operational overseas setting to NZDF personnel (may include Regular Force or Territorial Force personnel) deployed overseas on non-operational duty.

11.4.4.3 Out of scope

This rule does not discuss or define (as these are individual and dependent on circumstance)—

(1) limitations to physical fitness testing associated with pregnancy; or

(2) specific limitations within the garrison employment of pregnant NZDF personnel.

11.4.4.4 Domestic maternity care provision

a. In New Zealand, maternity care is available free of charge through the Lead Maternity Carer (LMC) scheme. The LMC scheme provides for the involvement of a midwife, general practitioner, or public hospital specialist during and after pregnancy. Government funding for the LMC scheme is paid to the LMC.

b. Private maternity care is also available. In the case of private maternity care, the private practitioner claims the allocated funding from the government. Any additional costs will be claimed from the individual.

c. Regular Force personnel are responsible for engaging an LMC or private provider for pregnancy-related care. This includes antenatal, delivery, and post-natal care.

d. During the maternity and post-partum periods, Regular Force personnel should continue to access Defence Health facilities for both pregnancy and non-pregnancy related routine healthcare, or in the event of a health emergency.

e. Regular Force personnel may have specialist care funded by the NZDF (for example termination/serious birthing injuries/prolapse) if the wait in the public system is long and having to wait for this level of care may cause an unnecessary delay in the individual's ability to return to full fitness/deployability (refer to Health Instruction: 012/15 *Authority for Private Healthcare at Public (NZDF) Expense*).

11.4.4.5 Pelvic physiotherapy

a. All pregnant Regular Force personnel should be offered the chance to attend a pelvic health physiotherapy consult at around 20 week's gestation and, if required, again in the third trimester for a pelvic health check-up. This is known as a pelvic health Warrant of Fitness (WOF).

b. All post-partum Regular Force personnel should be offered the chance to attend a pelvic health physiotherapy consult prior to recommencing high impact exercise post-partum.

c. Additional pelvic health physiotherapy consults may be provided depending on any symptoms of pelvic floor dysfunction/pelvic girdle pain and on recommendation from pelvic health physiotherapists.

d. If internal providers of pelvic health physiotherapy are not available in the individual's region, referral to a private pelvic health physiotherapist locally is to be arranged and funded by the NZDF (refer to Health Instruction: 012/15 *Authority for Private Healthcare at Public (NZDF) Expense*).

11.4.4.6 Non-operational overseas maternity care provision

Whilst on non-operational NZDF duty overseas, maternity care provision for NZDF personnel is covered in (refer to)—

(1) DFI 18.1 *Health Services*, Part 4 *Healthcare Delivery Framework*, Chapter 5 *Non-operational Overseas Travel Health Assistance*; and

(2) Part 3, Chapter 3 *Overseas Healthcare Processes*. Maternity care is specified in *Overseas Health Care Funding Schedules*.

11.4.4.7 Grading

a. The NZDF has a responsibility as an employer to ensure that the risk to the health and safety of NZDF personnel is eliminated or limited so far as is reasonably practicable. As such, it is the responsibility of NZDF medical practitioners to assess the fitness of NZDF personnel to participate in operational activities in order to inform the risk to command of deploying personnel.

b. There are risks to the health of the mother and the foetus in deploying pregnant NZDF personnel to operational environments. NZDF medical practitioners are to ensure command is aware of these risks. This then allows for effective decision-making and the consequent mitigation of any identified risk. Risk is communicated to command through the medical grading system.

11.4.4.8 Grading: Notification of pregnancy

a. The default grading for uncomplicated pregnancy is A4G4Z5, R12. However, dependent upon the stage of pregnancy and physical symptoms experienced, pregnant personnel may be considered for overseas non-operational travel following medical review.

b. Restrictions for pregnant personnel are to include—

(1) unfit operational deployment;

(2) unfit austere environment and remote non-operational overseas employment with limited access to appropriate healthcare;

(3) fitness restrictions of—

(a) excused mandatory unit physical training (PT), but encouraged to participate where possible with appropriate modifications; and

(b) excused mandatory fitness testing; and

(4) to remain under medical supervision (TRUMS).

c. Further limitations/restrictions are noted in DFO 3 *Defence Force Orders for Communications and Information Systems*, Part 12, Chapter 10, paragraph 12.10.33 and paragraph 12.10.34. Additional restrictions for pregnant personnel can be determined on a case-by-case basis. Medical practitioners are to work with the individual (who may also liaise with their LMC), health and safety and the individual's command/management regarding the exact limitations/restrictions and any alternative activities (eg an alternative, appropriate exercise regime or attendance at courses).

Note: See *Aircrew Medical Standards* for aircrew-specific pregnancy restrictions.

d. Upon notification or confirmation of pregnancy, the pregnant person is to be immediately regraded. Their updated grade and restrictions are to be conveyed via an MD906 *NZDF Medical Grading Review*.

11.4.4.9 Grading: Miscarriage, stillbirth or termination of pregnancy

a. NZDF personnel are to be assessed on an MD914 *Medical Re-examination Record* following miscarriage, stillbirth or termination of pregnancy.

b. Depending on how advanced the pregnancy was, some NZDF personnel may still require lengthy rehabilitation and may benefit from referral to physiotherapy/Exercise Rehabilitation Instructors for structured rehabilitation.

c. Grading in these situations is a clinical decision by the medical practitioner reflecting the individual's current fitness to deploy and ability to carry out their duties.

11.4.4.10 Grading: Return to duties

a. As per DFO 3, Part 12, Chapter 10, paragraph 12.10.28, NZDF personnel are to be re-assessed on an MD914 upon return to duty.

b. The individual is to be re-assessed on an MD906 three months following the initial MD914 assessment, and on a three monthly, or more frequent basis, until return to operational duties.

c. Grading in these situations is a clinical decision by the medical practitioner reflecting the individual's current fitness to deploy and ability to carry out their duties.

11.4.4.11 Breastfeeding

DFO 3, Part 12, Chapter 10, Annex C covers the employment and support of individuals who are breastfeeding. Grading in these situations is a clinical decision by the medical practitioner reflecting the individual's current fitness to deploy and ability to carry out their duties. This includes grading of individuals who are fully fit however continue to breastfeed.

11.4.4.12 Guidance on physical fitness testing, maintenance and rehabilitation services to pregnant and post-partum NZDF personnel

a. **Physical fitness testing**—

(1) Personnel are exempt from participating in fitness testing during pregnancy and for 12 months postpartum.

(2) Postpartum personnel should progressively prepare for the resumption of fitness testing, and, although they are exempt from being required to participate in fitness testing for 12 months postpartum, they may resume fitness testing at any time during this period.

(3) Where personnel do not pass their fitness test at 12 months postpartum, they should be reviewed by a medical practitioner for advice and consideration of further restriction.

(4) Exemption from fitness testing following pregnancy-related issues such as miscarriage, stillbirth or termination of pregnancy is to be based on the service person's ability to physically undertake fitness testing with consideration given to issues such as—

(a) pelvic floor dysfunction; and

(b) diastasis rectus abdominus.

b. **Physical fitness maintenance and rehabilitation**—

(1) Pregnant personnel should be encouraged to remain physically active dependent upon the physical symptoms of pregnancy they experience. Adaptations should be made to accommodate their participation in group PT as appropriate.

(2) To assist in maintaining the deployable fitness standard of a service person, both antenatally and postnatally, Defence Health are to utilise internal providers where available, including physiotherapists and Exercise Rehabilitation Instructors, to provide activities such as—

(a) core stability strengthening;

(b) pelvic floor strengthening;

(c) general conditioning; and

(d) return to physical training and fitness.

11.4.4.13 Mental health wellbeing

a. Issues such as miscarriage, stillbirth, post-natal depression or termination of pregnancy may impact on the mental health wellbeing of NZDF personnel. As such consideration by NZDF Health providers is to be given to the mental health wellbeing of an individual during, and following pregnancy as part of a health examination.

b. Referral to an appropriate provider (such as a clinical psychologist) may be funded in accordance with Health Instruction: 012/15.

11.4.4.14 Aircrew

Maternity and post-partum direction for aircrew is referenced in Aircrew Medical Standards Specifications. This covers—

(1) pregnancy;

(2) return to work;

(3) abortion/miscarriage;

(4) breastfeeding; and

(5) passenger fitness to fly.

Chapter 5 - Fertility Provision

Purpose of rule

The purpose of this rule is to specify the funding requirements for personnel wishing to access fertility treatments.

Application

This rule applies to New Zealand Defence Force (NZDF) personnel wishing to access fertility treatment.

Authorising Authority, Approving Authority, Regulator and Custodian

a. The Authorising Authority for this rule is the Surgeon General.

b. The Approving Authority for this rule is the Chief Medical Officer.

c. The Regulatory Custodian for the rule is the Chief Medical Officer.

d. The Custodian for this rule is the Director Defence Health Policy.

11.4.5.1 Authority

a. Publicly funded fertility treatment is available within the New Zealand public health system.

b. Defence Health providers may refer to fertility providers to access publicly or privately funded care, but any associated costs are to be met by the patient.

c. Defence Health providers must not approve applications of funding for fertility treatment.

PART 5 - TRANSITION TO VETERANS

Chapter 1 - Transition to Veterans (on issue)

To be issued

End Matter

Record of Change

Amendment Number	Commencement Date	Reference	Details of Change	Approving Authority
Version 1.00	01 June 2022	CMMS WO 70128970	Initial issue	**A GRAY** Brigadier Surgeon General
Version 2.00	28 November 2022	CMMS WO 70131400	P8 requirement update to Anthropometric Restrictions Table	**CM TATE** Colonel Surgeon General
Version 2.01	27 March 2023	DHP AR 230327	Preliminary Provisions and Part 3, Chapter 2 Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.02	05 July 2023	DHP AR 230705A	Preliminary Provisions; Part 1, Chapter 2; and Part 3, Chapter 3 Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.03	02 October 2023	DHP AR 231002B	Reissue of Part 4, Chapter 3 Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.04	05 December 2023	DHP AR 231205A	Addition of Command Medical Waiver policy in Part 1, Chapter 1 Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.05	06 March 2024	DHP AR 240306A	Addition of statements regarding duplicate records. Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.06	10 April 2024	DHP AR 240410A	Reissue of Pt 1, Ch 5 Changes to Pt 4, Ch 2. Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.07	04 June 2024	DHP AR 240604A	Reissue of Pt 2, Ch7 Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.08	15 August 2024	DHP AR 240814B	Changes to Part 1, Chapters 1 and 5; Part 2, Chapter 3; and Part 3, Chapter 5 Amendment Summary	**CM TATE** Colonel Surgeon General
Version 2.09	06 November 2024	DHP AR 241106D	Changes to Part 4, Chapter 4 Amendment Summary	**CM TATE** Colonel Surgeon General

Amendment Number	Commencement Date	Reference	Details of Change	Approving Authority
Version 2.10	13 December 2024	DHP AR 241213E	Changes to Part 4, Chapter 3 Amendment Summary	**CM TATE** Colonel Surgeon General