CONFIDENTIAL

DIRECTORATE GENERAL, C.R.P.F.,
BLOCK NO. 1,CGO COMPLEX,LODHI ROAD, NEW DELHI – 110 003.
(MINISTRY OF HOME AFFAIRS)

No. P.VII/I-2008-Pers.I Dated, the 15 December 2008.

STANDING ORDER NO. 04/2008

Subject:- **HEALTH CARE SYSTEM IN CENTRAL PARA MILITARY FORCES – INSTRUCTIONS FOR MEDICAL EXAMINATION AND CLASSIFICATION OF PERSONNEL IN CPMF's**

In Supersession of Standing Order No. 1/2003 and based on the detailed instructions issued, from time to time on the subject by the MHA vide their UO letters mentioned below, following instructions along with guidelines are issued for strict compliance by all concerned:-

1. No.I.45024/3/2004_pers-II dated 31/7/2007
2. No.I.45024/1/2008-Pers-II dated 29/10/2008
3. No.I-45024/1/2008-Pers-II dated 29/10/2008

APPENDICES

A. Declaration to be obtained from Individuals before medical examination.
B. Health Card format
C. Proforma of medical examination report.
D. Proforma for certificate to be produced by an appellant challenging the findings for the AMA/Medical board for review.
E&F Age and Height wise standard weight nomograms for male & female.

AIM

This order lays down instructions/Procedures for carrying out annual medical examination and classification of combatised officers and other personnel serving in the Central Reserve Police Force.

2. The instructions are enumerated under the following broad headings:-

Part-I Policy of Medical Examination and classification
Part-II Instructions and Procedure for Medical Classification

Part-III Disposal of various Medical Board Proceedings.
Part-IV Board technical guidelines for Medical Officers.

PART – I

POLICY OF MEDICAL EXAMINATION

3. GENERAL

The **object** of Medical Examination is for timely detection of any disease or infirmity that may still be in a latent (sub-clinical) stage for early intervention with preventive and curative measures to promote positive health. This will not only make the personnel health conscious but also enhance their physical ability, professionalism and alertness, so vital for the Armed Forces, particularly engaged in internal security duties in the prevailing security scenario. Our Officers and men must be mentally and physically healthy to face any challenge in order to preserve unity and integrity of the country, to protect life and property of citizens while simultaneously defending themselves with agility and valor. To expect the troops to remain healthy and efficient, its leaders must be examples to lead the way while working shoulder to shoulder with their personnel.

Therefore, all the combatised personnel and officers of all cadres and ranks will be subjected to medical examination every year. If a CRPF personnel is on deputation to an organization he should get his AME done at that organization only; however if infrastructure/MO is not available in that organization, he can get his SHAPE categorization done in his parent organization. It will be rather their own responsibility to get their own AME carried out on time. The annual medical examination (AME) up to NGO level will be carried out by their respective authorized medical attendant (AMA) of the unit or in his/her absence, by an MO/SMO/CMO, detailed by the concerned DIG(Medical)/CMO IC of administrative CH/GC Hospital. For routine investigation and treatment, the individual will depend on his /her AMA and the nearest unit/composit hospital or in its absence under the AMA's supervision, at the nearest CH of any CPF/Govt hospital to which his AMA refers him officially.

For GOs, AME will be carried out by a Board of two doctors one of whom may be from out side unit of the Force. The Board will be detailed by IG(Medical)/DIG(Medical).

4. Annual Medical Examination (AME)

ANNUAL MEDICAL EXAMINATION.

4.1 A **declaration** from the individual in proforma as in Appendix-A is to be obtained from officers each time before AME. In the case of others, such history will be obtained by the AMA himself and only a gist will be recorded in individual's health card/proforma. Thereafter, **a complete physical & clinical examination** will be done and **appropriate investigations** as indicated in proforma (Appendix-c) will be carried out.

4.2 The details of findings, including the medical advice if any, will be entered in the individual health card of officers and men along with proforma as in Appendix- C.

4.3 In case the AMA/Board feels that some more investigation/treatment is required, reference may be made to the nearest CPF/Govt. Hospital, where such facilities are available. Although the AMA/Board would take such reports/opinions into consideration, the Board's/AMA's independent opinion and decision on the matter will be final. The AMA/Board will suitably advise the Officer/men if a very minor disability is noted while recording the same in the report as well as Health Card.

4.4 If the AMA of men (NGOs) is of the view that the existing medical category of any one needs to be changed, he will refer the case with justification to the nearest CRPF Composite hospital with prior approval from DIG(Medical) or hospital ICs. In case of non-availability of a Specialist in the concerned field in the said hospital the MO IC may detail any experienced Medical Officer not less than the rank of CMO (OG) to undertake an initial assessment of the Officer. Medical category of an individual can be down graded (Temporary" or Permanent) by a duly constituted medical board. The AMA of the unit is competent to downgrade the category to temporary LMC for a period not exceeding 3 months with adequate justification placed in record. Also up gradation of temporary LMC cases or further continuation in the existing LMC can be done by the AMA on the basis of specialist's opinion. However, all such cases shall be put up to the inspecting medical authority during annual inspection of unit/ GC Hospital for perusal. For officers, board so detailed will be competent to down-grade the officer but this board should take specialists opinion into consideration while reaching a conclusion.

4.5 For NGO's, after clinical examination, necessary investigation and hospitalization/observation as required, the concerned specialist/CMO

will write his/her opinion with recommendation in Health proforma as in Appendix-B. Based on this recommendation and if the personnel is to be placed in LMC, the hospital IC will convene a medical board which will examine the individual along with all relevant medical documents, assign it s opinion along with final grading on the above proforma, subject to the approval of the Hospital I/.C or DIG(Medical)_. The initial assessing specialist./CMO shall invariably be included in the board. He/She will record the details of AME including the diagnosis, medical category etc on the individual's Health card. The board papers will be submitted to the approving and perusing authority as given below:-

Sl.No.	**Group of the Officer/men**	**Board Detailing authority**	**Perusing Authority**
A	Commandants & Above	IG (Medical) of nearest 100 bedded CH/ Director (Medical).	Director (Medical)
B	From Inspector up to 2 I/C	DIG(Medical)/IC of nearest 50 bedded CH.	IG(Medical) of 100 bedded CH/ Director(Medical).
C	Other SOs & ORs	DIG(Medical) of nearest Composite Hospital	-do-

4.6 Personnel away on temporary duty/course/overseas assignments will be subjected to AME within three months of his/her return from such duties.

4.7 **Communicating result of AME**

The hospital authorities shall not immediately communicate the medical classification grading awarded to the individual to him/her until the report/board proceeding is approved by the competent medical authority. However the individual may be advised about the nature of the disease/disability and given appropriate advice regarding treatment/ precautions to be observed. The medical categorization awarded will be communicated to the individual by his unit/establishment at the earliest but not later than 30(thirty) days from the date of holding the board.

4.8 Medical Category in AME to be incorporated in subsequent ACR

AME of all combatants will be completed by 31 December every year; and be accordingly planned by the unit/establishment at the beginning of the year. The medical category recorded in the AME immediately preceeding initiation of the ACR (Annual Confidential Report) is considered valid, unless it has been changed by the appropriate medical authorities due to diseases or injury during the intervening period. The AME must be complete before 15 November in case of personnel due to be included in the consideration zone for promotion. This aspect is to be watched and compliance ensured by the concerned administrative units/establishments.

4.9 Venue

The AME will be conducted by the AMA/Board at a unit/ Force hospital on which the officers and personnel are normally dependant, unless specifically permitted by Medical Officer I/C of the respective Group/Composite hospitals in case of others, SOs up to the rank of SI; and by the Director (Medical) in case of Officers and Inspectors, to undergo AME at any other Force Hospital, adequately justifying reasons for granting such permission.

4.10 Procedure for AME

a. The individual officer/personnel undergoing AME will ensure availability of his/her original Health card and previous year's AME in proforma B duly certified, while reporting for AME. No fresh/new Health card will be opened unless a COI has been conducted and responsibility fixed for loss of the previous health card to the satisfaction of the concerned controlling Officer.

b. The examining Medical Officer/ Board will endorse the medical categorization on completion of AME. The MO/Board will also enter the findings/remarks in a register to be maintained at the unit/Hospital level for record.

c. When ever an individual is already in temporary low medical category (LMC) in any factor of SHAPE system at the time of AME and his re-categorization medical board is due within next 3 months, the AME will be suitably advanced so that both are carried out together. If the gap is 6 months or more, both will be held separately.

d. The medical category in AME will remain valid for one year unless his/her medical category has been changed, for reasons of

subsequent diseases or injury. In that case, the changed grade will prevail till next AME or reclassification if recommended earlier for temporary LMC.

e. Officers on deputation with other Govt./PSUs at Delhi will have their AME got done at their respective Force CH/Station Hospitals at Delhi. Others, who are away from Delhi will get the same done at the nearest respective CH of any CPF, for which they shall apply in advance through their administrative authorities.

f. The previous year's AME report will be made available to the AMA/Medical board as the case may be, by the unit. It will insist this from the previous unit at the time, the member of the Force is received in the unit on transfer/attachment. In case the report is not received, the unit will demand the same in advance, much before AME.

g. The body weight will be checked as per the chart given in Appendix-E/F. Those found over weight, will be disposed of as per guidelines in Part-III 23.5(e).

4.11 Authority:

The concerned Unit/Office in which an individual is posted when due for AME will initiate it in a planned manner, taking up with the Medical authority of the concerned hospital as indicated in Para 4.15 below during January every year. The same will be done by the Force Directorate (Pers Branch) for Officers/Personnel on deputation to other organizations. All are required to be examined system wise with grater clinical details, including ECG, Chest X Ray, GTT, Lipid profile, RFT etc for all men; and USG abdomen, in addition Gynecological check-up for ladies, as per requirement. Services from other nearby Govt. Hospitals may be obtained in case facilities are not available at own force hospitals subject to the condition that these are carried out in the presence of at least one of the board members. The findings will be recorded in proforma C. It is the responsibility of the individual as well as the concerned unit Head to ensure that AME is held on time.

4.12 On conclusion of hospitalization & rest period.

On discharge from hospital as well as on completion of rest period on medical grounds, an individual will be classified by the AMA in the factors of SHAPE system with which the illness has a direct bearing. A minimum grade of 3 or less will be essential to resume duties. All hospitalization/rest period with details of diagnosis, investigations etc

and the sequela if any, will be recorded in individual's health card. The discharge slip in original must be sent to the concerned head of the unit for record/regularization of leave.

4.13 Mandatory for the purpose of promotion

Medical Category SHAPE-I will be an essential condition for promotion of all combatised personnel in all groups/ranks/cadres in the CPMFs. In case of those whose illness is of permanent nature and who are not SHAPE-I, they will be considered for promotion by DPC but will be declared unfit for promotion, even if, they are otherwise fit for promotion. In case of those personnel, whose illness is of temporary nature, after considering their cases for promotion along with others, if they are otherwise fit, the DPC will grade them as 'fit for promotion' subject to attaining SHAPE-I medical category. As and when they regain the SHAPE-I medical category, they will be promoted as per recommendations of DPC. But they will not be entitled to back wages. However they will retain their seniority.

4.14 The Force personnel above the age of fifty five years placed in the lower medical category of S1H2A1P1E1(Without hearing aid), S1H1A1P1E2 (dominant eye should not be worse than 6/9 with correction) and S1H1A1P2E1(for dental reasons only) will be treated at par with medical category SHAPE-1 and will be eligible for promotion to the higher ranks in a normal manner.

4.15 As regards officers, who have been put in lower medical classification by the medical board/review medical board of S1H1A2P1E1 and S1H1A1P2E1, who are otherwise fit for promotion, their suitability for promotion will be re-assessed by a board consisting of the Home Secretary as the Chairman, DG of the concerned Force, ADG(Med), MHA and a Specialist nominated by DGHS, as Members. The Board will assess the suitability of the officer, who is otherwise fit for promotion, but is in the above mentioned medical categories, in consideration of the following parameters:-

(a) The Officer is capable of performing the normal duties of the rank to which he is being promoted.
(b) Any defect, disability or discomfort which the officer is suffering from is not likely to be aggravated by the service conditions.
(c) The officers, assessed fit for promotion by the Board will be promoted to the next higher rank as per the recommendations of the DPC.
(d) The Board's assessment will be final.

4.16 If the actual promotion of Force Officer is delayed because of his/her low medical category and he/she is required to regain medical category SHAPE-I, the person below him can be promoted, but the officer will regain his/her seniority immediately on his/her, promotion, if he regains SHAPE-I medical category within the validity period of the recommendations of the DPC.

4.17 Relaxation in SHAPE-I Medical Category.

The relaxation in SHAPE-I Medical Category will be admissible to the following two categories of CPMFs personnel to the extent detailed below:-

a) Official/Personnel wounded/injured during war or while fighting against the enemy/militant/intruders/armed hostiles/insurgents due to an act of these in India or abroad will be eligible for promotion while placed in one of the following medical classification:-

i) Individual Low Medical Factors

(aa) H2 or E2 or P2(Dental) which will be considered at par with SHAPE-I; and ;
(ab) A2 or P2 or A3

ii) Conbined Low Medical Factors
(aa) H2 and E2 combined and
(ab) H2 or E2 combined with A2,A3 or P2

b) Officers/men who are wounded/injured during field firings/accidental firings/explosion of mines or other explosive devices and due to accidents while on active Government duty in India or abroad will be eligible for promotion in the following SHAPE Categories:-

i) S1H1A2P1E1 (ii) S1H1A1P2E1 (iii) S1H2A1P1E1
(iv) S1H1A1P1E2 (v) S1H2A1P1E2

PART- II

5. PROCEDURE FOR MEDICAL CATEGORISATION

5.1(a) General

These instructions contain procedures for medical categorization/re-categorization of the combatised officers and men of the CPF, including deputationists, medical, signal and Ministerial members of the Forces.

5.1(b) **AIM**

The aim of such categorization is basically to indicate the functional capacity of the Force Personnel for better cadre management; while encouraging them to maintain their general health at an higher attainable standard and adhere to regular treatment, follow up by the LMC personnel, due incentives are embedded in the system for those maintaining their health and disincentives for those who do not. A regular and compulsory health check-up is bound to result in early detection and timely treatment of diseases/disabilities, there by drastically reducing morbidity and mortality in the Force while enhancing efficiency.

5.2 **PROCEDURE FOR MEDICAL RE-CATEGORISATION**

(a) Personnel put on low-medical category are required to be reviewed. The responsibility to bring such Officers/personnel before the AMA/review board lies with the concerned unit/establishment. No prior approval is required for holding such reclassification as the concerned hospital/AMA is already in picture about the expected date of review while conducting the earlier classification. In case of delay for more than 60 days, prior approval of the Medical Officer in-charge/ DIG(Medical) of the concerned administrative Frontier/GC/Sector in the case of ORs; and of IG(Medical) of the nearest 100 bedded CH in case of GOs will be taken, forwarding him the details of the case with reasons for delay.

(b) However the previous LMC Category will continue to operate on the individual during the entire period till the date of reclassification. In case of negligence on the part of the individual, the concerned DIG(Medical) or IG (Medical) as the case may be, will refer the matter to the

unit commandant in case of UOs/ORs , to range DIGP in case of SOs and to the Sector IGP in case of GOs for appropriate action. On receipt of condonation, the concerned AMA/Medical board will cover up the delay period by the same medical category as it was operative prior to the due date and award fresh category for 24 weeks temporary/permanent or upgrade depending on the current status of the case.

5.3 **CLASSIFICATION PRINCIPLES.**

Medical classification/reclassification of combatised serving personnel be made after assessing his/her fitness under 5 sectors of health status, in terms of the code letters SHAPE' as under:

S - Psycological
H - Hearing
A - Appendages
P - Physical Capacity
E - Eye sight.

5.4 **FUNCTIONAL CAPACITY**

Functional capacity for duties in the CPF under each factor will be graded in the scale from 1 to 5 indicating declining functional efficiency and increasing employability limitations (For detail guidelines, please refer to Part-IV)

5.5 **Functional Capacity Scale**

1. Fit for all duties any where
2. Fit for all duties except with limitations in duties involving severe physical/mental strain. They would also required perfect acuity of vision and hearing.
3. Except S Factor, fit for routine or sedentary duties but have limitations of employability; both job wise and Terrain wise as spelt out in classification against each factor as specified in Part-IV.
4. Temporarily unfit for duties in the force on account of hospitalization/sick leave.
5. Permanently unfit for service for any type in the force.

5.6 **Employability of LMC Personnel:**

Posting/job assignment by the competent authority (Pers Directorate/Frontier/Sector/Range) of personnel under LMC wil be guided by matrix based on:

a. Medical advice as given in medical report/board proceedings.
b. Job contents.
c. Endorsement in ACR as given by initiating/reviewing/accepting Officer regarding individual's demonstrated Physical capacity.

5.7 **Demonstrated Physical capacity:**

Physical capacity of performance of LMC individual shall be suitably endorsed upon in the health column of ACR by the initiating officer.

6. **For individuals placed in temporary LMC** it is obligatory for them to appear before the reclassification medical board at the stipulated time as given in the previous medical board proceedings/medical examination. **No early premature review will be allowed in case of any temporary LMC,** irrespective of the duration. **In permanent LMC,** the individual will be reviewed after two years. However early review can be requested provided, the AMA certifies that the individual's condition has improved materially; along with a technical report on convincing grounds. This has to be recommended by the unit commandant certifying normal performance of the individual and this will be forwarded to the Director (Medical) for graning early review or otherwise.

7. **Recording of medical board proceedings:**

Due care should be taken in recording al types of medical board proceedings as prescribed in proforma given in appendix-'C'. The board will ensure that all columns are appropriately and completely filled in unambiguous terms. In permanent LMC cases, assessment of disability percentage shall be reflected on each occasion, including known aggravating or attributing factors, findings of COI if any. In confirmed, fresh IHD cases admitted to hospitals, last 14 days charter of duties shall be obtained from the concerned unit commandant immediately and placed before the subsequent classification board. When ever any personnel under going medical examination refuses to sign on the report/ board papers, the contents shall be read over to him/her by the PO in the presence of two witnesses, different from board members and their signatures obtained in confirmation thereof.

At the same time. The Commanding Officer of the concerned unit shall be informed in writing.

8. **Duration of classification**

Temporary classification will be awarded for not more than 24 weeks at a time. The officer will be due for review after this period and no review will be permissible before expiry of the initial period of LMC/ observation/ follow-up in any case.

9. Temporary classification in factor will be permissible for a maximum period of 24 weeks. If an individual requires observation beyond permissible period, he/she will be placed in permanent LMC except in 'S' Factor where provision of Para 10 given below will be applicable. Opinion given by a Specialist for review in Proforma as per appendix-D will be valid for a period of three months only.

10 All individuals in S-3 factor can be observed on a temporary basis for a maximum period of 48 weeks in all. He/She will not be placed in S-3 permanent. If after 48 weeks the individual can not be upgraded to S-2 temporary, he/ she will be down graded to S-5

11. Endorsement of temporary classification of a factor in the profile will be made against the numeral to which it refers and will consist of the capital letter "**I**" together with the figure to indicate weeks for which the temporary grading have been recommended. For example **S1H1A1P1E2(T-24)** in case of first grading, **S1H1A2(U) (T24+24)P1E1** in case of second grading or **S1H1A4(T-8)P1E1** in case sick leave for 8 weeks or **S1H1A1P4(T-4+4)E1** in the case where a second spell of sick leave has been granted as in case of IHD (Sick leave) followed by CABG(Sick leave). Temporary classification can be only for grades 2, 3 and 4 of SHAPE factors.

12. **Permanent grading** will be denoted only by using the requisite numeral against the factor e.g. S**2, H2** and so on.

13. There are certain diseases or group of diseases, which are not amenable to short term therapy or quick cure. Some of such diseases are ischeamic heart diseases, hypertension diabetes mellitus, Peptic Ulcer, Psychiatric and Malignant diseases. Medical experience and medical literature have shown that a large number of patients suffering from these type of diseases require prolonged medical treatment and surveillance. It is thus appropriate for individuals

placed in temporary LMC P-3 for diseases such as above, to be placed in appropriate permanent LMC (P2 or P3) after the initial observation of 24 weeks, depending on their clinical condition.

14. **Follow-up of personnel placed in low medical classification:**

Personnel placed in LMC are required to be kept under constant medical supervision with a view to ensure that there is no deterioration during the period of LMC and that the treatment as well as other medical advice is regularly followed by the individual. The follow up will be ensured as under:

a) The concerned Unit/GC hospital will maintain a register of all LMC personnel on posted strength of the unit and the unit Commandant will provide all the required information to the AMA. Such information will be sent to the MO IC of the concerned Unit/GC/Sector by the unit Commandant where no medical officer is posted.

b) The AMA will make schedule for medical examination of all such personnel, call or visit them from time to time, enter their personal particulars, nature of disability, medical category and the date of next review in a register which will have separate page for each individual. In case of new arrival of LMC cases in the unit, the information will be forwarded by the H.O.O. within one week to the AMA for entry into the register.

c) The register will be perused by the unit MO/AMA during first week of every month along with the individuals in LMC, to complete all entries. It will be ensured that reclassification medical board is held on due date. In the remarks column, entry will be made regarding the due date for review, any further investigation required, treatment advised and the follow up action required to be taken. Specialist's consultation will be taken form the nearest Force/Govt. Hospital if required by AMA.

d) A Separate Case sheet will also be raised in r/o each individual placed in LMC for monthly follow up. Entries will be made in separate columns such as physical condition, clinical findings, response to treatment, modification of treatment if done, investigation results, specialist's opinion if taken and progress of the case.

e) Required investigations will be carried out and expert opinion required if any will be obtained well in advance before the date of next review.

f) When an individual in LMC is posted out from the unit, all medical documents will be forwarded by the Commandant to the receiving unit with a request that these documents be handed over to the AMA of new unit.

g) Inspecting/visiting Medical Officers during their visits will check that such registers and case sheets are properly maintained.

15. **APPEAL AGAINST THE FINDINGS OF A MEDICAL BOARD.**

(i) DG of the Force may consider an appeal against low medical categorization received from a member of the Force and order the Director (Medical) to constitute a Review Medical Board. The appeal must be accompanied with necessary documents and certificate from Government Hospital stating that he/she is not suffering from the disease/conditions for which he/she has been categorized low. Specialists from relevant fields must be associated in the Review Medical Board, who may be from within the organization or outside the organization.

16. **RECLASSIFICATION OF PERSONNEL IN LMC**

When one is placed in a medical category lower than SHAPE-ONE, whether temporary or permanent, it is obligatory on his/her part to appear before a reclassification medical board on time. It is re-emphasized that it is the responsibility of the unit/establishment in which the officer is serving to ensure compliance of this mandatory requirement. It will be ensured by the unit Commandant/OC that if an individual who is due for such reclassification is not sent on annual leave/long casual leave/temporary out station duty if the board is due. He can be detailed for a course/temporary duty only after taking prior permission from the MO IC of the respective Unit /GC/Composite Hospital in case of SO & ORs and from the Director (Medical) in the case of officers; at least 2 weeks in advance with adequate justification for either postponing the medical board or for holding it at the station to which the individual is proceeding on longer attachment duty.

17. When ever a reclassification Medical board/ Examination falls due during the period of AME, the Individual will undergo reclassification first and the fresh medical category will be reflected in the AME when held subsequently. When AME falls due before reclassification both will be held independent of each other and in no circumstances,

the date of reclassification medical board will be changed. In case of permanent LMC board, it is to be preponed by 3 months to be held first, followed by the AME.

18. **RECLASSIFICATION OF PERSONNEL IN LMC FOR MULTIPLE DISABILITIES.**

When ever any members of the Force is in permanent LMC for 2 or more disabilities and where the reclassification is due for different disabilities within 12 weeks of each other, the individual will be assessed for all the disabilities together and awarded the deserving categorization. When one is already in LMC and develops another diseases/disability within 3 months of being reviewed for the former, he/she may be kept under observation category for the later disability for a period equal to the un-expired period of the previous condition so that he/she can be reviewed for both together.

19. If a member of the force is already in medical category S2 (irrespective of whether temporary or permanent), and shows deteriorating symptoms or is found incapable to perform the duties, the unit Commandant/H.O.O. may send him to the nearest GC/Composite hospital with a detailed behavior report in the format for review earlier than the scheduled date.

PART- III

20. DISPOSAL OF MEDICAL BOARD PROCEEDINGS

a) Disposal of AME Documents: In case of the GOs and Inspectors, the report will be sent in duplicate to the range DIGP confidentially by the unit Commandant for further action, besides keeping a record of medical classification grading, to be entered in the individual's ACR. In case of the Commandants, report/proceedings will be directly sent to the DIG. In case of the SIs and ORs, the report will be maintained by the respective Company Commanders, in addition to endorsement of the categorization in individuals confidential card. The same will also be published in the F.O.

b) In the case of **Medical Boards,** the proceedings in duplicate in respect of Gazetted Officers and Inspectors will be submitted to the Directorate Pers Branch by the hospital authorities where the board is held, with one copy to Sector IGP for further communicating it to the concerned unit. Only the gist and grading will be communicated to the individual in writing, besides entering the same in his/her health card and medical register maintained by the hospital. In case of SOs up to SIs and ORs, the proceedings after approval by the concerned

Medical authority, will be sent to the range DIGP, with a copy to the concerned unit for informing the individual and action as above.

21. **RECOMMENDATION FOR LEAVE ON MEDICAL GROUNDS AND IT'S APPROVAL**

When sick leave has been recommended by the AMA or Medical board on medical grounds to an individual, approval/counter signature will be required to be done by the In charge of the concerned Hospital.

PART-IV
DETAILED GUIDELINES ON TECHNICAL STANDARDS TO MEDICAL OFFICERS FOR CLASSIFICATION OF SERVING COMBATISED PERSONNEL IN THE CPFs

22. FUNCTIONAL CAPACITY & EMPLOYABILITY

22.1 "S" FACTOR (PSYCHOLOGICAL)

This factor denotes Psychological aspect and other personality defects, mental acuity, emotional stability and psychiatric diseases

Numerical Grading	Functional Capacity	Employability limitations
S-1	Can withstand severe mental stress. May have fully recovered from a psychological condition with no likelihood of further breakdown.	Fit for all duties any where
S-2	Can withstand moderate stress. Had suffered from Psychoneurosis, but now fully stabilized. Likelihood of breakdown under severe mental stress can not be ruled out.	Fit for all duties any where except at high altitude, solitary locations and operational duties during IS duty and hostilities. Not fit for independent Command and duty with live fire-arms.
S-3	Has limited tolerance to stress, recently recovered from Psychoneurosis or toxic/ confessional state; or acute psychotic reaction of temporary nature	Fit for only sedentary duties with limited/ restricted responsibilities under

	as a result of external causes, un-related to alcohol or drug addiction.	close supervision in peace/ field area but only where hospitals with psychiatric facilities are available nearby. Not fit for operational duties during war or peace on IS duty or duties with arms.
S-4	On sick leave/ in hospital	Temporary unfit for force duties.
S-5	Mentally unstable on account of psychological/psychiatric disorders or having psychopathic personality.	Permanently unfit for service.

22.2 **"H" Factor (Hearing)**

This factor covers auditory acuity, ability to hear spoken voice or auditory signals often against considerable background noise are important in certain trades and operational situations.

Numerical Grading	Functional Capacity	Employability limitations
H-1	Has excellent hearing in both ears viz. With back to examiner can hear forced whisper at a distance of 6 meters, each ear tested separately.	Fit for all duties any where
H-2	Has excellent hearing in one ear with impaired acuity in the other, partial or complete. With back to the examiner, can hear forced whisper at 6 meters with one ear (+/- 10 decibels) and conversational voice at 1.2 meters or less with the other ear (60 decibels).	No limitations in physical capacity and fit for duties in peace or field areas including IS duties and war any where except as under:- a) Not fit for patrol, scout and laying ambush. b) Not fit for duties which demand keen hearing acuity in both ears.
H-3	Is partially deaf in both ears. With back to the examiner can hear	No limitations in physical capacity and

	conversational voidce at 3 meters with both ears (40 decibels), each one tested separately.	fit for duties in peace or field areas including duties during IS duty and war anywhere except as under. a) Not fit for patrol, scout and laying ambush in noisy surroundings. b) not fit for duties which demand keen hearing acuity of both ears.
H-4	On rest/Leave on medical ground/ in hospital	Temporary unfit for Force duties.
H-5	Hearing acuity below H-3 standard.	Permanently unfit for Force duties.

NOTE: In assessing auditory acuity and assigning the grades under this factor, it is necessary to remember the following points:

a) An official may be required to achieve the standards laid down against considerable background noise, in certain trades and operational situations, although it is not an invariable requirement.

b) The standards set to be achieved under different grades are without the assistance of hearing aids. Hence, while determining the grade of an official's disability, improvement achieved by the use of hearing aids will not be taken into account.

c) Testing will normally be done in the usual way, dealing each ear separately. Resort to special testing will be made only under specific indications e.g.- audiometry etc.

When an individual is partially deaf in both ears, he will be examined with neither ear being dampened and if he can hear conversational voice from a distance of 3 meters (40 decibels), he will be placed in H-3. if the acuity is below this level even after appropriate treatment he will be placed in category H-5.

ENT Diseases e.g.- sinusitis, tonsillitis etc, not affecting hearing shall be classified under "P" factor.

22.2 **'A' Factor (appendages)**

This covers the functional efficiency of upper and lower limbs (including amputees, loss of fingers and toes) shoulder girdle, pelvic girdle and associated joints and muscles. A personnel who may be placed in Grade"2" or "3" of A factor, depending on whether their disability pertains to upper limbs or lower limbs, totally difference employability restrictions will be applicable. Hence the person placed in grade 2 or 3 of this factor will be further divided into classification A-2(U) or A-3(U) if this disability is in the upper limb(s) and A-2(L)/A-3(L) if this disability is in the lower limbs. This will give a clear picture of the individual to the administrative authorities to determine his/her suitable placement.

Numerical Grading	**Functional Capacity**	**Employability limitations**
A-1	Has full functional capacity though may be having minor impairments eg.-	Fit for all duties any where
A-1(U)	(a) Loss or disability of the terminal Phalanx of anyone of 5^{th},4^{th} or 3^{rd} fingers of dominant hand with other hand being normal OR, (b) Loss of terminal Phalanges of 3^{rd}, 4^{th} fingers of non dominant hand with grip in same hand being very god and other hand being normal	-do- -do-
A-1(L)	Loss of terminal phalanges of 3^{rd} and 4^{th} toe of any one foot	Fit for duties any where except operational/IS duties/during hostility.
A-2 (U)	Has moderate defects in function of upper limbs e.g.- (a) Deformity/Disease/Loss of index finger of dominant hand leading to its functional disability. OR, (b) Loss of terminal 2 Phalanges of 3^{rd} & 4^{th} fingers of non-dominant hand, with reasonable grip retained, and the other hand being normal OR, (c) Any other minor disease/disability in no dominant hand.	Fit for all duties which do not involve crawling, running, jumping long marching, hill climbing and handling of weapons.
A-2(L)	Has a defect/disease or disability of a moderate nature in one limb below	-do-

	knee capable of marching up to 8 KM and standing for 2 hours	

Note: In case the individual is placed in A2(L), each person's functional capacity in terms of employability has to be assessed on the basis of his disability e.g. a person having classical Symes operation with a good prosthesis is fit for crawling but NOT for jumping.

An individual who is placed in this classification due to an injury/disability/disease will be fit for duties anywhere except at hilly terrain (Where he has to go up and down the frequently).

A-3 A-3 (U)	Has major disability or disease in upper limb like complete loss of hand including fingers, or amputation through metacarpals, or a disease/disability of shoulder in one side	Not fit for operational/ Counter insurgency duties. Can do IS duties without fire-arm. Area restriction not applicable.
A-3 (L)	Has a disease or disability above knee on one side, including pelvic girdle but should be able to walk up to 5 Km at his own pace.	Fit for sedentary duties only. Not fit for high altitude/operational/CI/IS duties.
A-4	Sick in hospital/rest on medical ground	Temporarily unfit for Force duties.
A-5	Severe derangement of functional efficiency	Permanently unfit for Force duties.

22.4 **"P" FACTOR (PHYSICAL CAPACITY)**

This factor shall cover to describe in details about the physical capacity, strength, endurance, mobility, agility and activity of a person, which might be restricted by Medical /surgical conditions and those which are not covered under other factors. Concessions are embedded as a function of age under this factor, since stamina and endurance do decrease with ageing process without any obvious pathology being visible.

Numerical Grading	Functional Capacity	Employability limitations
P-1	Has full functional capacity and physical stamina Minor impairment fully under control, but has full physical stamina.	Fit for all duties any where Fit for all duties any where but under medical observation, having no

		employability restrictions.
P-2	Has moderate physical capacity and stamina. Suffered from constitutional metabolic/infective disease/operative procedures, but now well stabilized.	Fit for duties not requiring servere stress. May have restrictions in employability at high altitude (above 2,700 meters/9,000 feet in hilly terrain and extreme cold areas).
P-3	Has major disablement with limited physical capacity and stamina	Fit for sedentary duties not involving undue stress. May have restricted employability as advised by medical authorities such as :- a. To avoid places with high humidity level 75% round the year. b. Have access to specialist services near by. c. To avoid driving/handling of weapons near water, fire or heavy machinery. d. Restricting physical excess, work in desert/snow bound areas etc. e. Restricting active participation in hostilities, counter insurgency operations etc. (excluding staff, logistics and allied support duties.)
P-4	On sick/ leave on medical ground in hospital	Temporarily unfit for force duties.

P-5	Gross limitations on physical capacity and stamina	Permanently unfit for Force Service.

Note : It is envisaged that grading under "**P"** factor is likely to be fraught with ambiguity, mainly for the following counts:-

a) Diseases (not considered in other factors) affecting the physical capacity or stamina of a person owing to any type of medical or surgical condition, whose etiology may be constitutional metabolic, infective neoplastic or idiopathic are to be considered under this head.

b) The effect of therapy, whether medical or surgical, may widely vary from case to case, although the clinical presentation of the disease state may be similar or identical. The residual functional incapacity may not be easy to determine, except with experience. There are continuous changes in the concept of the natural history of disease processes, necessitating revision of our ideas regarding cure of disease, sequele, and employability restrictions.

22.5 In view of the above, issue of instructions based upon the prevailing consensus of medical opinion becomes necessary for guiding the medical officers. Currently the following instructions are in vogue and will be followed in grading individual suffering from the under mentioned conditions, utilizing the equivalence between grades 1-5 under this factor:-

(a) **HIGH ALTITUDE PULMONARY OEDEMA (H.A.P.O):**
All cases of high altitude pulmonary oedema, after clinical recovery, if there is no clinical radiological or electro-cardio graphic evidence of residual pulmonary hypertension will be placed in P-1 category without any restrictions for employment at high altitude. Officials developing high altitude pulmonary oedema for the second time will not be graded higher than P-2.

(b) **I. ISCHAECMIC HEART DISEASE:** The following policy shall be followed:

Clinical condition	Classification to be recommended
i) Cases of coronary artery disease (CAD) with normal CAG, echo and TMT/Stress Thallium.	**P-1**
ii) CAD with abnormal CAG with successful PTCA & Stent; CABG	**P-2(T)** to be evaluated regularly for one year. May be up-graded if

with normal systolic LV function and without angina.	remains as such to P-1 or down graded if deteriorates
iii) CAD with abnormal CAG with successful PTCA & Stent/CABG but with abnormal systolic LV function (Low ejection fraction).	**P-3(T)**, to be evaluated regularly for one year. May be up-graded to **P-2** on improvement or down graded to **P-5**
iv) Cases with congestic Cardiac failure, dialated cardio-myopathy, marked enlargement of the heart and cardiac aneurysm.	**P-5**

(b) II. OTHER CARDIO-VASCULAR DISEASES.

Valvular Heart Diseases:	**P-5**
Paroxysmal S.V.T	**P-3,** to be up-graded to **P-2** after EPS and Radio-frequency ablation and to **P-1** if remains asymptomatic for one year.
Permanent Pace-Maker implantation	Initially **P-3** to be up-graded to P-2 if remains asymptomatic for one year.

(c) <u>DIABETES MELLITUS</u>

Personnel who are known diabetes or having impaired Glucose Tolerance or those who have declared themselves to be so and are under treatment should be graded as follows:

P1 Personnel having diabetes or impaired Glucose Tolerance under treatment with Diet control and or oral Hypoglycemics within following parameters be classified as P1 depending on the health condition and follow-up requirement.

(i) Fasting glucose estimation less than 126mg (Plasma)/dl.

(ii) Random or 2 hr Post glucose (75 Gms) or <200Mg (Plasma)/dl. A known diabetic may be permitted to take his usual dose of OHA/insulin following glucose drink/ full meals for testing PGBS/PPBS **<u>provided that.</u>**

(iii) Glycosylated Hb(HbA1-c)<7%

(iv) Individual is free from any target organ involvement/complications.

(v) Lipid profile within normal limits.

(vi) No insulin requirement

(vii) No Glycosuria.

The above parameters must be maintained for a minimum period of six months with fasting and 2 hr Post Prandial sugar every six weeks and Glycosylated HbA1c every 3 months before the individual is upgraded to P1.

During this period of 24 weeks observation the individual shall be kept labeled as P1(O-24) and finally upgraded as P-1 as the case may be if he maintains the control consistently. Keeping the individual under P-1(O-24) will be done only once and need NOT be repeated every year during AME.

P2: Those who have fasting and Post Prandial as for P1 above for at least 6 months with HbA1c between 7&8 % on dietary restriction alone or with OHA; provided that there is no complication or Target organ involvement, including:

(i) No retinopathy of any grade on fundoscopy,
(ii) No clinical or electro-physiological evidence of neuropathy.
(iii) No neuropathy by clinical, bio-chemical or imaging criteria,
(iv) Normal lipid profile.,
(v) Normal ECG,
(vi) No History or evidence of cerebro-vascular or peripheral vascular disease.

P3: Those who have uncontrolled fasting and Post-Prandial sugar with OHA bt needing insulin in smaller dose additionally for control, with HbA1c more than 8% with or without any Target organ damage; but likely to reverse TOD with proper treatment and are likely to become non-insulin dependent.

P5: Patients on high dose of insulin, not responding to O.H.A, with complications and Target organ damage with obvious changes; and complete recovery is unlikely.

For the new cases detected during A.M.E the following procedure should be adopted. The newly detected case should initially be kept under category P3 (T-12). After 12 weeks if the individual fully complies and improves with treatment achieving parameters as given above, he/she be categorized as P2 (T-24) If he does not improves, he/she will continue in P3.

In case of newly detected cases of **Impaired Glucose Tolerance,** the individual should be placed in category P2 (T-12) if his parameters are of P2. If there is no CV risk factor or any target organ involvement, the

individual is placed in P-1. If the parameters fall in the category of P1, then he be labeled as P1(O-24) and then dealt with as given above for further categorization. In doubtful cases, complete GTT may be undertaken. If required, cases are hospitalized for 48 to 72 hours for close observation and final decision.

d) <u>HYPERTENSION.</u>

The JNC-7 guidelines about grading of hypertension are given below as a ready reference. Hypertension, when associated with diabetes mellitus is graded one step ahead to facilitate urgent intervention/treatment in view of added risk for irreversible target organ damage in general and IHD in particular.

Grade of Hypertension	**Blood Pressure**	
	Systolic	**Diastolic**
Normal	**120 and**	**80**
Pre-hypertension	**120-139 or**	**80-89**
Stage-I hypertension	**140-159 or**	**90-99**
Stage-II hypertension	**>160**	**>100**
-Severe	**180-209**	**110-119**
-Very Severe	**210 or more**	**120 or more.**

As a general rule the systolic Blood Pressure over 140 or/and diastolic over 90 should be now regarded as significant and such individuals should ideally be hospitalized for observation and due investigation before final opinion. BP is measured by the conventional mercury manometer after making the individual at home and comfortable for at least 30 mints and 2 to 3 repeated readings be obtained. Other cardio-vascular risk factors e.g. Smoking, obesity, diabetes, poor physical activity, dyslipidemia, micro-albuminuria or GFR <60ml/min, family history of CV disease be looked for.

i) Cases of hypertension with cardiac, renal and eye involvement who are not stabilized within 24 weeks treatment and are progressive or near decompensation or decompensated, will be placed in P-5. If, these have stabilized with treatment and are not progressive, the individual will be placed in P-3 for 24 weeks at a time to assess further progress, restricting his employment to sedentary duties only in areas not involving high altitude or exterminate cold climate.

ii) If complying with regular treatment over a continuous period and the cardiac, renal and retinopathy changes have become normal; with basal blood pressure consistently remaining normal or at the most within Stage-1 limit, the individual may be considered for up-gradation to P-2 with no restriction except rigorous physical exertion.

iii) Cases of hypertension without any cardiac, renal or eye involvement and whose blood pressure is within border line under treatment, will be placed in P-2 for 24 weeks at a time to assess progress and finally may be considered for up-gradation to P-1B and then to P-1 in deserving cases depending on response.

iv) In border line cases, the blood pressure may be checked once every 2 weeks, without changing the existing category, unless there are indications for such change.

(e) OVER WEIGHT & OBESITY

Take into account the average nude weights according to age and height given in Appendix-'F' to this order. Individuals who are found to be overweight will be dealt with as under:

i) If body weight is more than 10% but les than 20% over and above the ideal weight expected for the height and age, without any symptom/signs of metabolic abnormality, the official will be advised, in writing, to reduce his weight within 10 weeks under information to his controlling officer. He/she will be reassessed immediately on completion of this period.

ii) If the individual fails to reduce weight to the acceptable level even after 10 weeks, he will be down graded to medical category P2 (T-24) and if he/she reduces weight to the acceptable 10% limit within this period, the classification proforma will be completed.

iii) If the body weight is in excess of the Ideal Body Weight (IBW) by more than 20% investigations will be carried out to exclude any metabolic abnormality e.g.- abnormal GTT/RFT/Lipid profile, IHD, Osteo-arthritis etc. If the officer has no metabolic abnormality and ECG is normal, he should be examined by a Medical Specialist or in his absence, an experienced CMO (SG). The latter must decide whether it is due to obesity or due to increased muscle mass. Bone thickness by measuring the following parameters.

1. Body mass Index (BMI)- $\frac{\text{Weight (in Kg)}}{(\text{height in meter})^2}$

Normal range : 20-25.

A person is definitely obese if it is 27 or more.

2. Waist and hip ratio:

Method of measurement of waist: Take a point mid way between the 12^{th} rib and upper border of iliac crest on both sides and measure with a tape.

Method of Measurement of Hip: Take upper point of greater Trochanter of Femur on both side and measure the circumference with tape.

Normal range: 0.6 to 0.9 %

A person has definite central obesity if it is more than 0.9%

3. Skin fold thickness:

It is measured with the help of Caliper.

Normal range of Sub-Scapular skin fold: 18-20mm

-Triceps skin fold thickness: 12-15mm.

All the above measurements will decidedly determine whether increased weight is due to obesity or due to increased muscle mass/bone thickness. If it is due to obesity the individual should be down graded to medical classification p-2(T-24). If the individual fails to reduce his weight to ideal level by 48 weeks, he/she shall be placed in P-2 permanent and if does not comply by 72 weeks, in P-3 Permanent.

(f) ALCOHOL DEPENDENCE

Alcohol dependence and drug abuse are recognized as behavioral/psychiatric problems in ICD-10. These are incompatible with service/ethos in Armed Forces and all such cases should be invalidated/weeded out of service unless the patient shows an unequivocal determination to give up the use of alcohol/drug for good in the shortest time span. There is well laid down procedure for disposal of such patients of Alcohol dependence/drug abuse. However it doe not meet the organizational interests of forces where a large number of men are alcohol dependent and still continue to stay. In view of the above following instructions for disposal of Alcohol dependence/ drug abuse cases may be strictly adhered to:-

i) Alcohol dependence/drug abuse cases will be observed in temporary LMC in S-3(T-24) initially if showing favorable response to treatment.

ii) If during the period of such observation vide 2(a) his condition relapses again, he should be placed in S-5 and invalidated out of service.

iii) After six months of observation in LMC in S-3(T-24), if his behavioral/abstinence report is complimentary and his observation in hospital shows sign of abstinence (There should not be any symptom/sign of withdrawal when no alcohol/drug are allowed during the period of observation in psychiatric ward) he/ she should be upgraded to category S-2(T-24).

iv) During this period of observation in S-2(T-24) if the controlling officer of patent refers him to psychiatrist with adverse behavioral report/remark and patient shows signs of relapse, he should be placed in S-5.

v) After 6 months of observation in S2(T-24) if the report as above is complimentary and patient shows signs of alcohol abstinence he should be upgraded to S1.

vi) If after up-gradation to S-1, the patient shows any time any sign of relapse and referred by Controlling Officer/AMA to psychiatrist with adverse remarks in his report, then also patient should be placed in S-5.

g) <u>TUBERCULOSIS:</u>

(i) Fresh cases of tuberculosis on domiciliary anti-TB treatment should be placed in P-3 for six months initially with further extension of same till the drug regimen lasts. After treatment is completed, the individual be kept in P2 for 12 weeks if the disease is completely healed without residual fibrosis or with minimal fibrosis not affecting functional capacity before upgrading to P1.

(ii) If residual fibrosis or pleural thickening occurs with impairment of Pulmonary function after usual course of treatment, the individual will have to be down graded to P3 for 24 weeks and if after that period, his assessment shows no improvement, he be put in permanent P3 category, to be dealt with as per Para 7 above.

(iii) Resistant cases of tuberculosis or tuberculosis with HIV positive or with severe impairment of pulmonary function or requiring surgery for complications of tuberculosis, possible treatment should be given and individual placed in P5.

h) <u>MALIGNANCY & ORGAN TRANSPLANT CASES.</u>

For the period of active treatment in OPD individual be kept in P3 or P4 on rest. After completion of treatment individual be categorized as per assessment of his physical/mental condition. The terminal cases will be put in P3 permanent category.

g) <u>HIV/AIDS CASES:</u>

Individuals who are only HIV positive but asymptomatic will be categorized P-2 & required to be observed periodically. Those who are HIV positive and symnptomatic with or without opportunistic infection (AIDS disease), shall be assessed on their physical/medical condition and placed in P-3 permanent if ambulatory to facilitate continued ARTV, provided that they fully co-operate with management plan. If the disability percentage goes beyond 50%, individual will be placed in P-5

The medical classification for HIV positive personnel will be done as provided below:-

P1	HIV Positive Asymptomatic Not on ART CD4,CD8 Count normal Other Parameters like Viral load Normal	Fit for all duties anywhere
P2	HIV Positive Weight Loss more than 10% CD4(Above 200 Cells/Microlitre) CD8, Count within normal range Total Lymphocyte Count above 1200/mm3 Minor Mucocutaneous Manifestations/minor infections With or without ART	Fit for all duties anywhere except at difficult and solitary locations, preferably where ART facilities are available
P3	HIV Positive Weight loss more than 10% CD4 Count less than 200 Cells/	Fit for sedentary duties only and only at locations were

	Microlitre Viral load more than 50,000 copies, Unexplained chronic, Diarrhea/fever more than 1 month. Opportunistic infections:- (1) Pulmonary TB (2) Oral thrush (3) Herpes Zoster more than 1 month (4) Leukoplakia etc on ART	advance medical facilities are available.
P4	Hospitalization/leave due to HIV related diseases/AIDS	Temporary UNFIT for Force duties.
P5	Unsatisfactory response to ART, (CD4 count less than 200 cells/microlitre with ART) HIV wasting syndrome. Disabling Neurological/Psychiatric problems Disseminated Tuberculosis Poor Physical endurance Malignancies associated with AIDS Functional disability more than 50%	Permanently UNFIT for any type of service, invalidation.

j) <u>MISCELLANEOUS CONDITIONS TO BE CONSIDERED FOR P2:</u>

a) Asymptomatic **undescended testis** which is entirely intra abdominal, varicocele and **Hydrocele**(Treated or of a mild degree); healed **trachoma,** traumatic **rupture of the tympanic membrane,** healed/closed perforation, loss of teeth but fitted with suitable dentures and dental points>14, depending on the limitations.

b) Cases of **non-ulcer dyspepsia** where no abnormality was detected on G/E evaluation.

c) Cases of non-incapacitating Asthma, **chronic bronchitis and emphysema** should normally be placed in P-3 but may be considered for P-2 depending on clinical condition and disease behavior.

d) Cases of **Primary Hypothyroidism are placed in P2** provided that:

(i) T3,T4 &TSH confirm diagnosis and there is no other underlying cause found.

(ii) Individual continues to be euthyroid on oral thyroxin hormone replacement.

(iii) T3,T4 &TSH levels remain within normal limits consistently for 6 months of observation..

Note: While recommending employment restrictions for officers placed in P-2 the following conditions will be given due consideration.

(i) If disability is due to adverse effects of extreme cold on earlier occasion, or gout, arthritis, sciatica syndrome or chronic bronchitis, certain dermatological conditions and so on prohibition on employment in extreme cold areas will be restricted.

(ii) With history of persistent pulmonary hypertension, head injury, fits amoebic hepatitis chronic bronchitis, asthma, Ischeamic Heart disease, essential hypertension etc, restrictions on employment in high altitude (above 2700 meters) may be required.

(iii) In disability is due to past h/o Ischeamic heart disease, obesity, sequele of head injury etc, restrictions may have to be imposed on employment in mutinous areas, duties involving strenuous exercise, prolonged route march, long patrolling, running etc.

k) <u>DISABILITIES TO BE CONSIDERED UNDER P-1 WITHOUT EMPLOYABILITY RESTRICTIONS.</u>

1. <u>Asymptomatic Dyslipidemia</u>

- Detected incidentally during routine evaluation and,
- There is no cardio-vascular risk factor or obesity,
- Has normal thyroid function (T2,T4,TSH w.n.1)
- No indication for drug therapy.

2. <u>Asymptomatic hyper uricaemia (>7mg/dl)</u>

- No symptom of Gout
- Individual has modifiable food habits and is amenable to change
- No indication for drug therapy

3. <u>Asymptomatic ECG abnormality</u>

- Detected incidentally during routine evaluation and,
- There is absence of any risk factor or symptom/sign of cardio-vascular disease,
- No underlying cause is detected on cardio-vascular evaluation
- Must be under constant evaluation from time to time, not later than every 2 years or less if indicated.

4. Ventricular or supra-ventricular ectopics

- Detected incidentally during routine evaluation and,
- There is absence of any risk factor or symptom/ sign of cardio-vascular disease,
- No underlying cause is detected on cardio-vascular evaluation.

5. Asymptomatic cervical spondylosis/ Low back-ache.

- With no neurological deficit or vascular insufficiency,
- Normal spinal movement
- No sciatica.

6. Cholelethiasis

- Consistently asymptomatic,
- No complication of Gall-stone disease.

7. Chronic carriers of HBV & HCV with normal LFT and no evidence of Chronic Liver disease.

8. Benign Hyper Plasia of Prostate (BHP)

- Symptoms well controlled on drugs,
- There is no complication of BHP disease.

9. Fracture of non-weight bearing bones, stress factures & Sprains.

- When there is no pain persisting,
- There is no restriction of Joint mobility

10. Varicose veins

- No pain/ swelling/ulcer
- Uncomplicated.

11. operated cataract

- Corrected vision up to 6/9 BE with glasses not exceeding +/- 3.5D
- Uncomplicated IOL

l) DEMONSTRATED PHYSICAL CAPACITY AND ENDURANCE

For assessing endurance and physical efficiency, the Cooper's 12 minute Run/ Walk test* will be conducted for GOs and Inspectors up to 57 years of age. For NGOs, the performance report in his/her annual JD&PET will be taken into account.

***The Run / Walk Tests**

Such tests measure the basic endurance as well as the aerobic fitness of an individual, having positive correlation with his/her maximum oxygen consumption capacity (VO2).

Coopers 12 minutes Run/ Walk test.

The subject in this case is asked to run (also permitted to walk in between if wishes) for 12 minutes on a level surface and the maximum distance covered is noted to correlate for his/her maximal oxygen uptake capacity. The results of these tests are interpreted as under with due regard to one's age and sex. It is not only a good measure of fitness but also an excellent indicator of progress in physical performance. This test is considered most suitable in our setting.

INTERPRETATION:

Age range (In Years)	**Minimum expected distance must be covered to be certified as qualified:**	
	Male	**Female**
Up to 25	2.8	2.4
26 to 35	2.4	2.0
36 to 45	2.0	1.75
45 to 57	1.75	1.6

(Adapted from Cooper, 1968)

The above yardstick should be applied rationally with due regard for the age of an individual; the criteria being, younger the age, more is the distance to be covered. Beyond 57 years, the running may not be insisted upon. It may be left to the choice of the Officer whether he opts for this or his/her physical Capacity/Stamina be ascertained by employing other tests.

22.6 "E" Factor (Eye Sight) acuity:

This covers acuity of vision, colour vision and field of visions of an individual. A service in the Central Police Forces is concerned with safety of public life, property and therefore high grade of colour perception is considered essential.

Numerical Grading	**Functional Capacity**	**Employability limitations**
E-1	Must have a good eye sight and high colour perception with no ocular pathology. If corrected	Fit for all duties any where

	with conventional spectacles for Myopia or Hypermetropia, power not to exceed 7 diopters. Corrected vision must be: **Better Eye** **Worse Eye** a. 6/6 or 6/36 b. 6/9 or 6/24 c. 6/12 or 6/12	
E-2	Moderate eye sight: Corrected vision with conventional spectacles for myopia or manifest hypermetropia not exceeding 3.5 diopters. Corrected vision must be: 6/9 6/60 (Or less if other eye is aphakic or absent)	Fit for duties anywhere excepting jobs which required very accurate and frequent/rapid firing.
E-3	Adequate eye sight for ordinary purpose. Corrected vision with conventional spectacles or contact lenses. (a) 6/24 6/36 (b) 6/18 Other eye completely Blind or absent.	Fit for duties any where except duties requiring firing/driving.
E-4	In hospital/on leave/rest on medical ground	Temporarily unfit for force duties.
E-5	Acuity of vision below E-3 grade	Permanently unfit for Force Service.

Those diseases of eye not affecting vision must be assessed under "P" factor.

22.7 Intraocular – Lens (IOL)- Implantations in Aphakics and their disposal:

1. Bilateral aphakic and bilateral contact lens wearers will be placed in this grade irrespective of their visual acuity as long as it is not below E-3 grade.

2. All aphakics, weather uniocular or binocular, after IOL implantations, should be observed in E-3(T) for a period of one

year in two spells of six months each. If it is well tolerated with good visual return/binocular vision, and the field or vision, interlobular pressure and fundus are normal wherein corrective glasses required are not more than – 3.5 D in any axis then the following principles and sequence are to be followed:

(a) Uniocular Aphakics (other eye being normal)
i) Left eye with IOL (In Right handed man) - E1 Clasification
ii)Right eye IOL (In Rt. Handed man) - E2 (Permanent)
(b) Biocular Aphakics with IOL both eyes - E2(Permanent)
(c) Biocular Aphakics with one eye IOL and other Eye with or without contact lens but Correctable to 6/12 or more - E3(Permanent)
(d) Biocular Aphakics with IOL in one eye And other eye being absent or with no vision - E3(Permanent) may be awarded but only to highly skilled or professional individuals. In the routine course, such individuals are to be invalided out of service. Exceptional reasons for awarding E-3 classification should be specifically mentioned by the approving authorities.

3. **Bilateral aphakics- individuals with Bilateral Contact lenses.**

(a) E-3 Category: First 6 months (irrespective of the degree of visual acuity and binocular vision, but not below the visual standard of E-3, which is 6/24 vision in the better eye and 6/60 or better but lower than E-2 standard vision in the worse eye)
(b) E-2 Category: (Permanent): Thereafter (Provided the visual standard is that of E-2 which is 6/12 vision in the better eye and 6/30 or better but lower than E-1 standard in the worse eye along with good binocular vision).
(c) E-1 Category: Not to be granted to bilateral- Contact- lenses wearer under any circumstances.

Unilateral Aphakics- Individuals with Unilateral Contact –Lens:

E-1 Category can be granted but only by an Ophthalmologist at a composite hospital	If vision in the better eye is 6/12 or better and vision in the worse eye 6/12 or better along with excellent Biocular vision.

4. **Defective colour vision:** Those with defective colour vision will be categorized E-5

23. SPECIAL REFERENCE FOR LADY OFFICERS IN RELATION TO GYNAE/ OBSTETRICS STATUS (G 1-5) IN ADDITION TO SHAPE CATEGORY.

G-1	No obstetrics or Gynecological problem	Fit for duties any where
G-2	1st & 2nd Trimester of Pregnancy premenopausal/post menopausal syndrome Hormone replacement therapy causing no disability OR Minor disability/discomfort due to fibroid/ovarian tumor/cyst. PID	Fit for routine duties not requiring exertion of running, long walking jumping, climbing. PT Parade and such other duties.
G-3	Dysfunctional uterine bleeding controlled with treatment. Pregnancy with complications like Hypertension, PET, Diabetics bad Obstetrics history etc. Pre menopausal/ Post menopausal syndrome with severe disability. Hormone replacement therapy with complication causing severe disability. Pelvic inflammatory disease (PID) with severe disability. Uncontrolled cases of D.U.B moderate disability due to any Gynae/Obst problem. The officer should normally be placed in G-4 on the completion of 34 weeks of pregnancy.	Fit for duties other than Counter insurgency. Fit only for sedentary duties with treatment facilities existing nearby.
G-4	Delivery and confinement/ hospitalization/rest/ leave on medical grounds	Temporarily unfit
G-5	Severe incapacitation due to Sequels to Gynae/Obst. Problem not amenable to treatment.	Permanently unfit for service. Required to be invalided out.

Note: 1. All the above conditions should be suitably assessed depending on disability and graded accordingly after taking specialist opinion for their employability and restriction of duties/areas etc.

2. The categorization in G-2 and G-3 initially shall be in temporary grade and only after the treatment is completed or on confinement, LMC may be given after assessing the disability.

3. Disability due to these gynecological problems will also reflect in 'P' factor.

Sd/- 15/12/2008
(V.K.Joshi)
DIRECTOR GENERAL,CRPF

No. P.VII/I-2003-Pers.I Dated,the 15 December 2008
Copy forwarded to :

1. The Addl.DG,NWZ & East Zone CRPF.
2. All Sector IsG (including Ops IsG/ RAF/SAF) CRPF and Director/ IGP ISA
3. The IG(Medical) Composite Hospital, New Delhi/Hyderabad/ Guwahati & Jammu.
4. All Range DIsGP,CRPF,including Ops DIsGP/ RAF/SAF
5. The DIsGP(Medical) Composite Hospital CRPF Pallipuram/Chennai/ Bangalore/Pune/Nagpur/Neemuch/Gandhinagar/Ajmer/Rampur/Allahabad/ Muzafarpur/Sindri/Silchar/Bhopal/Bhubaneshwar/Bilaspur/Imphal.
6. All DIsGP,GC,CRPF including SWS/CWS/. Principal CTCs. & RTCs
7. All Commandants including Signal BNs CRPF.

Sd/- 15/12/2008
(Ramesh Chandra)
DIGP (Pers)

INTERNAL
Sr. PS to DG/ADG
IsGP (Pers & HQ)/(Ops & Trg)/(Prov & Works)
Director (Medical)
DIsGP Pers/Adm/Ops/Trg/Legal/Commn.
All Sections of the Dte.

*salesh

APPENDICES

Appendix –'A'

DECLARATION BY THE OFFICIAL TO BE EXAMINED FOR SHAPE CATEGORISATION.

		Please record your answer
1.	Where you examined for any major ailment or hospitalized during last one year?	
2.	Are you a Patient of : a. Hypertension (High Blood pressure) b. Ischaemic heart disease? c. Diabetes Mellitus? d. Chronic cough/Br.Asthma/COPD? e. Epilepsy (Fits)? f. Persistent Headache g. Mental instability?	
3.	Have you suffered from Giddiness at any time?	
4.	Have you suffered from chest pain./Palpitation.	
5.	Did you ever suffered from Tuberculosis?	
6.	Your (a) Appetite (b) Sleep	
7.	Smoking habit (if yes, no. of cigarettes per day).	
8	Alcohol intake (if yes, average quantity per day)	
9.	Any accident/injury/major surgery undergone so far?	
10	Have you been transferred recently or under orders of transfer? If so your a. Previous Unit b. New Unit.	

It is further certified that the above facts stated by me are true to my best knowledge and belief. I have not suppressed any fact concerning my health condition ever in past and as is at present.

Place:
Date:

Signature_____
Name_____ Rank_____
IRLA/F.NO._____
Designation_____
Unit:_____

Appendix – 'B'

INDIVIDUAL HEALTH CARD

HEALTH CARD

IRLA/FORCE NO._____

Rank_____
Name_____
Unit_____

TABLE – I (10 PAGES)
RECORD OF OPD TREATMENT OF DISEASES WHICH LEAVE RESIDUAL DISABILTY/NEEDS ATTEND.C/REST FOR MORE THAN SEVEN DAYS.

1	2	3	4	5
DATE	**PLACE**	**DISEASE**	**REMARKS CATEGORIZATION**	**SIGNATURE**

TABLE – II
RECORD OF ADMISSION IN HOSPITAL

1	2	3	4	5	6	7	8
Station	**Date of admission**	**Date of discharge**	**Duration**	**Disease**	**Particulars/ disease/ disability**	**Categorization**	**Signature of medical officer**

TABLE –III
ANNUAL MEDICAL CHECK UP AND CATEGORISATION

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Station	**Unit**	**Date**	**Height (cms)**	**Wt(Kg)**	**Chest**	**Waist/ hip ratio**	**Pulse & BP**	**S (Psychological)**	**H (Hearing)**	**A (Appendages**	**P (Physical capacity)**	**E (Eye Sight)**	**Final categorization**	**Reason in brief if category is down graded Signature of MOs**

TABLE – IV
RECORD OF VACCINATION TAKEN

Primary vaccination (eg. BCG): Taken Not taken

Tetanus toxoid: Date last Taken:

Hepatitis – B Taken Not taken

Any other optional Vaccination (Please specify):

APPENDIX- 'C'

MEDICAL EXAMINATION PROFORMA FOR OFFICERS AND MEN IN CRPF

1. Name :
2. IRLA/Force No.:
3. Age : 4. Sex: M/F
5. Height (Cms) : 6. Weight(Kg) : 7. Chest (Not for ladies):
On Expiration :
On full inspiration :

8. Abdominal girth: 9. Trans-trochanteric grith :
10. Ration (8/9):

S PSYCHOLOGICLA ASSESSMENT AS LAID DOWN

i) Any past history of psychiatric illness, if so details:
ii) Any history of breakdown/ outburst or taking wrong decisions, indecisiveness leading to public reaction or castigation of civil authority.
iii) History of any alcoholic/ drug abuse.
iv) History of Head injury/infective/ metabolic en-cephalopathy.
v) Objective psychometric scale if any applied and result there of:

CATEGORISATION : S-1 /S-2/ S-3/ S-4/ S-5

H HEARING

i) Normal in both ears
ii) Moderate defect in one ear
iii) Partial defect in both ears
iv) Any other combinations
v) Auroscopy-
vi) Rennie's Test-
vii) Weber's Test-
viii) Audiometry(if indicated)

CATEOGRISATION : H-1/ H-2/ H-3

A APPENDAGES

i) **Upper limb**
ii) Lower Limb
iii) Any loss/infirmity in any joint or part must be indicated in detail.

CATEGORISATION: A-1(U), A-2(U), A-3(U)
A-1(L), A-2(L), A-3(L)

P: PHYSICAL
General examination:
Distance covered in 12 minutes run/walk (Meters):
Body built : BP (mmHg) :

Tongue : **Pulse/mt :**
Anaemia : **Temp(c) :**
Cyanosis :
Icterus : **Respiration :**
Oedema :
Clubbing :
Koilonychia :
Lymph glands palpable: **Tonsils :**
JVP : **Teeth/Denture :**
Thyroid : **Throat :**
Spleen : **Liver :**
C.V.S. : **E.C.G.: Required after age of 45 years.**
S1 **Blood sugar : If applicable**
S2 **Urine exam : In all cases.**
Hb% : In all cases.

Murmur if any:

R-System: **Any deformity of Chest:** **Percussion**
Breath sounds **Adventitious sounds**

C.N.S. **Higher functions:** **Memory (Recent & Remote)**
Intelligence
Personality
Orientation (Time, Place & Person)

Cranial
Meningeal sign if any- **Nerves**

Motor System **Nutrition of muscles** **Wasting-**
Tone
Coordination
Abnormal movement/fasciculation
Power
DTR
Plantar- **Abdominal&Cremasteric Refle-**
Cerebellar Sign **Gower's Sign**

Sensory System-

Reflexes- **Foberg's Sign-** **SLR** **Finger-Toe Test**
Skull & Bone
Addomen: General: Any mass palpable any other abnormality

Piles/ Fissure- Fistula- Prolapse rectum

INVESTIGATION:

1. **Hb%**
2. **Urine examination for all ages**
3. **ECG after age of 45 years: Blood sugar if applicable and for all above 45 years.**
4. **Any other investigation as deemed necessary by examining Medical Board.(i.e. X-Ray Chest, Lipid Profile, Glycosylated Hb etc.)**

I Agree/Do not Agree to under go HIV test **Signature**

CATEGORISATION: P1/ P2 / P3

"E" Factor (Eye sight/Vision)

(a) Distant Vision
(b) Near Vision
(c) Colour Vision
(d) Field of vision
(e) Any other pathology
(f) IOL

CATEGORISATION : E1/ E2/ E3

FINAL CATEGORISATION

ADVICE/EMPLOYABILITY
RESTRICTIONS IF ANY

(NAME OF MEDICAL OFFICER):/BOARD MEMBERS : DESIGNATION/UNIT

APPENDIX-'D'

PROFORMA FOR CERTIFICATE TO BE PRODUCED BY AN APELLANT CHALLANGING THE FINDINGS OF AMA/MEDICAL BOARD REQUESTING FOR REVIEW.

I, Dr._____ certify that I have examined Shri/Smt/Kumari _____., aged_____years of Unit_____ who has been categorized in _____ due to _____. After careful examination and investigation , it is opined that S/He is not suffering from_____. To arrive at this decision, I have examined the relevant of medical documents and conducted necessary investigations.

Seal
Date:

Signature of Medical officer/civil Surgeon
Name/Designation----------
Reg. No._____
Hospital_____

APPENDIX-'E'

Male Average Nude Weight in Kilograms for Different Age Groups and Heights (10% variation on Either Side of Average Acceptable)

Height in cms	Age in Years							
	15-17	18-22	23-27	28-32	33-37	38-42	43-47	48-50
156	48	49	51	52.5	53.5	54	54.5	55
158	49	50	52	54	55	55.5	56	56.5
160	50	51	53	55	56	56.58	57	57.5
162	51	52.5	54.5	56	5705	58	58.5	59
164	52.5	53.5	55.5	57.5	59	59.5	60	60.5
166	53.5	55	57	59	60.5	61	61.5	62
168	55	56.5	58.5	60.5	62	63	63.5	64
170	56.5	58	60	62	64	64.5	65	65.5
172	58	60	61.5	63.5	65.5	66	66.5	67.5
174	59.5	61	63.5	65.5	67.5	68	68.5	69
176	61	62.5	65	67	69	69.5	70	71
178	62.5	64	66.5	68.5	70.5	71.5	72	72.5
180	64	65.5	68	70.5	72.5	73	74	74.5
182	66	67.5	69.5	72	74	75	75.5	76.5
184	67	70	71.5	74	76	76.5	77.5	78
186	69	70.5	73	75.5	78	78.5	79	80
188	70.5	72	75	77.6	79.5	80	81	82
190	72	73.5	76	78.5	80.5	81	82	83

* The body weights are given in this chart corresponding to height (in cms) on even numbers only. In respect of height in between the principle of 'Average' will be utilized for calculating body weights. For calculating average weight of those above the age of 50 years, 0.71 Kg may be added for each 5 years of age in the corresponding height group.

Appendix – 'F'

Female Average body Weights in Kilograms for Different Age Groups & height
(10% variation on either Side of Average Acceptable)

Height in Cms	Age in Years						
	20	25	30	35	40	45	50
148	38.5	41	42.5	44	45	46.5	47
150	40.5	41.5	43.5	45	46	47	48
153	42	43.5	45.5	46.5	48	48.5	49.5
155	43	44.5	46	47.5	49	49.5	50
158	45	46.5	48	49.5	50.5	51.5	52
160	46	47.5	49	50.5	51.5	52.5	53
163	47.5	49	51	52	52	54	55
165	49	50.5	52.5	54	55.5	56	57.5
168	50	52	54	55.5	57	58	59

***** **The body weights are given in this chart corresponding to height(in cms) on even numbers only. In respect of heights in between the principle of 'Average' will be utilized for calculating body weights.**

***** **For calculating average weight of those above the age of 50 years, 0.71 Kg may be added for each 5 years of age in the corresponding height group**