

DEPARTMENT OF HOMELAND SECURITY
UNITED STATES COAST GUARD AUXILIARY

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FLIGHT CREW MEDICAL SCREENING

STANDARD FOR AUXILIARY AVIATION

UNITED STATES COAST GUARD AUXILIARY

NATIONAL RESPONSE DEPARTMENT

AVIATION DIVISION STANDARDIZATION TEAM

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1. SCOPE

A. PURPOSE

This document provides guidance for initial and recurrent medical screening of all Auxiliary Flight Crew members. The goal of medical screening is to improve the safety of flight by decreasing the likelihood of incapacitation of crew members in flight and/or during strenuous activity, such as swim training. Medical screening is intended to bring to light any medical history which may be significant with regard to incapacitation or which may cause problems resulting from stressful activity.

B. APPLICATION

This Standard applies to all Auxiliary candidates for the position of Air Observer (Observer Trainees), all qualified Air Observers and all Auxiliary Air Crew members. Observer Trainees must accomplish this medical screening before beginning the flight training portion of the Auxiliary Air Observer Initial Qualification Syllabus, and before taking the Swim Test required by The Auxiliary Operations Policy Manual, M16798.3E, Annex 2, Section C.2.b.

C. REFERENCES

- a. United States Coast Guard Auxiliary Manual, M16790.1 (series)
- b. United States Coast Guard Auxiliary Operations Policy Manual, M16798.3 (series)
- c. Commandant Instruction 16798.2, The Auxiliary Air Crew Qualification Program

2. DEFINITIONS

Observer Trainee – Candidates for aviation qualification who have successfully passed the Air Operations Test, Level A, the “Pilot/Observer Test”, within the past 24 calendar months.

Auxiliary Air Observers – Auxiliarists who, by virtue of their training and testing in Coast Guard and Auxiliary procedures and practices, have been certified by the Director to exercise the duties of their level of qualification.

Auxiliary Air Crew - Auxiliarists who, by virtue of their advanced training and testing in Coast Guard and Auxiliary procedures and practices, have been certified by the Director to exercise the duties of their level of qualification.

Aviation Medical Examiner (AME) - Private physicians trained and authorized by the Federal Aviation Administration (FAA) to perform airman medical examinations and to issue medical certificates.

Flight Crew – All crew members of Auxiliary aircraft irrespective of level of qualification.

3. SPECIFICATION

AUXILIARY FLIGHT CREW MEDICAL SCREENING PROCEDURE:

1. An Auxiliary member possessing a valid FAA Medical Certificate of any class will be deemed to have satisfied the Medical Screening requirements of the program.
2. The member may chose to obtain the medical screening from a designated Federal Aviation Administration (FAA) Aviation Medical Examiner (AME) or the member's personal physician. If the member uses a designated FAA AME they may apply for an FAA Third Class medical or use the Auxiliary Flight Crew Medical Screening Form (ANSC 7042A).
3. If the member decides to use his or her personal physician, the USCG Auxiliary Flight Crew Medical Screening Form (ANSC 7042A) will be used.
4. After completion of the medical screening, the completed form will be forwarded to the DIRAUX for inclusion in the member's record.
5. If any of the categories in Section 1 (Examination) of the form are answered "no," and/or if any of the categories in Section 2 (Medical History) are answered "yes", the examining physician must provide an explanation of why that condition should not disqualify the member from participating in the program. Such explanation may be written on the ANSC 7042A form (front or reverse side) and/or may be on an attached sheet(s). All forms with such explanations will be forwarded by DIRAUX to National Branch Chief - Air Flight Surgeon (BC-RAA). The BC-RAA will review the form and verify that the member has received appropriate physician's approval for participation in the program. Following such review, the BC-RAA will forward written notification of his findings to DIRAUX.

MEDICAL CURRENCY:

The medical screening will be valid for 24 months for members 40 and older, and 36 months for members under 40, Members must have a valid medical screening on file to maintain their certification as Observers or Air Crew.

IMPLEMENTATION:

The requirements of this document are effective immediately upon publication by CG-5421.

4. APPENDIX

The revised USCG Auxiliary Flight Crew Medical Screening Form (ANSC 7042A) is attached.

UNITED STATES COAST GUARD AUXILIARY AVIATION PROGRAM

FLIGHT CREW MEDICAL SCREENING FORM

Date of Examination_____

Applicant Name_____

Auxiliary Number_____

DOB_____

AFTER COMPLETION OF THE MEDICAL SCREENING PLEASE
FORWARD THE COMPLETED FORM AS DIRECTED

Note to the physician:

This member of the US Coast Guard Auxiliary has come to you for an evaluation of basic health and condition, with specific information sought in certain areas which have a direct applicability to the member's potential performance and safety during the conduct of missions.

In addition to the data requested on the form, your judgment is sought regarding the member's ability to tolerate long flights (3 to 5 hours duration) in small aircraft and their ability to successfully egress from the aircraft and swim to a raft in the event of an emergency. Members must be capable of completing an annual drill in which they must swim 75 yards fully clothed and then climb into a raft.

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Section 1 - Examination

Please examine the member in each category below and circle the appropriate answer. For any "No" answers in this section, please explain (on the reverse of this form if necessary) why that condition should not disqualify the member from participating in the program.

Distant Vision – 20/40 or better in each eye with or without correction - Yes / No

Near Vision - 20/40 or better in each eye at 16 inches -- Yes / No

Color Vision - Able to discern Red, Green, & Yellow - Yes / No

Hearing - Hearing average conversational voice in a quiet room
Using both ears at 6 feet, with the back tuned to the examiner - Yes / No

Or -- Pass the audiometric test below.

Audiometry - Pure tone audiometric test: Unaided, no worse than:

	500 HZ	1000 HZ	2,000 HZ	3.000 HZ	
Better Ear	35 Db	30 Db	30 Db	40 Db	
Worst Ear	35 Db	50 Db	50 Db	60 Db	Yes / No

ENT - Absence of any ear condition manifested by vertigo or a disturbance of speech or equilibrium. - Yes / No

Pulse - Normal - Yes / No

Blood Pressure - Not over 155/95 with ___ or without ___ medication
Medication(s): _____ Yes / No

Mental - Absence of psychosis, bipolar disorder, or severe personality disorders - Yes / No

Substance Dependence and Substance Abuse – Absence of a diagnosis of substance dependence or established evidence of recovery, including total abstinence from the substance(s) for not less than the preceding 2 years. ("Substance" includes, PCP, sedatives, hypnotics, anxiolytics, marijuana, cocaine, opioids, amphetamines, hallucinogens, and other psychoactive drugs or chemicals.) Yes / No

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Section 2 – Medical History

Medical History Requiring Explanation - For any “Yes” answers in this section, please explain (on the reverse of this form if necessary) why that condition should not disqualify the member from participating in the program.

History of:

- | | |
|--|----------|
| 1. Diabetes Mellitus requiring medication - | Yes / No |
| 2. Angina Pectoris - | Yes / No |
| 3. Coronary heart disease being treated, is symptomatic or clinically significant . - | Yes / No |
| 4. Myocardial Infarction - | Yes / No |
| 5. Cardiac Valve Replacement - | Yes / No |
| 6. Permanent Cardiac Pacemaker - | Yes / No |
| 7. Heart Replacement - | Yes / No |
| 8. Epilepsy - | Yes / No |
| 9. Disturbance of Consciousness -
(without satisfactory explanation of cause) | Yes / No |
| 10 Transient Loss of Control of Nervous System Functions -
(without satisfactory explanation. of cause) | Yes / No |

Additional comments:

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Your signature on this form indicates your judgment that this member is capable of participating in the program as described above without undue risk to themselves and/or others due to their medical history and condition.

Please sign the form attesting to your findings and return the completed form to the examinee.

Signed _____ M.D./ D.O.

Name _____

Address _____

Phone _____

Additional comments: