UNITED STATES AIR FORCE
GROUND ACCIDENT INVESTIGATION
BOARD REPORT

375th FORCE SUPPORT SQUADRON
375th AIR MOBILITY WING
SCOTT AFB, ILLINOIS

TYPE OF ACCIDENT: Fitness Assessment Test Fatality

LOCATION: Scott AFB, Illinois

DATE OF ACCIDENT: 26 October 2015

BOARD PRESIDENT: COLONEL MICHAEL J. WOOD, USAF

Conducted IAW Air Force Instruction 51-503

ACTION OF THE CONVENING AUTHORITY 25 MAR 2016

The report of the ground accident investigation board, conducted under the provisions of AFI 51-503, that investigated the 26 October 2015 fitness assessment test fatality that occurred at Scott Air Force Base, Illinois, complies with applicable regulatory and statutory guidance and on that basis is approved.

\\signed\\

ROWAYNE A. SCHATZ, JR.
Major General, USAF
Vice Commander

United States Air Force Ground Accident Investigation Board Report
Scott AFB, Illinois

EXECUTIVE SUMMARY
UNITED STATES AIR FORCE
GROUND ACCIDENT INVESTIGATION

FITNESS ASSESSMENT TEST FATALITY
SCOTT AFB, ILLINOIS
26 OCTOBER 2015

On 26 October 2015, at Scott Air Force Base (AFB), Illinois, during the 0600 hours local (L) Air Force physical fitness assessment (FA) session, a 34 year old active duty technical sergeant (hereinafter referred to as Member of Concern (MOC)), collapsed to the running track during the last lap of the run component of his FA test. He had previously passed the waist measurement, push-up and sit-up components of his physical fitness assessment with maximum points in each component category. A Scott AFB Fitness Assessment Cell (FAC) member (FAC 1) saw MOC collapse to the track and immediately ran over to where MOC was lying on the track to render him assistance.

As he was lying on the track, MOC told FAC 1 that he had cramps and that his legs hurt. After spending approximately 5 minutes with MOC, FAC 1 determined that additional medical assistance was necessary. He called 9-1-1 at 0711 hours. Emergency medical service (EMS) personnel arrived to the Scott AFB FA track at 0719 hours. EMS personnel provided on-scene medical assistance to MOC and ultimately transported him by ambulance to St. Elizabeth's Hospital, a nearby civilian hospital. MOC departed the Scott AFB track at 0735 hours and arrived to St. Elizabeth's Hospital at 0748 hours.

MOC was admitted to St. Elizabeth's Hospital with a fever and a diagnosis of rhabdomyolysis (breakdown of muscle fibers), acute kidney injury and severe metabolic acidosis (acid imbalance falling below normal levels), but the underlying factor for these medical conditions was not initially known. Over the next several hours, MOC's doctors consulted several medical specialists in order to determine the best courses of treatment. By 27 October 2015, MOC's doctors began to think that sickle cell trait (SCT) was involved as the potential underlying factor for his conditions. Over the next two days, MOC's condition continued to deteriorate as the rhabdomyolysis continued despite medical interventions. MOC died on 29 October 2015 surrounded by family and co-workers. A post-mortem autopsy concluded that MOC died from natural causes due to complications of SCT.

United States Air Force Ground Accident Investigation Board Report
Scott AFB, Illinois

SUMMARY OF FACTS
Fitness Assessment Test Fatality
26 October 2015

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ACRONYMS AND ABBREVIATIONS

AF	Air Force
AFB	Air Force Base
AFI	Air Force Instruction
ALS	Airman Leadership School
AMC	Air Mobility Command
BMT	Basic Military Training
Capt	Captain
Col	Colonel
DEERS	Defense Enrollment Eligibility Reporting System
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMT-B	Emergency Medical Technician Basic
EMT-P	Emergency Medical Technician Paramedic
ER	Emergency Room
FA	Fitness Assessment
FAC	Fitness Assessment Cell
FAC 1	FAC Member 1
FAC 2	FAC Member 2
FSQ	Fitness Screening Questionnaire
GAIB	Ground Accident Investigation Board
IAW	In Accordance With
L	Local
Lt Col	Lieutenant Colonel
Maj	Major
MAJCOM	Major Command
M.D.	Medical Doctor
MOC	Member of Concern
MPH	Miles Per Hour
NCO	Non-Commissioned Officer
NCOIC	Non-Commissioned Officer in Charge
NOK	Next-of-Kin
SCT	Sickle Cell Trait
SGLI	Servicemember's Group Life Insurance
TSgt	Technical Sergeant
USAFA	United States Air Force Academy
vRed	Virtual Record of Emergency Data
18 AF	18th Air Force
375 AMW	375th Air Mobility Wing
375 FSS	375th Force Support Squadron

The above list was compiled from the Summary of Facts, the Index of Tabs, and Witness Testimony (Tab V).

United States Air Force Ground Accident Investigation Board Report
Scott AFB, Illinois

SUMMARY OF FACTS

1. AUTHORITY AND PURPOSE

a. Authority

On 6 November 2015, Major General Rowayne A. Schatz, Jr., Vice Commander, Air Mobility Command, appointed Colonel (Col) Michael J. Wood, M.D., as Board President of a Ground Investigation Board (GAIB) to investigate the on-duty fatality of an active duty technical sergeant (TSgt) (hereinafter referred to as Member of Concern (MOC)), who died following an Air Force (AF) physical fitness assessment (FA) test (Tab Y-3). The GAIB was conducted in accordance with (IAW) Air Force Instruction (AFI) 51-503, *Aerospace and Ground Accident Investigations*, dated 14 April 2015. The GAIB was conducted from 9-13 November 2015 and 7-16 December 2015. There was a break in the GAIB meeting in order to wait for receipt of autopsy and other important medical records. Additional members of the GAIB included a lieutenant colonel (Lt Col) medical member, a major (Maj) legal advisor, and a civilian paralegal (Tab Y-5 and Y-7).

b. Purpose

IAW AFI 51-503, *Aerospace and Ground Accident Investigations*, this investigation board conducted a legal investigation to inquire into all the facts and circumstances surrounding this Air Force ground accident, prepare a publicly releasable report, and obtain and preserve all available evidence for use in litigation, claims, disciplinary action, and adverse administrative action.

2. ACCIDENT SUMMARY

On 26 October 2015, at approximately 0545 hours local (L), MOC, a 34-year old active duty AF TSgt assigned to the 375th Force Support Squadron (375 FSS), 375th Air Mobility Wing (375 AMW), Scott Air Force Base (AFB), Illinois, reported to the Scott AFB Fitness Assessment Cell (FAC) located at James Gym to complete his 0600 hours FA test session (Tabs T-13, V-1.4, V-2.5, V-6.5, X-7, and AA-5). At James Gym, MOC's height and weight were measured and recorded (Tab T-13). At James Gym, MOC also completed the abdominal circumference, push-up and sit-up components of the FA test (Tabs T-13 and V-1.5). MOC then proceeded to a nearby track to complete the FA's 1.5 mile run component (Tabs V-1.5 and V-6.3). On the last lap, approximately 80-100 yards from the finish line of the 1.5 mile run, MOC collapsed to the track (Tabs V-1.5 to V-1.6 and V-6.3). MOC's push-up and sit-up FA partner (hereinafter FA partner) from James Gym and FAC Member 1 (FAC 1), who was administering the test, saw MOC fall to the track; his FA partner continued his run and FAC 1 immediately sprinted over to MOC to render assistance (Tabs V-1.5 and V-6.4). As he was lying on the track, MOC told FAC 1 that he had cramps and that his legs hurt (Tab V-1.5). He continued to evaluate MOC to determine if he needed additional medical assistance (Tab V-1.5 to V-1.7). At 0711 hours, approximately 5 minutes after MOC collapsed, FAC 1 called 9-1-1 (Tab V-1.6 to V-1.7). At 0719 hours, an ambulance with an Emergency Medical Technician (EMT) Paramedic and EMT Basic arrived to the Scott AFB track (Tabs V-7.2, Z-2, and DD-9 to DD-12). The EMTs walked

over to where MOC was lying on the track and made initial contact at 0721 hours (Tab DD-9 to DD-12). MOC was transported to St. Elizabeth's Hospital by an Emergency Medical Services (EMS) ambulance at 0735 hours and arrived to the hospital at 0748 hours (Tabs X-7 and DD-9 to DD-11). Over the next two and a half days, MOC received specialized medical care at St. Elizabeth's Hospital, but his medical conditions continued to deteriorate, and he died on 29 October 2015 (Tab X-8 to X-10). A post-mortem autopsy concluded that MOC died from natural causes due to complications of Sickle Cell Trait (SCT) (Tab X-10).

3. BACKGROUND

a. Air Mobility Command (AMC)

AMC's primary mission is to provide global air mobility, providing right effects, at the right place and right time (Tab CC-3). AMC provides worldwide cargo and passenger delivery, air refueling, and aeromedical evacuation (Tab CC-3). The command also plays a crucial role in providing humanitarian support at home and around the world (Tab CC-3).

b. 18th Air Force (18 AF)

18 AF's mission is to present air mobility forces to combatant commanders (Tab CC-5). It is charged with carrying out AMC's operational role as Air Forces Transportation, the air component of United States Transportation Command (Tab CC-5).

c. 375th Air Mobility Wing (375 AMW)

375 AMW's mission is to provide mission-ready Airmen and capabilities to enable rapid global mobility (Tab CC-7). It is also the host wing for AMC, United States Transportation Command, the 618th Air and Space Operations Center, the Air Force Network Integration Center, and numerous other partner units (Tab CC-7). The 375 AMW Wing (Installation) Commander overseas the AF FA program at Scott AFB (Tab BB-10).

d. 375th Force Support Squadron (375 FSS)

375 FSS provides quality of life services to the men and women of Scott AFB, their families, and the local community and surrounding seven-state region (Tab CC-13). 375 FSS also provides personnel, services, manpower, education, training, family support, and enlisted professional enhancement to the military, civilian, and family members assigned to Scott AFB during peacetime and contingency operations (Tab CC-13). The squadron organizes and executes the entire personnel portion of the deployment machine--training, processing, deployment and redeployment--resulting in a well-trained, rapid-response, war-ready force that keeps boots on the ground in theater and our homeland secure (Tab CC-13).

e. St. Elizabeth's Hospital, Belleville, Illinois

St. Elizabeth's Hospital has provided medical care to the Belleville, Illinois community (approximately 11 miles from Scott AFB) since 1865 (Tabs CC-19 and DD-15). St. Elizabeth's is affiliated with the Hospital Sisters Health Systems, which has 14 total hospitals in Illinois and Wisconsin (Tab CC-19 and CC-21). St. Elizabeth's is a teaching hospital affiliated with Saint Louis University Family Medicine Residency Program and Scott AFB's family practice residency program (Tab DD-15). St. Elizabeth's has an emergency room (ER), surgery center (to include neurology, pulmonary, vascular), and has other medical specialists on staff capable to treat SCT trait patients (Tabs X-8 and CC-20). In 2015, St. Elizabeth's was recognized as being in the top 50 cardiovascular hospitals in the United States (Tab CC-23).

f. Air Force Physical Fitness Assessment Test Program

Air Force members must remain physically fit (Tab BB-9). The Air Force assesses physical fitness by requiring Airman to complete an age and gender specific FA test (Tab BB-14). The Scott AFB FAC administers the Air Force FA test (Tabs V-1.1 and BB-10). The Air Force FA test is comprised of three components: 1) aerobic fitness (1.5 mile run or 2.0 kilometer walk), 2) body composition (abdominal circumference measurement), and 3) muscular fitness (push-ups and sit-ups)(Tab BB-14). Height and weight information of each Airman is collected, but a Body Mass Index test is completed only if the Airman fails the body composition component (Tab BB-19). Each component is scored based upon the Airman's performance for that component (e.g., faster run times are awarded more points)(Tab BB-23). Each component also has minimum requirements and/or maximum points (Tab BB-40). A total of 75 points out of 100 points is the minimum score necessary to pass the FA test (Tab BB-22). Airmen test biannually if their last FA test score was 75-89 points of 100 points and test annually if their last FA test score exceeded 90 points out of 100 points (scoring over 90 points is called an "excellent" score)(Tab BB-22 and BB-24). If the Airman has documented medical reasons exempting them from completing certain portions of the test (e.g., not run/walk or do sit-ups), that Airman tests on a medical profile, and they must take their next FA test within 6 months of the expiration of an Airman's medical profile (Tab BB-24).

g. Sickle Cell Trait (SCT)

SCT is an inherited condition in which an individual possesses both a normal (A) and abnormal (S) copy of the hemoglobin gene (Tab X-4). SCT is different from Sickle Cell disease in that it is often considered a benign condition that generally does not decrease life expectancy as compared to individuals without SCT (Tab X-5). Because there are usually no symptoms of SCT, most people find out they have SCT only through a blood test (Tab X-5).

Individuals with SCT have an increased risk for some kidney and urinary complications, including episodes of blood in the urine, urinary tract infections, chronic kidney disease and a rare form of kidney cancer (Tab X-4 to X-5). Individuals with SCT usually can safely participate in normal physical activity and sports (Tab X-5). However, exercise-related collapse is a rare but serious complication of SCT (Tab X-5). According to recent medical literature, exertion-induced hypoxia (oxygen deficiency in the blood cells) may initiate a chain of events inducing blood sickling (Tab X-5). Unlike normal red blood cells that are round and can easily

pass through blood vessels, sickled red blood cells are rigid and can block blood vessels (Tab X-5). This may lead to muscle rhabdomyolysis (the rapid breakdown of muscle tissue starved of blood), leading to blood chemistry problems and potentially sudden death (Tab X-5). High temperature and humidity, high altitude, an individual's poor conditioning, poor hydration, age, and high-intensity exercise have been suggested as being factors in causing blood sickling (Tab X-5). However, at times, no identifying risk factors are evident (Tab X-5).

Testing for SCT in the military has a long history, starting in the late 1960's (Tab X-5). In military populations, studies have shown that exercise-related deaths are 30-40 times higher in those with SCT compared to those without SCT (Tab X-5). Currently, each military service has its own policy on how to respond to SCT (Tab DD-17). The Air Force tests for SCT after accession at initial military training (Tabs X-5). At Basic Military Training (BMT), Airmen identified as being SCT positive are required to wear a white reflective armband during all BMT activities (Tabs X-5 and BB-51 to B-53). At the United States Air Force Academy (USAFA), SCT positive individuals are identified and monitored by staff; however, there are no visible identifiers during USAFA training (Tabs X-5 and Tab BB-56). At the time of the mishap, there was no Headquarters Air Force-level policy for post-BMT SCT mitigation strategies beyond those mitigation strategies briefed to trainees/cadets during training (Tabs X-5 and BB-67). According to DoDI 6465.01, dated 17 July 2015, the Air Force has been required to develop a comprehensive SCT screening policy related to, among other things, developing medical education programs that address the nature of the condition with associated risk factors and activities (operational, environmental, and recreational), to include SCT mitigation and self-awareness strategies (Tab BB-67). The Air Force meets the screening requirement of DoDI 6465.01 by screening appropriate members during initial military training (Tab BB-67). The policies for these programs are found in 737 TRG Operating Instruction 36-3, Basic Military Training (BMT), dated 17 March 2015 and in 10 MDGI 44-9, Cadet Sickle Cell Trait Screening Program, dated 16 April 2014 (Tab BB-67).

Additionally, there is reference to SCT in the Fitness Screening Questionnaire (FSQ) filled out by every Airman prior to taking an FA (Tab T-9). Question 1 of the FSQ asks whether the Airman had a medical condition (and SCT was one of the conditions listed) that "had not been evaluated, treated, or addressed" in a medical profile "that may prevent [Airman] from safely participating in this test" (Tab T-9). If the Airman checks the "yes" box, then he/she is to be evaluated by a medical professional (Tab T-9). If the Airman checks the box "no," then the FSQ directs the Airman to answer additional questions, which may or may not require medical evaluation and/or result in the Airman not taking the FA on the date scheduled (Tab T-9).

h. Acute Rhabdomyolysis

Acute Rhabdomyolysis is a potentially life-threatening medical condition resulting from the breakdown of skeletal muscle fibers with corresponding leakage of muscle contents into the blood circulation (Tab X-6). The most common causes are crush injury, overexertion, alcohol abuse and certain medicines and toxic substances (Tab X-6). Multiple complications can occur and are classified as early or late (Tab X-6). Early complications include severe hyperkalemia (high potassium in the blood) that causes cardiac arrhythmia (problems with heart rhythms) and arrest (heart stops beating)(Tab X-6). The most serious late complication is acute renal failure (kidneys stop working), which is common and occurs in approximately 15 percent of patients

with the syndrome (Tab X-6). Compartment syndrome can be an early or late complication of rhabdomyolysis, and occurs when the muscle swells more than allowed by the tight connective tissue and other structures around it (Tab X-6). Early recognition of rhabdomyolysis and prompt management of complications are crucial to a successful outcome (Tab X-6).

4. SEQUENCE OF EVENTS

a. Summary of Accident

On 26 October 2015, at approximately 0545 hours, MOC reported to the Scott AFB FAC located at James Gym to complete his FA test (Tabs T-13, V-1.4, V-2.5, V-6.5, X-7, and AA-5). MOC, along with 11 other FA participants (12 participants total), participated in the 0600 hours block of testing (Tab AA-5 to AA-7). Prior to beginning his FA test, MOC filled out an FSQ, on which he indicated no medical concerns (Tab T-9 to T-10). At James Gym, MOC's height (66 inches) and weight (191 pounds) were measured and recorded (Tabs T-13 and BB-43). At James Gym, MOC also completed the abdominal circumference, push-up and sit-up components of the FA test, achieving maximum points associated with each component category (34.5 inches abdominal circumference, 61 push-ups and 57 sit-ups)(Tab T-13). MOC did not complain of any pain or discomfort before or during the testing completed at James Gym, nor were any physical abnormalities noticed by FAC personnel, his FA partner, or observed on video taken during the FA (Tabs V-1.4 to V-1.6, V-6.2 to V-6.3, and DD-5).

MOC, along with other FA test participants, then walked approximately two blocks to the track to complete the 1.5 mile run component of the FA test (Tab V-6.3). MOC had completed 5 of 6 laps of the run and was approximately 80-100 yards from the run finish line when MOC's FA partner and FAC 1, one of FA test administrators, observed MOC stop his run and collapse to the track (Tabs V-1.6, V-6.3 to V-6.5, and X-7). MOC's FA partner was running behind MOC at the time MOC stopped his run and collapsed to the track (Tab V-6.3 to V-6.4). Based upon his overall run time and how far ahead MOC was ahead of him at the time of his collapse, MOC's FA partner believed that MOC would have finished his run in approximately 13 minutes and 15 seconds (13:15) had MOC continued running to the finish line; accordingly, MOC would have passed his FA test with 82.3 points had he clocked a 13:15 run time (Tabs T-13, V-6.4 to V-6.5 and BB-43). MOC's FA partner did not hear any cries of pain or visible signs of physical injury by MOC when he passed MOC on his way to finish his FA test (Tab V-6.4).

MOC collapsed to the track at approximately 0706 hours (Tab V-1.4 and V-1.7). FAC 1 sprinted the short distance from the start/finish line of the run to where MOC collapsed (Tabs V-1.5 and V-6.4)*(see* Figure 1). An unidentified individual not participating in the FA test also stopped and was with MOC and FAC 1 while MOC was lying on the track (Tab V-1.5). FAC Member 2 (FAC 2) initially stayed at the run start/finish line to record other FA participants' run times (Tab V-1.5 to V-1.6).

(Figure 1) Scott AFB FA Test Running Track (Tab Z-2)

FAC 1 asked MOC what the problem was, as he had collapsed to the track (Tab V-1.5 to V-1.6). MOC, who was concerned that he had only a little more to finish the run, told FAC 1 that he had cramps and that his legs hurt (Tab V-1.5 to V-1.6). Over approximately the next 5 minutes, FAC 1 observed MOC either lying on his back or rocking back and forth onto his hips while still lying on the ground (Tab V-1.6 to V-1.7). FAC 1 verified MOC was responsive and checked MOC's pupils, which looked normal (Tab V-1.5). However, FAC 1 believed at that time MOC did not look right (Tab V-1.6 to V-1.8). MOC requested FAC 1 not contact 9-1-1, but FAC 1 made an independent decision to do so, as MOC was not getting any better and FAC 1 determined that MOC needed medical assistance he could not provide (Tab V-1.6 to V-1.8).

FAC 1 called 9-1-1 at approximately 0711 hours and was subsequently three-way conference called into EMS to explain the circumstances of MOC's condition (Tabs V-1.6 to V-1.8 and DD-9). EMS was dispatched from Scott AFB Fire Station #1 at 0715 hours (Tabs V-7.2 and DD-9). FAC 1 remained on the phone with the 9-1-1 operator while an EMS ambulance was in route to the Scott AFB track (Tab V-1.7). At 0719 hours, an EMS ambulance with an EMT Paramedic (EMT-P) and EMT Basic (EMT-B) arrived to a parking lot near the Scott AFB track (Tabs V-7.2 and DD-9 to DD-10). They walked across the track to where MOC was lying and made contact with MOC at 0721 hours (Tabs V-7.2 and DD-9 to DD-12).

Upon contact with MOC at 0721 hours, EMT-P noted that MOS appeared confused but could obey EMS verbal commands (Tabs V-7.3 and DD-9 to DD-12). He also complained of leg pain in both legs (Tabs V-7.3 and DD-9 to DD-12). EMS personnel rendered standard on-scene emergency care including medical assessment, blood glucose test and oxygen to MOC (Tab X-8 and V-8.3). By 0735 hours, MOC became unresponsive to EMS commands and he was transported to St. Elizabeth's Hospital by EMS ambulance at 0735 hours (Tabs V-7.3 and DD-9 to DD-12). MOC arrived to St. Elizabeth's Hospital at 0748 hours (Tab V-7.3 and DD-9 to DD-12).

Upon arrival to the St. Elizabeth's Hospital ER, MOC received immediate care for his condition (Tab X-8). MOC's condition improved briefly with medical treatment, but he then started to

deteriorate (Tab X-8). MOC was admitted to St. Elizabeth's Hospital with a fever and a diagnosis of rhabdomyolysis, acute kidney injury and severe metabolic acidosis (acid imbalance falling below normal levels), but the underlying condition for these medical problems was not known at that time (Tab X-8 to X-9).

Throughout the morning and early afternoon of 26 October 2015, MOC's supervisor at the Airman Leadership School (ALS), MOC's duty location, and MOC's wife attempted to contact MOC on his cell phone and by text message (Tabs V-3.8 and Tab V-5.5). They were ultimately not successful in contacting MOC, which was initially not surprising to either of them at the time because MOC did not always carry his cell phone with him (Tabs V-3.8 and Tab V-5.5). Unbeknownst to them at the time, MOC was at St. Elizabeth's Hospital (Tabs V-3-8 and Tab V-5.5).

Sometime between 1300-1400 hours, after not hearing from MOC, MOC's supervisor contacted her squadron's command section to inquire about MOC (Tab V-5.5 to V-5.6). She spoke with the Acting First Sergeant (Tab V-5.5 to V-5.6). At 1356 hours, the Scott AFB FAC emailed MOC's command section with a generic "injury/illness" notice (although attached to the email was a copy of MOC's FA scorecard, on which was written "Member taken away by ambulance[,] no feeling in legs." (Tabs T-13 and AA-3). On 26 October 2015, there was no specific training or policy at Scott AFB for any other notification to leadership other than the e-mail at the time of the mishap (Tab DD-18). The Acting First Sergeant then realized at this time that the individual who had collapsed during his 0600 hours FA test (the Acting First Sergeant and MOC tested in the same session) was in his squadron (Tab V-2.6). The Acting First Sergeant contacted the Scott AFB FAC for more information on MOC's condition, but the Scott AFB FAC did not have any more information (Tab V-2.7). Sometime after the Acting First Sergeant contacted FAC for more information about MOC's status, MOC's Acting First Sergeant was contacted by St. Elizabeth's Hospital staff looking for contact information for MOC's next-of-kin (NOK) (Tab V-2.7 to V-2.8). The Acting First Sergeant then looked into various Air Force records systems (to include Virtual Record of Emergency Data (vRed), Servicemember's Group Life Insurance (SGLI), and Defense Enrollment Eligibility Reporting System (DEERS)) for more information (Tabs V-2.8 to V-2.9 and Tab V-5.6 to V-5.7).

Due to some of the contact information being outdated and MOC's wife being at work and not at home to answer her home phone, it took until about 1630 hours for MOC's mother to be contacted at her house, which was located in the Scott AFB area (Tabs V-2.9 to V-2.10, V-3.8, and V-5.5 to V-5.6). MOC's mother then called MOC's wife at work to notify her of MOC's condition (Tab V-5.7). En-route to St. Elizabeth's Hospital (about 1 hour drive away from MOC's wife's workplace), staff from St. Elizabeth's Hospital called MOC's wife to obtain verbal authorization to continue ongoing medical treatments and start new treatments to include kidney dialysis on MOC; MOC's wife granted the request (Tab V-3.9). As requested by St. Elizabeth's Hospital, MOC's wife went to her house to pick up the prescription medicine MOC was currently taking, and then proceeded to the hospital to be with MOC (Tab V-3.9). She arrived to St. Elizabeth's Hospital sometime after 1700 hours (Tab V-3.8 to V-3.10). MOC's commander, ALS supervisor, and ALS coworker were already at St. Elizabeth's Hospital when MOC's wife arrived to the hospital (Tab V-3.10).

In the hours post-arrival to the ER, MOC's doctors consulted several medical specialists in order to determine the best courses of treatment (Tab X-8 to X-9). Because of the emergent nature of MOC's condition, the staff at St Elizabeth's did not delay MOC's treatment in order to wait for family contact (Tab X-8). Once they contacted MOC's wife, they obtained her approval for their prior treatment and authorization to continue with their plan to initiate kidney dialysis (Tab X-9). MOC's treatment was not impacted by the delay in obtaining verbal authorization to continue their treatment from MOC's wife (Tab X-9).

Kidney dialysis was started the evening of 26 October 2015 as part of a comprehensive medical treatment program (Tab X-9). By the next morning, 27 October 2015, MOC was poorly responsive to commands and continued to have significant medical issues due to the rhabdomyolysis (Tab X-9). Medical records show around this time, MOC's doctors began to think that SCT was involved as a potential underlying condition for his medical problems (Tab X-9). MOC's doctors were apparently aware that he had SCT sometime on 26 October 2015, but the first annotation of SCT in MOC's medical records was 27 October 2015 (Tabs V-3.11 and X-9). Nevertheless, he was receiving appropriate medical care before SCT was positively identified (Tab X-9). Due to MOC's medical providers' refusing to testify, the precise timing of when and how MOC's doctors identified SCT as being relevant could not be addressed further during the investigation (Tab DD-15).

As a result of rhabdomyolysis, MOC's legs began to swell and his doctors performed surgery and other medical procedures to attempt to decrease internal pressure from MOC's leg muscles swelling on the evening of 27 October 2015 (Tab X-9). Rhabdomyolysis caused other medical complications as well (Tab X-9). These medical interventions provided some relief to MOC (to include being able to briefly exchange limited verbal communication with his wife and co-worker), but MOC continued to deteriorate and continued to have swelling in the legs (Tabs V-3.12 and V-5.9 and Tab X-9). Swelling also started to occur in MOC's arm muscles (Tab X-10). On 28 October 2015, MOC had a second surgery to decrease leg and arm muscle swelling (Tab X-10). That same day, MOC's liver and kidney also started to fail (Tab X-10). Over the next 24 hours, medical staff continued treating MOC in the intensive care unit; however, MOC's condition continued to deteriorate (Tab X-10). MOC died on the morning of 29 October 2015 in the presence of family and co-workers (Tabs V-3.12 to V-3.13 and Tab X-10).

A post-mortem autopsy reported that MOC died from complications of SCT (Tab X-10).

b. Impact

Not applicable.

c. Search and Rescue

Not applicable.

d. Recovery of Remains

Not applicable.

5. MAINTENANCE

A civilian ambulance and civilian medical equipment were used post-mishap (Tab V-7-1 to V-7.2). Accordingly, there are no Air Force maintenance issues to evaluate.

6. EQUIPMENT, VEHICLES, FACILITIES, AND SYSTEMS

A civilian ambulance and civilian medical equipment were used post-mishap (Tab V-7.1 to V-7.2). Accordingly, there are no Air Force equipment, vehicles, facilities and/or systems to evaluate. EMS personnel responded promptly to the 9-1-1 call (Tab V-7.2). There is no evidence that EMS equipment, vehicles, or system were a factor in this mishap.

7. ENVIRONMENTAL CONDITIONS

a. Forecast Weather

Forecast temperature at 0600 hours on 26 October 2015 was 39 degrees Fahrenheit and 6 knots of winds from the northeast (Tab W-3).

b. Observed Weather

Sunrise on 26 October 2015 was 0720 hours and skies were clear (Tab W-3). Observed temperature at 0700 hours was 43 degrees Fahrenheit and 5 knots of wind from the northeast (Tab W-3).

c. Other Environmental Conditions

Not applicable.

d. Restrictions, Warnings, and Procedures

IAW AFI 36-3209, *Fitness Program*, Paragraphs A6.2.13 and A6.2.14, in order to conduct a FA outside, the air temperature must exceed 20 degrees Fahrenheit and wind speed cannot exceed 15 miles per hour (MPH) sustained or 20 MPH gusting (Tab BB-40). As the FA test was administered within weather standards, there is no evidence to suggest that weather was a factor in this mishap.

8. PERSONNEL QUALIFICATIONS

a. MOC

MOC was a highly regarded member of the 375 FSS (Tab V-4.1 to V-4.2 and V-5.2). His commander described him as possessing "impeccable character" and "providing a consistent example of what we would have for an [Non-Commissioned Officer (NCO)] and a leader" (Tab V-4.2). ALS students also held him in high regard, citing him as a role model and one they would look up to (Tab V-4.1 to V-4.2 and V-5.2). In his 11 years of Air Force Service, MOC

earned 2 Air Force Achievement Medals and 3 Air Force Commendation Medals, one of which was from a combat deployment to Iraq (Tab DD-8). Additionally, in his 11 years of service, MOC had never failed a FA (Tab T-7). In his last seven FAs, MOC had never scored lower than 85 points; and his most recent FA (April 2015) to the date of the mishap was 92.5 points (excellent score)(Tab T-3 and T-7). During his April 2015 FA, MOC was exempt from one component for a medical condition not related to this mishap (Tabs V-5.4 and X-5).

b. EMT Personnel

Initial medical response was from a civilian ambulance service stationed at Fire Station #1, Scott AFB. (Tab V-7.2) The ambulance was staffed by a civilian EMT-P and a civilian EMT-B (Tabs V-7.1 to V-7 and V-8.1 to V-8.3). The EMT-P was certified and licensed as a paramedic, and was current in all appropriate training requirements (Tab V-7.1 to V-7.2). The EMT-B was certified and licensed as an emergency medical technician basic, meaning he had not been certified as a paramedic, and was current in all appropriate training requirements (Tab V-8.1 to V-8.2). There is no evidence to suggest ambulance crew qualifications were a factor in this mishap.

c. Treating Physicians

St. Elizabeth's Hospital is accredited by The Joint Commission, a hospital accreditation body (Tab CC-25). This accreditation, which was recently renewed in September 2013, is granted following Joint Commission's evaluation of the hospital's performance in patient safety, quality of care and other key areas (Tab CC-25). MOC's primary attending physician was credentialed at St. Elizabeth's Hospital, attended medical school and residency at the University of Missouri-Columbia, was board certified in family practice, and currently licensed in Illinois (through 2017) and Missouri (through 2016) (Tab DD-15). All other physicians treating MOC at various times were appropriately licensed and privileged (Tab DD-15). The Board made multiple attempts to contact the treating physicians but they declined to be interviewed (Tab DD-15). The Board was not able to compel them to provide testimony in accordance with AFI 51-503, paragraph 6.8.5.1 (Tab DD-15).

9. MEDICAL FACTORS

a. Pre-Mishap Medical Conditions

MOC played multiple sports in high school and had a physically demanding job before he enlisted (Tab V-3.3). He actively participated in physical fitness activities during and after the duty day (Tab V-3.5 and V-5.3 to V-5.4). During BMT, MOC was screened for SCT, and he was diagnosed as being SCT positive (Tab X-7). MOC's medical records were annotated accordingly and he was subsequently counseled at BMT on the significance and potential consequences of SCT (Tab X-6). He signed an acknowledgment of this risk at BMT, elected to remain on active duty, and proceeded on with his military career without any apparent medical complications until 26 October 2015 (Tab X-7).

On 21 October 2015, five days before the mishap, MOC also acknowledged on the FSQ form he filled out for his upcoming FA that he had no medical conditions/symptoms (SCT was a listed

condition) that he had not been medically cleared of, which allowed him unrestricted participation in the FA (Tab T-9). Given MOC's apparent good health, a history of no prior medical issues with SCT, there is no reason for MOC to check the box "yes" to the question, "Have you experienced any of the symptoms/problems listed below [sickle cell trait was a listed condition] and not been medically evaluated and cleared for unrestricted participation in a physical training program?" (Tabs T-9 and Tab X-6). Additionally, even if MOC had checked "yes" to the box, given his apparent good health, a history of no previous medical issues with SCT, and a lack of an overarching no-run Air Force policy for Airmen with SCT, there would likely not been a medical reason to place MOC on a no-run profile due solely to his SCT status (Tab X-6).

A review of MOC's pre-mishap medical records indicate no other underlying medical conditions were a factor in this mishap (Tab X-7 to X-8).

b. Injuries and Pathology

The post-mortem autopsy concluded that MOC died of natural causes from complications of SCT (Tab X-10 to X-11). According to a medical review of the facts and circumstances of this mishap, MOC's exercise on 26 October 2015 resulted in the ordinarily benign SCT condition to react negatively for reasons that are unclear, starting a chain of events that would lead to MOC's death (Tab X-8). The chain started when the exercise caused acidosis (an imbalance in the acid-base balance) and hypoxemia (lower oxygen level in the blood) to occur in MOC's blood, resulting in his blood cells changing shape (sickling-type changes)(Tab X-9 to X-10). The change in blood cells decreased the supply of oxygen to the muscles in the arms and legs, leading to ischemic (a decreased supply of oxygenated blood to a body part) injury, which led to compartment syndrome (excessive pressure inside an enclosed space in the body) in MOC's arms and legs (Tab X-10). As his muscle tissue expanded and died, rhabdomyolysis conditions occurred, which released myoglobin (a protein found in muscle) and electrolytes (minerals in the blood and body fluids that can carry an electric charge) into MOC's bloodstream, leading to kidney failure and a high level of potassium in MOC's blood (Tab X-10). The increased potassium in MOC's blood resulted in a fatal cardiac arrest (MOC's heart stopped beating) (Tab X-10).

c. Lifestyle

Complications from SCT are rare, such that the condition does not impact an individual's everyday life or preclude military service (Tab X-5). There is no evidence to suggest that lifestyle factors were a factor in this mishap. (Tabs V-3.2 to V-3.8 and X-6). MOC also appears to have maintained appropriate hydration before the mishap (Tab V-5.5).

d. Crew Rest and Crew Duty Time

Not applicable.

10. OPERATIONS AND SUPERVISION

a. Operations

Including MOC, there were 12 individuals participating in the 26 October 2015, 0600 hours FA test session (Tab AA-5 to AA-7). During the run component, FAC 1 observed MOC stop his run and lie on the track (Tab V-1.5). He immediately ran over to administer assistance to MOC, while FAC 2 remained at the run start/finish to record other test participants' run times (Tab V-1.5 to V-1.6). FAC 1 was with MOC until he was taken away by ambulance to St. Elizabeth's Hospital (Tab V-1.7 and V-8.4). After MOC was transported to St. Elizabeth's Hospital at 0735 hours, FAC personnel and the other 0600 FA participants returned to the James Gym to accomplish FA paperwork for the other 0600 hours FA test participants (Tabs V-1.8 to V-1.9, V-8.4 and DD-9). FAC personnel continued leading other FA test periods that morning, after which time they completed administrative tasks associated with the 26 October 2015 morning FA sessions (Tab V-1.9). There is no evidence to suggest that FAC operations were a factor in the mishap.

b. Supervision

FAC 1 was the Non-Commissioned Officer in Charge (NCOIC) of the FAC (Tab V-1.1). He also led the 0600 hours FA test session that MOC participated in on 26 October 2015 (Tabs T-13, V-1.2 and V-1.4). FAC 2, another member of the FAC, was also present during all portions of the 0600 hours FA test session (Tab V-1.2). Review of training records indicate that FAC 1 and FAC 2 were appropriately trained in basic emergency care to include CPR and AED certification, and equipped to execute the 0600 hours FA test session on 26 October 2015 (Tabs V-1.3 to V-1.4 and DD-3).

MOC's work center had scheduled physical fitness as part of the weekly ALS curriculum (Tab V-5.4). MOC participated in physical fitness activities with ALS students (Tab V-5.4). Outside scheduled physical fitness sessions, MOC included additional physical fitness activity, normally push-ups, as part of his ALS classes (Tab V-5.4). MOC also routinely set-aside time for personal physical fitness training sessions to include a minimum of running twice a week and weights twice a week (Tab V-3.5 and V-5.3 to V-5.4).

11. GOVERNING DIRECTIVES AND PUBLICATIONS

a. Publically Available Directives and Publications Relevant to the Mishap

(1) DoDI 6465.01, *Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency (G6PD) and Sickle Cell Trait Screening Programs*, dated 17 July
(2) AFI 51-503, *Aerospace and Ground Accident Investigations*, dated 14 April 2015
(3) AFI 36-2905, *Fitness Program*, dated 21 October 2013, incorporating Change 1, dated 27 August 2015

NOTICE: All directives and publications listed above are available digitally on the Air Force Departmental Publishing Office website at: http://www.e-publishing.af.mil.

b. Other Directives and Publications Relevant to the Mishap

(1) 737 TRG Operating Instruction 36-3, *Basic Military Training (BMT)*, dated 17 March 2015
(2) 10 MDGI 44-9, *Cadet Sickle Cell Trait Screening Program*, dated 16 April 2014

c. Known or Suspected Deviations from Directives or Publications

There are no known or suspected deviations from directives or publications by personnel involved in the mishap or emergency response.

\\signed\\

22 March 2016

MICHAEL J. WOOD, Colonel, USAF, MC, FS
President, Ground Accident Investigation Board

INDEX OF TABS

TAB A-S

THESE TABS NOT USED

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TAB T

PERSONNEL RECORDS (Not Included in Tab G)

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AIR FORCE FITNESS ASSESSMENT SCORECARD

Rank / Name: MOC Unit: 375 FSS Duty Phone:

E-mail: MOC Age: 34 (years)

Height: 67 (inches) Weight: 195 (lbs) FSQ Date: 28Apr15 Test Date: 29 Apr 15

Aerobic Component exemption: (Y) / N Date Start: 4/29/15 Date End: 6/27/15

Push-up exemption: Y / (N) Date Start: Date End:

Sit-up exemption: Y / (N) Date Start: Date End:

Abdominal circumference exemption: Y / (N) Date Start: Date End:

Component	Measurement / Reps / Time	Score	Minimum Value Met?
Abdominal Circumference (inches)	1: 36 2: 36 3: 36 Average: 36		Y / N
Push-ups (reps)	60		Y / N
Sit-ups (reps)	60		Y / N
1.5-Mile Run / 2.0-Kilometer Walk (mins:secs)	Time: EXEMPT		Y / N

Total Score: 925 of _____ Category (circle one): Unsatisfactory / Satisfactory / Excellent

I acknowledge the above information reflects my performance today. I also understand I may address discrepancies IAW the guidance in AFI 36-2905 on removing FA scores. ***NOTE:*** *Refusal to sign does not invalidate the test; score will be updated in Air Force Fitness Management System (AFFMS).*

TEST MEMBER: MOC DATE: 29 Apr 15
SIGNATURE

TEST ADMINISTRATOR: _____ _____ DATE: 29 Apr 15
AFFMS RECORDER: PRINT SIGNATURE

_____ _____ DATE: 20 Aug 15
PRINT SIGNATURE

☐ *I experienced an injury or illness during this FA and will immediately pursue evaluation at the Medical Treatment Facility. I understand this FA will count unless rendered invalid by the Unit Commander within 5 duty days (conclusion of next UTA for non-AGR ARC Airmen). If no request to invalidate this FA is received by the Fitness Assessment Cell (FAC) from the Commander by the 6th duty day (conclusion of*

***FAC Augmentee signature:** _____ **DATE:** _____

*FAC Augmentee (or UFPM if no FAC exists) will only sign above if member checks block indicating Presence of illness or injury during test. FAC signature acknowledges the requirement to hold score for 5 duty days (AFFMS input on 6th duty day) For non-AGR ARC Airmen, FAC staff Will hold scores until the next UTA and enter scores into AFFMS upon conclusion of that UTA.

☐ I have received and considered the provided medical documentation and render this test invalid due to injury/illness

UNIT COMMANDER: _____ DATE: _____
PRINT SIGNATURE

AF FORM 4446, 20131021

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DUTY LIMITING CONDITION REPORT

Name (Last, First MI)	RANK	DATE
MOC	TSG	04/28/2015

SSAN	MAJCOM / INSTALLATION	Squadron / Unit Of Assignment
	Scott AFB (AMC)	375 FORCE SUPPORT SQ

Squadron E-Mail Address	Duty Telephone:
375FSS.UDM@scott.af.mil; @us.af.mil; @US.AF.MIL; @us.af.mil; @us.	☐ DSN ☑ Commercial

HEALTH CARE PROVIDER'S MEDICAL RECOMMENDATION FOR THE SQUADRON COMMANDER

☑ DUTY RESTRICTIONS	☐ MOBILITY RESTRICTIONS	☐ 49 / 81

PHYSICAL LIMITATIONS / RESTRICTIONS (DO NOT include medical condition or diagnosis)

These limitations expire 06/27/2015
FITNESS TESTING:
1.5 Mile Run: EXEMPT
2.0 Kilometer Walk: EXEMPT
Pushups: Yes
Sit-ups: Yes
Abd Circumference: Yes

DUTY RESTRICTIONS:
No running greater than 100 yards.
No walking greater than 1.0 km.

The new profile process requires airman to present a current 469 form when completing the official AF fitness test. The 422 will contain only the
exercise prescription, which is generated by the HAWC EP. The 422 is optional except for the following conditions; 1) referral by the PCM; 2)
any profile issued for a continuous 12 months; 3) four FA exemptions in a 24 month period; 4)referral from the airmans commander or UFPM; 5)
self-referral by the airman. Please contact the HAWC at 256-7139 as soon as you receive your 469 if you require a 422.

IAW AFI 10-203, member is required to report any change in medical condition to the Primary Care Manager

Release Dates: 31 **37** **81** **MR** **DR** 06/27/2015 **FR** 06/27/2015

Name and Grade of Health Care Provider	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 04/28/2015
☐ 31 (ILLNESS OR INJURY WILL BE RESOLVED WITHIN 31-365 DAYS)	☐ 37 (MEDICAL DEFECT/CONDITION REQUIRES MEB OR PEB PROCESSING IAW AFI 41-210)	
Force Health Manager	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date 04/28/2015
Profile Officer Review	Signature This form has been reviewed by the signatories indicated and verified by PIMR	Today's Date

DUTY LIMITING CONDITION REPORT **AF FORM 469** Computer Generated

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Personnel information current as of 10/30/2014

My Fitness | Metrics | Log Out

Welcome ! ***MOC*** **Print**

Next Test Due Date: **04/30/2015**

Select Fitness Tool

Fitness Calculator

Use the Fitness calculator to enter in practice test scores to get a feel of your fitness level.

Fitness Test Score Charts

Review and print the Fitness Test Score Worksheet.

Fit-to-Fight Commander Toolkit

Use the Fit-to-Fight Commander Toolkit for Extended Tools.

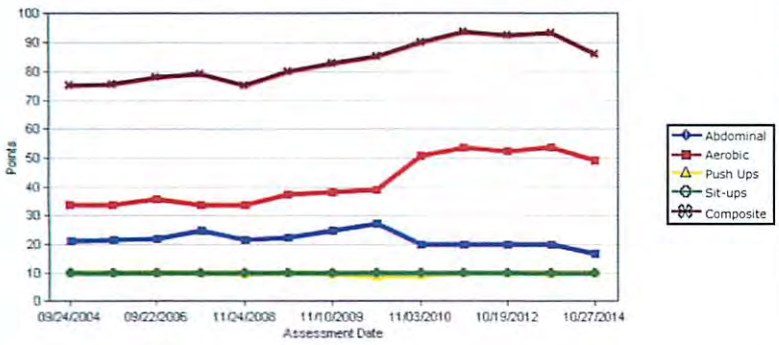
Fitness Management System User Manual

Fitness Management System User Manual.

Fit to Fight Air Force Fitness Management

Member Air Force fitness ranking is: **Lower 50% of the AF**
Member age and gender fitness ranking is: **Lower 50% of the AF**

Individual Fitness Assessment History



* Exemptions are indicated by breaks in the lines.

Test History

Name: MOC **Rank:** SSG **Unit:** 375 FORCE SUPPORT SQ

Test Date	Cardio Results	Abdominal Circumference (in)	Push Ups	Sit-ups	Composite Score	Fitness Level	Test Entered By
10/27/2014	12:15 / 49.20	36.00" / 17.00	59 / 10.00	58 / 10.00	86.20	Satisfactory	
10/25/2013	11:26 / 53.70	35.00" / 20.00	55 / 9.50	58 / 10.00	93.20	Excellent	
10/19/2012	11:53 / 52.40	34.00" / 20.00	59 / 10.00	56 / 10.00	92.40	Excellent	
10/24/2011	11:28 / 53.70	34.00" / 20.00	57 / 10.00	55 / 10.00	93.70	Excellent	
11/03/2010	12:09 / 50.90	34.50" / 20.00	60 / 9.30	60 / 10.00	90.20	Excellent	
05/27/2010	12:02 / 39.00	33.00" / 27.50	49 / 8.75	57 / 10.00	85.25	Good	
11/10/2009	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	
10/29/2009	12:43 / 37.50	35.00" / 22.50	67 / 10.00	70 / 10.00	80.00	Good	
11/24/2008	14:03 / 34.00	37.50" / 21.75	55 / 9.50	55 / 10.00	75.25	Good	
11/15/2007	37 / 34.00	34.00" / 25.00	63 / 10.00	71 / 10.00	79.00	Good	
09/22/2006	13:04 / 36.00	37.00" / 21.90	64 / 10.00	54 / 10.00	77.90	Good	
09/14/2005	13:48 / 34.00	38.00" / 21.60	65 / 10.00	62 / 10.00	75.60	Good	
09/24/2004	13:57 / 34.00	39.00" / 21.30	62 / 10.00	63 / 10.00	75.30	Good	

Individual Education & Intervention History

Enroll Date	Education/Intervention	Completion Date
No Education & Intervention History at this Time		

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FITNESS SCREENING QUESTIONNAIRE

Figure A4.1. Fitness Screening Questionnaire.

FITNESS SCREENING QUESTIONNAIRE

You are being asked these questions for your safety and health. The AF Fitness Assessment (FA) is a maximum-effort test. Airmen who have not been exercising regularly and/or have other risk factors for a heart attack (increasing age, smoking, diabetes, high blood pressure, etc.) are at increased risk of injury or death during the test. Answering these questions honestly is in your best interest.

1. Have you experienced any of the symptoms/problems listed below and not been medically evaluated and cleared for unrestricted participation in a physical training program?
    a. Unexplained chest discomfort with or without exertion
    b. Unusual or unexplained shortness of breath
    c. Dizziness, fainting, or blackouts associated with exertion
    d. Other medical problems that have not been evaluated, optimally treated, or not already addressed in an AF Form 469, that may prevent you from safely participating in this test (e.g. heart disease, sickle cell trait, asthma, etc.).
    e. Family history of sudden death before the age of 50 years

    ☐ **Yes:** Stop. Notify your UFPM and contact your PCP/MLO for evaluation/recommendations (or for ARC, contact the MLO for Duty Limiting Conditions (DLC) documentation and referral to PCP). Hand carry this form to medical evaluation.
    ☑ **No:** Proceed to next question.

2. Are you 35 years of age or older?

    ☐ **Yes:** Proceed to next question.
    ☑ **No:** Stop. Sign form and return to your UFPM. Member may take the FA.

3. Have you engaged in vigorous physical activity (i.e., activity causing sweating and moderate to marked increases in breathing and heart rate) averaging at least 30 minutes per session, 3 days per week, over the last 2 months?

    ☑ **Yes:** Stop. Sign form and return to your UFPM. Member may take the fitness assessment.
    ☐ **No:** Proceed to the next question.

4. Do one (1) or more of the following risk factors apply to you?
    - Smoked tobacco products in the last 30 days
    - Diabetes
    - High blood pressure that is not controlled
    - High cholesterol that is not controlled

- Family history of heart disease (developed in father/brother before age 55 or mother/sister before age 65)
- Age > 45 years for males; > 55 years for females

☐ **Yes:** Stop and notify UFPM.

NOTE: RegAF and ANG (Title 10 status): If member was cleared for entry into a fitness program at his/her last physical health assessment (PHA) and his/her PHA is current, the member will take the FA. If not cleared, refer member to PCM for evaluation, and, if medically cleared for unrestricted fitness program, the member will take the FA.

AFR: If member was cleared for participation into a fitness program at a PHA within the last 12 months, the member will take the FA. If not previously cleared, member will be referred to PCP for evaluation and, if medically cleared for unrestricted fitness program, the member will take the FA. Refer member to MLO if there is any combination of smoking, diabetes, uncontrolled high blood pressure, and/or uncontrolled high cholesterol. MLO will update medical records and/or initiate DLC documentation.

ANG (Title 32 status): Refer member to MLO if there is any combination of smoking, diabetes, uncontrolled high blood pressure, and/or uncontrolled high cholesterol. MLO will update medical records and/or initiate DLC documentation.

☐ **No:** Stop. Sign form and return to your UFPM. Member will take the FA.

If member experiences any of the symptoms listed in Question #1 during the fitness assessment, he/she should stop the test immediately and seek medical attention immediately.

MOC

Digitally signed by
DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=USAF, cn=[illegible]
Date: 2015.10.21 07:14:49 -05'00'

Signature: _____ Date: 21 Oct 15

Printed Name: *MOC* Rank: TSgt

Duty Phone: _____ Office Symbol: _____

T5. SURF

Printed By on 29-Oct-2015 at 09:41:29 **Personal Data -** Current as of 27-Oct-2015 at 09:41:29

Gr/DOR: TSGT/01-Nov-2014 **Name:** *MOC* **SSAN:**
Proj Gr: **DAFSC:** 8T000 **Duty Title:** ALS INSTRUCTOR
PAS: **Base:** SCOTT **Command:** AMC
Marital Status: M **Depns:** 02 **SEX/RACE/ETH-GR:**

*******MILITARY JOIN SPOUSE CONSIDERATION*******

Spouse SSAN: **Spouse Status:** NOT APPLICABLE **Spouse Intent:** NOT APPLICABLE

*******RESTRICTIONS*******

ASG AVAIL CD/DT: 50 / 1607 / / / **WEIGHT CONT:**
ASG LIMIT CD/DT: / / / **UIF:**

*******PROJECTED ASSIGNMENTS*******

	AAR	PAS	RNLTD	AAN	ASD	BASE
1)						
2)						

*******SERVICE DATES*******

DAS: 02-Jul-2004 **DOS:** 07-Aug-2019 **HYT:** 09/2023
DEROS: **ADSCD:** 11/01-Jul-2006 **TAFMSD:** 23-Sep-2003
ODSD: 03-Apr-2004 **EAD:** 23-Sep-2003 **PAY DATE:** 23-Sep-2003
STRD(##): 2004/04(.) **WEAPON SYSTEM BACKGROUND ID:**
RETURN TO FLY DATE:

*******AFSC INFORMATION*******

CAFSC: 8T000
PAFSC: 1C872
2AFSC: 8T000
3AFSC:
PSEI(1-5): / / / /

*******ACADEMIC INFORMATION*******

DEGREE	ACADEMIC SPECIALTY	YEAR	METHOD
BAC	BUS ADM/MGT ORG MGT	12	TUITION ASST
AA	INSTR-IN-TECH	13	COM COL AF
AA	ELECTRONIC SYS TECHNOLOGY	08	COM COL AF

*******PME INFORMATION*******

COURSE	METHOD	YEAR
NCO ACADEMY	NON-RESIDENCE	15
AIRMAN LEADERSHIP SCHOOL	RESIDENCE	08
NONE	NONE	

*******LANGUAGE INFORMATION*******

DLAB:
LANG1: NONE DT: . **S- L- R-** **LANG2:** NONE DT: . **S- L- R-**
LANG3: NONE DT: . **S- L- R-** **LANG4:** NONE DT: . **S- L- R-**
LANG5: NONE DT: . **S- L- R-** **LANG6:** NONE DT: . **S- L- R-**

*******PROJECTED TRAINING*******

COURSE ID	START DATE	GRAD DATE
KNCOA-ILE 101	18-Feb-2016	23-Mar-2016

*******DECORATIONS*******

(NOTE: This screen only shows personal medals not awards.)

Decoration	Auth No.	No	Seq	Close Date	Approval Date	Approving Unit	Reason
AF COMM MEDAL	389	02	N	31-May-2011	1105	375 CS	EXT
AF ACHIEV MEDAL	104	02	O	05-Dec-2008	0902	375 MSS	ACH

*******OTHER INFORMATION*******

SEC CLNC: **NON-CONUS RES:** YY **PSN#:** 1L0005909
TYPE CLNC: **Citizenship:** BY BIRTH IN UNITED STATES **DOB:**
CLNC Date: **FUNC CAT:** PERMANENT PARTY
PRP-SCI-STATUS: **RECORD STATUS:** ACTIVE NO PROJECTED ACTION

*******DUTY STATUS*******

Duty Status: 00-PRESENT FOR DUTY **Start Date:** 21 Jul 2015 **End Date:**
Proj Duty Status: NO PROJECTED DUTY STATUS **Start Date:** **End Date:**

*******EPR DATA*******

EPR	DATE	EPR	DATE	EPR	DATE	EPR	DATE	EPR	DATE	EPR	DATE
5B	30-Nov-2014	5B	23-May-2011	5B	23-May-2007						
5B	02-Apr-2014	5B	23-May-2010	5B	23-May-2006						
5B	02-Apr-2013	5B	23-May-2009	5B	23-May-2005						
5B	02-Apr-2012	5B	23-May-2008								

*******DUTY HISTORY*******

DAFSC	DUTY TITLE	DET	ORG KIND	ORG TYPE	LOCATION	DUTY EFF DATE
8T000	ALS INSTRUCTOR	0000	0375	SQ	SCOTT	01-Jul-2011
-3D156	AIRFIELD SYSTEMS CRAFTSMAN	0000	0375	SQ	SCOTT	01-Dec-2010
-3D156	QUALITY ASSURANCE EVALUATOR	0000	0375	SQ	SCOTT AFB MIDAMER	15-Nov-2009

-2E152	QUALITY ASSURANCE EVALUATOR	0000	0375	SQ	SCOTT	23-Feb-2009
-2E152	AIRFIELD SYSTEMS MAINT JRNEYMAN	0000	0375	SQ	SCOTT	01-Apr-2006
-2E152	METNAV MAINTENANCE JOURNEYMAN	0000	0375	SQ	SCOTT	27-Feb-2006
-2E132	METNAV MAINT APPRENTICE	0000	0375	SQ	SCOTT	27-Jul-2004
-2E132	STUDENT	0000	0375	SQ	SCOTT	02-Jul-2004
-2E112	STUDENT	0000	0338	SQ	KEESLER	11-Nov-2003

Printed By on 29-Oct-2015 at 09:41:29

Current as of 27-Oct-2015 at 09:41:29

AIR FORCE FITNESS ASSESSMENT SCORECARD

Rank / Name: MOC Unit: 375 FSS Duty Phone:

E-mail: MOC Age: 34 (years)

Height: 66 (inches) Weight: 191 (lbs) FSQ Date: 21 oct 15 Test Date: 26 oct 15

Aerobic Component exemption:

	Y / N	Date Start:	Date End:
Push-up exemption:	Y / N	Date Start:	Date End:
Sit-up exemption:	Y / N	Date Start:	Date End:
Abdominal circumference exemption:	Y / N	Date Start:	Date End:

Component	Measurement / Reps / Time	Score	Minimum Value Met?
Abdominal Circumference (inches)	1: 34.5 2: 34.5 3: 34.5 Average: 34.5		Y / N
Push-ups (reps)	61		Y / N
Sit-ups (reps)	57		Y / N
1.5-Mile Run / 2.0-Kilometer Walk (mins:secs)	Time: [redacted]		Y / N

Total Score: _____ of _____ Category (circle one): Unsatisfactory / Satisfactory / Excellent

* Member taken away by ambulance no Apelings in lgs

I acknowledge the above information reflects my performance today. I also understand I may address discrepancies IAW the guidance in AFI 36-2905 on removing FA scores. ***NOTE:*** *Refusal to sign does not invalidate the test; score will be updated in Air Force Fitness Management System (AFFMS).*

TEST MEMBER: _____ DATE: _____
SIGNATURE

TEST ADMINISTRATOR: _____ _____ DATE: 26 Oct 15
AFFMS RECORDER: PRINT SIGNATURE

_____ _____ DATE: _____
PRINT SIGNATURE

I experienced an injury or illness during this FA and will immediately pursue evaluation at the Medical Treatment Facility. I understand this FA will count unless rendered invalid by the Unit Commander within 5 duty days (conclusion of next UTA for non-AGR ARC Airmen). If no request to invalidate this FA is received by the Fitness Assessment Cell (FAC) from the Commander by the 6th duty day (conclusion of

***FAC Augmentee signature:** _____ **DATE:** 26 oct 15

*FAC Augmentee (or UFPM if no FAC exists) will only sign above if member checks block indicating Presence of illness or injury during test. FAC signature acknowledges the requirement to hold score for 5 duty days (AFFMS input on 6th duty day) For non-AGR ARC Airmen, FAC staff Will hold scores until the next UTA and enter scores into AFFMS upon conclusion of that UTA.

☐ I have received and considered the provided medical documentation and render this test invalid due to injury/illness

UNIT COMMANDER: _____ DATE: _____
PRINT SIGNATURE

FAC COMPLE

AF FORM 4446, 20131021

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TAB U

THIS TAB NOT USED

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TAB V

WITNESS TESTIMONY AND STATEMENTS

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V1. FITNESS ASSISMENT CELL ONE (FAC 1)
VERBATIM TESTIMONY

(PRESIDENT): All right, so again, this'll be the formal interview. So I've got a few things I've got to read here. My name is Colonel Michael Wood. I'm the board president for the ground accident investigation board investigating the circumstances surrounding the death of Tech Sergeant MOC . This investigation, conducted in accordance with AFI 51-503, is separate and apart from any safety investigation that may be conducted in accordance with AFI 91-204. This ground accident investigation board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC's death, to prepare a publicly releasable report and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes. A formal safety investigation has not been conducted to date. Your sworn testimony to the board may be used for any proper purpose. Additionally, your testimony can be released to the public. Do you understand how your testimony before this accident board maybe used?

(FAC 1): Yes, sir.

(PRESIDENT): Thank you.
Do you so solemnly swear or affirm that the testimony you're about to give in the matter now under investigation shall be the truth, the whole truth, and nothing but the truth, so help you God?
(FAC 1): I do, sir.

Q1 (PRESIDENT): All right. Can you please state your full name?
A1 (FAC 1): First name is

Q2 (PRESIDENT): Can you spell that for the recorder?
A2 (FAC 1): First name, and of course middle name is ; last name is

Q3 (PRESIDENT): Thank you. And what's your current rank?
A3 (FAC 1): Current rank is tech sergeant.

Q4 (PRESIDENT): And you're assigned to which unit?
A4 (FAC 1): To 375th FSS.

Q5 (PRESIDENT): And what's your duties there?
A5 (FAC 1): Duties, is fitness assessment cell, currently NCOIC.

Q6 (PRESIDENT): Thank you. Your fitness assessment cell, under which flight is that in the FSS?
A6 (FAC 1): It's under the Sustainment Flight, Flight…segment flight basically.

Q7 (PRESIDENT): All right. Who else is in the fitness assessment cell element with you?
A7 (FAC 1): Current we have myself, FAC 1 ; you have FAC 2 ; you have FAC 3 , and newly added was FAC 4 .

Q8 (PRESIDENT): Okay, and Airman got there after the incident?
A8 (FAC 1): Yes, sir.

Q9 (PRESIDENT): All right. Who was with you on the day of the incident?
A9 (FAC 1): The day of the incident would have been myself and also FAC 2 , and another gentleman that happen to be out there running as well, along with the rest of the folks that were actually taking the test as well, so total would be 11, and the gentleman was 12, all 12 folks were on sight.

Q10 (PRESIDENT): All right. Prior to this incident had you had any actual emergency responses that folks had to respond to?
A10 (FAC 1): We had one just recently, basically on the gentleman's Memorial, and then we had one also before, and emergency service were called and pretty much take it from there.

Q11 (PRESIDENT): All right. Have you ever had any exercises regarding any emergency response?
A11 (FAC 1): No, sir.

Q12 (PRESIDENT): All right.
Q12 (LEGAL ADVISOR): When…this is , the legal advisor. When…you mentioned before the incident there were discussing there was an emergency response. Approximately how many weeks or days before the incident that we're investigating?
A12 (FAC 1): About a month ago.

Q13 (LEGAL ADVISOR): That would have been, what, about three weeks prior to the?
A13 (FAC 1): Yeah, just about.

Q14 (PRESIDENT): Okay.
And to your knowledge no emergency responses other than that one?
A14 (FAC 1): That one and of course the one on the actual day of the Memorial.

Q14 (PRESIDENT): Right.
A14 (FAC 1): Yes.

Q15 (PRESIDENT): What kind of training do you have as an individual for going out there and doing the fitness assessment testing?
A15 (FAC 1): Training, we're all certified AED and BLS, Basic Life Support, so we have an AED on-site when we're there to take care of folks of course.

Q15 (PRESIDENT): All right.
A15 (FAC 1): If need be.

Q16 (PRESIDENT): Do you have any other training on how to conduct the test?
A16 (FAC 1): Training on conducting the test, yes, sir. We brief everyone. We have of course a mandated form that states the health of the individual, that's mandatory. Everybody has to sign it and attest that they're good to go to take the test. We also brief if there's any, you know, let's say if you are ill, you are…you're subject to basically reschedule if need be, or you can get a waiver, whichever it might be, if there's any issues why you're taking the test itself. But we do brief folks on…that they have to mandate…you have to have that FSQ, that needs to be filled out in order to take the test, as far as----

Q17 (LEGAL ADVISOR): FSQ, this is the Legal Advisor again. FSQ is the questionnaire?
A17 (FAC 1): Yes, sir. That's the fitness assessment questionnaire itself, which basically tells you, if you have any pre-assistant [sic] issue, then please go see a doctor, that's basically it. If you answered yes to the first question, I believe that what it says, you have to go see the doctor. You cannot continue. That's mandatory.

Q18 (PRESIDENT): So other than the AED training and the BLS training, do they give you any training on how to conduct the test, when you should give it, when you shouldn't give it, how to time people, anything like that? Or do they just hand you the stop watch and say good luck?
A18 (FAC 1): Oh, no. It's…there's procedures. You have an AFI that basically tells you about the wind speed, you know, the temperatures outside, of course to date that's when we call Weather, and from Weather they'll let us know what the weather is. If it's fine, and of course we'll take 'em out to the track. Or if not, if it's inclement, we'll take 'em indoors. So there are procedures to let us know, as far as weather-wise. So, that's pretty much it. And of course we all know the standards of doing waist measurement, push-ups and sit-ups. We actually brief that, as far as the form, and what we're going to correct if we see a form violations and things like that. So that's pretty much how we handle the test itself. And we brief that. We brief all that before we start, and we give another briefing before we actually start the run itself. A whole lot of briefings within, and also within…before you start the actual components, everything is briefed.

Q19 (PRESIDENT): Okay. Did they ever do any training on if an emergency happens, who to call or what to do?

A19 (FAC 1): At the moment of course, if we can't handle it with an AED, the most natural thing to do is to call 911. 911 is what we'll call.

Q20 (PRESIDENT): Right. So were you trained to do that or is that just one of----
A20 (FAC 1): That's just instincts, sir.

Q21 (PRESIDENT): Just instinct, okay.
A21 (FAC 1): That's just basic, if you cannot handle it with an AED, 911 are the experts.

Q22 (PRESIDENT): Call 911.
A22 (FAC 1): Stay on sight with the person, call emergency service so they can go ahead and take care of the business.

Q23 (PRESIDENT): All right. Sorry, I thought…did one of you have a question? I thought I saw somebody? Just to recap again, just to make sure I got my notes right. You didn't have any exercises for what to do in case of an emergency, for a response?
A23 (FAC 1): Not at the moment. But of course now, we have in place, we have pretty much a checklist that tells us, once we take care of the…what's going on on hand, then that's when we'll relay information up to our leaderships. So that is of course methodically put down now. So now we're actually on track to handle better…better handle mishaps when they occur.

Q24 (PRESIDENT): All right. Okay, so on the day of the incident, about what time did you all get out to the track?
A24 (FAC 1): We got out there, I want to say about 6:45, 7 o'clock-ish 11 is like when the…7:11 of course is when the mishap happened, and that's when we're calling 911. Of course the 911 call itself was at 7:11 for five minutes.

Q25 (PRESIDENT): I'm sorry, going back a little bit. The fitness assessment chalk if you will, that you did that day, started at 6 A.M., right?
A25 (FAC 1): 6 A.M. At a quarter till we let…we open the doors so that folks can come in and we can start, you know, basically taping them, getting 'em on the scales and all that. Pretty much at 6 o'clock, at…yeah, that's when we closed the doors. We closed the doors on there.

Q26 (PRESIDENT): All right.
A26 (FAC 1): So once before it starts out.

Q27 (PRESIDENT): So were you part of the taping then?
A27 (FAC 1): Yes, sir.

Q28 (PRESIDENT): Okay. Did you notice anybody having any issues whenever they came in to be taped or measured, or height and weight?
A28 (FAC 1): No, sir.

Q29 (PRESIDENT): Were you there when sit-ups and push-ups were being done as well?
A29 (FAC 1): Yes, sir.

Q30 (PRESIDENT): All right, did you notice any problems with the sit-ups and push-ups?
A30 (FAC 1): No, sir.

Q31 (PRESIDENT): And were…was sit-ups and push-ups being videotaped?
A31 (FAC 1): Yes, sir.

Q32 (PRESIDENT): And that videotape is still present somewhere?
A32 (FAC 1): Yes, sir.
(PRESIDENT): All right. Try to get a copy of that at some point.

Q33 (PRESIDENT): But not…any problems during sit-ups and push-ups by anybody?
A33 (FAC 1): No, sir.

Q34 (PRESIDENT): All right. So then you all go out to the track about 6:45 or so, you give your instructions, and people start running.
A34 (FAC 1): Yes, sir.

Q35 (PRESIDENT): Did anybody have any issues that they raised prior to the start of the run, like oh, not finish it, I'm not feeling good when you gave your brief?
A35 (FAC 1): No. I just had Sergeant MOC , himself. I briefed is anybody, you know, need any…do any I think is normal, I give them the option to either, you know, hear the laps as they're going, or they can put their playlist and all that. But he particularly told me, hold on a second. So he told me to hold on and I held on. And he basically grabbed his Air Force hat and he put it on his head. I thought that was pretty funny and he went ahead with a smiling face and we all started the run, and that was pretty much it.

Q36 (PRESIDENT): Okay. So everybody's doing their run. First five laps, did you notice anybody having any problems?
A36 (FAC 1): Not until just before Sergeant MOC hit the second to last corner is when I saw him look like he was coming down and he basically laid down. So once he laid down on the track, he took that plunge on the ground, and then there was another bystander out there, it was a person that was out there, which we really don't know who his name is. So he steps out there. I run immediately to his aid and I'm talking to him. So I ask him, brother, you doing all right? And he was like, no, I just got, you know, cramps, and my legs are hurting, stuff like that. He's…that's what he's communicating to me. So I'm like, okay, so we're out here. I want to make sure that you're good. I asked him to open his eyes, 'cause I wanted to see his pupils. Looked at his pupils. Pupils looked normal. They were not dilated or nothing that I could see out there. It was cold out there. What I saw that was very odd is that he kept rolling over to his

side and rolling back as he was talking. He kept on doing this while I was still communicating with him. And of course right after what's happening, my troop was actually still finishing up the chalk with the 11 people. So they were doing their rotations out there, finishing up. And after he was done with them, we went ahead and grabbed the orange…it's almost like a little John Deere type vehicle. So…the Kubota, to be exact. So he grabbed the Kubota, drives over there. So now we have my senior airman, FAC 2 , he's there. And we also have the one gentleman that was already there with me while we were waiting for the folks. So we sit there and I asked him, we're going to call 911. At the time, you know, he didn't really say nothing. He was actually wondering when…if he was already finished with the actual lap, 'cause----

Q37 (PRESIDENT): He asked you if he'd finished the test?
A37 (FAC 1): He was asking me more, hey, am I'm almost done? I was like, sir, don't worry about it, brother. Just stand right there, we're going to make sure you're good first off. You're almost done. You only had but two more, you know, two more corners to go and you were going to be done.

Q38 (LEGAL ADVISOR): Approximately how many--this is the Legal Advisor. Approximately how much…how many more meters or feet did he have to finish his test?
A38 (FAC 1): That shouldn't be no more those two corners there, involving that, not really good with distance, but I want to say about hundred feet almost. It was only two corners, you can easily sprint that, you know, finish that out. It wasn't not much to actually worry about, those two corners aren't much at all. He was pretty much like three-fourths done with the whole run itself.

Q39 (PRESIDENT): Okay, and how do you spell Kubota?
A39 (FAC 1): Kubota is K-A-B-U-T-A. Something like that. I'm not a good speller.
(PRESIDENT): Close enough.

Q40 (PRESIDENT): Did other than asking if he was done or finished with the test, did Tech Sergeant MOC say anything else while he was there?
A40 (FAC 1): While he was laying down?
[Affirmative response by the Board President.]
He was just basically communicating though, you know, that he was all right, that his legs were so cramping. And then of course that's when I called 9/11 'cause he kept…although he was talking to me he kept doing that rolling action over to the right and back. So he was rolling back, and I was like, we got…so I called 911. Then of course I talked them, they talked to me. I gave them the…what…assessing the area, what I saw. I got a gentleman, you know, it's not cardiovascular what is going on right now but he's complaining about severe cramps. We can't lift him up. So they went ahead and responded. They went ahead and put me like almost on a

conference call. They talked to me. They put EMS and 911, are both talking to me. They tracking me on GPS, 'cause at the time I didn't know exactly what street I was on. So we're out there, they're tracking me on GPS. They send emergency vehicle. And then from there, of course, is like we saw the sight itself, they park over, closer to the Children's, you know, Children's Day Care Center. So they park out there. They come out. And I can understand, it's not cardiovascular, you know, issues, but they get out there, you know, they go into the other side of the track. They meet us over there. They're talking to the gentleman right there, as he could speak. We're talking to him, and they're asking him questions, you know, same…pretty much the same thing. Ask him, hey, brother, what's going on. They asked him the same thing. He said he's going cramps and all that. They went into talking a little bit more. The last few statements that he said, that the EMS vehicle…that the EMS personnel said, was basically when was the last time you ate. At that point Sergeant MOC did not answer that question, although he was still there. You know, they went ahead and did a two-man carry. They grabbed his Air Force cap, put it on the little compartment they had for the stretcher. And then they pretty much carted him off to the ambulance. And that's pretty much how that incident went through.

Q41 (PRESIDENT): So before EMS got there did he complain of…other than the cramping, any pain, headaches, nausea, feel sick to my stomach, any other----
A41 (FAC 1): Not at all, sir.

Q42 (PRESIDENT): No other problems?
A42 (FAC 1): Just those leg cramps. He can't move his legs at all.

Q43 (PRESIDENT): Did he have any other comments, say other than his legs were cramping and hurting?
A43 (FAC 1): No.

Q44 (PRESIDENT): All right. About how long was it between him going down and you calling EMS?
A44 (FAC 1): I want to say that had to be about being with him out there about five minutes, just talking to him and finding out that I know that I can't do anything else. I cannot do any type of AED action because the gentleman is conscious.

Q45 (PRESIDENT): Right.
A45 (FAC 1): You can't do anything if the person is conscious. As far as a first aid I can provide, kind of very difficult to actually handle a situation like that. So the thing that I thought to my mind was call 911. They're the experts. They can assess it. They have all the equipment, all the medical equipment to go ahead and take care of a person. So that's what I ended up doing.

Q46 (PRESIDENT): All right, so you're talking to him for about five minutes. Did he ever say not to call EMS?
A46 (FAC 1): No. Well actually he did. He did tell me that not to call 'cause he felt that he didn't need the help.

Q47 (PRESIDENT): Okay.
A47 (FAC 1): I made a decision to actually call it because he kept doing the same rolling over. So I was like, okay, he's talking to me but he's actually still doing the same motion that I thought was strange anyway.

Q48 (PRESIDENT): Did he act strange in any other ways?
A48 (FAC 1): Not all. Like I say, he was laying down. It was cold out. It was almost like he was very relaxed, like if he was out…he would actually try to take a nap, almost. It's that type, exhausted.

Q49 (PRESIDENT): All right. So EMS comes. They take care of him for about five minutes you said?
A49 (FAC 1): Yeah. They talked to him.

Q50 (PRESIDENT): Talked to him.
A50 (FAC 1): Keep going.

Q51 (PRESIDENT): Seemed to be appropriate, talking back and forth?
A51 (FAC 1): Cohesive, right, yeah. Conscious, talking.

Q52 (PRESIDENT): Load him up, wheel him across the field, pack up and drive off?
A52 (FAC 1): Yes, sir.

Q53 (PRESIDENT): That's the last you see of him?
[Affirmative response by the FAC 1.]

Q54 (PRESIDENT): Okay. After EMS drove off, what did you all do next?
A54 (FAC 1): After that we went ahead and everybody was still waiting for us. So they were waiting for our scorecards to be brought…their scorecards to be brought back to the front counter. Right after we brought the scorecards, of course we went ahead and dispersed everybody. Folks that were already out there, they were wondering what happened to him, 'cause there were folks that were already knew that there was an issue going on out there and they knew that we were taking care of that so we can immediately go and take care of their issues, as far as, you know, giving them their copy of the scorecard. So they were asking, especially the one gentleman, the Lieutenant Colonel, he saw me coming in, 'cause he was partnered…partnered of with him. So he was, hey, is he okay? I was like, sir, you know, we

were out there. We called EMS. EMS came and then from there, he's at the hospital right now as far as I know.

Q55 (PRESIDENT): So other people that were taking the test that day were concerned about him as well?
A55 (FAC 1): Yes, sir.

Q56 (PRESIDENT): All right. So after you finished up with everybody that was taking the test that day, then what happened next?
A56 (FAC 1): After that, of course we had another chalk that was getting ready to come in, so we went ahead and took care of business with the new set of people that were basically going to be tested as well.

Q57 (PRESIDENT): All right. Did anybody reach out to the member's squadron or their leadership to say hey, just to let you know, the guy went to the hospital in an ambulance?
A57 (FAC 1): No, not us, we didn't. As far as myself, I didn't do that.

Q58 (PRESIDENT): All right.
A58 (FAC 1): Of course, then that's pretty much everything is right now with that.

Q59 (PRESIDENT): Right. When was the next time you heard anything about Tech Sergeant MOC ?
A59 (FAC 1): Next time I head, I actually had our acting first sergeant came over to the fitness assessment cell, and he asked did you hear anything about him. I was like, no, sir, not until the last time I heard is when we called EMS, and that was pretty much it. So that's when I was like, okay, well then I'll go ahead and at least send out an email. And even with that, when I did send my email, it stood in the Outbox. So I had to delete emails out so that I can actually get that email out, email traffic to leadership. So with that, like I said, I take full responsibility with that. It's nothing I can really do with that. Our main concern at the time was making sure that that gentleman had the care that he needed, and that's what we did. And then of course, we made it right and we sent the email out, then everybody else got an email. That's pretty much how that went down.
(PRESIDENT): All right.
Either of you have any questions?

Q60 (LEGAL ADVISOR): What was the…this is the Legal Advisor. What was the reason for delayed notification to the leadership?
A60 (FAC 1): As far as?

Q61 (LEGAL ADVISOR): Between the time of calling 911 to the email, 'cause that email happened later in the afternoon.
A61 (FAC 1): Yes, sir.

Q62 (LEGAL ADVISOR): Was it because other testing was occurring that day?
A62 (FAC 1): Yeah, we still had other chalks in there, so we went right in, you know?

Q63 (LEGAL ADVISOR): Okay.
A63 (FAC 1): Right in there 'cause I know we have people waiting for us to actually…they're not noticing, you know. Folks are not going to know what's going on unless you tell 'em. So they're going to be…they're just as customers, just as everybody else waiting out there.

Q64 (PRESIDENT): And approximately how long after he fell down did it take you to get to his position?
A64 (FAC 1): Shoot, when he fell down I was there probably in a few seconds 'cause I ran all…as fast I could possibly can to that corner of the track to go and take care of 'em.
(PRESIDENT): Okay.

Q65 (PRESIDENT): Did you take the AED with you?
A65 (FAC 1): No, I didn't. But right after, as I was there, like I said, I was talking to him. So at the time, of course he didn't need any AED 'cause he's conscious and talking to me. But of course right after the last few people went through and finished off their test, of course my troop grabs all his equipment and brings it over to me. So we're sitting there, of course with the Kubota, and all the equipment that we have for the test out there.

(PRESIDENT): Any other questions?
All right, I think at this time this concludes our interview for you. We may call you back again at some point in time if further questions come up. But since the investigation will continue over the near term I would ask that you not discuss your testimony today with anyone until after the formal report is published. Again, thank you for your time. That's it for today. Appreciate it.

V2. ACTING FIRST SERGEANT
VERBATIM TESTIMONY

(PRESIDENT): My name is Colonel Michael Wood. I'm the board president for the ground accident board. We're investigating the circumstances surrounding the death of Tech Sergeant MOC . This investigation is conducted in accordance with AFI 51-503, is separate and apart from a safety investigation that may be conducted in accordance with AFI 91-204. This ground accident investigation board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC death, to prepare a publicly releasable report and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes. A formal safety investigation has not been conducted to date. Your sworn testimony to the board may be used for any proper purpose. Additionally, your testimony may…can be released to the public. Do you understand how your testimony before this accident board maybe used?

(ACTING FIRST SERGEANT): Correct.

(PRESIDENT): Do you solemnly swear or affirm that the testimony that you're about to give in the mater now under investigation shall be the truth, the whole truth, and nothing but the truth, so help you God?

(ACTING FIRST SERGEANT): I do.

Q1 (PRESIDENT): Could you please state your full name for the record?
A1 (ACTING FIRST SERGEANT): First name…well full name, .

Q2 (PRESIDENT): Okay, and your rank?
A2 (ACTING FIRST SERGEANT): Tech Sergeant.

Q3 (PRESIDENT): And what's your current duty?
A3 (ACTING FIRST SERGEANT): Acting First Sergeant and Superintendent, Career Development.

Q4 (PRESIDENT): All right. For which squadron?
A4 (ACTING FIRST SERGEANT): Force Support Squadron.

Q5 (LEGAL ADVISOR): This is . I just want to let you know, , if you can speak up. If we'll all speak up to make sure we get it on the transcript.
A5 (ACTING FIRST SERGEANT): Okay.

Q6 (LEGAL ADVISOR): How do you spell your last name?

A6 (ACTING FIRST SERGEANT): My full name, I'll spell my whole full name.
last name is
Q6 (PRESIDENT): Thank you.

Q7 (PRESIDENT): So how long have you been the acting first sergeant?
A7 (ACTING FIRST SERGEANT): Since around the first week of October.

Q8 (PRESIDENT): Okay, and how did you know…did you know Tech Sergeant MOC ?
A8 (ACTING FIRST SERGEANT): Not necessarily, no. I just knew of him as an instructor at the ALS School.

Q9 (PRESIDENT): And were you testing that same day?
A9 (ACTING FIRST SERGEANT): That is correct.

Q10 (PRESIDENT): All right.
Q10 (LEGAL ADVISOR): And testing, at the same time period?
A10 (ACTING FIRST SERGEANT): Correct, 0600 hour test, we both were testing on that date. On the 26th of October.

Q11 (PRESIDENT): All right. When Tech Sergeant MOC arrived there, how did he appear?
A11 (ACTING FIRST SERGEANT): Everything seemed pretty normal. Nothing out of the norm.

Q12 (PRESIDENT): Did he look any different from anybody else that was there?
A12 (ACTING FIRST SERGEANT): No, sir.

Q13 (PRESIDENT): Did he appear to be sleepy or tired?
A13 (ACTING FIRST SERGEANT): As well as everyone else, yes, Sir.

Q14 (PRESIDENT): Okay. But no other concerns that you noted at that time?
A14 (ACTING FIRST SERGEANT): No, it was fine.

Q15 (PRESIDENT): All right. Went through the first portion of the exam with you?
A15 (ACTING FIRST SERGEANT): Well, he was in a different grouping than I was. We paired off into two's to do your push-ups and sit-ups. I was in the first grouping, he was in the second grouping. So I didn't get to…well, I didn't see his push-ups or sit-ups but. So we, you know, vice versa, to do the calisthenics part.

Q16 (PRESIDENT): All right. So then when did you see him again?

A16 (ACTING FIRST SERGEANT): The next time I remember seeing him is about 15 to 20 minutes after the initial part of the test, where we all met outside at the track. I can't give you an exact time but probably about 15 to 20 minutes after the initial part of test was over.

Q17 (PRESIDENT): All right. What was the weather like out there that morning?
A17 (ACTING FIRST SERGEANT): Was very brisk outside that morning, very cold.

Q18 (PRESIDENT): Okay. And what…did you notice anything about Tech Sergeant MOC before the run portion started?
A18 (ACTING FIRST SERGEANT): The only thing I can recall is right prior to the test is he seemed to want to try get more comfortable, so he took off a jacket and put on a sweater, then put on his fitness jersey number over top of the sweater.

Q18 (PRESIDENT): Okay.
A18 (ACTING FIRST SERGEANT): And that was right prior to those individuals starting the test.

Q19 (PRESIDENT): And then what happened once the test started?
A19 (ACTING FIRST SERGEANT): Once the test start, I don't really…I don't remember anything as far as ever seeing or ever having pass Sergeant MOC . I just remember when I finished the test, after I get around and cross the finish line I do a cool down, maybe like 75 meters. I walk about 75 meters, and I turn right back around and that's when I noticed Sergeant MOC maybe diagonal across the track, almost really stopped. He came to a stop. Excuse me. He came to a stop and then maybe goes down to a knee, and then completely lays completely out. From afar, it almost just looks like he's just having trouble breathing.

Q20 (PRESIDENT): Did you see him running before he stopped?
A20 (ACTING FIRST SERGEANT): Oh, he ran prior to.

Q20 (PRESIDENT): Okay.
A20 (ACTING FIRST SERGEANT): Yeah, he…I remember him starting the test, that's it. So after I started the test, we all started at the same time. I don't remember seeing having passed him. I remember seeing having lap him or anything like that. I just remember him starting the test and that's it.

Q21 (PRESIDENT): Okay, but when you turned around was he still running, or was he slowing down, or did he…walking or did he already stopped?
A21 (ACTING FIRST SERGEANT): Okay, got you. When I actually turned back around to…from my cool down walk, he was already slowing down.

Q22 (PRESIDENT): Okay, so he's slowing down.
[Affirmative response by the witness.]
You see him stop; put his hands in his knees.

[Affirmative response by the witness.]
And then go down to one knee.
A22 (ACTING FIRST SERGEANT): Correct.
Q22 (PRESIDENT): And then lay down.
A22 (ACTING FIRST SERGEANT): That's correct.

Q23 (PRESIDENT): About how long from, you know, the stop to going down, about how long was that?
A23 (ACTING FIRST SERGEANT): It all happened so quick, maybe seconds. Then I can't recall, but it happened really quick. Yeah, it happened really quick.

Q24 (PRESIDENT): So once he stops, did anybody go to assist him?
Q24 (ACTING FIRST SERGEANT): Yes, as soon as it happened, the FAC team was all over it. Sergeant [FAC 1] in particular, ran over to assist him. And I just…I just remember seeing him dart across the field to really check on him. You know, from that far, he might have been a hundred meters from where I was actually sitting or standing. You can't tell exactly what somebody's doing from that far.

Q25 (PRESIDENT): Yeah.
Q25 (ACTING FIRST SERGEANT): But we assumed he was good to go. And then another individual from the actual test, he ran over to assist as well.

Q26 (PRESIDENT): Okay, so from when did the first person run over to assist? Was he still standing or was he already down by that time?
A26 (ACTING FIRST SERGEANT): Well once he went down to a knee that's when Sergeant [FAC 1].

Q27 (PRESIDENT): Okay, so once he went down to the knee?
A27 (ACTING FIRST SERGEANT): Correct. So I said that's all I remember. I see the individual, and then I look over and I see the… [FAC 1] running over.

Q28 (PRESIDENT): And how long before the second individual went to assist?
A28 (ACTING FIRST SERGEANT): It was almost like immediately.

Q29 (PRESIDENT): Okay.
A29 (ACTING FIRST SERGEANT): So after we seen him running over there, that one particular…I don't know who he was, but he was testing with us that day.

Q30 (PRESIDENT): So seconds at most?
A30 (ACTING FIRST SERGEANT): That's correct.

Q31 (PRESIDENT): All right. Now was one of the fitness assessment cell folks that was running----
A31 (ACTING FIRST SERGEANT): Yeah.

Q32 (PRESIDENT): ----the second person----
A32 (ACTING FIRST SERGEANT): So it was two guys out there, FAC 2 , FAC 1 . FAC 1 took off after Sergeant MOC right at the time. And FAC 2 stayed, you know, to finish administering the test or just to monitor the individuals who were already complete.

Q33 (PRESIDENT): Okay. Did any of the test participants run over to assist?
A33 (ACTING FIRST SERGEANT): Well that's what I was saying, that one individual who did as well, other than FAC 1 , I just don't know who he was.

Q34 (PRESIDENT): Okay, got it.
A34 (ACTING FIRST SERGEANT): So I don't know what his role was or what he actually did when he got there, may be just to assist.

Q35 (PRESIDENT): All right. So then once…we've got the two individuals over there to assist Sergeant MOC . You've still got one FAC person back there with the group of you. What happens at that point in time?
A35 (ACTING FIRST SERGEANT): At that time they…we're informed or we're instructed to go ahead and head toward the James Gym to prepare to sign for our actual test.

Q36 (PRESIDENT): All right. So everybody goes back to the James Gym?
A36 (ACTING FIRST SERGEANT): That's correct.

Q37 (PRESIDENT): About how long was it before someone showed up to finish up your all's sign in for the test?
A37 (ACTING FIRST SERGEANT): I can't tell you exactly how long it was. To my recollection it was maybe 20, 25 minutes or so. From the point where we got to the actual gym, where we walked back, got to the gym, and just really sat there and wait for, you know, for those guys to finish up with everything.

Q38 (PRESIDENT): Okay. Was anybody concerned about the person that…who'd gone down at the track?
A38 (ACTING FIRST SERGEANT): Well the only individual that I spoke to at the time, we were just sitting there together, we never talked about it. So I'm not sure if they had any other side conversations about him.

Q39 (PRESIDENT): So when the…did the FAC say anything when they got there about what happened?
A39 (ACTING FIRST SERGEANT): No. They didn't make an announcement or anything. As soon as they came in, they were right about business, about getting the tests scoresheets. They made copies of those and they had I sign for 'em.

Q40 (PRESIDENT): Okay. Did they make any comment about an ambulance had picked the individual up?
A40 (ACTING FIRST SERGEANT): No. I know I remember asking 'em, I'm not sure about everybody else, it was just out of a personal concern. I just asked, hey, was that individual okay, and you know they stated yeah, an ambulance came and he seemed to be okay.

Q41 (PRESIDENT): Did they give you any indication of what the problem was?
A41 (ACTING FIRST SERGEANT): Nope.

Q42 (PRESIDENT): Did they give any names about who was involved?
A42 (ACTING FIRST SERGEANT): No names.

Q43 (PRESIDENT): Okay. Did anybody ever mention leg cramps?
A43 (ACTING FIRST SERGEANT): Yes. Yes, so when I asked what…is the individual okay, they said it seemed to be maybe like a severe case of leg cramps.

Q44 (PRESIDENT): Okay. All right. So then you sign your test and head back to work?
A44 (ACTING FIRST SERGEANT): Yes, sir. I go ahead and get showered and dressed, and head on over to work.

Q45 (PRESIDENT): And about what time do you think you got back to work? Ballpark.
A45 (ACTING FIRST SERGEANT): May be around 9:30.

Q46 (PRESIDENT): Okay. Anything with your…different from your morning routine once you got back to work?
A46 (ACTING FIRST SERGEANT): No, checking emails, seeing what's going on with my section, make sure everything's good to go.

Q47 (PRESIDENT): Okay. What was the first indication that something might've gone wrong with Tech Sergeant MOC , that you were aware of?
A47 (ACTING FIRST SERGEANT): Well, I actually received an email from our UFPM, just basically stating that, you know, an individual did not complete his test. His actual scoresheet for what turned out to be Sergeant MOC , and it only had the really the blurb on the actual scoresheet that said an individual or the first responders were called. I can't remember the correct verbiage, but it basically stated he was picked up by ambulance. So I just put two and two together to figure out, hey, that was the same incident from this morning.

Q48 (PRESIDENT): So was there any other indication or emails from the fitness assessment cell to you as the First Shirt, to say that somebody in your squadron had a problem?
A48 (ACTING FIRST SERGEANT): No, I didn't see anything else prior to that.

Q49 (PRESIDENT): Was there anything in the text, the email that you did get that would have indicated that there was some sort of a problem where they had to call an ambulance?
A49 (ACTING FIRST SERGEANT): From that email, no.

Q50 (PRESIDENT): All right.
Q50 (LEGAL ADVISOR): What time was this?
A50 (ACTING FIRST SERGEANT): It was after lunch, so maybe around the 1 o'clock hour, sir.

Q51 (PRESIDENT): Okay. So after you get the email, then what did you do?
A51 (ACTING FIRST SERGEANT): Go over to the actual fitness assessment cell, over to the FAC, across at the fitness center, to really just ask questions, like basically, hey, what actually happened, have you guys heard anything, do you know, you know, any of his whereabouts or anything like that.

Q52 (PRESIDENT): Did they have any other information to give you?
A52 (ACTING FIRST SERGEANT): No, they didn't.

Q53 (PRESIDENT): Did you get any calls from anybody in his section?
A53 (ACTING FIRST SERGEANT): Shortly thereafter, or right there around the same time, is when I talked to ALS Supervisor , and she was actually asking the same things.
Q54 (PRESIDENT): So once----
A54 (ACTING FIRST SERGEANT): Had we heard anything, or do I know anything. And so I said, hey, let me find some stuff out and then, you know, we'll re-engage.

Q55 (PRESIDENT): So how did you find stuff out?
A55 (ACTING FIRST SERGEANT): When I get back from talking to the FAC, from those guys, talked to ALS Supervisor . Soon thereafter is when the staff or the nurse practitioner, whoever the individual was, she actually called the military personnel section, just trying to find out any type of information on who the individual was. She knew he was on base, of course, he came in PT gear, had a military ID card. And so she was just trying to call anybody. And she said she actually got our number off the base website.

Q56 (PRESIDENT): What time did you interact or talk with ALS Supervisor ?
A56 (ACTING FIRST SERGEANT): It was around the 1 o'clock hours. It was right there around that time, I'm not sure exactly what type, sir.

Q57 (PRESIDENT): So what time did the hospital call?
A57 (ACTING FIRST SERGEANT): Closer to 2 o'clock, 1:30, 2 o'clock timeframe. So after they…after…'cause she…they didn't actually call me. They called a different section in the MPF, and so when she called that different section, the individual who actually…he came to get me, being in the role that I was sitting in. So you know, I go over to the phone, you know, and my thing was, I wanted to

make sure that I got all her information to be able to pass along to whoever I needed to talk to. So I talked to her and she's telling me different things. And so I get her information, and I'm like hey, I'll find you the information that she's looking for, which was next of kin information. And I was like I'll give you a call back. So you know, throughout the rest of the time, I'm constantly talking to those guys. I gave 'em my number so they can call me when, you know, if they have anything as well.

Q58 (PRESIDENT): The phone call from ALS Supervisor was that before or after you received the email?
A58 (ACTING FIRST SERGEANT): That was after, because she…I'm not completely sure, she might have gotten the email as well, as the supervisor I think we talked about that. I'm just not sure.

Q59 (PRESIDENT): Who answered the phone when the hospital called?
A59 (ACTING FIRST SERGEANT): FSS 1 , same individual who sent the email. She just happen to call and called our phone tree and got…and he picked up that particular call.

Q60 (PRESIDENT): All right. Do you still have the email?
A60 (ACTING FIRST SERGEANT): I believe so. I keep all my emails.

Q61 (PRESIDENT): We'll probably want a copy of that.
A61 (ACTING FIRST SERGEANT): I'll forward it to you.

Q62 (PRESIDENT): Or just print it off.
A62 (ACTING FIRST SERGEANT): Well it won't have the time of the actual email, so I can write it on there, sir.

Q63 (PRESIDENT): So hospital calls you looking for next of kin information, it's a nurse that's calling you. Who called the hospital back?
A63 (ACTING FIRST SERGEANT): To…who called them back to?

Q64 (PRESIDENT): Did anybody call the hospital back?
A64 (ACTING FIRST SERGEANT): While we were looking for information?

Q65 (PRESIDENT): Right.
A65 (ACTING FIRST SERGEANT): Yeah, we were looking for information, so I know they end up calling me back before I found anything, and you know, I just reiterated to her that I don't have anything else as of right now.

Q66 (PRESIDENT): Okay, so the hospital called you back?
A66 (ACTING FIRST SERGEANT): Correct.

Q67 (PRESIDENT): All right. And how are you looking for information about the next of kin information?
A67 (ACTING FIRST SERGEANT): Well anytime we have situations like that, we, you know, we contact the first, to see if maybe his people have anything. So ALS Supervisor , to see if they had any type of information for his wife. We pulled his emergency data card, his vRED, his SGLI, his life insurance form; we looked in DEERS, and we also pulled our information in MilPDS, that's just the personnel system that we have there to try to find any information. And everything was really consistent as far as the information that he put on everything. Everything has the house number, which of course nobody answered, nobody was actually home.

Q68 (PRESIDENT): The house number was listed against whose name?
A68 (ACTING FIRST SERGEANT): His wife's. So it didn't have a cell phone against her name, it just had the house number. And on the emergency data form, the vRED, it only had the wife, which has the house number; it had the mother, it had a cell phone number; it had the father, and a cell phone. So at the mother, address and a cell phone; the father, address and a cell phone.

Q69 (PRESIDENT): So was the cell phone number for the mother correct?
A69 (ACTING FIRST SERGEANT): No, sir.

Q70 (PRESIDENT): Was the cell phone number for the father correct?
A70 (ACTING FIRST SERGEANT): No, sir. And I actually both of those and the number for the mother rang to an individual, I'm not…I'm still not sure who the individual was. I left a pretty detailed message about, you know, needing to get in contact, and after a couple of calls she called back, basically stating, hey, I'm not that individual but you know, hope you guys find 'em. And the father, whoever picked up the phone really had no idea what I was talking about.

Q71 (PRESIDENT): But informed you it was a wrong number?
A71 (ACTING FIRST SERGEANT): That's correct.

Q72 (PRESIDENT): Okay. Was there an address for the father?
A72 (ACTING FIRST SERGEANT): There was, it was an out of town address, so it might have been , I think.

Q73 (PRESIDENT): Okay. Was there an address for the mother?
A73 (ACTING FIRST SERGEANT): Yes, it was a address.

Q74 (LEGAL ADVISOR): Okay. The home number you just mentioned, was that the home number for Sergeant MOC or was that the home number for the mother?
A74 (ACTING FIRST SERGEANT): The mother only had a cell phone. The number was their actual home number.

Q75 (PRESIDENT): Okay.
A75 (ACTING FIRST SERGEANT): Or at least that's what I assumed at the time.

Q76 (PRESIDENT): Okay. So once you found out that you didn't have good phone numbers, what happened next?
A76 (ACTING FIRST SERGEANT): Spoke it over with the ALS staff, ALS Supervisor and those guys, and decided to…she decided to take the trip up to the mother's house, because at the time she stated that she knew the mother lived in the area, because the child…she kept the child throughout the day. So she stated they would go over there to see if she was home.

Q77 (PRESIDENT): Okay. About what time did she say she was going to go over?
A77 (ACTING FIRST SERGEANT): That was after the 2 o'clock hour maybe, maybe 3 o'clock around that time, 2:30.

Q78 (PRESIDENT): What did you do at that point in time?
A78 (ACTING FIRST SERGEANT): Just talked it over with our leadership, just to see, hey, what's our next step, and then they decided, hey, we're going to go up there.

Q79 (PRESIDENT): Sorry, but who was your leadership?
A79 (ACTING FIRST SERGEANT): I'm sorry. At the time, our commander was out-of-pocket. He was tdy. So it was FSS 2 , which was…she happened to be our deputy at the time...well, she's our deputy, I'm sorry. Our superintendent, FSS 3 , and myself, we decided to go up to the hospital.

Q80 (PRESIDENT): All right.
Q80 (LEGAL ADVISOR): How do you spell the names of the major and then, Chief Master Sergeant?
Q80 (ACTING FIRST SERGEANT): The major, is Major…forgive me if I get this incorrect but I think it's FSS 2 . And Chief FSS 3 , and

Q81 (PRESIDENT): So the three of you go to the hospital?
A81 (ACTING FIRST SERGEANT): That's correct.

Q82 (PRESIDENT): About what time was that?
A82 (ACTING FIRST SERGEANT): It's around 3:30 or 4.

Q83 (PRESIDENT): Okay.
A83 (ACTING FIRST SERGEANT): Probably closer to the 4 o'clock hour.

Q84 (PRESIDENT): All right. Who got to the hospital after the three of you got to the hospital?
A84 (ACTING FIRST SERGEANT): After we arrived, FSS 2 was in contact with our commander, who happened to be returning from his tdy on that evening, or that early afternoon, and she let him know that we were actually up there. So we arrived after 4, maybe around 4:15, 4:30 or so, and then he arrived maybe half an hour later.

Q85 (PRESIDENT): Did anybody else arrive after that?
A85 (ACTING FIRST SERGEANT): They did. ALS Supervisor and ALS 1 also came to the hospital.

Q86 (PRESIDENT): Okay. Once you got to the hospital, did the hospital tell you anything or ask you for anything?
A86 (ACTING FIRST SERGEANT): Well, at the time that we originally got there, they hadn't spoken with the wife, as of that time that we originally arrived there. So you know, their whole thing was they couldn't divulge too much information. They let me know he wasn't doing good and because she had…I can't remember the nurse's name, but she actually let me come in to see if he maybe would have recognized me. So of course he didn't recognize me at the time. So you know, that's all I really knew. And then, almost really immediately after we get up there they get in contact with the wife. And she calls…she was able to call…well ALS Supervisor was able to get in contact with the mother. The mother was able to get in contact with the wife. So of course she calls immediately and from that point on the hospital, you know, of course only dealt with her.

Q87 (PRESIDENT): Okay. Were you aware of any calls from the fitness assessment cell to let your squadron or squadron leadership know about the ambulance or anything going on with Tech Sergeant MOC ?
A87 (ACTING FIRST SERGEANT): No, sir, I didn't receive anything. I'm not aware of any other calls or anything.

Q88 (PRESIDENT): And once the hospital start talking to the wife, did they give you any further information?
A88 (ACTING FIRST SERGEANT): No, they did not.

Q89 (PRESIDENT): How did you find out any information after the hospital got a hold of the wife?
A89 (ACTING FIRST SERGEANT): Anything afterwards, after that, really after that particular evening, that was the only night, that Monday night is when I went up to the hospital, and anything afterwards I received from Squadron Commander via text or via conversations, just really checking the status of what was actually going on.

Q90 (PRESIDENT): Did Squadron Commander go back to the hospital to your knowledge?
A90 (ACTING FIRST SERGEANT): To my recollection or to my knowledge he was there every day.

Q91 (PRESIDENT): Okay. Other than all of that, are you aware of any…as the first shirt, were you aware of any duty performance issues that Tech Sergeant MOC had?
A91 (ACTING FIRST SERGEANT): No. Myself and 1st Sgt , any time…I've been acting shirt before. Anytime the first sergeant has actually handing out, he'll sit you down and they'll go over the particular issues that the unit is having and the hot items, or may be any type of disciplinary actions that are going on. And you know, Sergeant MOC wasn't brought up throughout the time that we talked over the last couple of weeks prior to him leaving.

Q92 (PRESIDENT): Either of you have any other questions?
A92 (LEGAL ADVISOR): Nothing from me, sir.

(PRESIDENT): At this point that concludes our interview for today. The investigation will continue for the near term so until there's a public release of information I'd ask that you do not discuss your testimony today with anyone until after the formal report is published. If you have any questions, please give us a holler.

(ACTING FIRST SERGEANT): Yes, sir.

(PRESIDENT): Thank you.

V3. WIFE
VERBATIM TESTOMONY

(PRESIDENT): My name is Colonel Michael Wood. I'm the Board President for the Ground Accident Investigation Board, investigating the circumstances surrounding the death of Tech Sergeant MOC . This investigation, conducted in accordance with AFI 51-503, is separate and apart from any safety investigation that may be conducted in accordance with AFI 91-204. This Ground Accident Investigation Board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC's death, to prepare a publically releasable report, and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for any other purposes. A formal safety investigation has not been conducted to date. A sworn testimony to the board may be used for any proper purpose. Additionally, your testimony can be released to the public.

Do you understand how your testimony before this Accident Board may be used?

(WIFE): Yes.

Q1 (PRESIDENT): Okay. Do you solemnly swear or affirm that the testimony you're about to give, in the matter now under investigation, shall be the truth, the whole truth, and nothing but the truth, so help you God?
A1 (WIFE): I do.

Q2 (PRESIDENT): Thank you very much. Now, can you please, for the recording, say your name?
A2 (WIFE): .

(PRESIDENT): Thank you very much.

Q3 (LEGAL ADVISOR): How do you spell ?
A3 (WIFE): .

Q4 (LEGAL ADVISOR): Thank you. Where did you and Sergeant MOC meet?
A4 (WIFE): We met playing softball. And so, he was a -- he was -- his best friend was the brother of somebody that I worked with, and we all became friends; we're on the same softball team, and kind of met there. There was no other reason that our paths would've crossed.

Q5 (PRESIDENT): How long were ya'll married?
A5 (WIFE): It would've been 12 years in February; Friday the 13th.

Q6 (PRESIDENT): Did you know of any medical problems that he had in the past?
A6 (WIFE): No. None.

Q7 (PRESIDENT): None. Did he know of anything?
A7 (WIFE): No.

(PRESIDENT): Okay.

(WIFE): Well, I mean, I -- he would've told me if he would've known, so ----

(PRESIDENT): I'm -- I'm just -- I'm guessing, so ----

(WIFE): Right.

Q8 (PRESIDENT): Was he on any medications?
A8 (WIFE): Recently was just the high blood pressure medication; there were two. That should be in -- I didn't bring them, but they were ----

(PRESIDENT): It's all right.

(WIFE): It should be in his medical records. There are two -- two pills that he were -- he was taking. And that was new to this PT test. I mean, he had -- he'd never taken a PT test on that medication before.

Q9 (PRESIDENT): How long had he been on them?
(LEGAL ADVISOR): Ball park ----
A9 (WIFE): Four months, maybe.

Q10 (LEGAL ADVISOR): Did he take them regularly?
A10 (WIFE): Every day; uh-huh.

Q11 (PRESIDENT): So, other than the hypertension, the high blood pressure, and the two meds for the high blood pressure, no -- no medical problems?
A11 (WIFE): No. And then the -- I mean, he knew he had the sickle cell trait, but that was ----

(PRESIDENT): Okay.

Redaction of unrelated medical Issue

Redaction of unrelated medical issue

Q16 (PRESIDENT): All right. So, you knew he had sickle trait. When did he know he had the sickle trait? Do you know?
A16 (WIFE): I don't.

(PRESIDENT): Okay.

(WIFE): I know -- I think -- I don't know. I think in Basic was the first time he might have known, but I really don't know.

Q17 (PRESIDENT): Did it ever give him any problems?
A17 (WIFE): Nothing. He played sports all through high school; football, basketball, softball, baseball, and so he was an extremely active guy. A very physical -- he was a tile setter before, so he had a very physical labor job.

Q18 (PRESIDENT): Did he have any particular stressors going on? Anything that stressed him out, made him worried?
A18 (WIFE): I mean, the PT test stresses him out. That can be a career ender, so that's stressful. Not really. I mean, we -- no. I mean, we were slated to move. You know, he was going to -- but he was excited about going on a remote and then switching bases, so not -- not anything work related and not home related.

Q19 (PRESIDENT): Okay. Thinking back to before the 26th, we'll just take it as step-by-step for those first 3 days. The day before the test, do you remember anything about when he got up, when he went to sleep, what he ate that day?
A19 (WIFE): I mean, that was a day that -- you know, got up and he carved pumpkins with our daughter. And that was the sort of a daily thing there, and so we had, you know, roasted pumpkin seeds and I know I had a work thing, so he went out and got take-out food from Fresh

Time, you know, the already prepared meals that he and the daughter had. I didn't think I had any. He might have had some of the soup I made. I know he had -- he had a bowl of -- it was broccoli corn chowder cheddar soup that he really liked. He never eats leftovers, but he had a ton of that. He had soup, you know, at 9 o'clock at night, because I was eating it and he -- I let him have it, because I didn't eat dinner that night, so I let him have it, yeah.

Q20 (PRESIDENT): Okay. So, on that Sunday, about what time do you think he got up, ball park?
A20 (WIFE): I have no -- I probably got up -- I would say probably 8:30.

(PRESIDENT): 8:30?

(WIFE): Uh-huh.

Q21 (PRESIDENT): All right. About what time do you go to bed?
A21 (WIFE): He did have trouble sleeping, because he was nervous. So, he probably went to bed at 8, he was back up at 9, stole my food, went back to sleep, and then he was out the door, like I said, he had to be there at 6, so he was out the door, I think -- I mean, 5:30 -- he was up at 4. So, I know he was up very, very early.

Q22 (PRESIDENT): So, out the door probably about 5 ----
A22 (WIFE): 5:30 ----

Q23 (PRESIDENT): ---- 30?
A23 (WIFE): Maybe; 5:15/5:30. Uh-huh.

Q24 (PRESIDENT): So, all in all, a fairly normal Sunday, other than ----
A24 (WIFE): Carv -- yeah, pumpkin carving.

Q25 (PRESIDENT): ---- concerned about the PT test?
A25 (WIFE): Yeah, right.

Q26 (PRESIDENT): And pumpkin carving time with the daughter?
A26 (WIFE): Right.

Q27 (PRESIDENT): Okay. How about the Saturday before that?
A27 (WIFE): Okay, so before that, he, you know, again got up at, you know, the 8:30 timeframe, decided he was going to take Daughter to the -- and his mother to the sculpture garden, the Laumeier Sculpture Garden in St. Louis, and they looked at sculptures and went on a walk-around. Now, as far as what they had to eat, like I -- I have no idea what they had. It would've been probably, you know, ----

Q28 (PRESIDENT): Food while out and about?
A28 (WIFE): Yeah. I mean, that's -- he, I'm sure, would've tried something new. And then came home. I think we had tuna melts and corn chowder. It could've been the Friday before,

but I know I made soup and tuna, because that's what he just randomly decided that he wanted, so ----

(PRESIDENT): Okay.

(WIFE): I was impressed that I could whip that up, so ----

Q29 (PRESIDENT): About what time did he go to bed that night?
A29 (WIFE): I would say probably 10.

Q30 (PRESIDENT): And -- so, then the Friday before that?
A30 (WIFE): I don't remember. I mean, it would've been -- um, let me see, that would've been the -- I think that was the Friday after graduation. So, he probably would've -- would assume he would have napped all day. I would -- because that's the sort of decompression, but I can't remember, because I would've gone to work, he probably would've, you know, woken up at 8 and, you know, watched, I don't know, you know, Ancient Aliens or something. But sort of just relaxed, I think, and decompress from the -- would be my guess, I don't know.

Q31 (PRESIDENT): Any idea about when he probably went to bed that night?
A31 (WIFE): 10; he was not one for staying up late.

Q32 (PRESIDENT): On that Friday, Saturday, and Sunday, did he do any exercise during those days?
A32 (WIFE): I think he went to the gym. He might have gone to the gym or he probably went on a run; I'm not sure. Can't remember because he's been -- he runs, you know two to three times a week and goes to the gym two/three times a week. But I'm not sure the -- the schedule. But like I -- and nothing out of -- like, he didn't -- I don't think he took a break or did any more than he normally did.

Q33 (PRESIDENT): Okay. So, he ----
A33(WIFE): His regular ----

Q34(PRESIDENT): ---- kept with his routine?
A34 (WIFE): Yeah.

Q35 (LEGAL ADVISOR): Ma'am, this is the Legal Advisor. In terms of the gym and running ----
A35 (WIFE): Uh-huh.

Q36 (LEGAL ADVISOR): ---- activity, if you know, if -- if he would go to the gym and not run, like two or three times a week and then he'd run an additional two to three times a week, or was that -- would you say ----
A36 (WIFE): Separate days. So, he would go -- he'd either go to the gym or run. So, he would ----

(LEGAL ADVISOR): Okay.

(WIFE): He's alternate.

(LEGAL ADVISOR): Okay.

(WIFE): So, probably, you know, some sort of workout, 6 days a week is typically -- some sort of physical ----

Q37 (PRESIDENT): Was he taking any supplements, diet aids, anything to try to lose weight or get ready for the PT test?
A37 (WIFE): No.

Q38 (PRESIDENT): And the 2 weeks before, anything unusual, outside his normal routine?
A38 (WIFE): No.

Q40 (PRESIDENT): Did he usually work Monday through Friday?
A40 (WIFE): Uh-huh; yes.

Q41 (PRESIDENT): What time did he usually get up on Mondays through Fridays; usually?
A41 (WIFE): I would say 5:15, and in the shower at 5:30.

Q42 (PRESIDENT): And what time did he usually try to show up at work?
A42 (WIFE): I believe -- class was starting at 7, so he would like to get there early, between 6:15/6:30.

Q43 (PRESIDENT): Okay. About what time did he usually leave work in the evenings?
Q43 (WIFE): That really depended if he was lesson prepping or not. I would say -- he usually beat me home. So, I would say he probably leave at 5, and that's what he would shoot for.

Q44 (PRESIDENT): Did he have a -- in those 2 weeks before, did he have any late nights where he was outside of his routine?
A44 (WIFE): No.

(PRESIDENT): Okay.

(WIFE): No.

Q45 (PRESIDENT): Any weekend work during those last 2 weeks?
A45 (WIFE): No.

[Momentary pause.]

(WIFE): Sometimes they have a volunteer activity on the weekend, but I think that was past that point. And it was before 2 weeks ago.

Q46 (PRESIDENT): Any colds, fevers, aches, pains, throwing up; anything unusual ----

A46 (WIFE): Nothing. He was ----

Q47 (PRESIDENT): ---- with his health?
A47 (WIFE): ---- sneezing more than usual, a few days prior. But I was sneezing too, so we just assumed that was, ----

(PRESIDENT): Uh-huh.

(WIFE): ---- you know, some sort of allergies. But no being sick, like feverish or anything like that.

(PRESIDENT): Okay.

(WIFE): ---- just sneezing.

Q48 (PRESIDENT): So, overall, you would probably say he was feeling his usual ----
A48 (WIFE): Yes.

Q49 (PRESIDENT): ---- health?
A49 (WIFE): Uh-huh.

Q50 (PRESIDENT): No doctor appointments or anything like that?
A50 (WIFE): No. He might have a -- might have had a teeth cleaning, but I don't -- and he might have had a follow-up to the blood pressure -- so, within the 2 weeks, he had -- he might have had a -- you know, like a follow-up for blood pressure re-test, and he might have had a dental appointment, but I'm not sure.

(PRESIDENT): Okay.

(WIFE): So, you might want to -- that would be in his records.

(PRESIDENT): Right.

(WIFE): Yeah.

Q51 (PRESIDENT): But they didn't change his medication or anything that you're aware of?
A51(WIFE): Not that I'm aware of; no.

Q52 (PRESIDENT): Okay. All right. Is there anything going up to the -- the PT test that you can think back of, that you think that we need to be aware of, as far as his health, or work, or anything?
A52 (WIFE): Nothing. That's what makes this frustrating.

Q53 (PRESIDENT): Okay. So, he gets up on Monday for the PT test, early, gets there because it's a 6AM test, what do you know about what happened, after he left the house?

A53 (WIFE): All I can say is, normally, he would text me or call me and say, you know, "Hey, I passed and, you know, I got a 90," or whatever it was. He was always very excited when he passed. I was in meetings in the morning and was concerned when I didn't see anything on my phone. So, I thought, well, maybe he did badly, give him some time. So, I started texting, because, you know, usually, I warrant a -- something, "Hey, I didn't do well," or whatever.

(PRESIDENT): Uh-huh.
(WIFE): Nothing back. Now, again, he doesn't always have his phone with him, so not unusual. Texted again, a little bit later and, basically, texted that I was starting to worry, because this was -- this was out of the norm. Um, ----

Q54 (PRESIDENT): Now, ----
A54 (WIFE): ---- and then ----

Q55 (PRESIDENT): ---- when was that do you think?
A55 (WIFE): Oh, I would say probably the last text was probably 2:30 or 3.

(PRESIDENT): Okay.

(WIFE): Because I was starting to freak out by then. And then, I was starting to text again when I got the call, I think at 4:30 -- 4/4:30. More like 4:30, from Mom , because ALS Supervisor and ALS 1 had gone over her house, because they couldn't get a hold of me, I wasn't at my house, they found her, and then she had my phone number to call. Then so, what I hear, when I get to the hospital was that -- so, what was relayed to me was -- I believe it was the First Sergeant said that he -- he was running at the same time, and he saw MOC , I think he was on his last lap, that he stood and sort of bent over, he could see him across the way, that he bent over, like he was trying to catch his breath, then he went to one knee, and then collapsed. Then they apparently immediately went over, they tried to ask him his name. I think at that point he did know his name, and then I believe they called -- I don't know if they called 9-1-1 or the ambulance, something, you know, because I'm in a state of not knowing what's going on here.

(PRESIDENT): Uh-huh.

(WIFE): So, they called and then I believe the ambulance picked him up and brought him to St. Elizabeth's. As far as notification from there, I have no idea because I know said that she -- like nobody really knew. Nobody was contacted. So, once he went to the hospital, I don't know what happened from there. I think -- and of course, mine -- I don't know what number they had for me, but apparently it was one number off, or it was the home number, so they didn't have my cell number, and he didn't have his phone on him -- or he didn't have anything on him. And then -- then we were at the hospital and then they basically said, you know -- and they asked me what were his medications, what were -- because on the way back, driving home, I had to authorize dialysis, I needed to pick up his medications, and they kept asking me about supplements. And it seemed like they didn't have access to the medical records, because that should've all been in there, but -- and so, then it was just -- they really didn't know what was going on. Just that there were toxins in his body that they couldn't get out fast enough; they were very, very high, so that was what I knew that first night.

Q56 (PRESIDENT): Okay. So, just to make sure, because I'm a little bit misunderstood; so, you get a call from Mom , who's your mother-in-law?
A56 (WIFE): Correct.

Q57 (PRESIDENT): She tells you that he's in the hospital. Did you call the hospital then?
A57 (WIFE): She said that ALS Supervisor and ALS 1 -- or she said two -- two people are here ----

(PRESIDENT): Right.

(WIFE): ---- saying that MOC in the hospital.

(PRESIDENT): Right.

(WIFE): And then, got on the phone with me and said, "We don't know what happened, MOC collapsed at his PT test, you need to go to the hospital." And then so I left work, and then they had -- the hospital actually called me on the phone; I had to pull over. She said, "You have to call the hospital, because they need to get in touch with you." I called them, I can't remember what they asked; they wanted the medications, they asked me a few questions, they told me to get there, that they needed to talk to me. Mid-way -- like, I'm almost home, I get a call, the call gets dropped, I pulled over, I re-called back, and they said they needed my verbal authorization to put him on dialysis, which I gave them.

(PRESIDENT): Okay.

(WIFE): Picked up and then I went to the hospital.

Q58 (PRESIDENT): Okay. So, you get a call from your mother-in-law because there as well, they tell you to call, and you called the hospital?
A58 (WIFE): Correct.

Q59 (PRESIDENT): And ----
A59 (WIFE): Correct.

Q60 (PRESIDENT): ---- they're like, "Great. Glad to hear from you, we need" ----
A60 (WIFE): Right.

(PRESIDENT): ---- "boom, boom, boom, boom, boom," and ----

(WIFE): Right.

Q61 (PRESIDENT): ---- then everything ----
A61 (WIFE): Right. Then I'm on the ----

Q62 (PRESIDENT): It's crazy really fast?
A62 (WIFE): I'm an hour plus away, so ----

Q63 (PRESIDENT): Yeah. Where do you work?
A63 (WIFE): I work in Art City, Missouri.

Q64 (PRESIDENT): Art City out of Missouri. Okay, so that's a bit of a drive. So, you run by the house to pick up the meds on the way back over to St. Elizabeth's?
A64 (WIFE): Uh-huh.

Q65 (PRESIDENT): You get there, who's there whenever you get there?
A65 (WIFE): So, there was Squadron Commander, there's ALS Supervisor, ALS 1 , the First Sergeant, I believe, and there were a -- I would say a -- I think the Chaplain was there, and three other people I had no -- I didn't know who any of these people were.

(PRESIDENT): Uh-huh.

(WIFE): So, there were -- you know, like, there was a group of people. So, I think there was a female person and two others, ----

(PRESIDENT): Okay.

(WIFE): ---- I think.

(PRESIDENT): That's fine, I mean ----

(WIFE): Okay.

(PRESIDENT): Most of all I'm trying to get is your impressions, and feelings, and what ----

(WIFE): Uh-huh.

Q66 (PRESIDENT): ---- what's going on with you at this point. So, you get there, and they've probably started dialysis by that point in time, because you gave the verbal authorization?
A66 (WIFE): I believe that they had already; uh-huh.

Q67 (PRESIDENT): Okay. Who did you talk to when you got to the hospital? Did you talk to the hospital staff or just the Air Force folks?
A67 (WIFE): No, I like immediately spoke with the -- I believe there were -- I think it was -- can't remember if it was the female doctor, but there were several doctors.

(PRESIDENT): Okay.

(WIFE): Several. And I spoke to multiple -- I can't remember. There wasn't one person that I spoke to.

(PRESIDENT): That's fine.

(WIFE): But definitely multiple, multiple doctors.

Q68 (PRESIDENT): When you got there, was he awake, alert?
A68(WIFE): So, no -- well, he was awake, but he was incoherent. He did not -- so, his eyes were going all up, like he was, like, not my husband. I mean, it was -- he was -- like his eyes couldn't focus, and you could tell he could hear, but the two weren't -- so, there was an auditory recognition ----

(PRESIDENT): Uh-huh.

(WIFE): ---- but that he was completely disoriented, and did not -- could not answer questions. They did say when he got in there, he did know his name, but by the time I did not -- when I got in there, he did not. He was very agitated and it just -- yeah.

Q69 (PRESIDENT): Okay. So, whenever you got there, talked to a bunch of doctors, what did they tell you was going on at that point in time? Did they ----
A69 (WIFE): They didn't know.

Q70 (PRESIDENT): They didn't know.
A70(WIFE): They were very -- you can tell when seasoned professionals are confounded, where it just really doesn't make sense to them, which was also kind of frightening. They -- they really don't know because, again, they did know about the sickle cell trait. At this point, I don't think they've googled it. So, they -- you know, the collapse -- and they -- they didn't understand why the -- they had seen this Rhabdomyolysis, whatever that is, from exertion happen, but that it wasn't stopping and that they couldn't get the toxins out, and there wasn't really a reason why it wasn't slowing down. That was -- they didn't understand why that was -- was happening?

Q71 (LEGAL ADVISOR): Why it kept progressing?
A71 (WIFE): Correct. So, ----

(LEGAL ADVISOR): All right.

Q72 (PRESIDENT): So, when did it sound like they had an idea of what was going on?
A72 (WIFE): I would say maybe even the next day, but they had a stream of other physicians coming in. So, there was a Nephrologist, there were -- because also, you have the night and day shift as well, so there were two -- and then there were people that were residents from another hospital. Like -- so, there were teams of people that I don't know. I'm assuming they had talked to each other. They seemed like they were -- I didn't quite get that dynamic of what was going on there. That was a little frustrating, but they -- yeah, I mean, may -- maybe the next day I did get a pamphlet that they felt like, from 1996 that there was an incident of somebody with sickle cell trait and exertion, and that it, you know, possible death and something else. So, that was what they were sort of going with there. But, again, they couldn't. So, at that point, then his muscles began to swell.

(PRESIDENT): Uh-huh.

(WIFE): So, that's when they were -- they had to do the compartment. They suggested that compartment surgery where they slice to release -- release that. So, they -- so, that was an evening one, so the surgeon talked to me about that; essentially what was going to be taking place. And they were hoping -- because, again, it was cutting off circulation and they couldn't get a pulse, so they were hoping that that would release -- also help with release of some of the toxins. And that was a couple of hours of surgery. And they -- and -- while the surgery was a success, the results were not what they wanted. So, I think the -- the levels came down a little bit, but not -- it seemed like not what they were hoping. As it progressed, they kept saying that it's -- he's very, very sick, you know, so it was -- but again, in my mind I'm in disbelief at this point of his -- he was just on a PT test. So, I'm thinking this is, you know, I was -- surely he's going to, but it's not -- I don't have to see -- you know, so I'm not really accepting it at this point.

So, then, later -- so, at some point -- after that surgery, there was a point that I could see him. Again, he's incoherent. The doctor said that he was answering simple questions. I got to -- you know, I said, you know, "Honey, I'm here. I love you." He said, "I loved you." said that he had gone and said, "We're taking care of ." He said, "Good." But that's all that any of us got. And then he was -- then they had to -- they wanted to do another more compartment surgery. At this point, I think this is Wednesday night. Because, again, they're having -- they're having people come in; they're looking' they're just -- they're not -- it's not -- the numbers aren't getting better. There were times that they would stay okay and, you know, they keep him for a while and then they just start getting high again. The -- and they'd only -- they take a poll every -- about 4 to 6 hours, so whereas that was waiting time of not really knowing what was going on. So, then, Wednesday night, they did -- late into the morning, or 9 o'clock at night, I guess, they wanted to release all the rest of the compartments; forearms, everything else. So, took him back, it was a little bit longer of a surgery. They said he coded on the table. I think it was 20 minutes or something. They brought him back, and he coded another 3 times, and they kept giving him CPR; each time it was longer and longer.

The doctor called me in, it was early in the morning; midnight, maybe; and this upset me. She called me in there in the middle of working a code, and she said, "You know, your husband's not going to make it. He's not going to make it." Okay, at this point, I'm kind of figuring that, but I didn't need to see you, all the blood, and all the things that were happening. I didn't need to be in here for that. So, she tells me that, I go back into the waiting room, and there another hour before anyone comes out, and they said, "Well, we have him, you know, stable," no -- well, not -- they didn't say, "Stable," because he was always in critical, but he's, you know, basically, not coding at this point. And that -- you know, so this is what? Thursday morning. So, they were just going to watch him and I -- I don't know what else happened that night. Then I think it's 7 o'clock in the morning, that morning; 7 or 8; they basically said, you know, it's either -- you know, "The only thing that's keeping him alive is the medication that we're giving him. Your choice" -- and, basically, I had two choices; I can, you know, let them -- it's either going to keep him on the medications and let him, you know, have some sort of event, some sort of cardiac event, or once they take the medication, he will essentially just die after that. And, at some point

too, they did ask me if -- you know, if he were to code again, if I wanted to -- I'm like, do not resuscitate at this point. So, I did, that was probably the 2 o'clock in the morning. I did want to -- so, Wednesday -- I want to say Wednesday, I did have just for -- and it wasn't like to say goodbye, it was more like we need support here for , for just our emotional support, I had her sister come out and his best friend come out.

And so, that -- so, then on that Thursday morning, they were able to -- I believe and picked up the mother and the sister and they were able to be here and say goodbye. The decision was going to be that we're just going to take him off the medication and let him go, but he coded before that even happened. They were in the room with him. I couldn't do it; they were in the room with him when they called the time of death.

(LEGAL ADVISOR): Ma'am, this is , ----

(WIFE): Uh-huh?

Q73 (LEGAL ADVISOR): -- again, who is -- who is, "They"?
A73 (WIFE): I'm sorry; his mother, , and his aunt, .

[Momentary pause.]

(LEGAL ADVISOR): Thank you.

[Momentary pause.]

Q74 (PRESIDENT): Is there any thoughts or feelings that you have, regarding how -- how the Air Force handled this?
A74 (WIFE): The Air Force handle has been amazing. Squadron Commander was there, pretty much, with me on a nightly basis and, you know, we don't have any, you know, family; we have some friends, but we really don't have anybody out here. So, that he could be with me and kind of helped me through. That was just a life saver for me, for sure. The Chaplain was great. Just everybody in the Air Force handled it -- was good at keeping people -- because one thing I didn't want was just a bunch of people I didn't know in blue uniforms ask me questions and bothering me when my husband is, you know. So, he kept that at bay, and that was very helpful and any -- any questions that I had or anything that needed to be handled because, you know, there are things that needed to be handled, you know, he was very supportable. So, -- and then, you know, his Commandant, next Commandant and co-worker, they're very close, in that they were able to be there and they were in between sessions so, but that they were allowed to -- to grieve with us and to be there with him; that was very helpful as well. And they would -- you know, they'd watch Daughter while the mother-in-law could come and -- and visit, so that was -- and there wasn't a lot of -- that was unfortunate. The ICU was very -- was crowded, and there wasn't a -- like I couldn't be in there with him. So, that was unfortunate. Not that I would want to be, necessarily, but I really don't feel I would've had that option. So, -- but I have had zero -- nothing but praise for the Air Force.

Q75 (PRESIDENT): Do any of you have any questions?
A75 LEGAL ADVISOR: No, sir.

(PRESIDENT): I think we got what we need to at this point in time. I can't think of anything else at the moment. I'm sure you're probably not able to think of much else either. But, if you do, again, we work with FAR and any time you get other ideas, other thoughts, feel free to let us know. Likewise, if something comes up, I can't imagine what, but we might give you a call at some point in time to flesh out a detail here or there.

(WIFE): Okay.

(PRESIDENT): But other than that, this would conclude our interview of you. Since the investigation will continue for the near term, I would ask that you do not discuss your testimony today that you had with us, with anyone until after the formal report is published.

(WIFE): Understood.

(PRESIDENT): Unless you have any other questions, that's it and thank you so much for your time. I know this has been a rough time and, on behalf of the Air Force, we're very sorry for you. And, like, -- like, you know, if there's anything we can do for you, sounds like they're doing it, but ----

(WIFE): Yes.

[The audio stopped.]

V4. SQUADRON COMMANDER
VERBATIM TESTIMONY

(PRESIDENT): Good morning, my name is Colonel Michael Wood. I'm the board (PRESIDENT) for the ground accident investigation board, investigating the circumstances surrounding the death of Tech Sergeant MOC . This investigation, conducted in accordance with AFI 51-503, is separate and apart from any safety investigation that may be conducted in accordance with AFI 91-204. This ground accident investigation board is a legal investigation that was convened to inquire into all the facts and circumstances surrounding Tech Sergeant MOC's death, to prepare a publically releasable report, and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes. A formal safety investigation has not been conducted to date. Your sworn testimony to the board may be used for any proper purpose. Additionally, your testimony can be released to the public. Do you understand how your testimony before this accident board maybe used?

(SQUADRON COMMANDER): Yes, sir.

(PRESIDENT): Do you solemnly swear or affirm that the testimony that you're about to give in the matter now under investigation shall be the truth, the whole truth, and nothing but the truth, so help you God?

(SQUADRON COMMANDER): I do.

Q1 (PRESIDENT): Can you please state your name for the record?
A1 (SQUADRON COMMANDER): Sure. ; middle initial , as in ; , , as in .

Q2 (PRESIDENT): Thank you very much. Regarding Tech Sergeant MOC , can you say what his role was in your unit?
A2 (SQUADRON COMMANDER): Yes. Tech Sergeant MOC was an Airman Leadership School instructor, in his final year of his tour, which was about his fourth year of instruction.

Q3 (PRESIDENT): All right. How is he regarded by the students?
A3 (SQUADRON COMMANDER): Highly regarded by the students. Been stated numerous times by his students to being highly esteemed, their role model, one that they would like to look up to for a future NCO are some of the comments that we heard following his death.

Q4 (PRESIDENT): And how would you describe his character in general?
A4 (SQUADRON COMMANDER): Impeccable character. Doesn't matter how…where he is, if he's on the stage at the ALS graduation or in the Community Center, he is providing a consistent example of what we would have for an NCO and a leader.

Q5 (PRESIDENT): All right. Would you say that he was a leader model and dynamic go-getter?
A5 (SQUADRON COMMANDER): Extremely dynamic, definitely a go-getter, pushing others to excellence and the role model for all of us.

Q6 (PRESIDENT): All right. What is your role here at Scott?
A6 (SQUADRON COMMANDER): Currently Force Support Squadron Commander, Airman Leadership School is one of our subordinate units under our Education Services Flight. I'm also the Installation Mortuary Officer.

Q7 (PRESIDENT): About how long have you been here at Scott?
A7 (SQUADRON COMMANDER): Almost 18 months.

Q8 (PRESIDENT): All right. What were Tech Sergeant MOC's qualifications for working at the ALS?
A8 (SQUADRON COMMANDER): So for qualification for Airman Leadership School, requires them to be certified as an instructor from the Barnes Center, which is centered in Maxwell, Montgomery, Alabama. Required them to build curriculum, be able to instruct students, assess them through examination, also assess their physical and…physical fitness as far as their physical appearance, and then culminates into a graduation, 24-day curriculum.

Q9 (PRESIDENT): Did he have any sort of certification to be an instructor over there?
A9 (SQUADRON COMMANDER): It's required for them to be certified, and he had earned a level three certification by the time of his death.
Q9 (PRESIDENT): All right.

Q10 (LEGAL ADVISOR): What is…this , the Legal Advisor. What is a level III instructor? What does that term mean?
A10 (SQUADRON COMMANDER): It's the number of hours of instruction and so, if I recall, that's probably about 3,000 hours of instruction.

Q11 (PRESIDENT): To your recollection did Tech Sergeant MOC have any awards while he was here?
A11 (SQUADRON COMMANDER): Yes.

Q12 (PRESIDENT): Did he have NCO of the quarter award?
A12 (SQUADRON COMMANDER): I believe he had…was recognized at least on one account, probably multiple counts in his four-year term, as NCO of the quarter, as well as A1 function award nominee for ALS instructor, as well as a team award for the Barnes Center's recognition.

Q13 (PRESIDENT): All right. Do you recall any problems with his fitness history, with passing PT tests?
A13 (SQUADRON COMMANDER): No problem that I'm aware of.

Q14 (PRESIDENT): As far as unit PT, do you know anything about his unit PT history?
A14 (SQUADRON COMMANDER): So for the requirements for ALS, part of that curriculum includes fitness activities as a class, and he is often leading that PT during that period of time, different times of day, depending on their training schedule.

Q15 (PRESIDENT): Okay. Did other than ALS, did he have any other role in your squadron or in the community?
A15 (SQUADRON COMMANDER): So he was involved a community, a specific equestrian group, that I do know he personally invested time in. Each class also donates their time as part of teambuilding and being an ambassador of the community. So he is often leading that as a flight lead over there with his students. He was also involved in our unit booster club, also some activities over the last four years, so building morale in the squadron when he's not in session.

Q16 (PRESIDENT): Okay. And generally speaking, would you say he was well-known in the squadron?
A16 (SQUADRON COMMANDER): Yes, well-known from other military members, as well as some of my nonappropriated fund civilian employees who worked in the Event Center.

Q17 (PRESIDENT): Okay. On the 26th of October, how did you find out that there was a problem with his PT test?
A17 (SQUADRON COMMANDER): Yes, in returning from a TDY, in the afternoon, I was notified by telephone, by my Operations Officer, who's currently an IMA, FSS 2 , it's , , . And she notified me that Sergeant MOC was currently at St. Elizabeth's Hospital, in the intensive care unit, along with my chief master sergeant of the unit, Chief Master Sergeant FSS 3 , , first name, .

Q18 (PRESIDENT): All right. And about what time was that notification made to you?
A18 (SQUADRON COMMANDER): So by estimation of my travel and routing back to the installation, it was probably around 1500, 1530 hours.

Q19 (PRESIDENT): All right. When you were notified, what were your actions?
A19 (SQUADRON COMMANDER): Me actions, confirming who was currently on their way or with Sergeant MOC ; it was conferred that those two individuals were there at the hospital and that I would be joining them. So I dropped off my pet, I just picked up from boarding. And turned around and went down to St. Elizabeth's in my civilian clothes to join the team at ICU at St. Elizabeth's.

Q20 (PRESIDENT): All right. When you got there was anyone else there, other than Major FSS 2 and Chief---- FSS 3
A20 (SQUADRON COMMANDER): FSS 3 ?

Q21 (PRESIDENT): FSS 3 ?

A21 (SQUADRON COMMANDER): Yes. The interim first sergeant, Tech Sergeant , was present, along with the ALS Commandant, , .

Q22 (PRESIDENT): All right. Whenever you got to the hospital did they ask you for any materials or documents?
A22 (SQUADRON COMMANDER): So at the time they were addressing the group, as the medical team was in intensive care mode, my term. They were rapidly coming in and out of ICU trying to assess information. So they were…had asked questions of the spouse, who was in route at this point, over the phone, regarding medications. So they were extending that same information request to us, if we knew if he had any pre-existing conditions that we were aware of, was he taking any medication, was he taking any supplements specifically. That question was asked numerous times, not only at that intake point, but throughout the week.

(PRESIDENT): All right. Do you all have any other questions at this point?
(LEGAL ADVISOR): I do not, no, sir.

(PRESIDENT): I don't think I have any other questions at this point in time either. So I think for now that will conclude our interview. This concludes our interview of you. Since the investigation will continue in the near term I would ask that you do not discuss your testimony today with anyone until after the formal report is published. If we need any other information we'll get back with you. Hopefully we'll be wrapping up this investigation soon.

(SQUADRON COMMANDER): Thank you.

V5. AIRMAN LEADERSHIP SCHOOL SUPERVISOR
VERBATIM TESTIMONY

(PRESIDENT): Good afternoon. My name is Colonel Michael Wood. I'm the Board President for the ground accident investigation board, investigating the circumstances surrounded the death of Tech Sergeant MOC . This investigation, conducted in accordance with AFI 51-503, is separate and apart from any safety investigation that may be conducted in accordance with AFI 91-204. This ground accident investigation board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC's death, to prepare a publicly releasable report and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes. A formal safety investigation has not been conducted to date. Your sworn testimony to the board may be used for any proper purpose. Additionally, your testimony can be released to the public. Do you understand how your testimony before this accident board may be used?

(AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yes, I do.

(PRESIDENT): Do solemnly swear or affirm that the testimony that you're about to give in the matter now under investigation shall be the truth, the whole truth, and nothing but the truth, so help you God?

(AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yes**.**

Q1 (PRESIDENT): Thank you very much. Can you please state your name for the record? **A1 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR)**: .

Q2 (PRESIDENT): Thank you. Can you please spell your name? **A2 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR)**:
.

Q3 (PRESIDENT): Thank you. What's your position here?
A3 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I'm the Commandant here, at the Chief Master Sergeant of the Air Force Bud Andrews Airman Leadership School.

Q4 (PRESIDENT): How long have you been here?
A4 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Been here since October 1st, 2013.

Q5 (PRESIDENT): All right. What was the first time that you met Tech Sergeant ?
A5 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I dropped off my package to apply for the job sometime in September…actually in August of 2013, and he's the one that graded me.

Q6 (PRESIDENT): So he had already been here?
A6 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He's already been here, yes.

Q7 (PRESIDENT): How long he'd been here?
A7 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He got here in 2010.

Q8 (PRESIDENT): All right. What was your relationship with Tech Sergeant MOC ?
A8 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I was his supervisor.

Q9 (PRESIDENT): What was his position?
A9 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He was an instructor.

Q10 (PRESIDENT): All right. Just an instructor or was he any type of special?
A10 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I made him the interim commandant last year when I went to the Senior NCO Academy.

Q11 (PRESIDENT): All right.
A11 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): For two months.

Q12 (PRESIDENT): How would you describe his duty performance?
A12 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Oh, excellent. He trained myself. I have to become an instructor first before being a commandant. So, he trained me. Spent a lot of time training. He ended up training the other two instructors that also work here. So he was excellent.
Q13 (PRESIDENT): All right. Did he have to sign off on all the lessons that came through here?
A13 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah, well, I mean anything that was new; we had a huge curriculum update, about 75% updated. And him and I went through it and learned it together, taught it together, for months before the other instructs did. So, he was our lead instructor, the one with the most tenure and most knowledge about the curriculum.

Q14 (PRESIDENT): All right. How does other peers describe him in your opinion?
A14 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Same thing. If you need the right answer you ask Sergeant MOC . The other two instructors, again, were trained by him. So he didn't always pass us and that's why he did a good job. He didn't just do the job just to be nice or whatever. He's like, yeah, you suck. You need to redo this. So. Real good, real honest.

Q15 (PRESIDENT): All right. How would his student describe him?
A15 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Oh, amazing. They loved 'em. He has a funny…he had a funny…he was humorous, but it's in a weird way. Real smart. Real engaging. **Q16 (PRESIDENT):** Okay. What were his qualifications to be in that position?

A16 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): So we had to…you have to have all five EPRs--you mean to be in the position of…as an instructor?
[Affirmative response by the President.]

(AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah, all five EPRs, passing PT scores, letters of recommendation and then, the interview to get hired.

Q17 (PRESIDENT): All right. Did he have any awards or decorations while he was here do you know of?
A17 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): So he was the second quarter NCO of the quarter, for the squadron, last year, so 2014, second quarter. And then, he was the Lance P. Sijan squadron award winner for last year.

Q18 (PRESIDENT): Okay. Do you know anything about his family life?
A18 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah, his daughter's now three. She was two at the time of his death. His wife and he, once they had they flew his mom, out here. Bought her a house. So he told care of both those houses. He was the guy of their…both the households. So, he loved to hang out with his daughter. You know, she's funny. His dog…did a lot of home repairs. He did, when we had breaks, you know, he'd spend a lot of time there 'cause we spend so much time here. So he had a good home life. He was happy.

Q19 (PRESIDENT): Okay. Did you know anything about his, since you're his supervisor, about his fitness history?
A19 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah, I mean he loved to work out. He was happy that he…now that we…he was finishing training the newest instructor, that means his times gets to come back. So he was running, working out. There was a little workout room here, well, his workout room that he would put on silly videos, and jumping up and down. I don't know what he was doing, but he was working out. He would take his mom to Gold's…no, the YMCA to kind of get her to work out with him after work. Real active.

Q20 (PRESIDENT): Was he trying to lose weight in preparation for a PT test that was----
A20 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): No, no. Because he was losing weight. He was like, hey, guys, you know, he was so happy 'cause the last class on his critique form said, you need to get a smaller uniform. And he's like, ah, ha, look at me.

Q21 (PRESIDENT): All right.
A21 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I mean we pretty much eat pretty good here. He's not fast food. We cook a lot here. He grilled a lot here. So, we use to juice all the time, every day. But yeah, yeah, he was looking good.

Q22 (PRESIDENT): Okay. Do you know anything about his particular workout routine? Was he a runner? Did he lift weights?
A22 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Sometimes he ran. Sometimes he lifted weights. There was nothing concrete that he would do. He did pick up going running, and I'm not too sure what exactly he was doing with his mom at the YMCA, but…yeah, nothing too structured that he had. But he also ran PT for each class, all instructors run at least one session, and he'd play volleyball as well when we'd have our volleyball fit challenge.

Q23 (PRESIDENT): Was there any pushups or sit-ups done in his…while he was here?
A23 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah, all the time. He has a big…he had a thing about using profanity, and we're really, really big on that. And he's huge on that during class. So every hour you'd down, down. And so he was making them do pushups. There's a whole list. So if…whenever they did a profanity, they had to pull a card and if it's a diamond it's pushups, if it's, you know, spades, it's sit-ups. So, it's normally that's what they were doing, wall sits, that kind of stuff. So it happened often when he was instructing.

Q24 (PRESIDENT): Was he joining in with them?
A24 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Oh, yeah. Oh, yeah.

Q25 (PRESIDENT): All right. Did he ever have any profile issues that you are aware of?
[Affirmative response by the AIRMAN LEADERSHIP SCHOOL SUPERVISOR.]
A25 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): So last year…not last year. Earlier this year, he was having problems breathing a little bit and he didn't know what it was. He also had this weird thing that would happen, would puff up his face. And we're like, what's up with fat face. So he was going to the hospital. He said something's up with my blood pressure, and they put me on a profile, which he was real upset because he finds that cheating or something like that. He's like, you know…and I was on a profile 'cause I sprained my ankle. So, we were like, we're losers, we can't do the whole PT test. But his blood pressure was being watched and he had a chart, he was charting it, and he was taking it every morning. He was like, man, my doctor really likes my chart. Yeah. 'Cause he's real organized, as far as not organized but real detailed oriented with charts and stuff like that. So that was the only time he was on profile, earlier this year. And then, yeah, it expired and he was stoked about this test. He walked in the week before, he's like, ooo, I'm going to go try take my test right now. Really? He's like yeah, I'm ready, I'm ready. And he would, you know, he came back, was like, heck, no test. He's like got like 18 people trying to do walk-ins. So he wanted to get it done sooner than later.

Q26 (PRESIDENT): Okay. Did he ever mention any other medical issues other than the high blood pressure and the one time he had that problem with the profile that you know of?
A26 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): No. He just…his blood pressure, they kept on changing his medications. So…and this face thing would happen once in a while, we would crack on 'em and they said something with a lymph node or something. We would…it would just kind of poof up and he'd go to the hospital or put a hat on or something like that.

Q27 (PRESIDENT): Okay. Did he stay well hydrated?
A27 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Oh, yeah. He walked around with like a canteen and he wrote student tears on it. So yeah, he would constantly drink, because you know he's instructing, you get real parched, so he'd constantly had his big water jug with him and then we will fill it with water, here.

Q28 (PRESIDENT): Okay.
A28 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Didn't drink Cokes, nothing like that, he just lots of water and coffee.

Q29 (PRESIDENT): So on the morning of the 26th you knew he was supposed to test that morning? **A29 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR):** I did.

Q30 (PRESIDENT): Okay. What time was he supposed to test?
A30 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): 6:30.

Q31 (PRESIDENT): Okay. So what happened after that, as far as you remember from that point on?
A31 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): So I texted him at 7:30 and I said, how it go, and no response. But he's not one to be tethered to his phone like a lot of people are. So then I called him later on and I'm like, really. And then I texted him again, by lunch time I was like I'd really appreciate at least a text or you contacting me, at least tell me everything went cool. Because it's a test. We teach you…we're like, one of the…probably more important than promotion testing, you know? We teach how important the PT test was. So…and then I started making calls, where's--well no, not… at first I didn't make the call. ALS 2 new instructor, said he used to be a cop prior to… Security Forces prior to doing this job.

Q32 (PRESIDENT): I'm sorry? Can you spell that name?
A32 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): And he goes, , have you heard from Sergeant ? And I said no, he's making me really angry, you know. Good Lord, maybe he left his phone, lost his phone. He was like, well, somebody that I used to work with just texted me saying hey, Sergeant , still an instructor, because if so, he fell and was ambulanced. So I called the shirt, who was an acting first sergeant, , and I said, what is going on? Why have I not been told that somebody, my troop's, you know, in the hospital? And he's like, oh, my goodness, I was at that test too. And I'm like, are you kidding me? You're the first sergeant and you're at this test and he fell out and you didn't know? And he's like, well, I just asked the…Acting First Sergeant finished before MOC , and he saw someone fallout, and he wasn't sure who it was. So he asked the fitness assessment cell, did that person that fallout, is he okay, and they were like, oh yeah, he's going to the hospital. He never put together that it was a member of our own squadron. Even the FAT knows Sergeant MOC is a member of our own squadron. So I'm not sure what the hell happened but the first sergeant was like I'm going to find

out. And was like--he called me back and he's like, he's at St. Elizabeth's. And I say, my gosh, we need to find his wife and he was like, well we're all going to try to figure out how to do this. And I was like the number on his recall roster is for his home, not for his wife. His wife kind of stayed away from military stuff and he asked to make sure. She's never been called here. So we, ALS 1 , , and I went to Sergeant MOC house to try to find Wife . Although Wife works an hour away. And then, we got the address to go to Mom house, Sergeant MOC mom, Mom and she wasn't answering the door. So we went back to Sergeant MOC house and left a note, hey, there's an emergency. If you get this, whoever gets this, you need to call us. And we were like let's go back to Mom's house to leave the same note, and Mom answered the door. And I said, gosh, don't freak out but I need you to call MOC in a hospital. She's like why, 'cause she watches their daughter. So I was I don't know. He fell out. We're about to go over there but we need to get a hold of Wife So she put it on Speaker and she was real emotional, so I got on the phone and I said you need to come. He's at the hospital. We're about to go that way. She's like, why am I just now getting…I don't know what happened but please, you need to come. We don't know what's going on. So by the time we all got to the hospital, and Wife got to…before Wife got to the hospital I called her, I said the nurse wants you to call them while you're on your way because they're asking to put him on dialysis and you to authorize that, and she's like okay. So she did that over the phone and then, got to the hospital.

Q33 (PRESIDENT): Okay. So kind of back up a little bit. You guys figured we're not getting a hold of 'em, and you all call the first shirt. What time was it that you guys called the first shirt?
A33 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Had to be like one or two P.M. I think.

Q34 (PRESIDENT): And the first shirt didn't call you, you called them? **A34 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR)**:
Yeah.
Q35 (PRESIDENT): Okay. So then he calls you back?
A35 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): The first sergeant?
Q35 (PRESIDENT): Right.
[Affirmative response by the AIRMAN LEADERSHIP SCHOOL SUPERVISOR.]

Q36 (PRESIDENT): So after you talked to him and he says I'm going to figure out what's going on, he calls you back?
[Affirmative response by the AIRMAN LEADERSHIP SCHOOL SUPERVISOR.]

Q37 (PRESIDENT): Do you remember about what time that was?
A37 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): It was immediately after.

Q38 (PRESIDENT): So minute?
A38 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah.

Q39 (PRESIDENT): A couple of minutes?
A39 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Called me, he's like, okay, I'm getting reports that he's in the…it is him. He's in the hospital. The UFPM was finally notified and came to notify him. I guess at the end of the day, so it was two or three, something like that, to shirt, just was going quick after that.

Q40 (PRESIDENT): Okay. So the first shirt, do you know of any other times that they were trying to attempt to contact the family or was it just you guys?
A40 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): No. He didn't even know what we were talking about.

Q41 (PRESIDENT): Okay. So about what time was it that you went over to Sergeant house?
A41 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Immediately, I mean they…I said, listen, I don't have Mom's address, 'cause I've never been there. I've only been to house. So the shirt didn't have updated information on his vRED or whatever, so as we were driving, that's the calls were making, as we're trying to get there and the shirt, we finally got…he finally got us Mom's address, so we can get there.

Q42 (PRESIDENT): So the shirt found Mom's address?
A42 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I believe so, yeah.

Q43 (PRESIDENT): Called or texted you guys?
A43 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): We were…yeah, as we're driving, there's lots of things happening as we were going to MOC house, Sergeant MOC house. So, yeah, by the time Wife found out, by the time we…I think she actually got a call it's 4 or 4:30, something like that.

Q44 (PRESIDENT): Okay. And so you talked to Mom and she's the one that called his wife?
A44 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yes.

Q45 (PRESIDENT): Okay. About when did you all get to the hospital?
A45 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Well I don't know. 4,:30, 5, some…between there, somewhere around there. We… said you guys go, I'm going to stay here with Daughter Obviously we didn't think he…we just thought he was…he fell.

Q46 (PRESIDENT): He's hurt or----
A46 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah.

Q47 (PRESIDENT): Yeah.
A47 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): So it was like, now that Wife was on her way, she's like, all right, well just let me know, you know, whatever. We're like okay, we're just going to check him out, make sure he's okay.

Q48 (PRESIDENT): Okay. Did you get to the hospital before his wife got there
A48 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah. Yes, I did.

Q49 (PRESIDENT): Was anybody else there whenever you got there?
A49 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Squadron Commander was there. They were all showing up I think. Squadron Commander, FSS 3 there was a FSS 2 first time met her, and Acting First Sergeant

Q50 (PRESIDENT): Can you try to spell those names or?
A50 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Oh, okay.

Q51 (PRESIDENT): Don't worry about it. Don't worry about it.
A51 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I can do a couple of 'em.
(PRESIDENT): Don't worry. That's fine. We'll get 'em somewhere else.

Q52 (PRESIDENT): So a few other folks were there. Do you know how they got notified that there was a problem?
A52 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I don't…no, I'm assuming Sergeant did. I got a…I did get a…I got a text. I don't…a text started coming. I didn't know who these people were. One was the Major, she's like she's something Ops or something, but by then we were all there and our commander, was there so.

Q53 (PRESIDENT): Okay. Do you have a question?
Q53 (LEGAL ADVISOR): I do. This is legal advisor. Was Squadron Commander there before you arrived or did he arrive after you arrived?
A53 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He was…I was he was there. I'm pretty sure he was there. I'm not…or there…a couple of times we went there, we went there every day. So the first day, I think we could have all shown up at the same time. I don't…I just don't really remember. Every other time he was always there.
(PRESIDENT): Sure.

Q54 (PRESIDENT): So you all get there before the wife gets there. How did the wife seem when she got there?
A54 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Very angry.

Q55 (PRESIDENT): Did she express why she was angry?
A55 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yes. She said his test was at 6:30, you're telling me I don't get a call until now. Again, she worked about 45 minutes, an hour away. And the First Sergeant, there and he's just like, I was at the, you know, at the test. I was like oh, my gosh. And everyone's like, well, are you kidding me. And you know, I said I just found out and you know, me neither. And she did the same thing, she was texting him, saying, how'd the test go. But again, he's…he wasn't tethered to his phone, so not hearing from him for a while is kind of normal.
Q56 (PRESIDENT): Okay. When you got there that first day how did Sergeant MOC seem when you got there?
A56 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I did not go in the room. None of us went in the room that day. None of us…no, that's not true. I'm sure…I know Wife went in the room, but you know we just said…when something's going on obviously 'cause this dialysis stuff, his kidneys, so for us it was like all right, what do we need to do? In what capacity could we do something? And that's when we started our plan the next day, is to h out with Daughter and to Mom with to help out with Wife I saw him physically on Tuesday, the 27th.

Q57 (PRESIDENT): How'd he look then?
A57 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He looked like he was drunk or like on something. His eyes, one was right, one was like kind of going through me, off to my ear more like. He was lifting his head. He looked clean, 'ca ALS I saw him earlier and said he was not looking so hot. But someone cleaned him up.

Q58 (PRESIDENT): Okay.
A58 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He looked just out of it. They said he was, you know, they medicated.

Q59 (PRESIDENT): Did you see him any after that?
A59 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): When he passed away.

Q60 (PRESIDENT): Okay. So not until after.
A60 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): No, they called us on Thursday, the 29th. Squadron Commander called myself, and called said you need to come and say goodbye. So when we got there, was like I'm not going to go in there when he passes. So as we were in the hospital room, the nurse came out and said his heart just stopped. So sister flew in, so his aunt, and myself, the four of us, with the chaplain, I forgot his name, we

went in there and that was it. I mean they were taking, you know, they started taking everything off. Say goodbye. Yep.

Q61 (PRESIDENT): All right. Well prior to all this you said that you knew he was on some blood pressure meds.
A61 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR):[Affirmative response by the AIRMAN LEADERSHIP SCHOOL SUPERVISOR.]

Q62 (PRESIDENT): Do you know if he was on any other sort of supplements or anything else? **A62 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR):** Nope. He just drank coffee. He loved his coffee, with agave and almond milk, and lots of water, just drank a lot of water.

Q63 (PRESIDENT): Before he came over to ALS do you know where he worked?
A63 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He worked at the Comm Squadron.

Q64 (PRESIDENT): Did he deploy any?
A64 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah, he went to Kirkuk years ago, volunteered for a co-worker.

Q65 (PRESIDENT): Do you know if he ever failed a PT test?
A65 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): No. He's never failed a PT test.

Q66 (PRESIDENT): Okay. And what was his scores typically at? To your recollection.
A66 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): I have them. I can pull 'em up. Do you want me to do that?

Q67 (PRESIDENT): That would be very useful.
A67 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): The last one were from last year, I guess, 'cause my…his EPR, it went with his EPR.
[Pause for the AIRMAN LEADERSHIP SCHOOL SUPERVISOR.]
If I can find it.
Where would they be?
I'm just going to have to look at it at a different time. I can't find it.
Fitness assessment, here it is.
You want a copy of this?
(PRESIDENT): Yeah, that'll be great.

Q68 (LEGAL ADVISOR): This is Legal Advisor. Just for the record, what was the last test score that he had prior to the 26th of October?
A68 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Well the April one's not on here 'cause they were having a problem with their system. So they sent an MFR to everyone. We test on the same

day. So I got an MFR saying I passed. And he got an MFR. But I obviously only have this from last year, 'cause his EPR closed on…in November. He was…he did push-ups, sit-ups, and waist, because of his…he couldn't breathe----

Q69 (PRESIDENT): Cause of his profile?
A69 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Yeah. They…he couldn't do the run, so and again, we did it the same day, so it was…he was fine, I think he maxed out. I think, I'm not sure. I mean he did last year, so.

Q70 (LEGAL ADVISOR): But in October of 2014, what was his score?
A70 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): It's 86.20.

Q71 (PRESIDENT): As that prints off, what's the typical duty days and duty hours here at ALS?
A71 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Oh, well, okay. For instructors it's typically about 6:30 in the morning till about 1700.

Q72 (PRESIDENT): Okay. Monday through Friday?
A72 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): When there's class in session. When class is not in session we usually come in at 9, we'll all work out on our own. 9 o'clock, come in, and we have to start in-service training, get it ready for the next class. And we usually get out early, like 3. It's easy going.

Q73 (PRESIDENT): Okay. Any recent TDYs?
A73 (AIRMAN LEADERSHIP SCHOOL SUPERVISOR): He went to McGhee Tyson last year to instruct up there. They needed some help in Tennessee. So he went for a month in June.

(PRESIDENT): Okay. Either of you have any other questions? I miss anything?
(LEGAL ADVISOR): No, sir.

(PRESIDENT): Well thank you very much. This concludes our interview of you. Since the investigation will continue for the near future, I would ask that you not discussion your testimony today with anyone until after the formal report is published.

(AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Okay.

(PRESIDENT): Thank you very much.

(AIRMAN LEADERSHIP SCHOOL SUPERVISOR): Thank you.

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V6. PUSH-UP AND SIT-UP PARTNER
VERBATIM TESTIMONY

(PRESIDENT): All right. Good morning. My name is Colonel Michael Wood I'm the board president for the ground accident investigation board investigating the circumstances surrounding the death of Tech Sergeant MOC .

This investigation conducted in accordance with AFI 51-503 is separate and apart from any safety investigation that may be conducted in accordance with AFI 91-204.

This ground accident investigation board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC 's death, to prepare a publicly releasable report, and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes.

A formal safety investigation has not been conducted to date.

Your sworn testimony to the board may be used for any proper purpose. Additionally, your testimony can be released to the public.

Do you understand how your testimony before this accident board may be used?

(PUSH-UP AND SIT-UP PARTNER): Yes, sir.

(PRESIDENT): Do you solemnly swear or affirm that the testimony you're about to give in the matter now under investigation shall be the truth, the whole truth, and nothing but the truth so help you God?

(PUSH-UP AND SIT-UP PARTNER): I do.

(PRESIDENT): Thank you very much.

Q1 (PRESIDENT): Can you please state your full name for the record.
A1 (PUSH-UP AND SIT-UP PARTNER): .

Q2 (PRESIDENT): Thank you very much. And what's your normal -- what is your normal duty station and assignment?
A2 (PUSH-UP AND SIT-UP PARTNER): Yes, sir. I'm a duty officer assigned to the 618th Tanker Airlift Control Center. I'm an IMA reservist here at Scott Air Force Base.

Q3 (PRESIDENT): All right. And so normally you live where?
A3 (PUSH-UP AND SIT-UP PARTNER): I live in Indiana.

Q4 (PRESIDENT): All right. Great. So on the morning of the 26th when this all happened, how long had you been in town?
A4 (PUSH-UP AND SIT-UP PARTNER): I drove in the day before, stayed overnight, and then reported for the physical fitness test at 0515 in the morning.

Q5 (PRESIDENT): All right. Did you get to select who your partner for the assignment -- for the PT assignments would be or were they randomly assigned?
A5 (PUSH-UP AND SIT-UP PARTNER): We ended up selecting each other by process of elimination. Being the oldest officer on the floor, I was asked to be the monitor. And in the course of that, everybody else had paired up. And when that was done, I was looking for a partner; and MOC was the last one. And we pointed at each other and said, "How about together?" And we agreed.

Q6 (PRESIDENT): All right. Had you all met before?
A6 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q7 (PRESIDENT): Okay. When you met Tech Sergeant MOC , did you notice anything unusual?
A7 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q8 (PRESIDENT): Did he appear to be in any sort of distress?
A8 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q9 (PRESIDENT): All right. So you all were paired up for sit-ups and pushups. Correct?
A9 (PUSH-UP AND SIT-UP PARTNER): Correct.

Q10 (PRESIDENT): How did he do for his sit-ups and pushups**?**
A10 (PUSH-UP AND SIT-UP PARTNER): As I recall, he either maxed or got close to max. He did well. Young -- young man, seemed to be energetic and gave a vigorous effort.

Q11 (PRESIDENT): Did he seem to have any sort of problems during the sit-ups and pushups?
A11 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q12 (PRESIDENT): Any complaints of pain?
A12 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q13 (PRESIDENT): After he did his sit-ups and pushups portion, how did he seem after that exercise?
A13 (PUSH-UP AND SIT-UP PARTNER): Now again, I'm -- I'm dealing with my own pain. As I looked around the room, I don't recall anything about anybody that stood out to be abnormal. And I don't recall MOC saying anything about any pain at all.

Q14 (PRESIDENT): So no comments about "I'm feeling funny or I feel" -- --
A14 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q15 (PRESIDENT): -- "any pain"?
A15 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q16 (PRESIDENT): All right. Did -- and as you mentioned, so nothing stood out?
A16 (PUSH-UP AND SIT-UP PARTNER): Correct.

Q17 (PRESIDENT): All right. After the sit-ups and pushups portion, where did you all go next?
A17 (PUSH-UP AND SIT-UP PARTNER): We walked -- we left the gymnasium and walked over to the track; eighth of a mile walk. Waited for instructions; then began the run.

Q18 (PRESIDENT): All right. How did Tech Sergeant MOC seem during the run?
A18 (PUSH-UP AND SIT-UP PARTNER): I was either second to last or third to last. I was pretty close to the end; and he was for the -- for at least the second half, he was the first person ahead of me. He seemed to be keeping the pace I was keeping and seemed to be fine.

Q19 (PRESIDENT): All right. Did you have any indication that there was anything wrong during the run?
A19 (PUSH-UP AND SIT-UP PARTNER): I did not.

Q20 (PRESIDENT): All right. About how far was he whenever anything happened?
A20 (PUSH-UP AND SIT-UP PARTNER): As I recall, I was hustling the last lap to try to beat a time I needed; and so whether he was slowing down or I was closing, I cannot tell you; but the gap seemed to be narrowing. And when he eventually collapsed, it was about 25 yards in front of me.

Q21 (PRESIDENT): Okay. And about where was that in relation to the end line?
A21 (PUSH-UP AND SIT-UP PARTNER): In the last quarter turn, he collapsed going into the beginning of the last quarter turn of the last lap.

Q22 (PRESIDENT): All right. So just to summarize, he was ahead of you about how far for most of time?
A22 (PUSH-UP AND SIT-UP PARTNER): Well for most of the time, it would have been more like a quarter lap. And then that last lap I closed the gap, again, not knowing whether it was because I was trying to catch him or he was slowing down.

Q23 (PRESIDENT): Right.
A23 (PUSH-UP AND SIT-UP PARTNER): I didn't notice anything abnormal in his gait.

Q24 (PRESIDENT): Okay. Before he collapsed, did he have any sort of abnormalities in his gait?
A24 (PUSH-UP AND SIT-UP PARTNER): I would describe it as sudden.

Q25 (PRESIDENT): Okay.
A25 (PUSH-UP AND SIT-UP PARTNER): I would describe it he was running; two or

three knee-buckling stagger steps; and then a falling to the inside of the track.

Q26 (PRESIDENT): Okay. And you were about 15 yards at that time?
A26 (PUSH-UP AND SIT-UP PARTNER): At that point I was pretty close to him.

Q27 (PRESIDENT): Okay. When he stumbled and fell, did you notice any other problems before those last few steps?
A27 (PUSH-UP AND SIT-UP PARTNER): I did not.

Q28 (PRESIDENT): Okay. As you were approaching him, did he seem to be in any pain or have any problems that you noticed as you approached?
A28 (PUSH-UP AND SIT-UP PARTNER): One, it was dark. Two, I was gasping for air. Three, I was raising my hand and yelling for the test monitors to see -- to note there was a man down. And I did not hear any cries. He rolled over onto his back, and I did not see any visible signs of -- of injury; and I was past him within two or three seconds of him going down.

Q29 (PRESIDENT): Okay. So you noticed no sound?
A29 (PUSH-UP AND SIT-UP PARTNER): No, sir.

Q30 (PRESIDENT): All right. Did he seem to be conscious at the time -- --
A30 (PUSH-UP AND SIT-UP PARTNER): Yes, sir.

Q31 (PRESIDENT): -- you passed?
A31 (PUSH-UP AND SIT-UP PARTNER): He seemed to be conscious.

Q32 (PRESIDENT): All right. Did he appear to be in any pain?
A32 (PUSH-UP AND SIT-UP PARTNER): Well, I'm going to assume pain because he collapsed, but there was no -- there was -- that I can recall, there was no cries nor did I hear, like, a bone break; or I didn't hear any noise. But the fact that he collapsed would indicate to me he was in pain. I just didn't hear any.

Q33 (PRESIDENT): Okay. As he collapsed and you continued to run, did you notice anything going on with the test monitors?
A33 (PUSH-UP AND SIT-UP PARTNER): As soon as I raised my hand and yelled "We have a man down," the two -- at least one of them -- I want to say both of them started -- they left their post at the end line and headed towards -- towards MOC .

Q34 (PRESIDENT): Okay. What was your time when you finished?
A34 (PUSH-UP AND SIT-UP PARTNER): 13:30, or it could have been like 13:35. 13:36 I think is the changeover, so somewhere in that 1330.

Q35 (PRESIDENT): Yep.
A35 (PUSH-UP AND SIT-UP PARTNER): Yes, sir.

Q36 (PRESIDENT): All right. So in your estimation if he had managed to keep his pace during the whole time, at what time do you think he would have had to finish?
A36 (PUSH-UP AND SIT-UP PARTNER): I would have guessed 13:15 at the pace he was running.

(PRESIDENT): All right.

Do you all have any other questions?

[The board president conferred with the board members.]

(PRESIDENT): Right. Sorry. Didn't have that.

Q37 (PRESIDENT): All right. So you all finish up. They're attending to him. Did you all receive any instruction about what to do after that?
A37 (PUSH-UP AND SIT-UP PARTNER): Yes, sir. When I finished, obviously I was taking a little bit of time to catch my breath. The -- the rest of the runners had noticed that there was a person who had -- who had fallen down. At least one of the females asked "Should we call an ambulance?" Somewhere near there I think I recall hearing one of the test monitors say "He has leg cramps. And he seems to be doing okay." We waited at the track for probably five minutes where the -- both test monitors were with him. There may have been another test monitors out there, but I'm pretty sure there were two with him. And then we were given instructions to head back to the James Gym and wait there for our signing of our paperwork and dismissal. I think I recall as walking back to the gym -- because that would have been three-minute, four-minute walk -- hearing in sounds of an ambulance. And then we waited in the James Gym at least 15 minutes, if not 20, for the monitors to get back; hand out our paperwork. And I asked them explicitly how he was doing because he was my partner and I'm a pastor and I wanted to pray for him. And they said he seems to be doing fine, that he's going to be okay. And then we were dismissed, and I left and got in my car and drove back to Indiana.

Q38 (PRESIDENT): All right.
A38 (PUSH-UP AND SIT-UP PARTNER): The first I heard that there was a death was when I received the email from the Legal Advisor, so I did not know he was -- that it got worse**.**

(PRESIDENT): Okay. All right. Well, thank you very much for your time. Going back to my script. This concludes our interview of you. Since the investigation will continue in the near term, I would ask that you not discuss your testimony today with anyone until after the formal report is published.

And again, thank you very much

(WITNESS): Yes, sir, my pleasure.

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V7. EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC (EMT-P) VERBATIM TESTIMONY

(PRESIDENT): Good morning. My name is Colonel Michael Wood. I'm the board President for the ground accident investigation board investigating the circumstances surrounding the death of Tech Sergeant MOC . This investigation, conducted in accordance with Air Force Instruction 51-503 is separate and apart from any safety investigation that may be conducted in accordance with Air Force Instruction 91-204. This ground accident investigation board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC 's death, to prepare a publicly releasable report, and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes. A formal safety investigation has not been conducted to date. Your sworn testimony to the board may be used for any proper purpose. Additionally your testimony can be released to the public. Do you understand how your testimony before this accident board may be used?

(EMT-P): Yes.

(PRESIDENT): Do you solemnly swear or affirm that the testimony you're about to give in the matter now under investigation shall be the truth, the whole truth, and nothing but the truth, so help you God?

(EMT-P): I do.

Q1 (PRESIDENT): Thank you very much. Can you please state your name for the record?
A1 (EMT-P): .

Q2 (PRESIDENT): And who do you -- or who are you employed by?
A2 (EMT-P): MedStar Ambulance.

Q3 (PRESIDENT): And what's your role with MedStar Ambulance?
A3 (EMT-P): Paramedic.

Q4 (PRESIDENT): All right. Are you licensed in the state of Illinois?
A4 (EMT-P): Yes.

Q5 (PRESIDENT): Do you have a license number that you know of off the top of your head?
A5 (EMT-P): My state license number is .

Q6 (PRESIDENT): All right. Thank you. Have you been trained in CPR?
A6 (EMT-P): I have.

Q7 (PRESIDENT): Are -- who -- under what protocol were you trained?
A7 (EMT-P): The American Heart Association Health Care Provider.

Q8 (PRESIDENT): And are you current currently in CPR?
A8 (EMT-P): Yes.

Q9 (PRESIDENT): All right. Are you certified to be an EMT?
A9 (EMT-P): I am.

Q10 (PRESIDENT): And are you licensed to be a paramedic?
A10 (EMT-P): I am.

Q11 (PRESIDENT): How long have you been an EMT?
A11 (EMT-P): Total of about 15 years.

Q12 (PRESIDENT): And how long have you been a paramedic?
A12 (EMT-P): Twelve years of those.

Q13 (PRESIDENT): All right. And the medical direction for your EMT is provided by who?
A13 (EMT-P): Memorial Hospital in Bellville.

Q14(PRESIDENT): All right. On October 26th, about what time did your shift start that morning?
A14(EMT-P): Six-thirty.

Q15 (PRESIDENT): And where are you all based out of?
A15 (EMT-P): Fire Station 1, Scott Air Force Base.

Q16 (PRESIDENT): All right. How long is your shift when you're on shift?
A16 (EMT-P): Twenty-four hours.

Q17 (PRESIDENT): All right. So, that morning, about what time did you receive a call?
A17 (EMT-P): 0715.

Q18 (PRESIDENT): And about how long did it take you to get on the road?
A18 (EMT-P): Approximately 30 seconds.

Q19 (PRESIDENT): All right. How long did it take you to get to the scene?
A19 (EMT-P): Four minutes.

Q20 (PRESIDENT): And how long from then did it take you to have contact with the patient?
A20 (EMT-P): Approximately two minutes.

Q21 (PRESIDENT): What was your impression about -- when you arrived on scene, about what was going on?
A21 (EMT-P): We encountered a male patient lying supine on the track accompanied by two bystanders. Patient was awake, answering some of my questions, a little confused. Complaining of leg pain. Denying any other injuries or complaints.

Q22 (PRESIDENT): All right. And he was attended by a few people?
Q22 (EMT-P): Correct.

Q23 (PRESIDENT): Okay. You had been called out for some leg cramps. Did you notice anything that seemed unusual other than that?
A23 (EMT-P): Other than his level of consciousness, confused to some questioning, no.

Q24 (PRESIDENT): Okay. And that level of conscious change, is that what prompted you to decide to transport him to the hospital?
A24 (EMT-P): The initial level of consciousness where he was confused to some of my questioning was what warranted further evaluation.

Q25 (PRESIDENT): All right. So, you guys decided to take him in. Did he have any further change in his consciousness from the time that you initially assessed him to the time that you got him loaded?
A25 (EMT-P): He didn't. Upon loading the patient into the ambulance he became unresponsive, would no longer talk to me. Getting him into the unit I began treatment. Eventually the patient did start responding to verbal stimuli, however, he would not verbally communicate back.

Q26 (PRESIDENT): All right. About how long did it take you to get to the hospital?
A26 (EMT-P): Thirteen minutes.

Q27 (PRESIDENT): All right. During those 13 minutes, was there any care that you remember other that what was recorded in the pre-hospital care report summary?
A27 (EMT-P): No. Everything documented should have been looked -- taken place -- took -- excuse me, took place in the back of the ambulance.

Q28 (PRESIDENT): Okay. And after you got to the hospital and handed him off to emergency room staff, about how long did it take you to get back into cir -- or about what time did you all get back into service?
A28 (EMT-P): Eight-fifteen is when we called back in service.

Q29 (PRESIDENT): And "back in service" means what?
A29 (EMT-P): Our unit is cleaned up, re-stocked, and available for the next emergency call.

Q 30 (PRESIDENT): All right. Do you have any other questions? [Sound of whispering.] Oh, right. During the transport, were you driving or were you in back providing care?
A 30 (EMT-P): I was the paramedic in the back of the unit providing care.

Q31 (PRESIDENT): Correct. All right. And who was the person driving?
A 31 (EMT-P):

(PRESIDENT): All right. Any other questions? All right. I think that's all we have for you today. Thank you very much. This concludes our interview of you. Since the investigation will continue in the near term, I would ask that you not discuss your testimony today with anyone until after the formal report is published. If you have any questions, please let us know. Thank you.

(EMT-P): Thank you.

V8. EMERGENCY MEDICAL TECHNICIAN-BASIC (EMT-B)
VERBATIM TESTIMONY

(PRESIDENT): Good morning. My name is Colonel Michael Wood. I'm the board president for the ground accident investigation board investigating the circumstances surrounding the death of Tech Sergeant MOC . This investigation, conducted in accordance with Air Force Instruction 51-503 is separate and apart from any safety investigation that may be conducted in accordance with Air Force Instruction 91-204. This ground accident investigation board is a legal investigation that was convened to inquire into all facts and circumstances surrounding Tech Sergeant MOC 's death, to prepare a publicly releasable report, and to obtain and preserve all available evidence for use in litigation, claims, disciplinary actions, adverse administrative actions, and for other purposes. A formal safety investigation has not been conducted to date. Your sworn testimony to the board may be used for any proper purpose. Additionally your testimony may be -- can be released to the public. Do you understand how your testimony before this accident board may be used?

(EMT-B): Yes.

(PRESIDENT): Do you solemnly swear or affirm that the testimony you're about to give in the matter now under investigation shall be the truth, the whole truth, and nothing but the truth, so help you God?

(EMT-B): Yes, I do.

Q1 (PRESIDENT): Thank you. Can you please state your name?
A1 (EMT-B): It's .

Q2 (PRESIDENT): Sorry. Can you say that again? Because I think I coughed.
A2 (EMT-B): .

Q3 (PRESIDENT): Thank you.
A3 (EMT-B): [Affirmative response.]

Q4 (PRESIDENT): And who's your employer?
A4 (EMT-B): MedStar Ambulance.

Q5 (PRESIDENT): And what's your role with MedStar Ambulance?
A5 (EMT-B): EMT Basic.

Q6 (PRESIDENT): Do you have a license to -- in Illinois to be an EMT?
A6 (EMT-B): Yes.

Q7 (PRESIDENT): What's your license number?

A7 (EMT-B): .

Q8 (PRESIDENT): And is your license current?
Q8 (EMT-B): Yes.

Q9 (PRESIDENT): All right. Have you been trained in CPR?
A9 (EMT-B): Yes.

Q10 (PRESIDENT): By what protocol?
A10 (EMT-B): Healthcare Provider.

Q11 (PRESIDENT): By which branch?
A11 (EMT-B): American Heart.

Q12 (PRESIDENT): Oh, thank you. Are you current in CPR?
A12 (EMT-B): Yes.

Q13 (PRESIDENT): And are you an instructor as well?
A13 (EMT-B): Yes.

Q14 (PRESIDENT): All right. Are you currently certified as an EMT?
A14 (EMT-B): Yes.

Q15 (PRESIDENT): And your certification is current as well?
A15 (EMT-B): Yes.

Q16 (PRESIDENT): How long have you been an EMT?
A16 (EMT-B): Since 2004.

Q17 (PRESIDENT): All right. And your medical direction is provided by who?
A17 (EMT-B): Bellville Memorial Hospital.

Q18 (PRESIDENT): Thank you. On the morning of 26 October, about what time did your shift start that day?
A18 (EMT-B): Six-thirty a.m.

Q19 (PRESIDENT): And what -- on the 26th of October, where is your -- where were you based out of?
A19 (EMT-B): Station 1.

Q20 (PRESIDENT): And where are you all stationed now?
A20 (EMT-B): Station 2.

Q21 (PRESIDENT): All right. When you get on shift, how long are you on shift?
A21 (EMT-B): For twenty-four hours.

Q22 (PRESIDENT): Okay. About what time did you all receive the call for Tech Sergeant MOC ?
A22 (EMT-B): Seven-fifteen a.m.

Q23 (PRESIDENT): All right. And about how long did it take you to get on the road?
A23 (EMT-B): Less than a minute.

Q24 (PRESIDENT): All right. How long did it take you to get onto the scene?
A24 (EMT-B): Four minutes.

Q25 (PRESIDENT): And from then, how long did it take you to have contact with the patient?
A25 (EMT-B): Two minutes.

Q26 (PRESIDENT): When you got there, what was your impressions about MOC.
A26 (EMT-B): Okay. He was lying supine, which is on his back. And so, we gathered our equipment off the ambulance and got over to see him. And you could tell that he was in some distress. He was complaining of his legs hurting.

Q27 (PRESIDENT): All right. Was anybody there with him?
A27 (EMT-B): There was another gentleman, yes.

Q28 (PRESIDENT): Okay. When you got the initial call, what was the complaint that you had for the call?
A28 (EMT-B): I think they said it was -- let me look. [Sound of whispering.] I don't see where it says the complaint came in -- okay. It just says at -- this one right here. Okay. Alter level consciousness. I'm sorry.

(PRESIDENT): Okay.

Q29 (LEGAL ADVISOR): What does that mean? This is , Legal Advisor.
A29 (EMT-B): Okay. Alter level means they're not like currently -- it's -- they're not all here; they're not with it yet. You know? They're not all for sure about their surroundings. That's the best I can do.

Q30 (PRESIDENT): All right. And once you were on scene, what kind of care did you provide?
A30 (EMT-B): I assisted EMT-P with the -- we did oxygen with the patient and then did a blood glucose level on the patient.

Q31 (PRESIDENT): Okay. So, what was it about the way the patient was presenting that made you think that they needed to go to the hospital?
A31 (EMT-B): I've been doing this long enough, I've seen patients and I just could tell that he needed to go. Just based on my own observation and experience.

Q32 (PRESIDENT): Okay. So, you all decided that he needed to go to --
A32 (EMT-B): Yes.

Q33 (PRESIDENT): -- the hospital? About what time did you all leave the scene?
A33 (EMT-B): We left at seven-thirty-five.

Q34 (PRESIDENT): Was there any changes in the patient between when you arrived and when you left?
A34 (EMT-B): I didn't notice any. No.

Q35 (PRESIDENT): All right. What was your role on the way back? Going back to the hospital.
A35 (EMT-B): I was the driver of the ambulance.

Q36 (PRESIDENT): Okay. So, why did you drive to Saint Elizabeth's?
A36 (EMT-B): It was the closest facility.

Q37 (PRESIDENT): Okay. And about how long did it take you to get there?
A37 (EMT-B): Fifteen minutes, roughly.

Q38 (PRESIDENT): All right. Once you were there, what were your actions?
A38 (EMT-B): To take the patient and then transfer care to the attending ER doc and nurse.

Q39 (PRESIDENT): All right. And then about what time did you all get back in service?
A39 (EMT-B): Eight-fifteen.

Q40 (PRESIDENT): And "in service" means what?
A40 (EMT-B): Ready to go for the next call.

Q41(PRESIDENT): All right.
A41 (EMT-B): Available.

(PRESIDENT): Anybody else have any questions? All right. I think that takes care of it then. Thank you very much.

(EMT-B): You're welcome.

(PRESIDENT): This concludes our interview of you. Since the investigation will continue for the near term, I would ask that you not discuss your testimony today with anyone until after the formal report is published. Again, thank you very much for your time.

(EMT-B): Thank you.

(PRESIDENT): Appreciate it.

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TAB W

WEATHER AND ENVIRONMENTAL RECORDS AND DATA (Not Included in Tab F)

INTENTIONALLY

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USAF AFMC 18 AF/JA

From: Maj USAF ACC 15 OWS/DO
Sent: Thursday, November 12, 2015 4:34 PM
To: GS-09 USAF AFMC 18 AF/JA
Subject: RE: Weather Report

,

Sunrise on Oct 26 was: 7:20am
Forecast Winds: 6 knots from northeast
Observed Winds: 5 knots from northeast
Forecast Temperature: We only forecast high/low temp; High forecast temp was: 64F at 3pm; Low forecast temp was: 39F at 6am.
Observed Temperature at 7am: 43F; observed temp at 8am: 41F
Visibility: Forecast and observed was unrestricted Sky Condition: Clear

V/R -

-----Original Message-----
From: GS-09 USAF AFMC 18 AF/JA
Sent: Thursday, November 12, 2015 3:50 PM
To: Maj USAF ACC 15 OWS/DO
Subject: RE: Weather Report

V/r

-----Original Message-----
From: Maj USAF ACC 15 OWS/DO
Sent: Thursday, November 12, 2015 11:26 AM
To: GS-09 USAF AFMC 18 AF/JA
Cc: SMSgt USAF ACC 15 OWS/DOE
Subject: RE: Weather Report

,

Forecast for Scott AFB (KBLV) on Oct 26:

TAF KBLV 2600/2706 VRB06KT 9999 SKC QNH3023INS

BECMG 2602/2603 VRB06KT 9999 SKC WS020/7026KT QNH3023INS

BECMG 2614/2615 07012KT 9999 SKC QNH3026INS

BECMG 2617/2618 08015KT 9999 SCT030 QNH3013INS

BECMG 2705/2706 09009KT 9999 BKN022 QNH3010INS TX18/2620Z TN04/2611Z

All surface observations from Scott AFB (KBLV) on Oct 26:

20151026 2358 METAR KBLV 262358Z AUTO 08004KT 10SM FEW024 OVC037 18/09 A3015 RMK AO2 VIS 2 RWY32L SLP213 T01820086 10212 20182 57002 $=
20151026 2258 METAR KBLV 262258Z AUTO 06004KT 10SM OVC037 19/08 A3015 RMK AO2 VIS 1 1/4 RWY32L SLP213 T01900080 $=
20151026 2158 METAR KBLV 262158Z AUTO 07007KT 10SM BKN041 20/08 A3015 RMK AO2 VIS 1 1/4 RWY32L SLP213 T01980080 $=
20151026 2058 METAR KBLV 262058Z AUTO 07009G14KT 10SM FEW044 20/07 A3015 RMK AO2 VIS 1 1/2 RWY32L SLP213 T02030071 57020 $=
20151026 1958 METAR KBLV 261958Z AUTO 05009KT 10SM CLR 20/07 A3016 RMK AO2 VIS 1 1/2 RWY32L SLP216 T02030070 $=
20151026 1858 METAR KBLV 261858Z AUTO 09007G16KT 10SM CLR 21/07 A3018 RMK AO2 VIS 1 RWY32L SLP223 T02060070 $=
20151026 1758 METAR KBLV 261758Z AUTO 06009G18KT 10SM CLR 19/07 A3021 RMK AO2 SLP233 T01940066 10194 20051 57017 $=
20151026 1658 METAR KBLV 261658Z AUTO 08010G16KT 10SM CLR 18/06 A3024 RMK AO2 SLP243 T01770058 $=
20151026 1558 METAR KBLV 261558Z AUTO 07013G15KT 10SM CLR 16/05 A3025 RMK AO2 SLP247 T01590052=
20151026 1458 METAR KBLV 261458Z AUTO 09009KT 10SM CLR 13/05 A3026 RMK AO2 SLP251 T01300047 51003=
20151026 1358 METAR KBLV 261358Z AUTO 06009KT 10SM CLR 09/04 A3026 RMK AO2 SLP251 T00920040=
20151026 1258 METAR KBLV 261258Z AUTO 04005KT 10SM CLR 05/03 A3026 RMK AO2 SLP252 T00540028=
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20151026 0528 SPECI KBLV 260528Z AUTO 04004KT 5SM R32L/5000FT HZ CLR 08/04 A3026 RMK AO2=
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20151026 0313 SPECI KBLV 260313Z AUTO 02003KT 9SM R32L/5500FT CLR 10/03 A3028 RMK AO2=
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20151026 0243 SPECI KBLV 260243Z AUTO 03003KT 7SM R32L/5500FT CLR 09/04 A3028 RMK AO2 $=
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20151026 0233 SPECI KBLV 260233Z AUTO 03003KT 8SM R32L/5500FT CLR 09/05 A3028 RMK AO2=
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20151026 0213 SPECI KBLV 260213Z AUTO 05002KT 7SM R32L/5500FT CLR 10/05 A3029 RMK AO2=
20151026 0208 SPECI KBLV 260208Z AUTO 04003KT 7SM R32L/5000FT CLR 10/05 A3028 RMK AO2=
20151026 0203 SPECI KBLV 260203Z AUTO 03003KT 8SM R32L/5500FT CLR 10/05 A3028 RMK AO2=
20151026 0158 METAR KBLV 260158Z AUTO 02003KT 10SM CLR 10/06 A3028 RMK AO2 SLP258 T00960057 $=
20151026 0148 SPECI KBLV 260148Z AUTO 02003KT 10SM CLR 10/06 A3029 RMK AO2 $=
20151026 0143 SPECI KBLV 260143Z AUTO 02003KT 8SM R32L/5500FT CLR 09/06 A3029 RMK AO2=
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20151026 0123 SPECI KBLV 260123Z AUTO 02002KT 8SM R32L/5500FT CLR 09/05 A3029 RMK AO2=
20151026 0118 SPECI KBLV 260118Z AUTO 01003KT 10SM CLR 09/05 A3029 RMK AO2=
20151026 0103 SPECI KBLV 260103Z AUTO 00000KT 8SM R32L/5500FT CLR 09/04 A3030 RMK AO2=
20151026 0058 METAR KBLV 260058Z AUTO 00000KT 10SM CLR 09/04 A3030 RMK AO2 SLP265 T00920043 $=
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20151026 0028 SPECI KBLV 260028Z AUTO 01002KT 10SM CLR 11/06 A3028 RMK AO2=
20151026 0023 SPECI KBLV 260023Z AUTO 03002KT 8SM R32L/5500FT CLR 11/06 A3028 RMK AO2=

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V/R -

Maj, USAF
Operations Officer, 15 OWS
DSN: / COMM:

-----Original Message-----
From: GS-09 USAF AFMC 18 AF/JA
Sent: Thursday, November 12, 2015 8:28 AM
To: Maj USAF ACC 15 OWS/DO
Subject: Weather Report

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STATEMENTS OF INJURY OR DEATH

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

15 March 2016

MEMORANDUM FOR RECORD

FROM: GROUND ACCIDENT INVESTIGATION BOARD MEDICAL MEMBER

SUBJECT: Summary of Medical Data Concerning Fitness Assessment Fatality, 29 October 2015

1. I am the Medical Member recently appointed to the Ground Accident Investigation Board (GAIB), which is investigating the death of Member of Concern (MOC) on 29 October 2015 following injuries suffered during an Air Force Fitness Assessment (FA) test on 26 October 2015 at Scott Air Force Base (AFB), IL.

2. I am a graduate of the United States Air Force Academy and Midwestern Chicago College of Osteopathic Medicine. My medical background is in Internal Medicine. From 2002-2005, I completed a 3 year Internal Medicine (adult medicine) residency at David Grant Medical Center (Travis AFB, CA), which is affiliated with the UC Davis Medical Center (Sacramento University Hospital). I received board certification in Internal Medicine by the American Board of Internal Medicine in Fall 2005 and my board certification remains current. Immediately after graduating Internal Medicine residency in 2005, I entered a 2 year post-residency Nephrology (study of kidneys) Fellowship at the University of Texas San Antonio/Wilford Hall Medical Center, Lackland AFB, TX. I graduated in 2007 and received board certification in Nephrology in Fall 2007. Since graduation, I have continued to practice Internal Medicine and Nephrology as my primary medical duties. I currently teach and supervise Family Medicine residents at David Grant Medical Center (Travis AFB, CA) in outpatient and inpatient settings. I am also currently serving as an Associate Professor at UC Davis Medical Center (Sacramento University Hospital), which is affiliated with the Veterans Administration Mather Medical Center, where I supervise Nephrology Fellows (Nephrologists in training). I also currently work a weekend every six weeks for a private practice Nephrology group, during which time I care for 20-30 inpatients daily. Finally, I currently serve as the Chair of the Nephrology Department at Travis AFB and as the only Nephrology Consultant to the Surgeon General of the Air Force.

3. The overall management of rhabdomyolysis (muscle cell injury) is an Internal Medicine core clinical competency. Likewise, the management of the electrolyte (blood chemical) alternations in rhabdomyolysis is a Nephrology core clinical competency. Accordingly, Nephrologists are regarded as subject matter experts for the management of the complications of this disease. I manage this disease process regularly in my clinical practice. I also have experience with and

medical knowledge of Sickle Cell Trait (SCT) as it within the core competency of Internal Medicine; SCT it is also within the core competency of hematology/oncology (study of blood disorders).

4. In preparation for this GAIB, I performed a thorough search of the medical literature regarding the medical management of rhabdomyolysis in the setting of SCT. As part of my medical analysis discussed herein, I reviewed relevant medical literature published by the Association of Military Surgeons, Center for Disease Control and Prevention, The American Journal of Medicine, International Society of Hematology, American Academy of Family Physicians, and the American College of Sports Medicine.

5. In this memorandum, I articulate and interpret the medical events that led up to and culminated in the death of the MOC on 29 October 2015. My medical summary outlines relevant medical information without disclosing protected health information (PHI) or Privacy Act protected information. I reviewed MOC's outpatient and inpatient medical records, autopsy report, toxicology results, laboratory data, as well as EMS witness interviews. Of note, MOC's inpatient medical records were available but were not as completed as I would have liked. Further, physician interviews would have been helpful but MOC's doctors were not available to meet with the Board. With the above considerations in mind, I feel comfortable that the records provided sufficient information for me to understand and explain the circumstances of MOC's death.

6. As an initial matter, it is important to provide an overview of Sickle Cell Trait (SCT) and the medical condition called Rhabdomyolysis:

a) SCT: the hemoglobin molecule in the human body carries oxygen to the tissues. The normal adult hemoglobin A1 molecule is comprised of 2 alpha globin chains, 2 beta globin chains and heme. Each parent contributes to his or her child one alpha and one beta globin chains. The hemoglobin A1 molecule comprises approximately 95-98 percent of hemoglobin, while hemoglobin A2 and hemoglobin F contribute 2-5 percent of normal human hemoglobin. The sickle hemoglobin (S) comprises approximately 35-45 of the hemoglobin in SCT and approximately 85-90 percent in sickle cell disease. The sickle cell gene, on the 11th chromosome, is transmitted by a child's parents. SCT is an inherited condition in which an individual possesses both a normal (A) and abnormal (S) copy of the hemoglobin gene. Sickle cell disease occurs when a child inherits abnormal hemoglobin chains from both parents. Approximately 1.5 percent of Americans are affected by SCT (approximately 7.3 percent of blacks, 6.9 percent of Hispanics, and 0.5 percent of Caucasians possess SCT). While Sickle Cell Disease is significantly more serious and requires ongoing medical care and therefore precludes military service, SCT is a medical condition that does not currently preclude military service.

b) Known complications of SCT include hematuria (blood in the urine), renal papillary necrosis (death to the inner portion of the kidney), renal medullary carcinoma (rare form of kidney

cancer), splenic infarction (clotting of the vessels of the spleen), venous thromboembolic events (blood clots to the lungs and other organs), hyposthenuria (increased urine output due to kidney-related difficulty in making a concentrated urine) and hyphema (blood in the front eye chamber. SCT is different from Sickle Cell disease in that it is often considered a benign condition that generally does not decrease life expectancy as compared to individuals without SCT. Because there are usually no symptoms of SCT, most people find out they have SCT only through a blood test.

c) Individuals with SCT usually can safely participate in normal physical activity and sports. However, exercise-related collapse is a rare but serious complication of SCT. According to recent medical literature, exertion-induced hypoxia (oxygen deficiency in the blood cells) may initiate a chain of events inducing blood sickling. Unlike normal red blood cells that are round and can easily pass through blood vessels, sickled red blood cells are rigid and can block blood vessels to cells, tissues, and organs. The consequence of this obstruction results in organ injury. Known precipitants of sickle cell events include severe tissue hypoxia (low oxygen in tissues), increased blood viscosity (blood thickness), acidosis (too much blood acid), and hypothermia. Sickle cell events may lead to muscle rhabdomyolysis (the rapid breakdown of muscle tissue starved of blood), leading to blood chemistry problems and potentially sudden death. High temperature and humidity, high altitude, an individual's poor conditioning, poor hydration, age, and high-intensity exercise have been suggested as being factors in causing blood sickling. However, at times no identifying risk factors are evident.

d) Testing for SCT in the military started in the late 1960's. In military populations, medical studies have shown that exercise-related deaths are 30-40 times higher in those with SCT compared to those without SCT. I understand that each military service has its own policy on SCT. I am aware that the Air Force tests for SCT after accession at initial military training. At Basic Military Training (BMT), Airmen identified as being SCT positive are required to wear a white reflective armband during all BMT activities. Additionally, at the United States Air Force Academy (USAFA), SCT positive individuals are identified and monitored by staff; however, there are no visible identifiers during USAFA training.

e) I would note that the Fitness Screening Questionnaire (Tab T-9 to Tab T-10) MOC filled out did reference sickle cell trait. Question 1 states, "Have you experienced any of the symptoms/problems listed below [sickle cell trait was a listed condition] and not been medically evaluated and cleared for unrestricted participation in a physical training program?" Given MOC's SCT trait had been previously medically evaluated and the member was cleared for unrestricted participation in a physical training program, his apparent good health, a history of no previous problems with SCT since screening, and his not being on a medical profile for SCT, it was appropriate that he checked the box "no" to this question. Had he checked the box "yes," MOC would have been required to be medically evaluated. However, given his apparent good health

and a history of no previous problems with SCT, I do not see a medical reason to place MOC on a no-run profile due solely to his SCT status.

g) Rhabdomyolysis: muscles in the human body are comprised of cells called myoctyes. Like other organs, muscles require adequate delivery of oxygen and nutrition to function normally. In rhabdomyolysis events, myoctyes are damaged and release their contents in the blood circulation, resulting in a potentially life threatening medical condition called acute rhabdomyolysis. Myoglobin, a pigment protein located within the myocyte, is released into the blood circulation and can induce kidney failure through obstruction of the renal tubules (microscopic kidney urine drainage network), for which a patient may require emergency dialysis (process to remove toxic chemicals from the blood) to allow the patient to survive. Potassium, principally stored within myocytes, is also released and can cause life threatening arrhythmias (abnormal heart rhythm) and muscle paralysis. Phosphorous, principally stored in the bone but also in significant quantities in muscles, is released and can cause obstruction of the blood flow to skin and subsequent calciphylaxis (skin death). Calciphylaxis can be life threatening if infection develops. Further, the released phosphorous binds with calcium to result in low blood calcium levels, which can cause arrthymias, seizures, or tetany (non-voluntary muscle contractions). Risk factors for rhabdomyolysis include certain trauma, hyperthermia, low blood flow to the muscle, medicine, infection, dehydration, genetic muscle disorders, autoimmune diseases, and extreme exertion. The most common causes are crush injury, overexertion, alcohol abuse and certain medicines and toxic substances. As documented in medical literature, rhabdomyolysis may occur in physically fit SCT individuals who have no other apparent risk factors.

h) As discussed previously, multiple complications can occur during rhabdomyolysis events; and are classified as early or late onset. Clinical symptoms include muscle pain, tea-colored urine, fever, nausea, vomiting, confusion, agitation, and decreased urine output. Early complications include severe hyperkalemia (high potassium in the blood) that causes cardiac arrhythmia (problems with heart rhythms) and arrest (heart stops beating). The most serious late complication is acute renal failure (kidneys stop working), which is common and occurs in approximately 15 percent of patients with the syndrome. Compartment syndrome can be an early or late complication of rhabdomyolysis, and occurs when the muscle swells more than allowed by the tight connective tissue and other structures around it. Early recognition of rhabdomyolysis and prompt management of complications (to include rehydration and kidney dialysis) are crucial to a successful outcome.

7. A blood sample was taken from MOC at Air Force Basic Training (BMT). MOC's blood was tested for SCT, among other medical conditions. From this test, MOC was diagnosed with being SCT positive. On 29 September 2003, MOC was counseled that he was SCT positive and provided information about the condition. Specifically, he was informed that on rare occasions, individuals with SCT had died unexpectedly after physical exertion, but that the risk associated with SCT could be

minimized by maintaining high hydration as well as seeking medical care if he believed he was sick. On 29 September 2003, knowing this information, MOC was given a choice to be discharged from the Air Force or to remain on active duty. On a written memorandum, MOC indicated his decision to remain on active duty. On a separate form, MOC was placed on a no-run training activity status, with a restriction end date of 2 October 2003. MOC graduated from BMT proceeded with his military career without apparent medical complications until 26 October 2015.

8. In addition to the forms referencing MOC's acknowledgement of his SCT positive status, there was a form in MOC's medical records, in large and bold print, stating "SICKLE CELL TRAIT." It further stated that hydration was an important consideration for SCT positive individuals. Additionally, it stated that viral illnesses may require close monitoring and restriction activities, as appropriate.

9. On 3 August 2005 (doctor's visit for pulled muscle), MOC's medical records a medical history of SCT. Blood tests were conducted as part of MOC's physical health assessment on 9 August 2005 and September 2007 and the results were SCT negative (note: there was no further discussion of previous SCT positive tests in MOC's medical records). Nevertheless, there was a reference in the doctor's note in September 2008 that MOC was SCT positive (visit was related to MOC's complaint of a cold). In December 2008, there is reference in MOC's medical records that MOC and his doctor had a conversation about SCT (among other conditions), with a note to discuss all listed conditions with a health care profession at his next health care visit.

10. In Spring 2015, MOC was diagnosed with high blood pressure (although not relevant to this mishap) and was placed on appropriate medications. A medical profile was submitted at that time exempting MOC from the run/walk portion of the FA. His blood pressure was controlled within 7 days of the incident and was not related to the mishap. It appears MOC was adherent with medication administration. Although his height (66 inches) and weight (191 pounds) measurements on 26 October 2015 technically placed him into the "obese" (body mass index) category, MOC's waist measurement on his 26 October 2015 FA placed him at low risk and consequently he received maximal points for his waist measurement. From witness interviews, I am aware MOC exercised through running and weight lifting most days of the week. He appears to have focused on maintaining adequate hydration.

11. Outside of a runny nose, it appears the MOC was in his usual state of good health on 26 October 2015. Per usual protocol, the Fitness Assessment Cell (FAC) staff at James Gym briefed the FA participants regarding an ability to opt out of the FA in the case of injury or sickness. MOC did not opt out of the FA test. He received maximal points (perfect score) for waist measurement, sit-up, and push-up components of the FA. After each FA test component and immediately before the run portion of the FA, MOC did not appear ill.

12. For reasons that are unclear, MOC's exercise on 26 October 2015 resulted in the normally

benign SCT condition to react negatively, which started a chain of events that would ultimately lead to his death. During the run component of the FA, MOC appeared to perform adequately during the first five of six laps. On lap six of six, MOC's sit-up and push-up partner, who was running behind MOC, noticed he was gaining ground on the MOC, but he did not find this fact peculiar. At the 2nd to last corner of the track (about 80-100 yards to the run finish), MOC's sit-up and push-up partner, who was still running behind MOC, saw MOC take a few irregular steps, then take a knee, and then lied on his back facing up on the track. A FAC staff member immediately arrived to the scene and assessed MOC. MOC was rolling from his back to his side repetitively; he mentioned pain in both legs. He denied other symptoms to the FAC staff member. He did not appear to have lost consciousness but appeared mildly disoriented (for example, MOC asked the FAC staff member if he finished the test). The FAC staff member, concerned about the MOC's overall appearance/medical condition, called 9-1-1 for further evaluation approximately 5 minutes after MOC started lying on the track.

13. Emergency Medical Services (EMS) at Scott AFB received the call 0715 hours and arrived on-scene at 0719 hours. Initial EMS evaluation revealed MOC's mild disorientation (his eyes were closed and he had a confused response to questioning). MOC's heart rate was moderately elevated in the 140 range (normal 60-100 beats per minute) and his rate of breathing was elevated in the 30's (normal is 6-8 breaths per minute). His blood pressure, blood oxygen saturation, and blood sugar levels were normal. Due to EMS provider concern about the MOC's pain and mild disorientation, a decision was made to transport MOC to St. Elizabeth's Hospital, which was the nearest hospital to Scott AFB. St. Elizabeth's has an emergency room (ER), surgery center (to include neurology, pulmonary, vascular), and has other medical specialists on staff capable to treat sickle cell trait patients (although SCT was not known to emergency responders at the time the decision to transport MOC to St. Elizabeth's Hospital). On loading the MOC into the ambulance, MOC suddenly became unresponsive. Oxygen was applied and within minutes, MOC's eyes opened spontaneously and he was moving his arms. MOC arrived to St. Elizabeth's Emergency Room (ER) at 0748 hours.

14. Upon arrival to the ER, MOC had a normal blood pressure and oxygen saturation, but again, he had an elevated heart rate in the 140's. He had a body temperature of 103.5F and one hour later it was 103.8F. MOC's response to questioning was slow but it improved with treatment while in the ER. Medical workup obtained in the ER revealed a severe decrease in his blood pH (too much acid in his blood), which was due to lactate production (anaerobic metabolism commenced due to inadequate blood flow and oxygen to his tissues, resulting in lactate production as a metabolic byproduct). MOC's blood sugar was significantly elevated (no history of diabetes) and he had a mild elevation in his white blood cell count (WBC) with a left shift that indicates acute stress (infection, trauma, etc.). MOC's kidney function was also decreased on arrival to the ER. Initial analysis of MOC's urine revealed mild blood on the litmus test but no red blood cells were identified, consistent with muscle injury. His blood muscle injury marker (ck) was mildly elevated. His heart rhythm was sinus tachycardia (fast heartbeat, which was an appropriate response to illness) and a chest x-ray was unremarkable. A heart ultrasound and cat scan of MOC's brain did not reveal significant abnormalities.

A brain wave study revealed non-specific findings consistent with acute illness.

15. Because of the emergent nature of MOC's condition, the medical staff at St. Elizabeth's did not delay MOC's medical treatment in order to wait for family contact. Once they contacted MOC's wife, they obtained her approval for their prior treatment and authorization to continue with their plan to initiate kidney dialysis. MOC's treatment was not impacted by the delay in obtaining verbal authorization to continue their treatment from MOC's wife.

16. Based on the MOC's presentation, consultation with various medical providers, and his ER medical workup, MOC was diagnosed with rhabdomyolysis. He was treated with sodium bicarbonate fluids to help prevent worsening kidney failure and treat his severe decrease in blood pH. Antibiotics were administered in the event he had a bloodstream infection. Later on 26 October 2015, MOC's urine output decreased and he began to have laboratory evidence of Disseminated Intravascular Coagulation (DIC). DIC is a syndrome where blood platelets and coagulation factors are consumed due to an acute illness and render the patient at higher risk for both bleeding and blood clotting. Neurology evaluated MOC and concluded his confusion was due to MOC's acute illness and not a specific brain disease. Nephrology was consulted and started dialysis the evening of 26 October 2015 for his severe low pH, decreasing urine output, worsening kidney failure, and increased potassium. Cardiology saw MOC for concerns of a heart attack but attributed his elevated Troponin (a measure of heart injury) to rhabdomyolysis. After MOC's left thigh was palpated (e.g., felt), the muscle was determined to be tight, and Orthopedic Surgery was consulted for consideration of compartment syndrome. Compartment syndrome occurs when muscle is swollen but can't expand due to compression of surrounding tissue called fascia. The inability of the muscle to expand decreases blood supply to the muscle and worsens the muscle injury. Orthopedic testing confirmed elevated compartment pressures in both legs and concurred with the diagnosis of compartment syndrome.

17. Hematology saw MOC on 27 October 2015. The first annotation of SCT noted in MOC's medical records at St. Elizabeth's hospital was on 27 October 2015. Nevertheless, he was receiving appropriate medical care before SCT was positively identified. Hematology's exam was notable for a worsening of MOC's mental status; he had somnolence (sleepiness) and confusion, but did awaken to command and answered questions with one word. MOC's kidney function significantly deteriorated while his WBC count, potassium, ck, and liver enzymes increased, indicating progressive SIRS (systemic inflammatory response syndrome). SIRS is an inflammatory syndrome due to various causes, to include infection, heart failure and liver failure. No red cell fragmentation was noted on the peripheral blood smear reviewed by Hematology. Accordingly, the Hematologist diagnosed MOC with severe rhabdomyolysis and DIC, with sickle cell trait as an underlying contributing factor.

18. To relieve the compartment syndrome, Orthopedic Surgery performed faciotomies (cut the muscle compartment lining to allow the muscle to expand and renew blood flow) of both lower legs and the left thigh. Clinical confirmation of compartment syndrome (expansion of muscle after the fascia was incised) was noted after the fascial procedures.

19. On 28 October 2015, MOC was seen by Gastroenterology for worsening liver failure that was attributed to shock (low blood flow to the liver). On 28 October 2015, Orthopedic Surgery was re-consulted for MOC's deteriorating vital signs and laboratory parameters. Elevated compartment pressures were now found in MOC's right thigh and both upper extremities. Additional fascitomies were performed on MOC's arms and right leg. Again, muscle bulging after incision confirmed compartment syndrome. At the end of the surgery, MOC became pulseless due to high potassium and required chest compressions for about 2 minutes.

20. After return to the Intensive Care Unit (ICU), MOC again became pulseless due to increased potassium and required compression. Dialysis, as part of the overall medical care plan, was resumed to remove MOC's elevated blood potassium level on a continuous basis. He required increasing doses of three vasopressors (medications to increase blood pressure). Due to continued clinical deterioration despite maximal support MOC's treating physician met with MOC's spouse about end of life decisions. After discussing MOC's poor prognosis despite medical efforts, MOC's spouse modified his status to "Do Not Resuscitate." On the morning of 29 October 2015, MOC sustained a slow wide complex heart rhythm (from high potassium) that quickly deteriorated to asystole (flat line). MOC died at 0851 hours on 29 October 2015.

21. I would also note that sometime on 28 October and then again on 29 October 2015, one of MOC's nurse's and senior medical staff at the 375th Medical Group (Scott AFB Clinic) had telephone conversation(s) about moving MOC to another nearby hospital for a higher echelon of medical care. However, MOC never stabilized enough at St. Elizabeth's Hospital in order for MOC to be transferred to another hospital before his death.

22. The pathologist's post-mortem autopsy summary was as follows: "The cause of death is complications of sickle cell trait. The manner of death is natural. The presence of sickle cell trait (not sickle cell disease) is demonstrated by the hemoglobin electrophoresis testing. The decedent's exercise led to acidosis and hypoxemia in the muscles that resulted in morphological changes (sickling-type changes) in the red blood cells that led to ischemic injury of the skeletal muscle of the extremities and resultant compartment syndrome. As the skeletal muscle tissue expanded and died (rhabdomyolysis), myoglobin and electrolytes were released into the bloodstream resulting in renal compromise and increased potassium. The increased potassium resulted in a fatal cardiac arrhythmia. The small intracerebral hemorrhages are likely due to acute coagulopathy and increased intracranial pressure. The liver and spleen necrosis are secondary to cardiac failure."

23. The pathologist's determination can be explained as follows: MOC's exertion led to low oxygen and blood flow to his muscles. His red cells changed shape to sickle type cells and further impeded oxygen and blood flow delivery to the muscles. Due to this, MOC's muscle cells became injured and swelled. MOC's swollen muscles were not able to expand due to surrounding tissue structure, which further reduced blood flow to his muscles and exacerbated his muscle injury. As MOC's muscle cells

died, their contents (such as potassium) were released into the circulation and resulted in a fatal heart rhythm.

24. In my medical opinion, I conclude that MOC's determination of death was severe rhabdomyolysis due to extreme exertion during his FA. His SCT is a notable risk factor for disease development. Based on documentation available to me at the time of this review, it appears the medical standard of care by the FAC team, EMS team, ER team, and inpatient medical team was met.

Lt Col, USAF, MC
Element Chief, Nephrology Services, David Grant Medical Center
Nephrology Consultant to the US Air Force Surgeon General

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LEGAL BOARD APPOINTMENT DOCUMENTS

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

6 November 2015

MEMORANDUM FOR COLONEL MICHAEL WOOD MC, FS, HQ AMC/SGP

FROM: AMC/CV
402 Scott Drive, Unit 3EC
Scott AFB IL 62225-5310

SUBJECT: Convening of AFI 51-503 Ground Accident Investigation Board, Class A, PT Test Fatality, 29 Oct 2015, Scott AFB, IL

1. In accordance with AFI 51-503, I hereby convene a Ground Accident Investigation Board (GAIB) to investigate the fatality of TSgt MOC . I have appointed you to serve as the GAIB President. You must avoid accessing any privileged safety information regarding this mishap until approval of the report. This appointment letter is your authority to interview witnesses, take sworn testimony, and review all documents, reports, records, and other evidence relevant to your investigation. The legal advisor and additional technical advisors you may need will be appointed in writing by HQ AMC/JA. Once the GAIB investigation begins, you and the other detailed members are relieved of all other duties until the GAIB Report is submitted for approval. You may consider releasing any member when their responsibilities are complete.

2. Your investigation will follow the guidelines and procedures in AFI 51-503. HQ AMC/JA will advise you on preliminary administrative matters, as required. Your legal advisor is required to be present during all witness interviews, and must review all evidence, documents, transcripts, and statements prior to inclusion in your report. Your report will include an Executive Summary, and, Summary of Facts as required by AFI 51-503. Other than privileged safety information, all witnesses, documents, records, and other evidence within the control of the Air Force will be made available to you. All witnesses who testify must do so under oath or affirmation. Your report shall be released to the public and shall not contain any privileged safety or Privacy Act-protected information.

3. Your legal advisor will assist you in evaluating evidence. Do not include a Statement of Opinion, or recommendations for corrective or disciplinary action in your report. You and the other GAIB members are not authorized to disclose board findings or opinions, except to members of my staff, prior to approval and public release of the report.

4. Travel and billeting will be funded by Air Mobility Command. You will be provided a cross organizational funding authorization for your travel by HQ AMC/JA. Travel orders should be issued locally and should authorize variations in travel, full per diem, and rental cars. All travel costs for witness interviews outside the host installation area should be coordinated with HQ AMC/JA in advance.

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5. Colonel , 375 AMW/CC, will appoint a host liaison officer to help arrange billeting, government vehicles if available, facilities, administrative and computer support, reproduction services and access to witnesses. Make contact with the host installation liaison officer through the wing commander's office. Additionally, 375 FSS/CC shall appoint a point of contact to assist the GAIB with access to witnesses and evidence secured by the unit.

6. Your investigation should be completed within 30 days from the start of your investigation. Submit any requests for extensions, additional board members or advisors, or other matters to HQ AMC/JA. Submit your final report to HQ AMC/JA, and they will forward it to me for approval.

7. As part of your duties as GAIB president, you will serve as the conduit for accident investigation information to the next-of-kin (NoK) and family members of the deceased, and to the public. You should work with the family assistance representative (FAR) to conduct an initial in-person briefing with the NoK, unless they do not wish to receive an initial briefing. You should prepare and process an Early Release of Information for release to the NoK and to the public in accordance with AFI 51-503, Chapter 7.

8. The HQ AMC/JA point of contact for any questions is Col .

ROWAYNE A. SCHATZ, JR.
Major General, USAF
Vice Commander

cc:
HQ AMC/SG
18 AF/CC/JA
375 AMW/CC/JA
375 FSS/CC

Y2. ADDITIONAL MEMBER APOINTMENT MEMORANDUM

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

6 November 2015

MEMORANDUM FOR COLONEL MICHAEL WOOD , MC, FS, HQ AMC/SGP

FROM: HQ AMC/JA
102 E. Martin St, Room N-119
Scott AFB IL 62225-5012

SUBJECT: Appointment of Additional Ground Accident Investigation Board Members, PT Test Fatality, 26 Oct 15, Scott AFB, IL

1. On 6 Nov 15, AMC/CV convened a Ground Accident Investigation Board (GAIB) under AFI 51-503 to investigate the above referenced mishap.

2. Pursuant to my authority under AFI 51-503, paragraph 2.1.3., I appoint the following individuals to serve on the GAIB:

Major	, AFLOA/JACC, JB Andrews, MD	Legal Advisor
Mr.	, 18 AF/JA, Scott AFB, IL	Recorder

3. You must ensure that all GAIB members are briefed on the requirements of AFI 51-503, paragraph 7.1.3, which prohbit the disclosure of information regarding the GAIB investigation until the report is released to the public.

4. The HQ AMC/JA point of contact for any questions is Col .

., Colonel, USAF
Acting Staff Judge Advocate

Attachment:
Convening Order, 6 November 2015

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

2 December 2015

MEMORANDUM FOR COLONEL MICHAEL WOOD , HQ AMC/SGP

FROM: HQ AMC/JA
102 E. Martin St, Room N-119
Scott AFB IL 62225-5012

SUBJECT: Appointment of Additional Ground Accident Investigation Board Member, Class A, PT Test Fatality 26 Oct 15, Scott AFB, IL

1. On 6 Nov 15, AMC/CV convened a Ground Accident Investigation Board (GAIB) under AFI 51-503 to investigate the above referenced mishap.

2. Pursuant to my authority under AFI 51-503, paragraph 2.1.3., I appoint Lt Col , 60 MDOS/SGOMK, Travis AFB, CA, to serve as the Medical Member on the GAIB.

3. You must ensure Lt Col is briefed on the requirements of AFI 51-503, paragraph 7.1.3, which prohbit the disclosure of information regarding the GAIB investigation until the report is released to the public.

4. The HQ AMC/JA point of contact for any questions is Col ,

, Colonel, USAF
Staff Judge Advocate

Attachment:
Convening Order, 6 November 2015

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TAB Z

PHOTOGRAPHS, VIDEOS, DIAGRAMS, AND ANIMATIONS (Not Included in Tab S)

Z1. SCOTT AFB TRACK

TAB AA

ACCIDENT-RELATED DUTY DOCUMENTS

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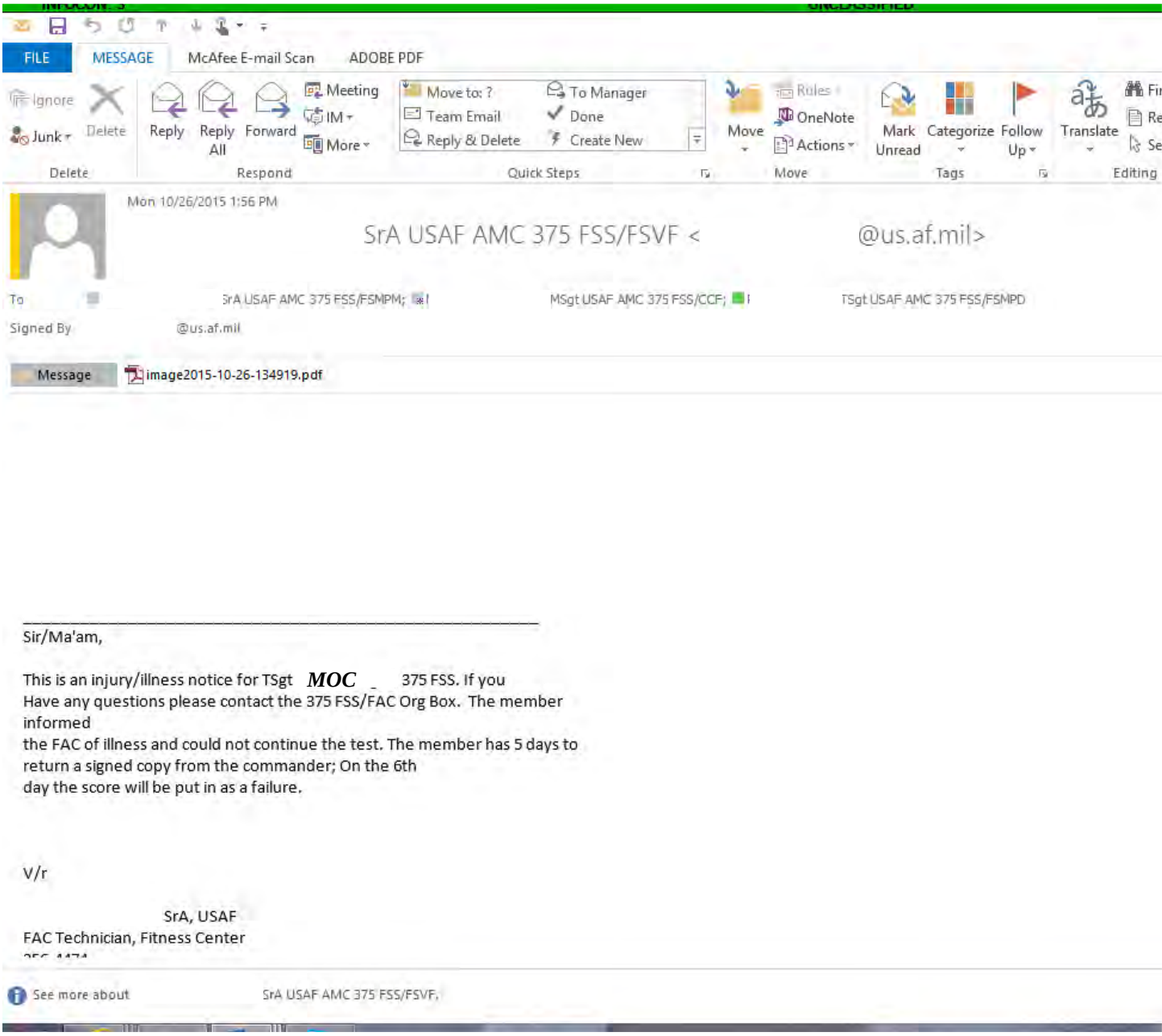
FILE
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Reply
Reply All
Forward
Meeting
IM
More
Move to: ?
Team Email
Reply & Delete
To Manager
Done
Create New
Move
Rules
OneNote
Actions
Mark Unread
Categorize
Follow Up
Translate
Delete
Respond
Quick Steps
Move
Tags
Editing
Mon 10/26/2015 1:56 PM
SrA USAF AMC 375 FSS/FSVF <
@us.af.mil>
To
SrA USAF AMC 375 FSS/FSMPM;
MSgt USAF AMC 375 FSS/CCF;
TSgt USAF AMC 375 FSS/FSMPD
Signed By
@us.af.mil
Message
image2015-10-26-134919.pdf
Sir/Ma'am,
This is an injury/illness notice for TSgt MOC _ 375 FSS. If you
Have any questions please contact the 375 FSS/FAC Org Box. The member informed
the FAC of illness and could not continue the test. The member has 5 days to return a signed copy from the commander; On the 6th
day the score will be put in as a failure.
V/r
SrA, USAF
FAC Technician, Fitness Center
See more about
SrA USAF AMC 375 FSS/FSVF.

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Date : 10/14/2015 (21)

Date : 10/15/2015 (36)

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Date : 10/26/2015 (37)

Time : 0600 (12)

MSgt USAF AMC [illegible]	GS-07 USAF AMC AMC/CCQ	9/15/2015 0:51	(no title)	10/26/201
1st Lt USAF AMC A2/A2A	GS-07 USAF AMC AMC/CCQ	9/15/2015 1:10	(no title)	10/26/201
A1C USAF AMC A3/A3CPX	GS-07 USAF AMC AMC/CCQ	9/15/2015 1:48	(no title)	10/26/201
USAF AMC AMC/PAX	GS-07 USAF AMC AMC/CCQ	9/15/2015 2:00	(no title)	10/26/201
SrA USAF AMC 375 FSS/FSOXI	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:54	(no title)	10/26/201
TSgt USAF AMC 375 FSS/FSI	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:56	(no title)	10/26/201
USAF AMC 375 FSS/FSMPD	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:57	(no title)	10/26/201
TSgt USAF AMC 375 FSS/FSMPD	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:58	(no title)	10/26/201
Maj USAF AMC 375 DS/SGDO	SSgt USAF AMC 375 DS/SGDO	9/15/2015 6:38	(no title)	10/26/201
MSgt USAF AMC 375 AFW/DOT	SSgt USAF AMC 375 DS/SGDO	9/15/2015 6:39	(no title)	10/26/201
SSgt USAF AMC 375 FSS/FSVM	SSgt USAF AMC 375 FSS/FSVF	9/29/2015 7:50	(no title)	10/26/201
SSgt USAF AMC AFSOC/A5/8/9	GS-07 USAF AMC AMC/CCQ	10/19/2015 10:41	(no title)	10/26/201

Time : 0800 (13)

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MSgt USAF AMC 375 AW/SCO	TSgt USAF AMC 375 CSPTS/SCE	9/15/2015 0:02	(no title)	10/26/201
SrA USAF AMC AMC/CCCA	SSgt USAF ACC 15 OWS/WXC	9/15/2015 0:07	(no title)	10/26/201
SSgt USAF AMC 375 CES/CEF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:13	(no title)	10/26/201
SSgt USAF AMC 375 CES/CEF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:14	(no title)	10/26/201
SSgt USAF AMC 375 CES/CEF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:16	(no title)	10/26/201
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SrA USAF AMC 375 CS/SCIN	TSgt USAF AMC 375 CS/SCO1	9/15/2015 0:34	(no title)	10/26/201
SSgt USAF AMC 618 AOC/XOFDC	MSgt USAF AMC 618 AOC/XOPM	9/15/2015 0:43	(no title)	10/26/201
SrA USAF AMC 375 CS/SCOT	TSgt USAF AMC 375 CS/SCO1	9/15/2015 0:56	(no title)	10/26/201
SSgt USAF AFMC 437 SCOS/SCWFB	TSgt USAF AFMC 437 SCOS/GWFB	10/9/2015 8:48	(no title)	10/26/201
Maj USAF AMC A5/A8Z	TSgt USAF AMC 375 ASS/FSVS	10/22/2015 13:45	(no title)	10/26/201

Time : 1000 (12)

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A1C USAF AMC 375 CES/CEOPF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:19	(no title)	10/26/201
A1C USAF AMC 375 CES/CEOPF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:20	(no title)	10/26/201
SSgt USAF AMC 375 MDOS/SGOP	TSgt USAF AMC 375 MDOS/SGOW	9/15/2015 6:55	(no title)	10/26/201
SrA USAF AMC 375 MDOS/SGOP	TSgt USAF AMC 375 MDOS/SGOW	9/15/2015 6:56	(no title)	10/26/201
SrA USAF AMC 375 MDOS/SGOP	TSgt USAF AMC 375 MDOS/SGOW	9/15/2015 7:00	(no title)	10/26/201
Maj USAF AMC 618 AOC/XOOP	MSgt USAF AMC 618 AOC/XCOB	9/15/2015 7:01	(no title)	10/26/201
TSgt USAF AMC 618 AOC/XOBA	MSgt USAF AMC 618 AOC/XCOB	9/15/2015 7:03	(no title)	10/26/201
MSgt USAF AMC 375 AMOS/SGPB	SSgt USAF AMC 375 AMOS/SGPO	9/15/2015 13:31	(no title)	10/26/201
SrA USAF AMC 375 SCOS/SCWAB	TSgt USAF AFMC 437 SCOS/GWFE	10/15/2015 10:42	(no title)	10/26/201
SSgt USAF ANG 305 ARS/OSL	SSgt USAF ANG 305 ARS/OSL	10/15/2015 11:24	(no title)	10/26/201

Date : 10/27/2015 (36)

Date : 10/28/2015 (36)

Date : 10/29/2015 (36)

Date : 10/30/2015 (25)

Date : **10/14/2015** (21)

Date : **10/15/2015** (36)

Date : **10/16/2015** (35)

Date : **10/19/2015** (36)

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Date : **10/26/2015** (37)

Time : 0600 (12)

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	1st Lt USAF AMC A2/3/6A	GS-07 USAF AMC AMC/CCQ	9/15/2015 1:10	(no title)
	A1C USAF AMC A3/A3CP2	GS-07 USAF AMC AMC/CCQ	9/15/2015 1:48	(no title)
	Capt USAF AMC AMC/PAX	GS-07 USAF AMC AMC/CCQ	9/15/2015 2:00	(no title)
	SrA USAF AMC 375 FSS/FSDXI	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:54	(no title)
	TSgt USAF AMC 375 FSS/FS	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:56	(no title)
	TSgt USAF AMC 375 FSS/FSDXI	SSgt USAF AMC 375 FSS/FSVF	9/15/2015 4:58	(no title)
	Maj USAF AMC 375 DS/SGDO	SSgt USAF AMC 375 DS/SGDO	9/15/2015 6:38	(no title)
	JR MSgt USAF AMC 375 AW/DO	SSgt USAF AMC 375 DS/SGDO	9/15/2015 6:39	(no title)
	SSgt USAF AMC 375 FSS/FSVF	SSgt USAF AMC 375 FSS/FSVF	9/29/2015 7:50	(no title)
	SSgt USAF AMC AMC/CCQ	GS-07 USAF AMC AMC/CCQ	10/19/2015 10:41	(no title)

Time : 0800 (13)

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	SrA USAF AMC BA	SSgt USAF AMC BA	9/15/2015 0:00	(no title)
	MSgt USAF AMC 375 DO/SCO	TSgt USAF AMC 375 ESPTS/SCE	9/15/2015 0:02	(no title)
	SrA USAF AMC AMC/CCA	SSgt USAF AMC 375 DS/SGDO	9/15/2015 0:03	(no title)
	SSgt USAF AMC 375 CES/CEF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:14	(no title)
	SSgt USAF AMC 375 CES/CEF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:16	(no title)
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	SrA USAF AMC 375 CS/SCM	TSgt USAF AMC 375 CS/SCO	9/15/2015 0:34	(no title)
	SSgt USAF AMC 618 AOC/XOFP	MSgt USAF AMC 618 AOC/XOFM	9/15/2015 0:43	(no title)
	SrA USAF AMC 375 CS/SCO	TSgt USAF AMC 375 CS/SCO	9/15/2015 0:56	(no title)
	SSgt USAF AFMC 412 SCOS/GWSB	TSgt USAF AFMC 437 SCOF/GWFE	10/9/2015 8:48	(no title)
	Maj USAF AMC AS/A0Z	TSgt USAF AMC 375 FSS/FSVS	10/22/2015 13:45	(no title)

Time : 1000 (12)

	SSgt USAF AMC 375 CSPTS/SCE	TSgt USAF AMC 375 CSPTS/SCE	9/15/2015 0:11	(no title)
	SrA USAF AMC 375 CES/CEHS	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:17	(no title)
	A1C USAF AMC 375 CES/CEF	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:19	(no title)
	A1C USAF AMC 375 CES/CEOI	TSgt USAF AMC 375 CES/CEF	9/15/2015 0:20	(no title)
	SSgt USAF AMC 375 MDOS/SGOP	TSgt USAF AMC 375 MDOS/SGOW	9/15/2015 6:55	(no title)
	SrA USAF AMC 375 MDOS/SGOP	TSgt USAF AMC 375 MDOS/SGOW	9/15/2015 6:56	(no title)
	SrA USAF AMC 375 MDOS/SGOP	TSgt USAF AMC 375 MDOS/SGOW	9/15/2015 7:00	(no title)
	Maj USAF AMC 618 AOC/XOOP	MSgt USAF AMC 618 AOC/XOOP	9/15/2015 7:01	(no title)
	TSgt USAF AMC 618 AOC/XOOP	SSgt USAF AMC 618 AOC/XOOP	9/15/2015 7:03	(no title)
	MSgt USAF AMC AMC/SGFP	SSgt USAF AMC 375 MDOS/SGFP	9/15/2015 13:31	(no title)
	1I SrA USAF AMC 375 SCOS/SCSB	TSgt USAF AFMC 437 SCOF/GWFE	10/15/2015 10:42	(no title)
	JR SSgt USAF AMC 375 AMDS/OSEI	JR SSgt USAF ANG 375 AMDS/OSEI	10/15/2015 11:24	(no title)

Date : **10/27/2015** (36)

Date : **10/28/2015** (36)

Date : **10/29/2015** (36)

Date : **10/30/2015** (25)

Walk in

Date	Time	Name/Rank	Unit	Jersey	
26 Oct 15	0600	SSgt	618 AOC	AC only	Sqt
		Lt Col	618 AOC	G 13	Sqt
		MSgt	375 MSFS	G 14	Exc
		TSgt	54 AS	01	Sqt
		SrA [redacted]	375 DS	02	Sqt
	0800	SMSgt	38 CYRS	M12	Sqt
		MSgt	315 CES	M14	Exc
A	1000	Lt Col	USTC	Y2	A Exc
		MSgt	375 MDG	AC only	Sqt
		MSgt	618 AOC	AC only	Sqt
		Lt Col	18 AF	~~M10~~ Y10	Sqt
		Maj	54 AS	Y12	Exc

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APPLICABLE REGULATIONS, DIRECTIVES, AND OTHER GOVERNMENT DOCUMENTS

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BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 36-2905

21 OCTOBER 2013

Incorporating Change 1, 27 AUGUST 2015

Personnel

FITNESS PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at **www.e-publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFPC/DPS

Certified by: AF/A1P
(Brig Gen Gina Grosso)

Supersedes: AFI36-2905, 1 July 2010

Pages: 147

This instruction implements Air Force Policy Directive (AFPD) 36-29, *Military Standards*. It complements the physical fitness requirements of DoD Directive 1308.1, *DoD Physical Fitness and Body Fat Program*, DoD Instruction 1308.3, *DoD Physical Fitness and Body Fat Procedures*, AFI 40-101, *Health Promotion*, and Air Force Policy Directive (AFPD) 10-2, *Readiness*. This instruction applies to all Regular Air Force (RegAF), Air National Guard (ANG), and Air Force Reserve (AFR) members, except where noted otherwise. This instruction relates to AFI 10-203, *Duty Limiting Conditions*, AFI 34-266, *Air Force Fitness and Sports Programs* and AFI 40-104, *Health Promotion Nutrition*. This AFI may be supplemented at any level, but all supplements must be routed to AF/A1P for coordination prior to certification and approval. Refer recommended changes about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records,* and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm.** This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by 10 U.S.C. 8013 and Executive Order 9397. The applicable Privacy Act SORN F036 AF A1 I, Fitness Program Case File, is available at **http://privacy.defense.gov/notices/usaf/**.

SUMMARY OF CHANGES

This interim change revises AFI 36-2905 to provide updates to program policies by (1) extending post-pregnancy Fitness Assessment (FA) requirement from 6 months to 12 months, (2) removing Exercise Physiologist (EP) positions, (3) authorizing Airmen on permanent medical

exemptions to test annually, (4) making referral performance reports optional for FA failures upon close-out of EPR/OPR/TR, (5) making enlisted Airmen either not current or with a FA failure at Promotion Eligibility Cut-Off Date (PECD) ineligible for promotion, (6) adding mandatory and modified optional command actions for failed FA, (7) exempting Airmen with approved retirement/separation dates within 12 months of last FA, (8) officially recognizing FAs administered at commissioning sources, and (9) authoritizing local Fitness Info Managers (FIM) to update corrections resulting from administrative errors/records approved through the appeal process in the Air Force Fitness Management System II and is effective 31 July 2015. A margin bar (|) indicates newly revised material.

This instruction implements Air Force Policy Directive (AFPD) 36-29, *Military Standards*. It complements the physical fitness requirements of DoD Directive 1308.1, *DoD Physical Fitness and Body Fat Program*, DoD Instruction 1308.3, *DoD Physical Fitness and Body Fat Procedures*, AFI 40-101, *Health Promotion*, and Air Force Policy Directive (AFPD) 10-2, *Readiness*. This instruction relates to AFI 10-203, *Duty Limiting Conditions*, AFI 34-266, *Air Force Fitness and Sports Programs,* and AFI 40-104, *Health Promotion Nutrition*. It applies to Regular Air Force (RegAF), Air Force Reserve (AFR), and Air National Guard (ANG) personnel. In collaboration with the Chief of Air Force Reserve (AF/RE) and the Director of the Air National Guard (NGB/CF), the Deputy Chief of Staff for Manpower, Personnel, and Services (AF/A1) develops personnel policy for the fitness program. This Air Force Instruction (AFI) may be supplemented at any level; MAJCOM-level supplements must be approved by the Human Resource Management Strategic Board (HSB) prior to certification and approval. Refer recommended changes about this publication to the office of primary responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records,* and disposed of in accordance with the Air Force Records Management System (AFRIMS) Records Disposition Schedule (RDS). This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by Title 10, United States Code (U.S.C.), Section 8013 and Executive Order 9397 (SSN), as amended. The applicable Privacy Act System of Records Notices F036 AF PC C, *Military Personnel Records Systems*, F036 AFPC J, *Promotions Documents and Records Tracking System (PRODARTS)* and F036 AFPC K, *Enlisted Promotion Testing Record,* are available at **http://dpclo.defense.gov/Privacy/SORNs.aspx**. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the publication OPR for non-tiered compliance items.

2.10. MAJCOM/A1, DRU/A1 or Equivalent.

2.10.1. DELETED

2.10.2. Ensures UFPMs/PTLs are used to supplement FACs for testing in a manner that minimizes undue burden on units.

2.10.3. NGB/A1 ensures policy is disseminated and implemented by states/wings.

2.10.4. DELETED

2.11. AFRC Fitness Program Manager (FPM).

2.11.1. Senior noncommissioned officer, officer, or civilian equivalent appointed by the AFRC/CC or AFRC/CV.

2.11.2. IMA Readiness Management Group/CC will appoint a senior noncommissioned officer or above as an FPM to train and support Individual Mobilization Augmentee (IMA) Program Managers and Base IMA Administrators.

2.12. Installation Commander, ANG WG/CC, or Equivalent.

2.12.1. Executes and enforces the FP and ensures compliance with appropriate administrative action in cases of non-compliance.

2.12.1.1. Ensures equitable administration of FA throughout the installation.

2.12.2. Provides an environment that supports and motivates a healthy lifestyle through optimal fitness and nutrition IAW AFI 40-104, *Health Promotion Nutrition.*

2.12.3. Ensures commanders implement and maintain unit fitness programs.

2.12.4. Provides the appropriate oversight for FAs going through the appeal process. (T-1). Provides the first coordination on any appeal FAs. (T-1).

2.12.4.1. DELETED

2.12.4.2. DELETED

2.12.4.3. DELETED

2.12.5. Provides appropriate manpower, safe facilities, equipment, resources, and funding to support the FAC and FP. (T-1). Installation commanders will approve, in writing, the plan appointing certified PTLs/UFPMs to augment the FAC to conduct FAs and input scores. (T-1). Periodically reviews use of personnel to augment FAC operations to ensure they are used in a manner that minimizes undue burden on units. (T-1).

2.12.5.1. Provides a location for administration of all components of the FA. (T-1).

2.12.5.2. Approves 1.5-mile run/2.0-kilometer walk assessment course in conjunction with local CES, FSS, and Wing Safety and files approval memorandum at the FAC. (T-1).

2.12.5.3. Plans, programs, and budgets training to support the installation FP. (T-1). This includes UFPM/PTL training and the FIP education/intervention program.

2.12.6. ARC Wing commanders promote and support unit FP as mission requirements allow. Wing commanders will establish local guidance for subordinate Unit commanders regarding

use of duty time for physical training (PT) during Unit Training Assemblies (UTA), Annual Tours (AT), and special tours. (T-1).

2.12.6.1. Coordinates with host Military Treatment Facility (MTF) to establish medical support for the fitness program, to include space-available access to FIP and UFPM/PTL training.

2.12.7. Designates, in writing, an individual to oversee the Fitness Assessment Cell (FAC), or Wing Fitness Program for ANG. (T-1). This individual can be any AFSC and is required to be an NCO or SNCO. (T-2). NOTE: At AFRC stand-alone bases, the EP oversees the FAC and is appointed by the Installation Commander.

2.12.7.1. At installations where the Fitness and Sports Center (FSC) is operated by military and/or GS employees, the Fitness and Sports Manager (FSM) assigns a 3M SNCO/ NCO/GS civilian employee already working at the FSC to oversee the FAC program management (including UFPM/PTL augmentees). These duties, however, cannot be performed by Non-Appropriated Fund (NAF) or contract employees.

2.12.7.2. At installations where the FSC is operated under a NAF Instrumentality (NAFI) memorandum of agreement (MOA) or contract and there are no 3M NCOs, FSS/CC in conjunction with installation leadership, will identify a military member (minimum grade of SSgt) from anywhere on the installation to perform FAC Program Manager duties. The military member assigned as the FAC Program Manager reports to and elevates FAC issues and concerns to the Sustainment Flight Chief (FSV).

2.13. Medical Group Commander (MDG/CC).

2.13.1. Provides medical support for the installation FP. (T-1). Plans, programs, and budgets for medically-related intervention and training programs. (T-1).

2.13.2. DELETED

2.13.3. Ensures all MTF providers for AF members receive training on FP and Duty Limiting Conditions (DLC) guidance during initial and annual refresher training.

2.13.3.1. Ensures training includes FP policies, DLC procedures and medical conditions and medications affecting FAs.

2.13.4. DELETED

2.14. ARC Medical Unit Commander Responsible for Health Service Support to the Wing/ Group.

2.14.1. Appoints a credentialed provider as FP Medical Liaison Officer (MLO) to serve as the FP consultant to all other medical providers and support staff.

2.14.2. Ensures all medical providers receive training on FP and DLC guidance. Training should include FP policies, medical conditions, and medications affecting FAs and DLC procedures.

2.15. Chief, Aerospace Medicine (MDG/SGP) or Equivalent.

2.15.1. Duty Limited Conditions (DLC) related to Fitness Restrictions (FR) and Fitness Assessment Restrictions (FAR) IAW AFI 10-203, *Duty Limiting Conditions*. (T-1).

2.29.4.1. Documents FA results on a hard copy AF Form 4446, signs scorecard, and obtains member's signature on the scorecard, acknowledging run/walk time, abdominal circumference measurements, and muscular fitness repetitions. (T-1). PTL provides a copy of the signed scorecard to the FAC (or UFPM where no FAC exists) for AFFMS II entry and to the member for their personal records.

2.29.5. Can conduct unofficial practice tests on Airmen from their own unit. Tests conducted as unofficial practice tests cannot be counted as official. NOTE: ARC Airmen testing must be in a military status (active or inactive) when taking official and unofficial practice tests. (T-1).

2.29.6. Maintains a minimum Satisfactory score on the FA. (T-1). NOTE: If, at any time, their score drops below 75.0, they will be removed as a certified PTL-B. Once they achieve a passing score PTL-B certification can be reinstated, but all training must be reaccomplished.

2.29.7. Wears Uniform of the Day (UOD) or PT uniform when administering official and unofficial FAs. Local leadership will establish which uniform (UOD or PT Uniform) must be worn in the performance of this duty.

2.30. Physical Training Leader-Advanced (PTL-A).

2.30.1. PTL-A certification consists of PTL-B certification plus certification from online PTL-A training course. (T-1). PTL-A online training course may be completed before attending PTL-B certification however, until both certifications are complete the Airman cannot conduct any FAs or lead any squadron, group, etc. fitness sessions. Refresher training must be accomplished annually.

2.30.2. Leads CC-approved unit PT and conducts all portions of the FA IAW **Chapter 3.**

2.30.3. Can conduct unofficial practice tests on Airmen from their own unit. Tests conducted as unofficial practice tests cannot be counted as official if an Airman achieves a passing score. NOTE: ARC Airmen testing must be in a military status (active or inactive) when taking official and unofficial practice tests. (T-1).

2.30.4. Documents FA results on a hard copy AF Form 4446, signs scorecard, and obtains Airman's signature on the scorecard, acknowledging run/walk time, abdominal circumference measurements, and muscular fitness repetitions. PTL provides a copy of the signed scorecard to the FAC (or UFPM where no FAC exists) for AFFMS II entry and to the Airman for their personal records. (T-1).

2.30.5. Maintains a minimum Satisfactory score on the FA. (T-1). NOTE: If, at any time, their score drops below 75.0, they will be removed as a certified PTL-A. Once they achieve a passing score they can be recertified as a PTL-A.

2.30.6. Wears Uniform of the Day (UOD) or PT Uniform (PTU) when administering official and unofficial FAs. Local leadership will establish which uniform (UOD or PTU) must be worn in the performance of this duty.

2.31. Member.

2.31.1. Maintains individual year-round physical fitness through self-directed and unit-based fitness programs and proper nutrition standards.

2.31.2. All Airmen are responsible for:

2.31.2.1. Knowing the block of time within which his or her FA is required in order to remain current IAW paragraph 3.12.

2.31.2.2. Notifing the UFPM, designated FAC representative, or superior authority, in writing (includes e-mail) of the need to schedule the FA and requests that it be scheduled immediately for accomplishment within the required window, if not scheduled in a period required to remain current.

2.31.2.3. Remaining current as defined in paragraph 3.12. It is the commander's discretion to annotate a non-current/failing FA within the reporting period on the evaluation. Additionally, it is the commander's discretion to document the evaluation as a referral for a non-current/failing FA at the evaluation close-out date or EPR SCOD. NOTE: See Table A14.1. and A14.2. for mandatory and optional commander actions upon FA failure.

2.31.2.4. Monitoring any personal FA exemptions, scheduling all necessary medical appointments, and initiating FA test arrangements in a timely manner.

2.31.2.5. Seeking medical evaluation/intervention if a medical condition is believed to impact his/her ability to complete the FA.

2.31.3. Completes FSQ IAW paragraph 3.3.2. (T-1). If the Airman arrives at the FAC without a FSQ, the FAC staff/augmentee will ensure the Airman completes a FSQ for review before the FA is administered. NOTE: Failure to complete FSQ does not invalidate the FA. FAC will document any cases where FSQ is not complete and attach to FA. (T-1).

2.31.3.1. Upon completion of the FSQ, provide a copy of the FSQ to the UFPM and FAC member prior to the FA.

2.31.3.2. If the Airman has a medical condition or identifies a medical condition on the FSQ that would limit him/her from completing all components of the FA and he/she does not have a current AF Form 469 documenting FA exemptions, the Airman must notify his/her UFPM and schedule an appointment with his/her MTF (ANG MLO). A new FA appointment must be scheduled within 5 duty days (90 days for ANG) of the original FA date. NOTE: If no FA appointments are available within this timeframe, Airman must be scheduled for first available FA appointment and notify their UFPM. Failure to comply with this direction will be addressed by Airman's leadership.

2.31.3.3. Notifies UFPM upon receiving an AF Form 469 from healthcare provider with Fitness Restrictions and/or Fitness Assessment Exemptions IAW AFI 10-203. Provides a copy of AF Form 469 to FAC staff/augmentee/PTL prior to taking FA.

2.31.3.4. Submits an updated FSQ, prior to completing a FA, if health condition changes at any time prior to FA.

2.31.4. If entered into intervention program(s), meets all program requirements and if appropriate, provides documentation of compliance IAW **Chapter 6.**

2.31.5. May access individual fitness reports directly from the Air Force Personnel Center (AFPC) Secure website.

2.31.6. Will acknowledge FA component results by signing a hard copy AF Form 4446 following completion of the FA. (T-1). Refusal to sign the scorecard does not invalidate the FA results.

2.31.7. Will wear the Air Force PT uniform to complete all components of the FA IAW AFI 36-2903, *Dress and Personal Appearance of Air Force Personnel*. **NOTE:** Due to operational requirements AFOSI special agents are authorized to complete official fitness assessments without meeting dress and appearance requirements as outlined in AFI 36-2903 , but must be capable of providing documentation to confirm grooming waiver is in effect. AFOSI agents in this status may wear suitable civilian PT clothing during testing.

2.31.8. ARC Airmen must ensure they are in an approved military status for FAs. (T-1). Appropriate military duty status for FAs is IAW AFI 36-2254,V1. FAs may be performed in the following statuses: active duty status: Annual Tour (AT), Initial Active Duty Training (IADT), Proficiency Training (PT), Reserve Personnel Appropriation (RPA)/Military Personnel Appropriation (MPA), Reserve Management Period (RMP), and School Tour; inactive duty status: Inactive Duty Training (IDTs) and Unit Training Assemblies (UTAs).

2.31.8.1. No other duty status, i.e., Equivalent Reserve Instruction (ERI), Equivalent Training (ET), Additional Training Period (ATP), Additional Flying Training Period (AFTP), Ground Training Period (GTP), etc., is an appropriate status to be used for the performance of the FA requirement.

2.31.9. Understand and comply with the guidelines contained in AFI 44-102, *Medical Care Management* regarding the use of weight control drugs and surgery.

Chapter 3

FITNESS ASSESSMENT

3.1. General. The AF uses an overall composite fitness score and minimum scores per component based on aerobic fitness, body composition, and muscular fitness components to determine overall fitness. Members must earn a composite score of 75 or greater, and meet the component minimums identified in Attachment 10 (and Attachment 12 if taking the 2.0 kilometer walk test). (T-1). NOTE: Airmen will be tested against performance standards by gender reflected in MilPDS.

3.1.1. Scoring. Minimum component points do not constitute the minimum required to earn a composite passing score and points below the required minimum component values read zero. Scoring the minimum component points in all FA components will not generate enough points to earn a composite score of 75 or greater. The minimum components are established to ensure that members test adequately in all components rather than excelling in some and disregarding others.

3.1.2. Target values are designed to illustrate a combination of component points which would equal an overall 75 composite score. Airmen failing to meet a target component value, but still scoring at or above the minimum component point value (lowest "fitness/health risk" limit), can still pass the assessment by exceeding targets in other components.

3.1.3. Overall fitness is directly related to health risk, including risk of disease and death. Health and readiness benefits increase as aerobic fitness, body composition, and muscular fitness improve with increases in physical activity.

3.1.4. A FA will be deemed official or unofficial prior to the administration of the first component. A FA started as official cannot be changed to unofficial during administration. Likewise, a FA started as unofficial cannot be changed to official.

3.2. Fitness Assessment Components.

3.2.1. Body composition component.

3.2.1.1. Evaluated by abdominal circumference (AC) measurements.

3.2.2. Aerobic component.

3.2.2.1. Evaluated by the 1.5-mile timed run.

3.2.2.2. Alternative Aerobic Test: Members not medically cleared to complete the 1.5-mile run will be assessed by the 2.0-kilometer walk as determined by the PCM or ANG MLO unless otherwise exempted.

3.2.3. Muscular fitness component.

3.2.3.1. Evaluated by number of push-ups and sit-ups completed within 1 minute.

3.3. Fitness Assessment Requirements. FAC augmentees will conduct the FA for all Airmen (RegAF, AFR, and ANG), (except basic military and technical training students, tested by training cadre PTLs/MTLs IAW paragraph 7.1.3) and will support FAs for ARC tenant units at RegAF installations to include UTA weekends. (T-1). Installations will develop a local plan,

signed by the Installation Commander, for Unit Commanders to appoint PTLs and UFPMs to augment the FAC for the purpose of administering FAs. (T-3). FAC augmentees will conduct FAs and the designated FAC Manager will provide oversight. (T-1). FAC augmentees will not test Airmen from their own unit/PAS code. (T-1). FA scores will only be updated by Fitness and Sports Center personnel, or designated UFPMs/FAC augmentees per local guidance. (T-3). NOTE: UFPMs/FAC augmentees will not update FA scores in AFFMS II for personnel from their own unit/PAS code. (T-1). Fitness Center staff should not be used to augment the FAC to conduct FAs.

3.3.1. FA procedures training will cover official testing procedures, using the AF/A1 approved standardized slides, and will not be deviated from under any circumstances. UFPMs and PTLs augmenting the FAC must possess PTL-B certification and complete refresher FA procedure training prior to administering any FAs as a FAC augmentee.

3.3.2. All members must complete the FSQ (**Attachment 4**) and provide it to their UFPM (Wing FPM for ANG) for review prior to FA. If the member arrives at the FAC without a FSQ, the FAC will ensure the member completes a FSQ for review before the FA is administered. **NOTE:** Failure to complete FSQ does not invalidate the FA. FAC will document any cases where FSQ is not complete and attach to FA.

3.3.2.1. The FSQ will be completed no earlier than 30 calendar days (90 days for ARC), but NLT 7 days prior to FA to provide time for medical evaluation, when indicated.

3.3.2.2. A medical provider must evaluate all members with health issues identified on the FSQ prior to the FA. If any item on the FSQ indicates a condition which might limit performance of any component of the FA, and there is not an accompanying current AF Form 469, the UFPM will refer the member for medical evaluation. The member will carry the FSQ to the medical evaluation. The provider or ARC MLO will complete and sign the appropriate place on the FSQ, and complete an AF Form 469 if applicable, and the member will return the FSQ to the UFPM and/or FAC.

3.4. Assessment Procedures.

3.4.1. All components of the FA must be completed within a 3-hour window on the same day. If FAC staff/augmentees determine extenuating circumstances prevent completion of the test (e.g., rapidly changing or severe weather conditions, emergencies, injury during FA, or travel time needed to complete other components at alternate locations, etc…) then all components must be rescheduled and completed at the earliest opportunity, but within 5 duty days. ARC members must be in military duty status for assessments. ARC Airmen will be required to retest the next date they are in appropriate military duty status and official FAs are being conducted.

3.4.2. Airmen only have one opportunity to complete each of the FA components per FA. If an Airman refuses to complete their FA due to failing to meet the minimum in one or multiple components, their incomplete FA will still count and be updated in AFFMS II. (T-1) Scores for all components are final when entered into AFFMS II.

3.4.2.1. Illness or injury during the FA. If an Airman becomes injured or ill during the FA, he/she will have the option of being evaluated at the Medical Treatment Facility (MTF) whether they complete the FA or not. Before departing the test location, Airmen must notify the FAC of the presence of illness/injury by checking the illness/injury block

on the AF Form 4446. NOTE: ARC Airmen must promptly report any medical condition (i.e. disease, injury, operative procedure or hospitalization, etc) that might impact their utilization and readiness to his or her commander, supervisor, or supporting military medical facility personnel. Each commander and supervisor must notify the servicing medical facility when he/she becomes aware of any changes in an ARC member's medical status including any medical condition that occurred during the FA and/or prevented the member from completing the FA. Any concealment or claim of disability proven to be made with the intent to defraud the government may result in appropriate punitive action under the Uniform Code of Military Justice or appropriate administrative action.

3.4.2.1.1. If an Airman checks the illness/injury block of the AF Form 4446, the FAC staff (or UFPM where no FAC exists) will sign the form acknowledging that they will hold scores to allow for medical evaluation and Commander review. (T-1). Additionally, the FAC staff will transmit a copy of the AF Form 4446 to the UFPM for the Unit Commander's review within two duty days. (T-1). For RegAF and AGR Airmen, the FAC (or UFPM where no FAC exists) will enter the FA results in AFFMS II on the 6th duty day if the Commander does not invalidate test results or no response from the Commander is received within this timeframe. (T-1). For non-AGR and Traditional ARC Airmen, the FAC (or UFPM where no FAC exists) will enter scores into AFFMS II at the conclusion of the next UTA if the Commander does not invalidate the test results or no response from the Commander is received within this timeframe. (T-1).

3.4.2.1.2. If the medical evaluation validates the illness/injury (**Attachment 15**), the Unit Commander may invalidate the FA results by checking the "I render this test invalid" block of the AF Form 4446, signing, and returning the form to the FAC. If the FA is invalidated, the Airman will be required to retest on all non-exempt FA components within five duty days from original FA test date. If an AF Form 469 is required, an additional five duty days from medical evaluation date will be allowed for the AF Form 469 to be generated and provided. Non-AGR and Traditional ARC Airmen will be required to retest the next date they are in appropriate military duty status and official FAs are being conducted. **NOTE:** Original FA will count unless rendered invalid by the Unit Commander.

3.4.2.1.3. Airmen will notify their Commander within one duty day of the FA regarding the injury/illness to ensure communication regarding test validity with the MTF and FAC staff occurs prior to score entry into AFFMS II. (T-1).

3.4.3. Body composition (height, weight, and AC) must be the first component assessed in the FA.

3.4.4. The muscular fitness components (push-ups and sit-ups) may be accomplished before or after the 1.5-mile run or 2.0-kilometer walk according to the installation FACs established procedures.

3.4.5. There is a minimum 3-minute rest period between components.

3.4.6. Airmen must take the FA at their home station FAC unless written approval by the Unit CC has been given to test at another AF FAC.

3.5. Body Composition Assessment.

3.5.1. Height and Weight.

3.5.1.1. Obtain height and weight IAW DoDI 1308.3. These measurements are not factored into the member's composite score

3.5.2. Abdominal Circumference (AC).

3.5.2.1. The AC measurement is used to obtain the body composition component score. The use of AC measurement has been authorized by DoD to meet the body composition requirement. See **Attachment 7**.

3.6. Body Composition Assessment Procedures.

3.6.1. Height Assessment.

3.6.1.1. Measurement will be taken in the FAC in conjunction with weight and AC measurements. Where a FAC does not exist, Unit CCs may designate a location for body composition measurements.

3.6.1.2. Measurement will be taken with member in Air Force PT t-shirt, PT shorts and/or PT pants. Air Force PT jacket and shoes will not be worn during measurements.

3.6.1.3. Member will stand on a flat surface with the head held horizontal looking directly forward, and the chin parallel with the floor. The body should be straight, but not rigid, similar to the body position when at attention.

3.6.1.4. Measurement will be recorded to the nearest inch.

3.6.1.4.1. If the height fraction is less than ½ inch round down to the nearest inch.

3.6.1.4.2. If the height fraction is ½ inch or greater round up to the nearest inch.

3.6.2. Weight Assessment.

3.6.2.1. The measurement will be made on a scale calibrated IAW TO 33K-1-100-1, Section 3, *Technical Manual on Calibration Procedure for Maintenance Data Collection Codes and Calibration Measurement Summaries,* and recorded to the nearest pound with the following guidance.

3.6.2.2. If the weight fraction is less than ½ pound, round down to the nearest pound.

3.6.2.3. If the weight fraction is ½ pound or greater, round up to the nearest pound.

3.6.2.4. Two pounds will be subtracted for clothing worn during official FA.

3.6.3. Abdominal Circumference (AC) Assessment.

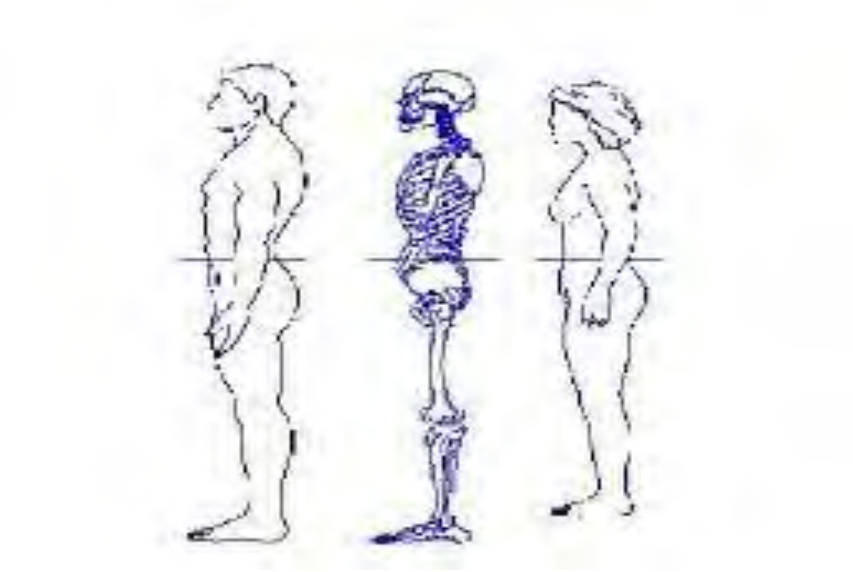
3.6.3.1. FAC staff or trained augmentee will take the AC measurement in a private room or in a partitioned area. Individuals conducting AC measurements will be of the same gender as the member being taped. Where a FAC member or a PTL of the same gender is not available, an observer of the same gender must be present.

3.6.3.2. Tape measure made of non-stretch (fiberglass) material will be used for the AC measurement.

3.6.3.3. The tester will start the measurement on the right side of the Airman. The tester will locate the measurement landmark immediately above the right uppermost hip bone (superior border of the iliac crest) at the side of the body vertically in line with the right armpit (midaxillary line). If desired, the Airman may assist the tester in locating the measurement landmark by resting the right hand on the hip, using rearward facing right thumb to locate the iliac crest. The tester will determine final horizontal - vertical intersection point for landmark confirmation.

3.6.3.4. The Airman will stand on a flat surface with feet no more than shoulder width apart. The head should be horizontal, looking directly forward with the chin parallel to the floor. The Airman may use one hand to initially assist the tester in anchoring the tape measure to the body, but must remove the hand from the tape measure before the official measurement is recorded. Measurement will be taken on bare skin. The free hand may be used to hold the shirt out of the way, but no part of the hands or arms may extend above the shoulders.

Figure 3.1. Measuring Tape Position for Abdominal Circumference.



3.6.3.5. The Airman will remain stationary while the tester conducts the measurement by initially moving around the Airman to place the tape in a horizontal plane around the abdomen (**Figure 3.1**). The tester will ensure tape is parallel to the floor at the level of the landmark (bottom edge of the tape just contacts landmark), is snug, but does not compress the bare skin. The tester will take the measurement at the end of the Airman's normal respiration.

3.6.3.6. The tester will take the circumference measure three times and record each measurement rounding down to the nearest ½ inch. If any of the measures differ by more than one inch from the other two, the tester will take an additional measurement. The tester will add the three closest measurements, divide by three, and round down to the nearest ½ inch. The tester will record this value as the AC measurement.

3.6.3.7. If an Airman tests on the AC only, he/she is required to meet the minimum component measurement (39.0 for males and 35.5 for females) to pass the FA.

3.6.3.7.1. DELETED

3.6.3.7.2. DELETED

3.6.3.8. If an Airman fails the abdominal circumference measurement of the FA yet takes and passes the other three components with a score of at least 75 points of the remaining 80 points, the FAC will administer the DoD prescribed Body Mass Index (BMI) screen. (T-1) If the Airman passes the BMI screen, the Airman passes the body composition component of the fitness assessment. If the Airman does not pass the BMI screen, the Airman will receive a Body Fat Assessment (BFA). (T-1) If the Airman passes the BFA, the Airman passes the body composition component of the fitness assessment. If the Airman fails the BFA, the Airman fails the body composition component of the fitness assessment.

3.6.3.8.1. If an eligible Airman passes either the BMI screen or BFA, the Airman passes the FA and will be marked "Exempt" in AFFMS for the AC measurement, but all other scores will be recorded as tested. To properly track these instances, the FAC manager will submit an exception to policy (ETP) letter (refer to Attachment 22) within two duty days to AFPC/DPSIM (**DPSIM.orgbox@randolph.af.mil**) if an Airman qualifies to take and passes either the BMI screen or the BFA. (T-1). The AC measurement, BMI score, and BFA (if performed) will be provided in the letter.

3.6.3.8.2. Airmen who take the alternate aerobic component (2.0 kilometer walk-test), or are exempt from any other component, are ineligible to take the BMI screen and BFA.

3.6.4. Body Mass Index (BMI) Screen

3.6.4.1. The tester will perform the BMI screen after all other components of the fitness assessment have been accomplished

3.6.4.2. The tester will use the height and weight mesurements obtained earlier in the fitness assessment. To pass the BMI the Airmen, regaurdless of age or gender shall not exceed the maximum BMI of 25 kg/m^2. Refer to the BMI chart at **Attachment 13**.

3.6.5. Body Fat Assessment (BFA)

3.6.5.1. The BFA will be performed by the FAC Manager, FAC staff, or an alternate. The FAC Manager must approve all alternates and ensure enough alternates are appointed to handle the needs of each specific location.

3.6.5.2. The FAC Manager approved tester will perform the BFA using a 2-site taping (neck and waist) for males or a 3-site taping (neck, waist, hip) for females. Refer to **Attachment 19** for instructions.

3.6.5.3. To pass the BFA, a female Airman must achieve a body fat percentage equal to or lower than 26%. A male Airman must achieve a BFA equal to or lower than 18%. Refer to **Attachments 20 and 21** for score tables.

3.7. Aerobic Fitness Assessment.

3.7.1. The run and walk will be performed on an approved distance course.

3.7.1.1. When the run is performed at elevation levels of 5,250 feet and higher, refer to the altitude adjustment chart at **Attachment 17.**

3.7.2. Aerobic fitness is measured with a 1.5-mile run according to procedures outlined in **Attachment 5**. Test administrator will read verbal instructions to those performing 1.5 mile run at **A5.5**. All members will complete the 1.5-mile timed run unless medically exempted.

3.7.3. Members medically exempted from the run and cleared for an alternate assessment will, upon recommendation by the clinical provider/FPM/MLO, complete the 2.0-kilometer walk, according to procedures in **Attachment 11**. Members performing the 2.0-kilometer walk will not be allowed to run (i.e., at least one foot must be in contact with the ground at all times) or the assessment will be terminated. Test administrator will read verbal instructions to those performing 2.0 kilometer walk at **A5.6**.

3.7.3.1. The 2.0-kilometer walk is the only authorized alternate assessment. **NOTE:** Airmen do not select the aerobic assessment method. The clinical provider/FPM/MLO determines which assessment to use based on the member's assessment history and medical recommendation as documented on the AF Form 469.

3.8. Muscular Fitness Assessment.

3.8.1. Muscular fitness is measured with a 1-minute timed push-up component and a 1-minute timed sit-up component. Assessment procedures and techniques are outlined in **Attachment 5**. FAC augmentees will demonstrate proper push-ups and sit-ups prior to administering the FA unless the instructional video is shown. The FAC is the authority on standards and procedures; they will address all discrepancies and will provide indisputable on the spot correction.

3.8.2. Push-Up Component: Purpose. The push-up is used to assess the member's upper body muscular fitness.

3.8.2.1. Assessment Duration. Members have 1 minute to complete as many correct push-ups as possible.

3.8.2.2. Assessment Explanation. The test assessor must read the push-up script to the member and demonstrate proper technique **(A5.3)** or may show the Air Force instructional video. If the instructional video is shown, script reading and demonstration is not required. This video can be found at: **http://www.afpc.af.mil/affitnessprogram/index.asp**.

3.8.2.3. Starting Position. The member will begin in the starting position with hands slightly wider than shoulder width apart, palms or fists on the floor with arms fully extended and the body in a straight line from head to heel. The feet may be no more than 12 inches apart. The member may rest in the up position only. The member may remove their hands or feet from the floor, or bridge or bow their back, but only in the up/rest position. The body should maintain a rigid form from head to heel. The feet may not be supported or braced (e.g., no crossing of the feet).

3.8.2.4. Complete Push-up. From the starting position (elbows extended), the member will lower the body to the ground until the upper arm is at least parallel to the floor (elbow bent at least 90 degrees or less) before pushing back up to the starting position (the chest may touch but not rest on or bounce off the floor). The member completes one

full push-up after returning to the starting position with elbows fully extended. It is important to monitor the member's form and make sure the body does not bow at the waist as the member tires. The body must remain rigid during the assessment (the back must remain straight unless resting). Incorrect push-ups (e.g., member does not lower body until upper arm is at least parallel to the floor, member does not fully extend elbows when returning to starting position, body bows at the waist, etc.) will not be counted. If an incorrect push-up is performed, assessor will repeat the number of the last correct push-up and explain what is being done incorrectly. Member may rest in the up position only. If member rests in the down position with their body on the ground, the push-up component of the test will be terminated.

3.8.2.5. Stopwatch. The test assessor is responsible for operating the stopwatch. The assessor will start the stopwatch when the member(s) is/are instructed to begin, observe the assessment and notify the member how much time is remaining at 30 seconds and 15 seconds. Prior to beginning the assessment the assessor will inform the members to continue to perform push-ups until directed to stop or until the member is no longer able to continue.

3.8.2.6. Counting/Monitoring. FAC augmentee or another Airman paired to accomplish muscle fitness components will monitor and count the correct number of push-ups. (T-1). When Airmen are paired off for the assessment, the FAC will oversee and spot-check technique to ensure accurate and safe assessment. The counter/monitor will count the number of push-ups out loud. (T-1). If the Airman breaks correct form, the counter/monitor repeats the last correct number (e.g., one, two, three, three, four, etc.), as well as gives instruction on what was done incorrectly (e.g., you are not extending your arms fully, keep your back straight, etc.). Counter and FAC staff/augmentee will monitor the Airman from a position that allows observance of the Airman's form and the arm angles.

3.8.2.7. Completion/Recording. Upon completion of the assessment, record the total number of correct push-ups.

3.8.3. Sit-Up Component Purpose. The sit-up component is used to assess a member's muscular fitness.

3.8.3.1. Assessment Duration. The member will have 1 minute to complete as many correct sit-ups as possible

3.8.3.2. Assessment Explanation. The test assessor will read the sit-up script to the member **(A5.4)** and demonstrate proper technique or may illustrate using the Air Force instructional video. If the instructional video is shown, script reading and demonstration is not required. This video can be found at: **http://www.afpc.af.mil/affitnessprogram/index.asp**.

3.8.3.3. Starting Position. The use of a mat is optional. The member will be instructed to lie face up on the floor/mat. In the starting position, the member's feet may extend off the mat, but the buttocks, shoulders, and head must not extend beyond the mat. The member's knees will be bent at a 90 degree angle (throughout the assessment), with the feet or heels in contact with the floor at all times. The member's arms will be crossed over the chest with the hands/fingers on the shoulders or resting on the upper chest.

3.8.3.4. Foot Hold. The member's heels must remain anchored to the floor throughout the assessment. The member may request to have their feet held down with the hands or by putting knees on feet but the monitor may not anchor the member's legs by holding onto the calves or stand on the feet during the assessment. Enough force must be applied to keep the feet/ankles from rising while the sit-ups are being accomplished. If member requests a member of the same gender to hold their feet, they must be granted that request. In place of a monitor holding the feet, a bolted non-portable toe-hold bar may be used (where available) to anchor the feet so long as the member's heels remain in contact with the ground at all times and the bar cannot move.

3.8.3.5. Complete Sit-up. A complete sit-up is accomplished when the upper torso of the member is raised off the floor/mat, the elbows touch the knees or thighs, and the upper torso is lowered back to the floor/mat until the shoulder blades touch the floor/mat. Elbows must touch the knees or thighs at the top of the sit-up, and the shoulder blades must touch the floor/mat at the bottom of the sit-up. Any part of your hands/fingers must remain in contact with your shoulders/upper chest at all times. Incorrect sit-ups (e.g., elbows do not touch the knees or thighs at the top of the sit-up, shoulder blades do not touch the floor/mat at the bottom of the sit- up, hands/fingers lift completely off the shoulders/upper chest, etc.) will not be counted. If an incorrect sit-up is performed, assessor will repeat the number of the last correct sit-up and explain what is being done incorrectly. The member may only rest in the up position. If the member rests in the down position or holds onto their knees/legs while in the up position, the sit-up component of the assessment will be terminated.

3.8.3.6. Stopwatch. The assessor is responsible for operating the stopwatch. The assessor will start the stopwatch when the member(s) is/are instructed to begin, observe the assessment and notify the member how much time is remaining at 30 seconds and 15 seconds. Prior to beginning the assessment the assessor will inform the members to continue to perform sit-ups until directed to stop or until the member is no longer able to continue.

3.8.3.7. Counting/Monitoring. The FAC augmentee or another member paired to accomplish muscle fitness components will monitor and count the correct number of sit-ups. When members are paired off for the assessment, the FAC will oversee and spot-check technique to ensure accurate and safe assessment. The counter will count the number of sit-ups out loud. If the member breaks correct form, the FAC staff/augmentee repeats the last correct number (e.g., one, two, three, three, four, etc.), as well as gives instruction on what was done incorrectly (e.g., your shoulder blades are not touching the mat/floor, keep your hands on your shoulders or chest, etc.). Counter and FAC staff/augmentee will monitor the member from a position that allows observance to ensure the shoulder blades touch the floor and elbows touch the knees or thighs.

3.8.3.8. Completion/Recording: upon completion of the assessment, record the total number of correct sit-ups.

3.9. Fitness Categories.

3.9.1. **Excellent.** Composite score ≥ 90 and minimums met.

3.9.2. **Satisfactory.** Composite score of 75 - 89.99 and minimums met.

3.9.3. Unsatisfactory. Composite score ≤ 74.9 and/or one or more component minimums not met.

3.9.4. Exempt. Airmen must be exempt in all four components to be entered exempt in AFFMS II. (T-1). For deployment/extended TDY purposes, Airmen must be categorized as Excellent, Satisfactory, or Unsatisfactory before being updated as exempt in AFFMS II. (T-1).

3.10. Determining Composite Fitness Score.

3.10.1. Age and gender-specific fitness score charts are provided in **Attachments 10** and **12**.

3.10.1.1. Airmen will be tested against performance standards by gender reflected in MilPDS.

3.10.2. Members will receive a composite score on a 0 to 100 scale based on the following maximum component scores: 60 points for aerobic, 20 points for body composition, 10 points for push-ups and 10 points for sit-ups.

3.10.3. Determine the score by the following formula in **Figure 3.2**:

Figure 3.2. Composite Fitness Score Formula.

Composite score =	$\frac{\text{Total component points achieved X 100}}{\text{Total possible points}}$			
Component:	Aerobic	Body Composition	Push-ups	Sit-ups
Possible Points:	60	20	10	10

3.10.4. Scoring for exemptions: Members with an AF Form 469 prohibiting them from performing one or more components of the FA will have a composite score calculated on the assessed components. AC will be performed on all members, unless exempted by medical provider IAW **paragraph 5.2**, since there is no risk to the member. Members must achieve a minimum of 75 adjusted points, based on points available, and meet minimum component standards in order to receive a Satisfactory rating.

3.10.4.1. Example: Airman exempted from push-ups: If Airman receives 48 points for aerobic fitness, 16 points for AC and 8 points for sit-up component; the total component points achieved = 72. Possible points from aerobic fitness, AC, and sit-up components = 90 points. Composite score is: (72/90) x 100 = 80 points. As long as the Airman meets component minimums, Airman receives a Satisfactory rating.

3.10.4.2. Example: Airman exempted from aerobic fitness: If Airman has a 39.5 inch waist and receives 11.7 points for AC, 9.5 points for push-ups and 9.5 points for sit-ups; the total component points achieved = 30.7. Possible points from AC, push-up and sit-up components = 40 points. Composite score is: (30.7/40) x 100 = 77 points. However, based on minimum component score (because Airman did not meet minimum AC requirement of 39.0 inches), Airman receives an Unsatisfactory rating.

3.10.4.3. Example: Airmen testing on AC-only: Airmen testing on just the AC are only required to meet the minimum component standard in this area to pass the assessment. As such, an AC of ≤39.0 for males and ≤35.5 for females will result in a Satisfactory rating.

NOTE: All measurements between the AC target and minimum will yield an overall FA score of 75.0 (e.g., Male: AC of 38.0 – 39.0 = 75.0 points & Female: AC of 34.5 – 35.5 = 75.0 points)

3.10.4.4. Airmen on a *permanent* medical profile, documented appropriately as a "permanent component exemption" on an AF Form 469 (only), that achieve a score of 90 or above (Excellent) on the remaining components (using calculations above) will be tested annually. Example: Airman is *permanently* exempted from the run but can test on the walk: If the Airman is female and 35 years of age, passes the walk test, receives 17.6 points for AC, 9.5 points for push-ups and 10.0 points for sit-ups; the total component points achieved = 37.1. Total possible points from AC, push-ups and sit-up components = 40 points. Composite score is: (37.1/40) x 100 = 92.75. The Airman scored above a 90 (Excellent) and will test annually. NOTE: Every 365 days *permanent* medical profiles are reviewed by medical to determine if they are still valid.

3.11. Scheduling.

3.11.1. Frequency of the FA will be based on the previous fitness score unless an earlier assessment is necessary to accommodate a TDY, PME or other training courses, PCS moves, leave schedules, or other situations that would preclude member from maintaining fitness currency. Commanders may not direct out of cycle official FAs. However, Airmen may volunteer to take a fitness assessment early at their own discretion.

3.11.1.1. Excellent. All Airmen will test by the last day of the month, 12 calendar months following the previous Excellent test as outlined above. (T-1). NOTE: Airman must have earned an Excellent by completing all four FA components (aerobic: 1.5 mile run; AC measurement; push-ups; and sit-ups) or be on a *permanent* medical profile and declared medically incapable of performing one or more components of the FA and achieve a composite score of 90 or above on the remaining components in order to test on a 12-month currency cycle. (T-1). See paragraph 3.10.4.4.

3.11.1.2. Satisfactory. RegAF, AFR, and NGB (Title 10/Statutory Tour) Airmen who score a Satisfactory score on their FA must complete an official FA at a minimum of twice per year. RegAF, AFR, and NGB (Title 10/Statutory Tour) Airmen with a current Satisfactory FA will test by the last day of the month, six calendar months following the previous Satisfactory test (e.g., if Airman tested on 15 April, then Airman must retest on/before 31 October of the same year). (T-1). ANG Title 32 must complete an official FA at least annually and must be tested by the last day of the month, 12 calendar months following the previous Satisfactory test, even if the administered test included one or more component exemptions (e.g., if an Airman tested on 15 April, the Airman must retest on/before 30 April of the following year). (T-1). NOTE: Airmen who take the walk test, and who are not on a *permanent* aerobic exemption, are ineligible to take the FA on an annual basis and will test by the last day of the month, six calendar months following the previous Satisfactory test.

3.11.1.3. Unsatisfactory. RegAF, AFR, and NGB (Title 10/Statutory Tour) Airmen must retest within the 90 days following an Unsatisfactory FA. (T-1). Unit Commanders may not mandate Airmen to retest any sooner than the end of the 90-day reconditioning period, however, Airmen may voluntarily retest before the end of the 90-day reconditioning period. It is the Airman's responsibility to ensure he/she retests before the

90-day reconditioning period expires as non-currency begins on the 91st day. NGB Title 32 must retest within 180 days following an Unsatisfactory FA. Unit Commanders may not mandate NGB Title 32 Airmen retest any sooner than the end of the 180-day reconditioning period; however, Airmen may voluntarily retest. Non-currency for NGB Title 32 begins on the 181st day. (T-1). NOTE: Retesting in the first 42 days (90 days for ANG Title 32) after an Unsatisfactory FA is not recommended; recognized medical guidance recommends a minimum of 42 days as the timeframe to recondition from Unsatisfactory to Satisfactory status in a manner that reduces risk of injury.

3.11.1.3.1. Airmen who want to retest during the 42-day period (90 days for ANG Title 32) immediately following an Unsatisfactory FA are highly encouraged to complete an unofficial practice FA (administered by a unit PTL) prior to scheduling their official FA. If an Airman disregards this recommendation, the FA test score will still count as an official score and be entered in AFFMS II.

3.11.2. In addition to the mandatory official test, commanders may direct unofficial practice tests administered by trained/certified PTLs. This will afford Airmen regular opportunities to assess their compliance with AF fitness standards, minimizing any surprise assessment failures at the time of official assessments. These assessment scores do not require FAC presence and will not be entered into AFFMS II; however, they may be used as a commander's tool to evaluate fitness/readiness. Tests conducted as unofficial practice tests cannot be counted as official.

3.12. Currency. Each Airman is responsible for knowing the block of time within which his or her Fitness Assessment is required. Currency is established upon completion of the following program requirements based on the member's most recent fitness level as described in paragraph 3.11.

3.12.1. If a FA has not been scheduled in the period required to remain current, notify the designated FAC representative, UFPM, or superior authority, in writing (includes e-mail) of the need to schedule the FA and requests that it be scheduled immediately for accomplishment within the required window. It is ultimately the Airman's responsibility to ensure their FA is scheduled within their installation's guidelines.

3.12.2. Failing to remain current, as well as failing to attain a passing score on the applicable FA before the end of any performance report reporting period, will be considered as part of the performance assessment on the Airman's evaluation if, as of the closeout date of any performance report, currency or a passing score is not obtained. Enlisted Airmen failing to have a current/passing FA score by the SCOD/PECD will render them ineligible for promotion during that cycle. Accordingly, commanders should consider delaying the promotion of officers failing to have a current/passing FA at the Projected Date of Promotion (PDOP). Officers in this fitness status will remain eligible for promotion (See AFI 36-2501, *Officer Promotions and Selective Continuation*, Chapter 5). Monitor any personal FA exemptions, schedule any necessary medical examinations, and initiate FA test arrangements in a timely manner. NOTE: See Table A14.1. and A14.2. for mandatory and optional commander actions upon FA failure.

3.12.3. Waivers. If an Airman is unable to complete any required portion of the AF Fitness Program (e.g., FA, intervention classes), the Airman must receive written approval (Table 5.1) from the Unit commander for rescheduling. (T-3). A copy of the written approval is

filed by the UFPM in the Airman's fitness program case file. For ARC Airmen unable to complete any scheduled FA, the Airman must be rescheduled to test on the next date the Airman is in a military duty status and official FAs are being conducted. (T-1).

3.12.4. Deployments. Airmen must have a current FA on file prior to arrival at their deployed location. (T-1). Airmen will not be considered Exempt in the deployed location until their current FA expires. If an Airman fails before deploying/extended TDY and their evaluation closes out after the deployment starts, this failure will be considered as part of the performance assessment on the evaluation. Exempt will be marked when the Airman's current FA expires in a deployed location where they CANNOT test or choose not to volunteer to test at locations where FA testing is available. NOTE: See Table A14.1. and A14.2. for mandatory and optional commanderactions upon FA failure.

3.12.4.1. Any failures will be annotated in AFFMS II and will be considered IAW 10.1. However, if an Airman reaches the 91-day mark after the FA (failure), but before the evaluation closes out, the Unsatisfactory score is no longer current and the evaluation will be marked Exempt. For Satisfactory and Excellent scores, deployed Airmen become Exempt when they reach the first day of the month, seven/thirteen calendar months following the previous official FA rating.

3.12.4.2. Home station UFPM will notify the FAC to update AFFMS II placing the deployed Airman in exempt status after their "current" FA expires. (T-1). UFPMs performing FAC duties at GSUs will update exempt status in AFFMS II. (T-1). NOTE: The end date/duration of the deployment exemption should include in the 42-day reconditioning period (90 days for non-AGR and Traditional ARC) afforded to all Airmen returning from a deployment of greater than 30 days.

3.12.4.3. Members who are due to take a FA upon return from deployment will be given 42 days for post deployment reconstitution and training from the date they sign into their home unit. UFPMs must communicate with the FAC when members return from deployment.

3.12.4.3.1. RegAF and AGR personnel deployed for greater than 30 consecutive days will be given a 42-day acclimatization period starting the date they arrive back at homestation prior to taking their FA, unless the member requests to be assessed earlier. All non-AGR and Traditional ARC personnel will be given a 90-day acclimatization period starting the date they arrive back at homestation prior to taking their FA, unless the member requests to be assessed earlier. Member will become noncurrent on day 43 (day 91 for non-AGR and Traditional ARC), if applicable. **NOTE:** OPRs/EPRs that close out during this post deployment 42-day reconditioning period will be marked "exempt".

3.12.5. Extended TDYs. Airmen must have a current FA prior to departure to an extended TDY location. (T-1). For the purpose of this instruction, extended TDY is defined as more than 30 consecutive days. Airmen will not be considered Exempt at the extended TDY location until their current FA expires. If an Airman fails the FA before the extended TDY and the evaluation closes out while the Unsatisfactory FA score is still applicable, this failure will be considered as part of the performance assessment on the evaluation. Exempt will be marked when the Airman's current FA expires at the extended TDY location prior to

evaluation close out. NOTE: The deployment exemption category in AFFMS II will be utilized to annotate Airmen whose FA expired during an extended TDY.

3.12.5.1. RegAF and AGR personnel TDY for greater than 30 consecutive days will be given a 42-day acclimatization period starting the date they arrive back at homestation prior to taking their FA, unless the member requests to be assessed earlier. All non-AGR and Traditional ARC personnel will be given a 90-day acclimatization period starting the date they arrive back at homestation prior to taking their FA, unless the member requests to be assessed earlier. Member will become noncurrent on day 43 (day 91 for non-AGR and Traditional ARC), if applicable. **NOTE:** OPRs/EPRs that close out during this post TDY 42-day reconditioning period will be marked "exempt".

3.13. Unsatisfactory education and intervention.

3.13.1. RegAF and ARC AGR Airmen must participate in a unit FIP and start FIP (if co-located, otherwise online) within 10 days of the failed FA. (T-1). All Airmen in the Unsatisfactory fitness category will remain in the FIP/SFIP until they achieve a Satisfactory or Excellent FA score.

3.13.1.1. RegAF GSU Airmen at non-collocated Air Force bases will start the FIP within 10 days of the FA. (T-1). The online FIP is available via ADLS.

3.13.1.2. Non-AGR ARC (AFR and ANG) must accomplish FIP within 60 days of Unsatisfactory FA. (T-1). The online FIP is available via ADLS.

Chapter 4

FITNESS ASSESSMENT WAIVERS

4.1. Installations with Extreme Weather Conditions and/or Higher Altitudes.

4.1.1. Installation CCs may request a waiver from MAJCOM/CV or equivalent (NGB/A1 for ANG) to adjust scheduling of the 1.5-mile run or 2.0-kilometer walk assessments for extreme seasonal weather conditions (see **Attachment 6**) if an appropriate indoor facility is not available. The waiver must specify periods unable to complete the run/walk assessment safely. Any approved installation waiver will be extended to all tenant units physically located on the installation. The ARC MAJCOM/CV (or equivalent) that owns the tenant unit also has the authority to approve a tenant waiver. Members will still test on remaining components and will be granted an exemption from the aerobic component of the test for the time period specified in the approved waiver. RegAF, Title 10 Statutory Tour and ARC AGR members will be required to test again in 6-months, even if they score 90 or above. Member's composite score will be determined in accordance with paragraph 3.10.

4.1.1.1. MAJCOM/A1s will forward a copy of approved waivers to AF/A1PP. For ARC stand-alone installations, AFRC/A1 and ANG/A1 will forward a copy of approved waivers to AF/A1PP.

4.1.2. ARC Airmen who commute from a lower altitude to perform duty at their assigned/attached unit at a location where the altitude ≥ 5,250 feet, may perform FA with an AF unit at or near their home altitude, with commander's approval. The UFPM at the unit of assessment will forward a copy of FA results to ARC member's assigned/attached UFPM for AFFMS II update and tracking purposes. This variation is only for ARC Airmen who are not afforded the 42-day acclimatization period at the assessment site.

Chapter 5

EXEMPTIONS

5.1. General. Exemptions are designed to categorize Airmen as unable or unavailable to train or assess for a limited time period. Exemptions, for medical reasons, are entered into AFFMS II using the current AF Form 469 following FA completion.

5.2. Exemptions. Commanders may grant exemptions as outlined in Table 5.1. Airmen with exemptions prohibiting them from performing one or more components of the FA will be assessed on the remaining components and scored IAW paragraph 3.10. FA exemption recommendations for medical reasons can only be made by a MTF provider or ANG MLO. All Airmen will complete an AC assessment as listed in paragraph 5.2.7., unless they have a Deployment Availability Working Group (DAWG) approved exemption for a condition that the MTF provider/FPM/MLO deems would warrant AC assessment exemption. (T-1). Temporary exemptions will not be issued for Airmen still currently assigned to a unit solely for the purpose of improving currency compliance rates (i.e., where Airman is not on terminal leave).

5.2.1. Airmen with an approved retirement or separation date within 12 months (365 days) of the last Satisfactory, Excellent, or Exempt FA that is current are Exempt. If the separation or retirement date is cancelled, Airmen will complete the FA IAW their original FA cycle (i.e. 6 or 12 months) or, if the original cycle date has passed, within 42 days (reacclimation time).

5.2.2. Airmen with chronic medical DLCs preventing them from performing one or more components of the FA will be medically reviewed during the annual PHA, at a minimum, and referred to the DAWG for evaluation as appropriate IAW AFI 10-203, AFI 48-123, *Medical Examinations and Standards*, and AFI 41-210, *Patient Administrative Functions*. (T-1).

5.2.2.1. DELETED

5.2.2.1.1. DELETED

5.2.2.2. DELETED

5.2.2.3. DELETED

5.2.2.4. DELETED

5.2.3.

5.2.3.1. Providers will list physical limitations and FA exemptions on the AF Form 469. (T-1). Unless given a composite exemption, Airman will continue to prepare for and be assessed on non-exempt component of the FA.

5.2.3.1.1. ANG. Airmen with physical limitation that prevent participation in fitness activities for greater than 30 days and/or preclude the Airmen from completing a full FA will provide medical documentation from their Personal Care Provider (PCP) to the Wing Medical Group. (T-1). The Wing Medical Group will issue an AF Form 469 as appropriate addressing each component of the FA. (T-1). MLO will review AF Form 469 and issue an AF Form 422 to the Airman's UFPM. (T-1). UFPM

ensures Airmen due an FA are assessed on non-exempted components per the AF Form 469.

5.2.3.2. A military provider must make the final disposition for any physical limitations in cases where Airmen are seen by non-military providers or when ARC Airmen bring recommendations from their PCP. (T-1). Limitations will be transcribed by an AF provider to an AF Form 469 IAW AFI 10-203.

5.2.3.3. The expiration date on the AF Form 469 represents the date the Airman is medically cleared to resume physical activities previously restricted. For DLCs of 30 days or less, Airmen are eligible to complete a full, four component FA when their AF Form 469 restrictions expire, and will be tested within 30 days, if due or overdue. (T-1). For DLCs lasting 31 days or more, Airmen will be eligible to complete the full, four component FA 42 days after the expiration date of physical limitation, as annotated on the AF Form 469, if due or overdue. This allows time for reconditioning, if exempted for 31 days or more. NOTE: Reference 5.2.4. for guidance regarding prenant members.

5.2.3.3.1. Expiration date on the AF Form 469 will be determined by the provider and represents the date the member is medically cleared to begin an unrestricted physical training program.

5.2.3.4. Airmen with an AF Form 469, lasting any length of time, must maintain FA currency standards. (T-1). If an Airman, is due to test during the AF Form 469 effective dates or during the 42-day reconditioning period, the Airman will complete the FA components that he/she is cleared to test on per the AF Form 469. **NOTE:** Airmen who are not due to test during the AF Form 469 effective dates or 42-day reconditioning period to maintain currency may not volunteer to take an FA until the AF Form 469 or 42-day reconditioning period expires. NOTE: Reference 5.2.4. for guidance regarding pregnant Airmen.

5.2.4. Pregnancy.

5.2.4.1. Provider will include information on physical activity during prenatal counseling.

5.2.4.1.1. DELETED

5.2.4.2. Airmen will be Exempt from the FA during pregnancy. Effective 1 Jan 2015, Airmen with pregnancies lasting 20 weeks or more are also exempt from FA for 12 months after discharge from the hospital upon completion of pregnancy (delivery, miscarriage, etc.). The Airman must test by the last day of the 12th month. On the 1st day of the 13th month after the discharge from the hospital of pregnancies lasting 20 weeks or more the Airman becomes non-current. Pregnancy-related exemptions apply to the FA and do not Exempt the Airman from participating in an approved physical fitness program.

5.2.4.2.1. DELETED

5.2.4.3. AF Form 469 will be re-accomplished by the provider (or ANG Wing Medical Group) IAW AFI 10-203 in cases where pregnancy ends prior to 20 weeks. Providers will take into account physiological and psychological changes when determining days

required for recovery and reconditioning prior to FA eligibility. MLO will issue corresponding AF Form 422 for the duration of the AF Form 469.

5.2.4.3.1. Expiration date on the AF Form 469 will be determined by the provider and represents the date the Airman is medically cleared to begin an unrestricted physical training program.

5.2.4.4. Pregnant ARC Airmen should discuss their fitness program with their PCP.

5.2.5. PCS Moves. Airmen are given 42 days from Date Arrive Station (DAS) at new duty location to acclimatize before being required to complete an FA. Airmen pending PCS must have a current FA score on file that will not expire through the Report-No-Later-Than-Date (RNLTD) and 42-day acclimatization period. (T-1). If the current FA expires prior to the member's RNLTD + 42 days, the Airman must complete a FA before departing their losing duty station. (T-1). Exemptions will not be granted for Airmen in outbound status for any circumstance other than those addressed in paragraphs 5.2.5.1. and 5.2.5.2.

5.2.5.1. Airmen returning from a deployment who PCS before the end of their 42-day post deployment acclimatization period will have their deployment exemption duration extended by the losing home station to cover the additional 42 days they will receive post RNLTD to acclimatize. (T-1). To prevent going non-current, Airman will test 43 days following RNLTD. NOTE: Not applicable if Airman's FA remains current for 43 days post RNLTD.

5.2.5.1.1. Airmen who are due to PCS following the completion of the post-deployment acclimatization period must complete an FA if their FA is already expired or expires any time prior to RNLTD + 42 days. (T-1).

5.2.5.2. Airmen returning from an extended TDY (> 30 consecutive days) who PCS before the end of their post-TDY 42-day acclimatization period will be granted a composite "deployment exemption" by their losing home station. This exemption will only be awarded upon expiration of the Airman's current FA. Exemption duration will not exceed RNLTD + 42 days. NOTE: Not applicable if Airman's FA remains current for 43 days post RNLTD.

5.2.5.2.1. Airmen who are due to PCS following the completion of the post-TDY acclimatization period must complete an FA if their FA is already expired or expires any time prior to RNLTD + 42 days. (T-1).

5.2.5.3. Airmen may volunteer to test during either the post-deployment/extended TDY or RNLTD acclimatization period but cannot be directed to do so.

5.2.6. Accessions. FAs administered at comminissioning sources are considered official, provided they are administered IAW Chapter 3, and will be recorded into AFFMS II upon arrival at the first duty station. If the officer reports to the duty location without a FA AF Form 4446 the officer will be given 42-days from their DAS to acclimatize, but will test NLT 6 months following DAS. DAS may include tech school or their first duty location.

5.2.7. Airmen who are TDY for greater than 30 consecutive days will be given a 42-day acclimatization period prior to being required to complete their FA.

5.2.7.1. DELETED

5.2.8. All Airmen will complete AC assessment unless there is a composite exemption or, under rare medical circumstances (e.g., abdominal surgery), an AC component exemption is recommended by a medical provider/FPM/MLO and approved by the DAWG. (T-1).

5.2.8.1. The DAWG reviews all non-pregnancy related AC exemption requests. AC component exemptions will not be granted for non-medical reasons (e.g., physique that nonetheless has AC that exceeds AF standards). The presence of a rare medical issue is the only consideration required/allowed to grant an AC exemption; no other methods such as alternative body composition measurements shall be used to determine whether to grant an AC exemption.

5.2.9. ARC medical unit providers will advise Airmen to consult their PCP to recommend specific PT appropriate for medical condition or may refer the Airman to the FIP if available. (T-1). MTFs can provide space available evaluation as required for eligible ARC Airmen. To obtain an exemption based on evaluation and recommendation of PCP, the Airman must provide the ARC medical unit with medical documentation to include diagnosis, treatment, prognosis, and period and type of physical limitations or restrictions. (T-1). Individual Reservists (IR) may be referred by the MTF to their PCP or ARC EP where applicable.

5.3. Exemption Categories.

5.3.1. Component Exemption. Member is exempt from one or more components of theFA, but will be assessed on remaining components.

5.3.2. Composite Exemptions. Airman is exempt from all components of the FA.

5.3.2.1. Composite Deployment Exemption. Airmen deployed for less than one year on Contingency Exercise Deployment (CED) or Military Personnel Appropriation (MPA) orders in direct support of a contingency will receive a composite deployment exemption following the expiration of their current FA in the deployed location. All Airmen with a composite deployment exemption may complete FAs on a voluntary basis only.

5.3.2.1.1. DELETED

5.3.2.2. Permanent party personnel and 365-day deployers will test when their current FA expires in the deployed location, unless the location is not resourced, equipped, or otherwise capable of administering FAs. If testing for the permanent party personnel and 365-day deployers is not feasible, the Air Component Commander must grant a composite deployment exemption to all individuals deployed.

5.3.2.2.1. RegAF and AGR Airmen deployed/TDY for greater than 30 consecutive days will be given a 42-day acclimatization period starting the date they arrive back at home station prior to taking their FA, unless the Airman requests to be assessed earlier. All non-AGR and Traditional ARC personnel will be given a 90-day acclimatization period starting the date they arrive back at home station prior to taking their FA, unless the Airman requests to be assessed earlier.

Table 5.1. Exemptions.

Type	Definition	Assessment/Reassessment Requirements
Composite (Medical)	Airman is prohibited from completing all components of the FA due to medical conditions, other than pregnancy (e.g.,	The Airman is allowed 42 days for reconditioning following the expiration of the medical exemption. (Exception: Pregnancy-related exemptions)
Composite (Commander)	Airman is unable to complete an assessment for a time-limited, unforeseen catastrophic event that precludes training and assessment for greater than 30 days (e.g., personal catastrophe, etc.). Commanders will exempt Airmen who are incarcerated or on appellate/excess leave pending separation. NOTE: This exemption category is not authorized for medical or	If the exemption exceeds 30 days, the Airman is given 42 days following the expiration of the exemption for training. (See NOTE 1)
Composite (Pregnancy)	Airman is prohibited from completing FA due to pregnancy. Pregnant Airmen who were in the Unsatisfactory fitness category prior to becoming pregnant will continue to participate in the FIP. (T-1).	The Airman must test by the last day of the 12th month. On the 1st day of the 13 month after discharge from the hospital after pregnancies lasting 20 weeks or more the Airman becomes non-current. For pregnancies that end prior to 20 weeks, see paragraph 5.2.4.2.

Composite (Deployment)	Airmen due to deploy must have a current FA score on file prior to departure. (T-1). Airmen deployed for less than one year on Contingency Exercise Deployment (CED) or Military Personnel Appropriation (MPA) orders in direct support of a contingency will receive a composite deployment exemption following the expiration of their current FA in the deployed location.	RegAF and AGR Airmen deployed for greater than 30 consecutive days will be given a 42-day acclimatization period starting the date they arrive back at home station prior to taking their FA. Non-AGR and Traditional ARC personnel will be given a 90-day acclimatization period starting the date they arrive back at home station prior to taking their FA.
Component (Medical)	Airman is prohibited from performing one or more components of the FA. The medical provider/FPM/MLO, may grant exemption from aerobic and muscle fitness components of PT or FA based on medical evaluation IAW para 5.2 for a time-limited period. Other components of the FA will	Upon expiration of the exemption, or when the medical provider/FPM/MLO clears the exempted component of assessment, the Airman will meet their next scheduled FA. If the exemption exceeded 30 days, the Airman is allowed 42 days for training following the expiration of the component exemption. If an Airman's next required FA is due during the 469 effective dates or 42

Composite (Extended TDY) *use Composite (Deployment) exemption for AFFMS II input	Granted only to Airmen TDY more than 30 consecutive days whose current FA expires at the extended TDY location. Airmen returning from an extended TDY (> 30 consecutive days) who PCS before the end of their post-TDY 42-day acclimatization period may be granted a "deployment exemption" by losing home station. This	RegAF and AGR personnel TDY for greater than 30 consecutive days will be given a 42-day acclimatization period starting the date they arrive back at home station prior to taking their FA. Non-AGR and Traditional ARC personnel will be given a 90-day acclimatization period starting the date they arrive back at home station prior to taking their FA. Airman who PCS following an extended TDY but cannot complete the 42-day acclimatization period at losing home station will be assessed 43 days following their RNTLD.
Not Participating ARC Only	ARC only: Non-participating ARC Airmen listed on unit roster, but unable or unavailable to participate for pay or points (examples are new accessions awaiting OTS/COT/BMT, etc.) may be classified under Commander exemption in AFFMS II.	Exempt until resolved. If the exemption exceeds 30 days, the Airman is given 42 days following the expiration of the exemption for training.

*NOTES:
1. Commanders will document all non-medical commander exemptions by e-mail or memorandum and forward to the FAC for action. (T-1). Composite exemptions due to medical reasons can only be granted under the Composite (Medical) exemption type as documented by an AF Form 469.
2. Airmen on consecutive profiles will be given 42 days following the expiration of the most recent AF Form 469.

Chapter 6

PHYSICAL FITNESS AND NUTRITION EDUCATION/INTERVENTION

6.1. Physical Fitness and Nutrition Education. Physical fitness and nutrition education will be incorporated into training programs and unit PT. Ongoing commander emphasis and a supportive environment are essential to maintain health and fitness of the force.

6.2. Fitness Improvement Program (FIP). This program targets nutritional and exercise behavior changes necessary to improve one's health and fitness utilizing three intervention options. Airmen and their commanders select an option appropriate to their fitness improvement requirements. Available options include: BE WELL online, a Healthy Weight program, and Military OneSource Health Coaching. FIP is mandatory for all AF Airmen with an Unsatisfactory FA score and is available for any member who wish to improve their overall health and fitness.

6.2.1. RegAF, Title 10 Statutory Tour and ARC AGR members must start FIP within 10 duty days of their Unsatisfactory FA. (T-1). If members are unable to start within 10 duty days, they must obtain written authorization from their Unit Commander. (T-3). Traditional ARC personnel (except AGRs) are required to accomplish FIP within 60 days of the Unsatisfactory FA. (T-1).

6.2.2. DELETED

6.2.3. Airmen who receive consecutive Unsatisfactory FAs are required to re-enroll in the FIP. Additionally, Airmen who receive nonconsecutive Unsatisfactory FAs must start FIP within 10 days of their latest Unsatisfactory FA and 60 days for ARC Airmen. (T-1).

6.2.4. UFPM will inform Airmen of FIP requirements per AFMOA guidance and document FIP start date in AFFMS II. (T-1).

6.2.5. Airmen who retest within 10 duty days of their Unsatisfactory FA and achieve an Excellent/Satisfactory score are not required to complete FIP.

6.2.6. Members are ultimately responsible for improving their fitness level to achieve a minimum Satisfactory FA score, and if appropriate, provide documentation of compliance with FIP to their leadership.

Attachment 4

FITNESS SCREENING QUESTIONNAIRE

Figure A4.1. Fitness Screening Questionnaire.

FITNESS SCREENING QUESTIONNAIRE

You are being asked these questions for your safety and health. The AF Fitness Assessment (FA) is a maximum-effort test. Airmen who have not been exercising regularly and/or have other risk factors for a heart attack (increasing age, smoking, diabetes, high blood pressure, etc.) are at increased risk of injury or death during the test. Answering these questions honestly is in your best interest.

1. Have you experienced any of the symptoms/problems listed below and not been medically evaluated and cleared for unrestricted participation in a physical training program?
   a. Unexplained chest discomfort with or without exertion
   b. Unusual or unexplained shortness of breath
   c. Dizziness, fainting, or blackouts associated with exertion
   d. Other medical problems that have not been evaluated, optimally treated, or not already addressed in an AF Form 469, that may prevent you from safely participating in this test (e.g. heart disease, sickle cell trait, asthma, etc.).
   e. Family history of sudden death before the age of 50 years

   ☐ **Yes:** Stop. Notify your UFPM and contact your PCP/MLO for evaluation/recommendations (or for ARC, contact the MLO for Duty Limiting Conditions (DLC) documentation and referral to PCP). Hand carry this form to medical evaluation.
   ☐ **No:** Proceed to next question.

2. Are you 35 years of age or older?

   ☐ **Yes:** Proceed to next question.
   ☐ **No:** Stop. Sign form and return to your UFPM. Member may take the FA.

3. Have you engaged in vigorous physical activity (i.e., activity causing sweating and moderate to marked increases in breathing and heart rate) averaging at least 30 minutes per session, 3 days per week, over the last 2 months?

   ☐ **Yes:** Stop. Sign form and return to your UFPM. Member may take the fitness assessment.
   ☐ **No:** Proceed to the next question.

4. Do one (1) or more of the following risk factors apply to you?
   - Smoked tobacco products in the last 30 days
   - Diabetes
   - High blood pressure that is not controlled
   - High cholesterol that is not controlled
   - Family history of heart disease (developed in father/brother before age 55 or mother/sister before age 65)
   - Age > 45 years for males; > 55 years for females

   ☐ **Yes:** Stop and notify UFPM.

NOTE: RegAF and ANG (Title 10 status): If member was cleared for entry into a fitness program at his/her last physical health assessment (PHA) and his/her PHA is current, the member will take the FA. If not cleared, refer member to PCM for evaluation, and, if medically cleared for unrestricted fitness program, the member will take the FA.

AFR: If member was cleared for participation into a fitness program at a PHA within the last 12 months, the member will take the FA. If not previously cleared, member will be referred to PCP for evaluation and, if medically cleared for unrestricted fitness program, the member will take the FA. Refer member to MLO if there is any combination of smoking, diabetes, uncontrolled high blood pressure, and/or uncontrolled high cholesterol. MLO will update medical records and/or initiate DLC documentation.

ANG (Title 32 status): Refer member to MLO if there is any combination of smoking, diabetes, uncontrolled high blood pressure, and/or uncontrolled high cholesterol. MLO will update medical records and/or initiate DLC documentation.

☐ No: Stop. Sign form and return to your UFPM. Member will take the FA.

If member experiences any of the symptoms listed in Question #1 during the fitness assessment, he/she should stop the test immediately and seek medical attention immediately.

Signature: _____ Date: _____
Printed Name: _____ Rank: _____
Duty Phone: _____ Office Symbol: _____

Authority: 10 USC 8013. Routine Use: This information is not disclosed outside DoD. Disclosure is Mandatory. Failure to provide this information may result in either administrative discharge or punishment under the UCMJ.

Medical Evaluation (Only applicable if member marked Yes on Question 1; provider answers all 4 statements)

If medical evaluation is required IAW this FSQ, the provider will complete the following.

_____

I medically evaluated _____ on _____. Medical recommendations are:
(rank, name) (date)

Member (is/is not) medically cleared for the maximal effort 1.5-mile run.

Member (is/is not) medically cleared for the maximal effort 2.0-kilometer walk.

Member (is/is not) medically cleared for push-ups.

Member (is/is not) medically cleared for sit-ups.

NOTE: An AF Form 469 has been initiated, if appropriate. Airmen with fitness limitations for greater than 30 days must be referred to the EP/FPM for fitness prescription IAW AFI 36-2905.

_____
(Signature/Stamp of Provider)

Attachment 6

1.5-MILE RUN AND 2.0-KILOMETER WALK COURSE REQUIREMENTS

A6.1. Course Requirements for 1.5-mile timed run (2640 yards/2414 meters) and 2.0-kilometer timed walk (2187 yards/2000 meters).

A6.1.1. Establish a standard course of accurate distance that is as level and even as possible.

A6.1.1.1. If a typical 6-lap track is used:

A6.1.1.1.1. For a 1.5-mile timed run, it should be 440 yards per lap; or 6 laps on a 400-meter track plus an additional 46 feet for 1.5-miles.

A6.1.1.1.2. For a 2.0-kilometer timed walk, it should be 5 laps on a 400-meter track or 4 laps on a 440 yard track plus an additional 427 yards.

A6.1.1.2. Course should have limited exposure to traffic, should not have a continuous incline/decline or rolling hills; avoid slopes exceeding two degrees. If using a road course, where possible, start and finish should be at the same location.

A6.1.1.3. Clearly mark the start and finish lines (and half-way point for road courses).

A6.1.2. Trained personnel will monitor participants, ensuring all members complete entire course and are continuously observed for course completion, safety, counting laps if required and recording run times.

A6.1.3. Indoor track may be used at the discretion of installation leadership however the track must be certified.

A6.2. Evaluate course safety/environmental conditions to determine if assessment can be properly conducted.

A6.2.1. Snow: no snow accumulation on the running surface.

A6.2.2. Ice: no ice on the running surface that cannot be easily observed and avoided.

A6.2.3. Water: no standing water that a large group cannot easily avoid on the running surface.

A6.2.4. Mud: no mud on the running surface that cannot be easily avoided.

A6.2.5. Lightning: no lightning within 5 nautical miles (~6 miles) and wait at least 30 minutes after the last observed lightning.

A6.2.6. Rain: No significant rain. If assessing on a wet day (rain, mist or heavy dew), the temperature must be > 34 degrees F, including wind chill.

A6.2.7. Hail: no hail forecasted or reported within 25 miles.

A6.2.8. Shelter: establish a safe shelter procedure if there is any storm threat.

A6.2.9. Visibility: must be greater than ¾ mile if crossing or running beside vehicular traffic.

A6.2.10. Light: reflective belts/vests are required if running near traffic from 1 hour before sunset to 1 hour after sunrise.

A6.2.11. Intersections: crossing guards with reflective safety vests/lights must be positioned at all active intersections.

A6.2.12. Medical: establish a method of communication/access for emergency medical services (e.g., cell phone, hand-held radio, etc. to call 911). If AEDs are available, they must be on-site during all portions of FA.

A6.2.12.1. Safety is the number one concern. If during or after the test, the member experiences unusual shortness of breath, chest pain, dizziness or lightheadedness, or any other unusual symptoms, please notify FAC or FA administrator immediately.

A6.2.13. Wind Speed: max wind allowed ≤ 15 mph sustained, ≤ 20 mph gusting.

A6.2.14. Cold Stress: air temperatures must be ≥ 20 degrees F with wind ≤ 15 mph sustained, ≤ 20 mph gusting.

A6.2.15. Heat Stress: Wet Bulb Globe Temperature (WBGT) must be ≤ 86 degrees F at the start of the walk/run (**NOTE:** Consult with base environmental engineering, base weather, or civilian agencies to determine environmental conditions)

Attachment 10

FITNESS ASSESSMENT CHARTS

A10.1. Fitness Assessment Chart – Male: Age: < 30.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 9:12	Low-Risk	60.0	≤ 32.5	Low-Risk	20.0	≥ 67	10.0	≥ 58	10.0
9:13 - 9:34	Low-Risk	59.7	33.0	Low-Risk	20.0	62	9.5	55	9.5
9:35 - 9:45	Low-Risk	59.3	33.5	Low-Risk	20.0	61	9.4	54	9.4
9:46 - 9:58	Low-Risk	58.9	34.0	Low-Risk	20.0	60	9.3	53	9.2
9:59 - 10:10	Low-Risk	58.5	34.5	Low-Risk	20.0	59	9.2	52	9.0
10:11 - 10:23	Low-Risk	57.9	35.0	Low-Risk	20.0	58	9.1	51	8.8
10:24 - 10:37	Low-Risk	57.3	35.5	Moderate Risk	17.6	57	9.0	50	8.7
10:38 - 10:51	Low-Risk	56.6	36.0	Moderate Risk	17.0	56	8.9	49	8.5
10:52 - 11:06	Low-Risk	55.7	36.5	Moderate Risk	16.4	55	8.8	48	8.3
11:07 - 11:22	Low-Risk	54.8	37.0	Moderate Risk	15.8	54	8.8	47	8.0
11:23 - 11:38	Low-Risk	53.7	37.5 #	Moderate Risk	15.1	53	8.7	46 #	7.5
11:39 - 11:56	Low-Risk	52.4	38.0	Moderate Risk	14.4	52	8.6	45	7.0
11:57 - 12:14	Low-Risk	50.9	38.5	Moderate Risk	13.5	51	8.5	44	6.5
12:15 - 12:33	Low-Risk	49.2	39.0 *	Moderate Risk	12.6	50	8.4	43	6.3
12:34 - 12:53	Moderate Risk	47.2	39.5	High Risk	0	49	8.3	42 *	6.0
12:54 - 13:14 #	Moderate Risk	44.9	40.0	High Risk	0	48	8.1	41	0
13:15 - 13:36 *	Moderate Risk	42.3	40.5	High Risk	0	47	8.0	40	0
13:37 - 14:00	High Risk	0	41.0	High Risk	0	46	7.8	39	0
14:01 - 14:25	High Risk	0	41.5	High Risk	0	45	7.7	38	0
14:26 - 14:52	High Risk	0	42.0	High Risk	0	44 #	7.5	37	0
14:53 - 15:20	High Risk	0	42.5	High Risk	0	43	7.3	36	0
15:21 - 15:50	High Risk	0	43.0	High Risk	0	42	7.2	35	0
15:51 - 16:22	High Risk	0	≥ 43.5	High Risk	0	41	7.0	34	0
16:23 - 16:57	High Risk	0				40	6.8	33	0
≥ 16:58	High Risk	0				39	6.5	32	0
						38	6.3	31	0
NOTES:						37	6.0	30	0
Health Risk Category = low, moderate or high risk for current and future						36	5.8	≤ 29	0
cardiovascular disease, diabetes, certain cancers, and other health problems						35	5.5		
						34	5.3		
Passing Requirements - member ***must***: 1) meet minimum value in each of						33 *	5.0		
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						32	0		
						31	0		
* Minimum Component Values						30	0		
Run time ≤ 13:36 mins:secs / Abd Circ ≤ 39.0 inches						29	0		
Push-ups ≥ 33 repetitions/one minute / Sit-ups ≥ 42 repetitions/one minute						28	0		
						27	0		
# Target Component Values						26	0		
Member should attain or surpass these to achieve ≥ 75.0 composite score						25	0		
						24	0		
Composite Score Categories						23	0		
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0						22	0		
						21	0		
						20	0		
						19	0		
						18	0		
						≤ 17	0		

A10.2. Fitness Assessment Chart – Male: Age: 30 – 39.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 9:34	Low-Risk	60.0	≤ 32.5	Low-Risk	20.0	≥ 57	10.0	≥ 54	10.0
9:35 - 9:58	Low-Risk	59.3	33.0	Low-Risk	20.0	52	9.5	51	9.5
9:59 - 10:10	Low-Risk	58.6	33.5	Low-Risk	20.0	51	9.4	50	9.4
10:11 - 10:23	Low-Risk	57.9	34.0	Low-Risk	20.0	50	9.3	49	9.2
10:24 - 10:37	Low-Risk	57.3	34.5	Low-Risk	20.0	49	9.2	48	9.0
10:38 - 10:51	Low-Risk	56.6	35.0	Low-Risk	20.0	48	9.2	47	8.8
10:52 - 11:06	Low-Risk	55.7	35.5	Moderate Risk	17.6	47	9.1	46	8.7
11:07 - 11:22	Low-Risk	54.8	36.0	Moderate Risk	17.0	46	9.0	45	8.5
11:23 - 11:38	Low-Risk	53.7	36.5	Moderate Risk	16.4	45	8.9	44	8.3
11:39 - 11:56	Low-Risk	52.4	37.0	Moderate Risk	15.8	44	8.8	43	8.0
11:57 - 12:14	Low-Risk	50.9	37.5 #	Moderate Risk	15.1	43	8.7	42 #	7.5
12:15 - 12:33	Low-Risk	49.2	38.0	Moderate Risk	14.4	42	8.6	41	7.0
12:34 - 12:53	Low-Risk	47.2	38.5	Moderate Risk	13.5	41	8.5	40	6.5
12:54 - 13:14 #	Moderate Risk	44.9	39.0 *	Moderate Risk	12.6	40	8.3	39 *	6.0
13:15 - 13:36	Moderate Risk	42.3	39.5	High Risk	0	39	8.0	38	0
13:37 - 14:00 *	Moderate Risk	39.3	40.0	High Risk	0	38	7.8	37	0
14:01 - 14:25	High Risk	0	40.5	High Risk	0	37	7.7	36	0
14:26 - 14:52	High Risk	0	41.0	High Risk	0	36 #	7.5	35	0
14:53 - 15:20	High Risk	0	41.5	High Risk	0	35	7.3	34	0
15:21 - 15:50	High Risk	0	42.0	High Risk	0	34	7.0	33	0
15:51 - 16:22	High Risk	0	42.5	High Risk	0	33	6.8	32	0
16:23 - 16:57	High Risk	0	43.0	High Risk	0	32	6.7	31	0
≥ 16:58	High Risk	0	≥ 43.5	High Risk	0	31	6.5	30	0
						30	6.0	29	0
NOTES:						29	5.5	28	0
Health Risk Category = low, moderate or high risk for current and future						28	5.3	27	0
cardiovascular disease, diabetes, certain cancers, and other health problems						27 *	5.0	26	0
						26	0	≤ 25	0
Passing Requirements - member ***must***: 1) meet minimum value in each of						25	0		
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						24	0		
						23	0		
* Minimum Component Values						22	0		
Run time ≤ 14:00 mins:secs / Abd Circ ≤ 39.0 inches						21	0		
Push-ups ≥ 27 repetitions/one minute / Sit-ups ≥ 39 repetitions/one minute						20	0		
						19	0		
# Target Component Values						18	0		
Member should attain or surpass these to achieve ≥ 75.0 composite score						17	0		
						16	0		
Composite Score Categories						15	0		
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0						14	0		
						13	0		
						≤ 12	0		

A10.3. Fitness Assessment Chart – Male: Age: 40 - 49

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 9:45	Low-Risk	60.0	≤ 32.5	Low-Risk	20.0	≥ 44	10.0	≥ 50	10.0
9:46 - 10:10	Low-Risk	59.8	33.0	Low-Risk	20.0	40	9.5	47	9.5
10:11 - 10:23	Low-Risk	59.5	33.5	Low-Risk	20.0	39	9.4	46	9.4
10:24 - 10:37	Low-Risk	59.1	34.0	Low-Risk	20.0	38	9.2	45	9.2
10:38 - 10:51	Low-Risk	58.7	34.5	Low-Risk	20.0	37	9.1	44	9.1
10:52 - 11:06	Low-Risk	58.3	35.0	Low-Risk	20.0	36	9.0	43	9.0
11:07 - 11:22	Low-Risk	57.7	35.5	Moderate Risk	17.6	35	8.8	42	8.8
11:23 - 11:38	Low-Risk	57.1	36.0	Moderate Risk	17.0	34	8.5	41	8.7
11:39 - 11:56	Low-Risk	56.3	36.5	Moderate Risk	16.4	33	8.4	40	8.5
11:57 - 12:14	Low-Risk	55.4	37.0	Moderate Risk	15.8	32	8.3	39	8.0
12:15 - 12:33	Low-Risk	54.3	37.5 #	Moderate Risk	15.1	31	8.1	38	7.8
12:34 - 12:53	Low-Risk	53.1	38.0	Moderate Risk	14.4	30	8.0	37 #	7.5
12:54 - 13:14	Low-Risk	51.5	38.5	Moderate Risk	13.5	29 #	7.5	36	7.0
13:15 - 13:36	Low-Risk	49.8	39.0 *	Moderate Risk	12.6	28	7.3	35	6.5
13:37 - 14:00	Moderate Risk	47.7	39.5	High Risk	0	27	7.2	34 *	6.0
14:01 - 14:25 #	Moderate Risk	45.2	40.0	High Risk	0	26	7.0	33	0
14:26 - 14:52 *	Moderate Risk	42.3	40.5	High Risk	0	25	6.5	32	0
14:53 - 15:20	High Risk	0	41.0	High Risk	0	24	6.0	31	0
15:21 - 15:50	High Risk	0	41.5	High Risk	0	23	5.8	30	0
15:51 - 16:22	High Risk	0	42.0	High Risk	0	22	5.5	29	0
16:23 - 16:57	High Risk	0	42.5	High Risk	0	21 *	5.0	28	0
16:58 - 17:34	High Risk	0	43.0	High Risk	0	20	0	27	0
17:35 - 18:14	High Risk	0	≥ 43.5	High Risk	0	19	0	26	0
≥ 18:15	High Risk	0				18	0	25	0
						17	0	24	0
NOTES:						16	0	23	0
Health Risk Category = low, moderate or high risk for current and future						15	0	22	0
cardiovascular disease, diabetes, certain cancers, and other health problems						14	0	≤ 21	0
						13	0		
Passing Requirements - member ***must***: 1) meet minimum value in each of						12	0		
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						11	0		
						10	0		
* Minimum Component Values						9	0		
Run time ≤ 14:52 mins:secs / Abd Circ ≤ 39.0 inches						≤ 8	0		
Push-ups ≥ 21 repetitions/one minute / Sit-ups ≥ 34 repetitions/one minute									
# Target Component Values									
Member should attain or surpass these to achieve ≥ 75.0 composite score									
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

A10.4. Fitness Assesment Chart – Male: Age: 50 – 59.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 10:37	Low-Risk	60.0	≤ 32.5	Low-Risk	20.0	≥ 44	10.0	≥ 46	10.0
10:38 - 11:06	Low-Risk	59.7	33.0	Low-Risk	20.0	39	9.5	43	9.5
11:07 - 11:22	Low-Risk	59.4	33.5	Low-Risk	20.0	38	9.4	42	9.4
11:23 - 11:38	Low-Risk	59.0	34.0	Low-Risk	20.0	37	9.4	41	9.2
11:39 - 11:56	Low-Risk	58.5	34.5	Low-Risk	20.0	36	9.3	40	9.1
11:57 - 12:14	Low-Risk	58.0	35.0	Low-Risk	20.0	35	9.3	39	9.0
12:15 - 12:33	Low-Risk	57.3	35.5	Moderate Risk	17.6	34	9.2	38	8.8
12:34 - 12:53	Low-Risk	56.5	36.0	Moderate Risk	17.0	33	9.2	37	8.7
12:54 - 13:14	Low-Risk	55.6	36.5	Moderate Risk	16.4	32	9.1	36	8.5
13:15 - 13:36	Low-Risk	54.5	37.0	Moderate Risk	15.8	31	9.1	35	8.0
13:37 - 14:00	Low-Risk	53.3	37.5 #	Moderate Risk	15.1	30	9.0	34	7.8
14:01 - 14:25	Low-Risk	51.8	38.0	Moderate Risk	14.4	29	8.8	33 #	7.5
14:26 - 14:52	Low-Risk	50.0	38.5	Moderate Risk	13.5	28	8.5	32	7.3
14:53 - 15:20	Moderate Risk	47.9	39.0 *	Moderate Risk	12.6	27	8.3	31	7.0
15:21 - 15:50 #	Moderate Risk	45.4	39.5	High Risk	0	26	8.2	30	6.5
15:51 - 16:22 *	Moderate Risk	42.4	40.0	High Risk	0	25	8.0	29	6.3
16:23 - 16:57	High Risk	0	40.5	High Risk	0	24 #	7.5	28 *	6.0
16:58 - 17:34	High Risk	0	41.0	High Risk	0	23	7.3	27	0
17:35 - 18:14	High Risk	0	41.5	High Risk	0	22	7.2	26	0
18:15 - 18:56	High Risk	0	42.0	High Risk	0	21	7.0	25	0
18:57 - 19:43	High Risk	0	42.5	High Risk	0	20	6.5	24	0
19:44 - 20:33	High Risk	0	43.0	High Risk	0	19	6.0	23	0
≥ 20:34	High Risk	0	≥ 43.5	High Risk	0	18	5.8	22	0
						17	5.5	21	0
NOTES:						16	5.3	20	0
Health Risk Category = low, moderate or high risk for current and future						15 *	5.0	19	0
cardiovascular disease, diabetes, certain cancers, and other health problems						14	0	18	0
						13	0	17	0
Passing Requirements - member ***must***: 1) meet minimum value in each of						12	0	16	0
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						11	0	15	0
						10	0	≤ 14	0
* Minimum Component Values						9	0		
Run time ≤ 16:22 mins:secs / Abd Circ ≤ 39.0 inches						8	0		
Push-ups ≥ 15 repetitions/one minute / Sit-ups ≥ 28 repetitions/one minute						7	0		
						6	0		
# Target Component Values						≤ 5	0		
Member should attain or surpass these to achieve ≥ 75.0 composite score									
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

A10.5. Fitness Assessment Chart – Male: AGE: 60+.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 11:22	Low-Risk	60.0	≤ 32.5	Low-Risk	20.0	≥ 30	10.0	≥ 42	10.0
11:23 - 11:56	Low-Risk	59.7	33.0	Low-Risk	20.0	28	9.5	39	9.5
11:57 - 12:14	Low-Risk	59.4	33.5	Low-Risk	20.0	27	9.3	38	9.4
12:15 - 12:33	Low-Risk	59.0	34.0	Low-Risk	20.0	26	9.0	37	9.2
12:34 - 12:53	Low-Risk	58.5	34.5	Low-Risk	20.0	25	8.8	36	9.1
12:54 - 13:14	Low-Risk	58.0	35.0	Low-Risk	20.0	24	8.5	35	9.0
13:15 - 13:36	Low-Risk	57.3	35.5	Moderate Risk	17.6	23	8.0	34	8.9
13:37 - 14:00	Low-Risk	56.5	36.0	Moderate Risk	17.0	22 #	7.5	33	8.8
14:01 - 14:25	Low-Risk	55.6	36.5	Moderate Risk	16.4	21	7.0	32	8.6
14:26 - 14:52	Low-Risk	54.5	37.0	Moderate Risk	15.8	20	6.5	31	8.5
14:53 - 15:20	Low-Risk	53.3	37.5 #	Moderate Risk	15.1	19	6.3	30	8.0
15:21 - 15:50	Low-Risk	51.8	38.0	Moderate Risk	14.4	18	6.0	29	7.8
15:51 - 16:22	Low-Risk	50.0	38.5	Moderate Risk	13.5	17	5.8	28 #	7.5
16:23 - 16:57	Moderate Risk	47.9	39.0 *	Moderate Risk	12.6	16	5.5	27	7.3
16:58 - 17:34 #	Moderate Risk	45.4	39.5	High Risk	0	15	5.3	26	7.0
17:35 - 18:14 *	Moderate Risk	42.4	40.0	High Risk	0	14 *	5.0	25	6.8
18:15 - 18:56	High Risk	0	40.5	High Risk	0	13	0	24	6.5
18:57 - 19:43	High Risk	0	41.0	High Risk	0	12	0	23	6.3
19:44 - 20:33	High Risk	0	41.5	High Risk	0	11	0	22 *	6.0
20:34 - 21:28	High Risk	0	42.0	High Risk	0	10	0	21	0
21:29 - 22:28	High Risk	0	42.5	High Risk	0	9	0	20	0
22:29 - 23:34	High Risk	0	43.0	High Risk	0	8	0	19	0
≥ 23:35	High Risk	0	≥ 43.5	High Risk	0	7	0	18	0
						6	0	17	0
NOTES:						5	0	16	0
Health Risk Category = low, moderate or high risk for current and future						4	0	15	0
cardiovascular disease, diabetes, certain cancers, and other health problems						≤ 3	0	14	0
								13	0
Passing Requirements - member ***must***: 1) meet minimum value in each of								12	0
the four components, ***and*** 2) achieve a composite point total ≥ 75 points								11	0
								10	0
* Minimum Component Values								≤ 9	0
Run time ≤ 18:14 mins:secs / Abd Circ ≤ 39.0 inches									
Push-ups ≥ 14 repetitions/one minute / Sit-ups ≥ 22 repetitions/one minute									
# Target Component Values									
Member should attain or surpass these to achieve ≥ 75.0 composite score									
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

A10.6. Fitness Assessment Chart – Female: Age: < 30.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 10:23	Low-Risk	60.0	≤ 29.0	Low Risk	20.0	≥ 47	10.0	≥ 54	10.0
10:24 - 10:51	Low-Risk	59.9	29.5	Low Risk	20.0	42	9.5	51	9.5
10:52 - 11:06	Low-Risk	59.5	30.0	Low Risk	20.0	41	9.4	50	9.4
11:07 - 11:22	Low-Risk	59.2	30.5	Low Risk	20.0	40	9.3	49	9.0
11:23 - 11:38	Low-Risk	58.9	31.0	Low Risk	20.0	39	9.2	48	8.9
11:39 - 11:56	Low-Risk	58.6	31.5	Low Risk	20.0	38	9.1	47	8.8
11:57 - 12:14	Low-Risk	58.1	32.0	Moderate Risk	17.6	37	9.0	46	8.6
12:15 - 12:33	Low-Risk	57.6	32.5	Moderate Risk	17.1	36	8.9	45	8.5
12:34 - 12:53	Low-Risk	57.0	33.0	Moderate Risk	16.5	35	8.8	44	8.0
12:54 - 13:14	Low-Risk	56.2	33.5	Moderate Risk	15.9	34	8.6	43	7.8
13:15 - 13:36	Low-Risk	55.3	34.0 #	Moderate Risk	15.2	33	8.5	42 #	7.5
13:37 - 14:00	Low-Risk	54.2	34.5	Moderate Risk	14.5	32	8.4	41	7.0
14:01 - 14:25	Low-Risk	52.8	35.0	Moderate Risk	13.7	31	8.3	40	6.8
14:26 - 14:52	Low-Risk	51.2	35.5 *	Moderate Risk	12.8	30	8.2	39	6.5
14:53 - 15:20	Moderate Risk	49.3	36.0	High Risk	0	29	8.1	38 *	6.0
15:21 - 15:50 #	Moderate Risk	46.9	36.5	High Risk	0	28	8.0	37	0
15:51 - 16:22 *	Moderate Risk	44.1	37.0	High Risk	0	27 #	7.5	36	0
16:23 - 16:57	High Risk	0	37.5	High Risk	0	26	7.3	35	0
16:58 - 17:34	High Risk	0	38.0	High Risk	0	25	7.2	34	0
17:35 - 18:14	High Risk	0	38.5	High Risk	0	24	7.0	33	0
18:15 - 18:56	High Risk	0	39.0	High Risk	0	23	6.5	32	0
18:57 - 19:43	High Risk	0	39.5	High Risk	0	22	6.3	31	0
19:44 - 20:33	High Risk	0	≥ 40.0	High Risk	0	21	6.0	30	0
≥ 20:34	High Risk	0				20	5.8	29	0
						19	5.5	28	0
NOTES:						18 *	5.0	27	0
Health Risk Category = low, moderate or high risk for current and future						17	0	26	0
cardiovascular disease, diabetes, certain cancers, and other health problems						16	0	25	0
						15	0	24	0
Passing Requirements - member ***must***: 1) meet minimum value in each of						14	0	23	0
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						13	0	≤ 22	0
						12	0		
* Minimum Component Values						11	0		
Run time ≤ 16:22 mins:secs / Abd Circ ≤ 35.5 inches						10	0		
Push-ups ≥ 18 repetitions/one minute / Sit-ups ≥ 38 repetitions/one minute						9	0		
						8	0		
# Target Component Values						≤ 7	0		
Member should attain or surpass these to achieve ≥ 75.0 composite score									
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

A10.7. Fitness Assessment Chart – Female: Age: 30 – 39.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 10:51	Low-Risk	60.0	≤ 29.0	Low Risk	20.0	≥ 46	10.0	≥ 45	10.0
10:52 - 11:22	Low-Risk	59.5	29.5	Low Risk	20.0	40	9.5	42	9.5
11:23 - 11:38	Low-Risk	59.0	30.0	Low Risk	20.0	39	9.4	41	9.4
11:39 - 11:56	Low-Risk	58.6	30.5	Low Risk	20.0	38	9.3	40	9.0
11:57 - 12:14	Low-Risk	58.1	31.0	Low Risk	20.0	37	9.3	39	8.8
12:15 - 12:33	Low-Risk	57.6	31.5	Low Risk	20.0	36	9.2	38	8.5
12:34 - 12:53	Low-Risk	57.0	32.0	Moderate Risk	17.6	35	9.1	37	8.3
12:54 - 13:14	Low-Risk	56.2	32.5	Moderate Risk	17.1	34	9.1	36	8.2
13:15 - 13:36	Low-Risk	55.3	33.0	Moderate Risk	16.5	33	9.0	35	8.0
13:37 - 14:00	Low-Risk	54.2	33.5	Moderate Risk	15.9	32	8.9	34	7.8
14:01 - 14:25	Low-Risk	52.8	34.0 #	Moderate Risk	15.2	31	8.9	33 #	7.5
14:26 - 14:52	Low-Risk	51.2	34.5	Moderate Risk	14.5	30	8.8	32	7.0
14:53 - 15:20	Low-Risk	49.3	35.0	Moderate Risk	13.7	29	8.7	31	6.8
15:21 - 15:50 #	Moderate Risk	46.9	35.5 *	Moderate Risk	12.8	28	8.6	30	6.5
15:51 - 16:22	Moderate Risk	44.1	36.0	High Risk	0	27	8.6	29 *	6.0
16:23 - 16:57 *	Moderate Risk	40.8	36.5	High Risk	0	26	8.5	28	0
16:58 - 17:34	High Risk	0	37.0	High Risk	0	25	8.3	27	0
17:35 - 18:14	High Risk	0	37.5	High Risk	0	24	8.2	26	0
18:15 - 18:56	High Risk	0	38.0	High Risk	0	23	8.0	25	0
18:57 - 19:43	High Risk	0	38.5	High Risk	0	22	7.9	24	0
19:44 - 20:33	High Risk	0	39.0	High Risk	0	21	7.8	23	0
≥ 20:34	High Risk	0	39.5	High Risk	0	20	7.6	22	0
			≥ 40.0	High Risk	0	19 #	7.5	21	0
						18	7.0	20	0
NOTES:						17	6.8	19	0
Health Risk Category = low, moderate or high risk for current and future						16	6.5	18	0
cardiovascular disease, diabetes, certain cancers, and other health problems						15	6.0	17	0
						14 *	5.0	16	0
Passing Requirements - member ***must***: 1) meet minimum value in each of						13	0	15	0
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						12	0	≤ 14	0
						11	0		
* Minimum Component Values						10	0		
Run time ≤ 16:57 mins:secs / Abd Circ ≤ 35.5 inches						9	0		
Push-ups ≥ 14 repetitions/one minute / Sit-ups ≥ 29 repetitions/one minute						8	0		
						7	0		
# Target Component Values						6	0		
Member should attain or surpass these to achieve ≥ 75.0 composite score						≤ 5	0		
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

A10.8. Fitness Assessment Chart – Female: Age: 40 – 49.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 11:22	Low-Risk	60.0	≤ 29.0	Low Risk	20.0	≥ 38	10.0	≥ 41	10.0
11:23 - 11:56	Low-Risk	59.9	29.5	Low Risk	20.0	33	9.5	38	9.5
11:57 - 12:14	Low-Risk	59.8	30.0	Low Risk	20.0	32	9.4	37	9.4
12:15 - 12:33	Low-Risk	59.6	30.5	Low Risk	20.0	31	9.2	36	9.2
12:34 - 12:53	Low-Risk	59.4	31.0	Low Risk	20.0	30	9.1	35	9.1
12:54 - 13:14	Low-Risk	59.1	31.5	Low Risk	20.0	29	9.0	34	9.0
13:15 - 13:36	Low-Risk	58.7	32.0	Moderate Risk	17.6	28	8.9	33	8.8
13:37 - 14:00	Low-Risk	58.2	32.5	Moderate Risk	17.1	27	8.8	32	8.5
14:01 - 14:25	Low-Risk	57.7	33.0	Moderate Risk	16.5	26	8.7	31	8.3
14:26 - 14:52	Low-Risk	56.9	33.5	Moderate Risk	15.9	25	8.6	30	8.2
14:53 - 15:20	Low-Risk	56.0	34.0 #	Moderate Risk	15.2	24	8.6	29	8.0
15:21 - 15:50	Low-Risk	54.8	34.5	Moderate Risk	14.5	23	8.5	28 #	7.5
15:51 - 16:22	Low-Risk	53.3	35.0	Moderate Risk	13.7	22	8.4	27	7.0
16:23 - 16:57	Moderate Risk	51.4	35.5 *	Moderate Risk	12.8	21	8.3	26	6.8
16:58 - 17:34	Moderate Risk	49.0	36.0	High Risk	0	20	8.2	25	6.4
17:35 - 18:14 *#	Moderate Risk	45.9	36.5	High Risk	0	19	8.1	24 *	6.0
18:15 - 18:56	High Risk	0	37.0	High Risk	0	18	8.0	23	0
18:57 - 19:43	High Risk	0	37.5	High Risk	0	17	7.8	22	0
19:44 - 20:33	High Risk	0	38.0	High Risk	0	16 #	7.5	21	0
20:34 - 21:28	High Risk	0	38.5	High Risk	0	15	7.0	20	0
21:29 - 22:28	High Risk	0	39.0	High Risk	0	14	6.5	19	0
≥ 22:29	High Risk	0	39.5	High Risk	0	13	6.0	18	0
			≥ 40.0	High Risk	0	12	5.5	17	0
						11 *	5.0	16	0
NOTES:						10	0	15	0
Health Risk Category = low, moderate or high risk for current and future						9	0	14	0
cardiovascular disease, diabetes, certain cancers, and other health problems						8	0	13	0
						7	0	12	0
Passing Requirements - member ***must***: 1) meet minimum value in each of						6	0	11	0
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						5	0	10	0
						4	0	≤ 9	0
* Minimum Component Values						≤ 3	0		
Run time ≤ 18:14 mins:secs / Abd Circ ≤ 35.5 inches									
Push-ups ≥ 11 repetitions/one minute / Sit-ups ≥ 24 repetitions/one minute									
# Target Component Values									
Member should attain or surpass these to achieve ≥ 75.0 composite score									
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

A10.9. Fitness Assessment Chart – Female: Age: 50 – 59.

Cardiorespiratory Endurance			Body Composition			Muscle Fitness			
Run Time (mins:secs)	Health Risk Category	Points	AC (inches)	Health Risk Category	Points	Push-ups (reps/min)	Points	Sit-ups (reps/min)	Points
≤ 12:53	Low-Risk	60.0	≤ 29.0	Low Risk	20.0	≥ 35	10.0	≥ 32	10.0
12:54 - 13:36	Low-Risk	59.8	29.5	Low Risk	20.0	30	9.5	30	9.5
13:37 - 14:00	Low-Risk	59.6	30.0	Low Risk	20.0	29	9.4	29	9.0
14:01 - 14:25	Low-Risk	59.3	30.5	Low Risk	20.0	28	9.3	28	8.9
14:26 - 14:52	Low-Risk	58.9	31.0	Low Risk	20.0	27	9.2	27	8.8
14:53 - 15:20	Low-Risk	58.4	31.5	Low Risk	20.0	26	9.1	26	8.6
15:21 - 15:50	Low-Risk	57.7	32.0	Moderate Risk	17.6	25	9.0	25	8.5
15:51 - 16:22	Low-Risk	56.8	32.5	Moderate Risk	17.1	24	8.8	24	8.0
16:23 - 16:57	Low-Risk	55.6	33.0	Moderate Risk	16.5	23	8.7	23 #	7.5
16:58 - 17:34	Low-Risk	54.0	33.5	Moderate Risk	15.9	22	8.6	22	7.0
17:35 - 18:14	Low-Risk	51.9	34.0 #	Moderate Risk	15.2	21	8.6	21	6.5
18:15 - 18:56	Moderate Risk	49.2	34.5	Moderate Risk	14.5	20	8.5	20 *	6.0
18:57 - 19:43 *#	Moderate Risk	45.5	35.0	Moderate Risk	13.7	19	8.4	19	0
19:44 - 20:33	High Risk	0	35.5 *	Moderate Risk	12.8	18	8.3	18	0
20:34 - 21:28	High Risk	0	36.0	High Risk	0	17	8.2	17	0
21:29 - 22:28	High Risk	0	36.5	High Risk	0	16	8.1	16	0
22:29 - 23:34	High Risk	0	37.0	High Risk	0	15	8.0	15	0
≥ 23:35	High Risk	0	37.5	High Risk	0	14 #	7.5	14	0
			38.0	High Risk	0	13	7.0	13	0
			38.5	High Risk	0	12	6.5	12	0
			39.0	High Risk	0	11	6.0	11	0
			39.5	High Risk	0	10	5.5	10	0
			≥ 40.0	High Risk	0	9 *	5.0	9	0
						8	0	8	0
NOTES:						7	0	7	0
Health Risk Category = low, moderate or high risk for current and future						6	0	6	0
cardiovascular disease, diabetes, certain cancers, and other health problems						5	0	≤ 5	0
						4	0		
Passing Requirements - member ***must***: 1) meet minimum value in each of						3	0		
the four components, ***and*** 2) achieve a composite point total ≥ 75 points						≤2	0		
* Minimum Component Values									
Run time ≤ 19:43 mins:secs / Abd Circ ≤ 35.5 inches									
Push-ups ≥ 9 repetitions/one minute / Sit-ups ≥ 20 repetitions/one minute									
# Target Component Values									
Member should attain or surpass these to achieve ≥ 75.0 composite score									
Composite Score Categories									
Excellent ≥ 90.0 pts / Satisfactory = 75.0 - 89.9 / Unsatisfactory < 75.0									

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DEPARTMENT OF THE AIR FORCE
737th TRAINING GROUP (AETC)
Joint Base San Antonio (JBSA)
Lackland Air Force Base, Texas 78236-5511

737 TRG OPERATING INSTRUCTION 36-3
17 Mar 2015

Personnel
BASIC MILITARY TRAINING (BMT)

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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OPR: 737 TRG/CCR (Mr. B. Miller) Certified by: 737 TRG/CD (Lt Col Fuller)

Supersedes 737 TRGOI 36-3, 4 Dec 2013 Pages: 210

The 737th Training Group (TRG) Instruction 36-3, establishes the policies, procedures and responsibilities for training in the 737 TRG. This instruction applies to all personnel assigned to the 737 TRG and 433 Training Squadron (TRS) to include DoD civilians and contrators that provide training or support BMT. Squadron supervisory personnel are defined as an instructor supervisor, flight commander, first sergeant, superintendent, director of operations and squadron commander. The squadron leadership team is defined as the squadron commander, director of operations, superintendent and first sergeant. Variances to this instruction are authorized as Airman Training Complexes (ATC) stand-up, document variances for inclusion in this instruction. NOTE: This instruction does not cover all possible training situations; therefore, use good judgment and common sense. Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) AFMAN 37-123, Management of Records and disposed of IAW the Air Force Records Disposition Schedule (RDS) available at https://afrims.amc.af.mil. Any issues regarding safety or risk management are immediately forwarded to 737 TRG leadership. The 737 TRG/CC is the waiver authority for instruction.

SUMMARY OF REVISIONS: This document contains changes from previously published 737 TRGOI 36-3, 4 Dec 2013. Revisions are identified in red font text, review instruction in its entirety.

emergency and an ambulance is not needed the CQ can call the 737 TRSS/CQ for a van to pick-up the trainee for a non-emergent transport to medical care.

Table. 8.1. Emergent Care

NOT AN EMERGENCY	EMERGENCY (CONTACT 671-0911)
Have the Trainee report to the squadron IDMT dispensary, Reid/Trainee Health Clinic or UCC within 24-48 hours.	*When you are not sure and if the Trainee appears to be in danger of losing life, limb or eyesight, it is never wrong to seek emergency care. Go to the emergency room or call 671-0911 for immediate assistance for the following:*
• Cold Symptoms (runny nose) for 48-72 hours • Feverish/night sweats for 24-48 hours • Bone, muscle or joint ache • Stomach pain • Skin problems (rash, sore) • Female health concerns • Arm/leg pain clearly not broken/messed up • Pain while urinating • Vomiting • Diarrhea • The trainee is speaking coherently, fully aware and in no signs of distress/discomfort	• Extreme pain or swelling (stomach, legs, arms or other parts of the body) • Major injury—could lose life, limb, or eyesight • No pulse or no breathing • Unconscious/Passed out • Gushing blood • Very confused • Breathing too fast to speak • You genuinely feel it's an emergent condition *Other examples of when to call 671-0911:* • If the person is choking and unable to speak or cry out • If the Trainee has swallowed poison or many pills • If the Trainee is getting active CPR or the Heimlich Maneuver

8.5. Shaving Waivers.

8.5.1. Pseudofolliculitis barbae (PFB), otherwise known as razor or shaving bumps is a common medical condition of the beard. Trainees with shaving problems must be identified early in training to prevent injury.

8.5.1. During the BMT Orientation briefing instructors must ask trainees if they have any known problems with shaving. Those identified are sent to the 737 TRSS IDMT for an evaluation. The IDMT issues a shaving waiver on the IMT Form 422, *Physical Profile Report* and outline shaving procedures. If necessary, the IDMT provides referrals and appointments for the Reid Shaving Clinic.

8.6. Issue of White Arm Band (Sickle Cell Trait Positive and Previous Heat Related Injuries).

8.6.1. Trainees who are vulnerable to injury (or death) based on prolonged strenuous exercise or have had a previous heat related injury are issued a white reflective arm band during BMT. Trainees wear the white arm band during all activities (while in all uniform combinations) through the Airman's Run.

8.6.2. The squadron DO executes the white arm band program. As the point of contact for the program, **the DO will**:

8.6.2.1. Verify all squadron personnel are trained on white arm band issuance, wear procedures and meaning.

8.6.2.2. Provide PT/Supply or designated squadron personnel with sufficient guidance to administer the program for squadron physical training.

8.6.2.3. Verify flight MTIs are conducting checks prior to any physical activity or appointment as dictated by the WAS.

8.6.2.4. Conduct weekly checks for white arm band compliance by cross-checking the roster against personnel actually wearing the white arm band.

8.6.2.5. Verify all squadron personnel are trained in work-rest cycles and hydration standards for BMT.

8.6.2.6. Immediately decertify and develop recertification protocols for MTIs found to be deficient enough to jeopardize trainee health due to noncompliance with white arm band Procedures, work-rest cycle, or hydration standards enforcement.

8.6.3. Early IS or PT/Supply NCO will print a current White Armband Report daily and allow every MTI to review the list during morning roll call. All MTIs will cross check white arm band reports with white arm bands worn every day prior to any appointment (MTIs) and prior to physical training (MTI and IDMT). MTIs and IDMTs will also comply with work/rest/hydration requirements and monitor individuals for potential medical problems. All MTIs, PT/Supply NCOs and IDMTs cross check the white arm band report with wearers through the Airman's Run.

8.6.4. Sickle Cell Trait Positive (SCT)/G6PD.

WARNING

Trainees testing positive for the sickle cell trait (SCT) are more susceptible to heat-related injuries. Undetected, or due to lack of preventive measures, the risk of injury or death to the trainee is increased substantially. Therefore, only those trainees CONFIRMED to test negative for SCT can participate in all BMT training activities. Trainees testing positive for sickle cell trait MUST have a white arm band issued by the squadron AND a medical briefing by the IDMT prior to participating in all BMT activities. FAILURE TO COMPLY WITH THE FOLLOWING GUIDANCE COULD RESULT IN TRAINEE INJURY OR DEATH.

8.6.4.1. Trainee blood draws are conducted on Thursday or Friday during processing week of training.

8.6.4.1.1. All trainees assigned to a 0 WOT flight MUST HAVE their blood drawn and tested. No trainee will participate in squadron PT until a confirmed blood draw AND a confirmed negative result.

8.6.4.1.2. The 737 TRSS scheduling office provides the Reid Clinic (59 LSQ) an electronic listing of the names of all incoming trainees. Reid clinic (559 MDG/SGOF) notifies the 737 TRSS scheduling office. IDMTs and squadrons Friday afternoon of any trainees that were a blood draw no-show.

8.6.4.1.3. MTIs confirm with Reid Clinic (59 LSQ) staff that all flight members received a blood draw prior to departure.

8.6.4.2. Reid Clinic personnel receive test results on Fridays, organize a list by squadron, and forward positive SCT/G6PD e-mail notification to the trainees' assigned squadron NLT 1900 Friday evening. Reid clinic will also send a courtesy e-mail to squadrons indicating no trainees in the flight are positive for either trait.

8.6.4.3. **The late evening IS will:**

8.6.4.3.1. Obtain the positive SCT/G6PD personnel list NLT 1900 Friday evening. If the positive list or courtesy e-mail is not received, notify Reid clinic immediately via telephone.

8.6.4.3.1.1. Verify all trainees on list are assigned to parent squadron. If not, notify Reid Clinic immediately via telephone.

8.6.4.3.2. Complete appointment slips for each trainee in their respective squadron identified as having a positive result. Appointment slips will inform trainees to be at the 323 TRS Dispensary (bldg 6578) by 0715 on Saturday. This is a **mandatory appointment**.

8.6.4.3.3. Contact and muster each trainee identified with a positive result to their Squadron CQ where they will be issued an appointment slip and white arm bands NLT 2000L on Friday. Individuals identified with only G6PD deficiency will require an appointment slip only (No white arm band required). All trainees issued a white arm band will require a BMT 105a comment from the late evening IS and acknowledged by the trainee and a witness. Comment will merely state trainee was notified of appointment and is required to attend a mandatory briefing at 323 TRS Dispensary at 0715 on Saturday.

8.6.4.4. On Saturday morning the PT/Supply NCO and 737 TRSS IDMTs will print the briefing list for their squadrons. This list will be verified on the PT pad with each 0 week flight prior to initial evaluations to ensure **NO** trainees positive for SCT or G6PD conduct PT prior to receiving the briefing at the 323 TRS Dispensary. If the trainee did not have an appointment slip or receive notification the night before, trainees identified from the cross check as positive sickle cell trait and/or G6PD will be promptly issued an appointment slip. Trainee's positive for SCT will be issued a white arm band at the owning squadron. Trainees are dismissed from PT immediately, sent to breakfast, and are required to report to the 323 TRS dispensary (bldg 6578) NLT 0715L.

8.6.4.5. SCT/GP6D Briefing Instructions.

8.6.4.5.1. Trainees report to their respective squadron CQ area at 0610.

8.6.4.5.2. 737 TRSS/IS or MTL will designate Holdover/Medical Hold Airmen to serve as escorts for trainees requiring escort to the SCT and/or G6PD briefing. All supported squadrons will receive an escort roster from 737 TRSS/CQ. Escorts will be in place at each respective squadron NLT 0610 to escort the trainees to eat breakfast and transit to the 323 TRS Dispensary. After breakfast, trainees are escorted to the 323 TRS Dispensary, Bldg 6582 NLT 0715 for the mandatory medical appointment (approximate 2 hour appointment). Escorts will remain until briefing is complete to accompany briefed trainees back to their squadrons.

NOTE

If escorts do not arrive at line squadrons to pick up trainees by 0610, contact the 737 TRSS/CQ immediately at 671-3507, or ensure trainees receive proper directions and a wingman to get to the medical appointment on time.

8.6.4.5.3. Medical personnel conducting briefings on Saturday morning will report to the 323 TRS dispensary (bldg 6578) immediately following PT, but NLT 0715.

NOTE

Due to the sensitivity of these discussions, medical personnel will discuss G6PD and positive sickle cell notifications with the trainees in a separate group setting divided by G6PD trainees and separate SCT trainees. One-on-one Q&A is available and offered and also a meeting with a medical provider is offered. Medical personnel will assist in filling out forms and answer any questions the trainee may have so the trainee fully understands the implications of their condition and the risks inherent in BMT.

8.6.4.6. **Medical Personnel (Reid Staff) will:**

8.6.4.6.1. Escort trainees to the briefing classroom.

8.6.4.6.2. Conduct roll call and sign in each trainee. Notify squadron CQ immediately by telephone of a trainee No-Show.

8.6.4.6.3. Follow up with No-Show/Show email to the distribution list identified in para 8.6.4.2. NLT 1200L. The squadron DO will ensure all No-Shows are re-scheduled for blood testing.

8.6.4.6.4. Issue SF 600, *Chronological Record of Care* and pamphlets to trainees as they sign in.

8.6.4.6.5. Conduct the G6PD briefing in group sessions followed by a question and answer session.

8.6.4.8.6. Conduct the Sickle Cell briefing in group sessions followed by a question and answer session.

8.6.4.8.6.1. If the trainee elects to not continue in training after the briefing, notify medical provider and refer to the Squadron Commander for ELS without prejudice.

8.6.4.8.7. Assist trainees with the completion and signing of the SF 600.

8.6.4.8.8. Check and collect each SF 600 before trainees are dismissed.

8.6.4.8.9. Update appropriate medical records after completion of all briefings for the day.

8.6.4.8.10. Forward completed roster to squadrons for BTMS update by Reid staff. MTI 105a comments will be limited to an MFR stating for example, "AB LAST, FISRT, MI" received medical briefing required for clearance for all BMT activities. Reid staff updates BTMS showing that a WAB is required and the individual attended SCT+ briefing.

8.7. Squadron Fever Flight (SFF), Quarters

8.7.1. Trainees diagnosed with a Febrile Respiratory Infection (FRI) are placed on quarters and sent back to their squadron for bed rest. Squadrons may use empty dormitories if the number of sick trainees exceeds the tunnel capacity.

8.7.2. All trainees with FRI are housed in their respective SFFs and adhere to standard infection control practices to include: wearing a surgical mask at all times while indoors; use of instant hand sanitizer at least 6 times per day; washing their hands at least 6 times a day, particularly before and after using the latrine; practicing good cough etiquette any time a surgical mask is not worn (i.e. coughing into their elbow).

8.7.3. Squadrons ensure that disinfection of common contact surfaces (i.e. bed rails and doorknobs) of their SFF room be accomplished with Wexcide at least twice a day.

8.7.4. All ill trainees may eat at the dining facility at normal meal times, but must sit a least 3 feet away from non-ill trainees, preferably at a separate table.

8.7.5. Trainees will not be discharged from their SFF until cleared by Reid Clinic Trainee Surveillance provider. Once returned to training, the squadron reviews any missed training and determine if it can be made-up to maintain an on-time graduation (return to original flight). If the training cannot be made-up, transfer trainee into a flight in order to make-up required training objectives.

8.7.6. If capacity to house trainees in the squadron (tunnel or open dorm) is exhausted, then transfer to the 737 TRSS. The 737 TRSS Fever Flight commences if housing or outbreak conditions are warranted.

8.8. Behavioral Analysis Service (BAS) Evaluations. The following guidance is provided for referrals to BAS for potential mental/behavioral problems:

BY ORDER OF THE COMMANDER

10TH MEDICAL GROUP INSTRUCTION 44-9

16 APRIL 2014

Medical

CADET SICKLE CELL TRAIT SCREENING PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: This publication is available electronically on the shared drive at: W:\General Information\MDG Instructions.
RELEASABILITY: There are no releasability restrictions on this publication.

OPR: 10 AMDS/SGPF Certified By: 10 MDG/SGA (Col Bonnie E. Goodale)
Supersedes 10 MDGI 49-9, 12 Jan 12 Pages: 9

This instruction provides guidelines for the testing and monitoring of USAFA cadets enrolled to Cadet/Flight Medicine clinic with sickle cell trait. Scope of responsibility: Physicians/PA/NP who function as primary providers assigned to the Cadet/Flight Medicine clinic. This instruction references DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* and AFI 48-123, *Medical Examinations and Standards* and requires the collection and maintenance of information protected by the Privacy Act of 1974. The requestor will show, and upon request, give the affected individual a Privacy Act Statement. Authority to obtain this information is Title 10, U.S. Code, Section 133 and 8013, and Executive Order 9397. The Health Insurance Portability and Accountability Act (HIPAA) signed into federal law in 1996, set national standards regarding security and privacy of a person's health information and define provision for electronic data interchange.

SUMMARY OF REVISIONS

This is a new instruction.

1. Introduction. Sickle Cell Trait (SCT) is a hereditary condition in which an individual is heterozygous for hemoglobin S (sickle hemoglobin). Generally SCT does not result in disease. There is increasing recognition in the medical community, however, that exposure to certain conditions can lead to exertional sickling of red blood cells in those with SCT. These conditions include altitude greater than 5000 feet, dehydration, illness, and the performance of strenuous physical exertion. In the past four decades, exertional sickling is believed to have led to the death of at least 15 football players, 9 of whom died in the past 7 years alone. Exertional sickling and its sequelae are preventable if training requirements are modified. In April 2010 the National Collegiate Athletic Association (NCAA) adopted the recommendations of the National Athletic Trainers Association (NATA) and the College of American Pathologists (CAP) by requiring all NCAA Division I institutions to offer SCT testing to all Division I athletes. The intent of the requirement is to identify SCT positive athletes for closer monitoring by the coaching and medical staff and for training modifications to prevent exertional sickling and associated sequelae. In August 2010, USAFA published guidelines bringing USAFA's athletic program into compliance

with NCAA requirements. Risk of injury and death due to SCT, however, is not restricted to elite NCAA Division I athletes. Exertional sickling has led to several deaths in U.S. Armed Forces basic trainees. Given the strenuous physical requirements and classes that all USAFA cadets complete including Basic Cadet Training (BCT), intra-mural sports, recognition events, Commandants Challenge, etc, it is appropriate to consider all USAFA cadets to be athletes. Furthermore, the physical altitude of the USAFA campus and the fact that illness is common among cadets during basic training both increase the risk of exertional sickling in any USAFA cadet with the sickle cell trait. Therefore, it is appropriate to identify all SCT positive cadets for monitoring and potential training modifications. Currently, all USAFA cadets are tested for SCT upon entrance to USAFA IAW DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* and AFI 48-123, *Medical Examinations and Standards.*

1.1. The purpose of this instruction is to describe the process whereby cadets who test positive for SCT are identified to appropriate staff including: Cadet/Flight Medicine providers, Safety Medical Officers (SMO), training cadre, and cadet squadron leadership (Air Officer Commanding (AOC)).

1.2. Counseling should be given by the Cadet/Flight Medicine staff to SCT positive cadets and their training cadre, to discuss the signs and symptoms of exertional sickling. Additional counseling will be given for training modifications for SCT positive cadets, and the emergency response procedures related to exertional collapse in SCT positive cadets.

2. Program Operations.

2.1. Hemoglobin S screening results of entering basic cadets will be maintained in a 10 AMDS/SGPF database.

2.2. Each SCT positive cadet will be contacted.

2.2.1. SCT positive cadets will have a counseling session with a healthcare provider (HCP) regarding their condition. This counseling will be documented in the cadets' medical records.

2.2.2. SCT positive cadets will be provided with materials (Attachment 2) supporting the counseling above and describing the training and exercise modifications that may be necessary to reduce their risk of exertional sickling.

2.3. The AOC of each basic cadet who tests positive for SCT will be identified.

2.4. Each AOC with a basic cadet positive for SCT will be contacted.

2.4.1. Each contacted AOC will be provided with materials (Attachment 3) describing SCT, the training modifications that may be necessary for SCT positive cadets, and the recommended training personnel who should be made aware of SCT positive cadets' status.

2.4.2. Disclosure of cadets' SCT status to AOCs will be documented IAW 10 MDG Health Insurance Portability and Accountability Act (HIPAA) compliance directives.

2.5. Cadet Clinic medical personnel will be familiar with exertional sickling emergency response procedures (Attachment 4).

3. Responsibilities.

3.1. The Chief of Preventive Medicine will:

3.1.1. Ensure the maintenance and currency of the SCT database.

3.1.2. Ensure that AOCs with cadets positive for SCT have been notified, counseled, and provided with educational materials.

3.1.3. Ensure documentation of cadet counseling regarding SCT positivity.

3.1.4. Conduct initial training regarding the SCT screening program and exertional sickling emergency response procedures for all cadet clinic HCPs and EMTs, or delegate such training to an appropriate subordinate. With the coordination of the Commandant of Cadets, cadet cadre EMTs may receive the training as well.

3.1.5. Ensure that SCT educational materials for cadets and AOCs are current and available.

3.1.6. Ensure that exertional sickling emergency response procedures are current.

3.1.7. Maintain and update this MDGI as appropriate.

3.2. Cadet Clinic HCPs will:

3.2.1. Conduct appropriate SCT counseling for SCT positive cadets, as well as provide them with educational materials. This counseling will be documented in the cadets' medical records.

3.2.2. Contact AOCs with SCT positive cadets and provide such AOCs with educational materials. This interaction will be documented in the cadets' medical records.

3.2.3. Document AOC notifications in compliance with 10 MDG HIPAA directives.

3.2.4. Update the SCT screening database appropriately.

3.2.5. Be familiar with exertional sickling emergency response procedures.

3.3. Cadet Clinic Independent Medical Technicians and 4N/Emergency Medical Technicians (EMT) will be familiar with exertional sickling emergency response procedures.

//SIGNED//
TIMOTHY D. BALLARD, Col, USAF, MC, CFS
Commander

Attachments:
1. SCT Positive Cadet Educational Pamphlet
2. AOC Educational Memorandum
3. Exertional Sickling Emergency Response Procedures

Attachment 1

SCT Positive Cadet Educational Pamphlet

Questions and Answers about Sickle Cell Trait (SCT)

Q1. What is SCT?
A1. SCT is a medical condition in which a person has one gene for normal hemoglobin and one gene for sickle hemoglobin. Hemoglobin is the molecule in red blood cells that carries oxygen.

Q2. How did I get SCT?
A2. SCT is almost always hereditary; in other words, you inherited your sickle gene from one of your biological parents.

Q3. Does this mean I have Sickle Cell Disease?
A3. No, you would have to have two copies of the sickle hemoglobin gene to get Sickle Cell Disease.

Q4. Does this mean I can't be in the Air Force? Does it mean I can't be a pilot? Will it hurt my career?
A4. Unless you have had a sickle crisis of some kind before, having SCT should have no impact on your ability to join the Air Force or to apply for aircrew training. Having SCT should not impact your military career.

Q5. What are the risks of SCT?
A5. During Basic Cadet Training, and at other times in your USAFA career, you will undergo rigorous physical training. This training might cause some of your red blood cells to "sickle". When red blood cells sickle, they change shape and can block blood vessels. Sickled red blood cells can hurt your kidneys, spleen, and/or muscles. Very rarely, hospitalization and/or death are possible.

Q6. I've never had a problem with exercise before. Why should I be concerned about it now?
A6. It is possible that USAFA physical training will be more rigorous than any physical training you have experienced before. Also, you will be at high altitude and may be ill during Basic Cadet Training – both of which increase the risk of sickling in people with SCT.

Q7. How do I minimize the risks?
A7. There is a lot you can do to minimize your risk of sickling.

- In general, you should exercise at your own pace.
- Engage in a slow and gradual conditioning regimen.
- Use adequate rest and recovery between repetitions. You should not exert yourself at maximum for more than two minutes without a rest.

- Be excused from timed sprinting drills or maximal exertion timed runs.
- Stop activity immediately upon struggling or experiencing symptoms such as muscle pain, abnormal weakness, abnormal fatigue, or breathlessness.
- Stay well hydrated at all times, especially in hot and humid conditions.
- Avoid strenuous exercise when you are ill, especially if you have a fever.
- Seek medical care immediately if you feel unusually unwell.

Q8. Will my training cadre disapprove of me or give me poor performance ratings if I follow the recommendations above?
A8. Your AOC, and such other training cadre as he or she sees fit to notify, will be aware of your SCT status and will know about the recommendations.

Q9. What if I don't want my AOC to know about my SCT?
A9. Because your AOC is responsible for your personal safety, he or she has a right to be aware of your SCT status. It is not possible to keep your SCT status from your AOC. Your AOC may see fit to inform other training cadre, such as your AMTs, flight commander, and SMOs. You may, however, ask your AOC to notify as few other people as possible. Also, your healthcare provider will not tell your AOC anything more than the absolute minimum necessary for your AOC to ensure your safety.

Q10. Is it possible that I could pass SCT on to my children?
A10. About half of your children will inherit SCT. If you have a child with someone who also has SCT, there is about a 25% chance that child could have full-fledged Sickle Cell Disease. If you have a child with someone who has Sickle Cell Disease, there is about a 50% chance that child will have Sickle Cell Disease as well. Your healthcare provider can give you counseling about how to approach having children and can refer you to a genetic counselor, if necessary.

Q11. What if I think of other questions?
A11. Your healthcare provider will always be happy to answer your questions about SCT. Schedule an appointment at the Cadet Clinic if you want to talk more about SCT.

Attachment 2

AOC Educational Memorandum

DEPARTMENT OF THE AIR FORCE
10TH MEDICAL GROUP
USAF ACADEMY, COLORADO

Date

MEMORANDUM FOR: AOC

FROM: 10 AMDS/SGPF

SUBJECT: Cadets with Sickle Cell Trait

1. You are receiving this memorandum because one or more cadets under your command has been identified as having Sickle Cell Trait (SCT). SCT is a medical condition that, while not disqualifying for entry into USAF service, can have implications for a cadet's health during rigorous physical training.

2. Cadets with SCT have one gene for normal hemoglobin and one gene for sickle hemoglobin. Hemoglobin is the molecule in red blood cells that carries oxygen. Under normal conditions, people with SCT have no limitations or symptoms. There is increasing medical evidence, however, that when subjected to strenuous physical exertion, particularly in a high altitude setting where hydration can be an issue, people with SCT will experience some "sickling" of their red blood cells. These sickled red blood cells can block blood vessels and can lead to damage to the kidneys, spleen, and/or muscles. Rarely, such damage can be incapacitating and life-threatening.

3. Sickling can be prevented in people with SCT, even in a strenuous training environment, by following simple guidelines and allowing modifications to military and physical training regimens. Cadets with SCT should:

a. set their own pace.

b. engage in slow and gradual conditioning regimens.

c. receive adequate rest and recovery between repetitions of strenuous/maximal physical exertion. A good rule of thumb is that cadets with SCT should not exert themselves at maximum effort for greater than two minutes without a period of rest and recovery.

d. allow for additional recovery time between PFT and AFT and during PFT. If Cadet is symptomatic during PFT must be allowed to seek treatment and retake the fitness testing at a later time.

e. stop activity immediately upon struggling or experiencing symptoms such as muscle pain, abnormal weakness, abnormal fatigue, or breathlessness.

f. stay well hydrated at all times and be allowed hydration during physical fitness testing.

g. refrain from extreme exercise during illness.

h. seek prompt medical care when experiencing unusual distress.

4. To ensure that SCT cadets are not required to train beyond their ability, it might be advisable to inform other members of your squadron's training cadre of each SCT cadet's identity. Such personnel might include the AMTs, the flight commanders, and/or the squadron SMOs.

5. If you have any questions about SCT and its implications, please feel free to contact me at darren.campbell@usafa.af.mil. You may also contact Lt Col (Dr.) Witkop at catherine.witkop@usafa.mil.

//SIGNED//
DARREN E. CAMPBELL, Lt Col, USAF, MC
Chief, Primary Care/Sports Medicine

Attachment 3

Exertional Sickling Emergency Response Procedures

1. Know the signs and symptoms of SCT Collapse. It is different from collapse due to cardiac arrhythmia or heat exhaustion/cramping.

A. It often occurs within the first half-hour of strenuous physical exertion.
B. There is generally no prodrome.
C. The patient is generally lucid and still able to talk.
D. The patient generally does not have muscle cramps or excruciating pain, but may complain of muscle weakness and soreness and an inability to go on.
E. The patient recovers fairly rapidly upon cessation of exercise.

2. Take appropriate measures:

A. Allow the patient to rest.
B. Obtain vital signs.
C. Administer high flow oxygen at 15 Lpm with a non-rebreather facemask.
D. Cool the athlete, if necessary.
E. If the athlete becomes obtunded or as vital signs decline, activate EMS, attach an AED, obtain IV access, and transport the patient to higher echelon of care ASAP.
F. Warn the higher echelon to consider rhabdomyolysis in their differential diagnosis.

Taken from the Consensus Statement on Sickle Cell Trait and the Athlete, National Athletic Trainers' Association, June 2007.

INTENTIONALLY

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Department of Defense
INSTRUCTION

NUMBER 6465.01
July 17, 2015

USD(P&R)

SUBJECT: Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency (G6PD) and Sickle Cell Trait Screening Programs

REFERENCES: See Enclosure 1

1. PURPOSE. This instruction:

a. Reissues DoD Instruction 6465.1 (Reference (a)) in accordance with the authority in DoD Directive 5124.02 (Reference (b)) to establish policy, assign responsibilities, and provide procedures for G6PD and sickle cell trait screening, in accordance with sections 1074a and 10206 of Title 10, United States Code (Reference (c)) and DoD Directive 6200.04 (Reference (d)).

b. Establishes screening requirements for the presence of G6PD deficiency in all personnel entering the Military Services and those Service members on active duty who have not previously been tested.

c. Establishes screening requirements for sickle cell trait following established clinical and preventive medicine recommendations for the Military Services' operational requirements.

2. APPLICABILITY. This instruction applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this instruction as the "DoD Components").

3. POLICY. It is DoD policy that:

a. All personnel entering the Military Services will be screened for G6PD deficiency.

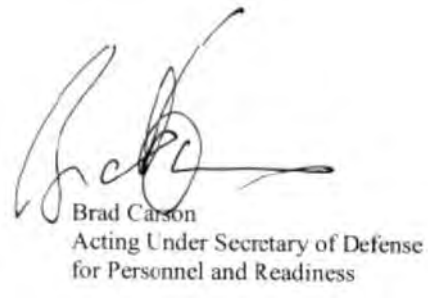
b. Sickle cell trait screening will be done according to Service-specific operational requirements.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES: See Enclosure 3.

6. RELEASABILITY. **Cleared for public release**. This instruction is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

7. EFFECTIVE DATE. This instruction is effective July 17, 2015.



Brad Carson
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure
1. References
2. Responsibilities
3. Procedures

Glossary

ENCLOSURE 1

REFERENCES

(a) DoD Instruction 6465.1, "Hemoglobin S and Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency Testing Program," July 29, 1981 (hereby cancelled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) Title 10, United States Code
(d) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004, as amended
(e) DoD Instruction 8320.02, "Sharing Data, Information, and Information Technology (IT) Services in the Department of Defense," August 5, 2013
(f) DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014
(g) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(h) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(i) DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
(j) DoD Instruction 6040.45, "Service Treatment Record (STR) and Non-Service Treatment Record (NSTR) Life Cycle Management," October 28, 2010

ENCLOSURE 2

RESPONSIBILITIES

1. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for Health Affairs:

a. Oversees the development and implementation of the G6PD and sickle cell trait screening programs.

b. Recommends changes or revisions to policy and issues Military Health System guidance, as necessary, to implement this instruction.

c. Establishes performance measures and goals, provides guidance for the development of metrics, and monitors metrics implementation and analysis.

d. Requires appropriate information sharing, except where limited by law, policy, or security classification. Data produced as a result of the assigned responsibilities must be visible, accessible, and understandable to the rest of the DoD, as appropriate, in accordance with DoD Directive 8320.02 (Reference (e)), DoD Directive 5400.11 (Reference (f)), DoD 5400.11-R (Reference (g)), and DoD 6025.18-R (Reference (h)).

e. Ensure that the policies and procedures of this instruction are implemented to protect the privacy of individuals in the collection, use, maintenance, and distribution of personally identifiable information, as required by References (f) and (g).

2. DIRECTOR, DEFENSE HEALTH AGENCY. Under the authority, direction, and control of the Assistant Secretary of Defense for Health Affairs, the Director, Defense Health Agency:

a. Establishes implementation procedures in a Defense Health Agency procedural instruction.

b. Monitors the implementation of this instruction.

c. Establishes quality assurance and quality control parameters for the uniform implementation of the G6PD screening program, and defines follow-on education activities for those with G6PD deficiency.

d. Establishes minimum requirements and criteria for the development of Service-specific requirements during the implementation of the sickle cell trait screening program, and defines follow-on education activities for those with sickle cell trait.

e. Establishes quality assurance and quality control parameters for defined inclusion criteria in the implementation of a sickle cell trait screening program by the Military Services.

3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT OF THE U.S. COAST GUARD. The Secretaries of the Military Departments and the Commandant of the U.S. Coast Guard:

a. Develop and implement a comprehensive plan to screen for G6PD deficiency.

(1) Ensure all Service members are screened upon entry for G6PD deficiency and assessed to determine whether the condition found during the testing is consistent with continuation of military service, in accordance with DoD Instruction 6130.03 (Reference (i)).

(2) Develop medical education programs for all Service members identified during the screening for G6PD deficiency and ensure the programs include the nature of the condition with associated risk factors and activities in all areas, including operational, occupational, environmental, and recreational.

(3) Ensure Service members identified to have G6PD deficiency participate in selected medical education programs.

(4) Ensure medical personnel are trained in the administration of a comprehensive medical education program on G6PD deficiency.

b. Develop and implement a comprehensive plan to screen for sickle cell trait.

(1) Define case definition criteria, special situations and populations, operational requirements, and clinical indications in the sickle cell trait screening plan.

(2) Develop medical education programs for all Service members identified during the screening for sickle cell trait.

(3) Ensure the medical education program includes the nature of the condition with associated risk factors and activities in all areas including operational, occupational, environmental, and recreational, as well as the genetic implications.

(4) Include mitigation strategies and self-awareness assessments along with Service-specific restrictions and requirements in the education programs.

c. Provide the necessary resources to support these programs.

ENCLOSURE 3

PROCEDURES

1. G6PD SCREENING PROCESS

a. All personnel entering or on active duty in the Military Services will be screened for the presence of G6PD deficiency and results will be documented in their electronic health record (EHR) and in the Service Treatment Record when the EHR is not accessible in accordance with DoD Instruction 6040.45 (Reference (j)).

b. Personnel who already have been screened do not need to be retested, provided documentation in the Service member's EHR and Service Treatment Record is adequate.

c. Personnel identified as having G6PD deficiency will participate in an educational program directed by trained medical personnel.

d. Participation in the educational program for personnel identified as having G6PD deficiency must be documented in the Service member's EHR (or Service Treatment Record when the EHR is not accessible).

2. SICKLE CELL TRAIT SCREENING PROCESS

a. Sickle cell trait screening will be done only on those Service members who meet demographic, clinical, or operational criteria as developed by the Military Services.

b. The results of testing must be documented into the Service member's EHR (or Service Treatment Record when the EHR is not accessible).

c. Personnel identified as having sickle cell traits will participate in an educational program administered by trained medical personnel, documented in accordance with paragraph 1d of this enclosure.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

EHR electronic health record

G6PD glucose-6-phosphate dehydrogenase

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this instruction.

G6PD. A red blood cell enzyme that catalyzes the first step in a metabolic pathway that serves as precursor for important molecules. The red blood cell is particularly dependent on G6PD for protection against oxidative stress because, unlike other cells in the body, red blood cells lack a nucleus, mitochondria, and other organelles necessary to produce the proteins involved in alternate pathways that can generate nicotinamide adenine dinucleotide phosphate, responsible for cellular respiratory, oxidative, burst. Red blood cells deficient in G6PD are therefore susceptible to oxidation and hemolysis under conditions of oxidative stress.

G6PD deficiency. The most prevalent human enzyme deficiency in the world, the disorder stems from an intrinsic metabolic defect of the red blood cells. The majority of people with G6PD deficiency are unaware of their status, living out their lives with no anemia, no symptoms, and no complications. The disorder becomes recognized when an episode of acute hemolysis (rupture of the red blood cell) is triggered by exposure to oxidant drugs, infection, or ingestion of fava beans.

personally identifiable information. Information that can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, including any other personal information that is linked or linkable to a specified individual.

screening. A method of surveillance used in a population to identify an unrecognized disease in individuals without signs or symptoms.

sickle cell trait. All conditions in which an individual carries the sickle hemoglobin gene mutation on only one beta globin gene. If the other beta globin gene is normal, the individual has sickle cell trait, which is not a disease and does not alter the individual's life expectancy. Individual knowledge of carrier status is important for family planning to assist in the prevention of new cases of sickle cell disease. Sickle cell trait is generally a benign carrier condition, usually with none of the symptoms of sickle cell anemia. In rare instances some individuals with sickle cell trait, when subjected to the extremes of exertion, in particular when compounded by the environmental challenges of altitude or heat, have been shown to possess an increased

relative risk for organ infarct, fulminant exertional rhabdomyolysis, and exertional nontraumatic sudden death.

sickle cell disease. A hereditary condition, also called sickle cell anemia, that causes a type of faulty hemoglobin in red blood cells. Some red blood cells can become hard, change shape and don't move well through the smallest blood vessels. This can stop or slow blood flow to parts of the body, causing less oxygen to reach these areas. The sickle cells also die earlier than normal blood cells, which can cause a shortage of red blood cells in the body. For most people, there is no cure for sickle cell disease.

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

22 Mar 2016

MEMORANDUM FOR RECORD

FROM: Ground Accident Investigation Board President

SUBJECT: Department of Defense and Air Force Policy on Sickle Cell Trait screening

1. The governing policy for screening for Sickle Cell Trait (SCT) in the Department of Defense (DoD) is DoD Instruction 6465.01, dated July 17, 2015. The instruction directs each military service to establish their own SCT screening program.

2. According to DoDI 6465.01, the Air Force is required to develop a comprehensive SCT screening policy related to, among other things, developing medical education programs that address the nature of the condition with associated risk factors and activities (operational, environmental, and recreational), to include SCT mitigation and self-awareness strategies.

3. Current Air Force SCT policies are found in 737 TRG Operating Instruction 36-3, *Basic Military Training (BMT)*, dated 17 March 2015, and in 10 MDGI 44-9, *Cadet Sickle Cell Trait Screening Program*, dated 16 April 2014. I have reviewed the Member of Concern's medical records. He was screened at Basic Military Training and received some education on the condition and how he could mitigate risks of complications. I currently serve at HQ AMC/SG. I am not aware of efforts taken at higher headquarter concerning whether different screening and education programs are necessary in light of DoDI 6465.01 requirements.

MICHAEL J. WOOD, Colonel, USAF, MC, FS
President

UNRIVALED GLOBAL REACH FOR AMERICA ... ALWAYS!

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AIR MOBILITY COMMAND

Posted 10/9/2014 Printable Fact Sheet

Air Mobility Command, activated on June 1, 1992, is a major command headquartered at Scott Air Force Base, Ill. AMC provides worldwide cargo and passenger delivery, air refueling and aeromedical evacuation. The command also transports humanitarian supplies to hurricane, flood and earthquake victims both at home and around the world.

Mission
Air Mobility Command's mission is to provide global air mobility ... right effects, right place, right time.

Vision
Unrivaled Global Reach for America...ALWAYS!

Personnel and Resources
More than 133,700 active-duty, Air National Guard, Air Force Reserve Command and Department of Defense civilians make the command's rapid global mobility operations possible.

Organization
AMC has one numbered air force, 17 Wings, two airlift groups and one air base group.

18th Air Force -- Headquartered at Scott AFB, 18th Air Force's mission is tasking and executing all air mobility missions. Units reporting to 18 AF include 11 airlift, air mobility and air refueling wings; one airlift group, and the 618th Air and Space Operations Center or Tanker Airlift Control Center.

Photos

The AMC shield

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Wings flying airlift, air mobility and air refueling missions are located at Joint Base Andrews, Md; Joint Base Charleston, S.C.; Dover AFB, Del.; Fairchild AFB, Wash.; Little Rock AFB, Ark.; MacDill AFB, Fla.; Joint Base Lewis-McChord, Wash.; McConnell AFB, Kan.; Joint Base McGuire-Dix-Lakehurst, N.J.; Scott AFB, Ill. and Travis AFB, Calif. The airlift group is at Dyess AFB, Texas.

There is one contingency response wing at Joint Base MDL. The 18th Air Force also leads two air mobility operations wings in Germany and Hawaii.

The last organization reporting to 18th AF is the 618th Air and Space Operations Center (TACC). Located at Scott AFB, the TACC is AMC's execution arm for providing America's global reach. It plans, schedules and directs mobility aircraft in support of combat delivery and strategic airlift, air refueling and aeromedical evacuation operations around the world.

U.S. Air Force Expeditionary Center -- AMC has one major direct reporting unit, the U.S. Air Force Expeditionary Center located at Joint Base MDL. The center serves as the Air Force's premier organization for expeditionary innovation, education, training and exercises.

Reporting to the USAF EC are three air base wings located at Joint Base Charleston, Grand Forks AFB, N.D., and Joint Base MDL. Also reporting to the USAF EC is an air base group located at Joint Base Lewis-McChord and an airlift group at Pope Field, N.C. They all provide installation support to the myriad organizations on their bases and provide mission-ready expeditionary service members to combatant commanders in support of joint and combined operations.

Capabilities
Airlifters provide the capability to deploy American armed forces anywhere in the world and keep them supplied. Air refuelers are the lifeline of global reach, increasing range, payloads and flexibility. Air Force tankers can also refuel Navy, Marine and NATO aircraft and have an inherent cargo-carrying capability. Aeromedical evacuation missions transport wounded and injured service members to critical care hospitals far away from the battle space.

History
Air Mobility Command activated on June 1, 1992, when the Military Airlift Command and Strategic Air Command were inactivated. Elements of those two organizations, MAC's worldwide airlift system and SAC's KC-10 and KC-135 tanker force, combined to form AMC. Three tanker bases also joined AMC. They were Grand Forks AFB, McConnell AFB and Fairchild AFB.

AMC has undergone considerable change since its establishment. Focusing on the core mission of strategic air mobility, the command divested itself of infrastructure and forces not directly related to global reach. The Air Rescue Service, intratheater aeromedical airlift forces based overseas and much of the operational support airlift fleet transferred to other commands.

On Oct. 1, 2003, AMC underwent a major restructuring by reactivating 18th Air Force and re-designating its two former numbered air forces as the 15th and 21st EMTFs.

(Current as of August 2013)

Point of Contact
Air Mobility Command, Office of Public Affairs; 402 Scott Drive, Unit 1-M-8; Scott Air Force Base, Ill. 62225; DSN 779-7843 or (618) 229-7843.
email: amc-pao@us.af.mil.

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18TH AIR FORCE

Posted 2/20/2014 **Printable Fact Sheet**

The 18th Air Force, headquartered at Scott Air Force Base, Ill., was reactivated Oct. 1, 2003 as the operational component of Air Mobility Command. It is AMC's only numbered air force and the Air Force's largest NAF.

Mission
Eighteenth Air Force's mission is to present air mobility forces to combatant commanders. It is charged with carrying out AMC's operational role as Air Forces Transportation (AFTRANS), the air component of U.S. Transportation Command.

Resources
Eighteenth Air Force's mobility aircraft include the C-5 Galaxy, KC-10 Extender, C-17 Globemaster III, C-130 Hercules, and KC-135 Stratotanker. Operational support aircraft include the VC-25 (Air Force One), C-21, C-20, C-32, C-37, and C-40.

Personnel
Eighteenth Air Force has an assigned active duty military and civilian workforce of approximately 37,000 people.

Organization
Eighteenth Air Force, commanded by a three-star general, is charged with executing air mobility missions worldwide. Active duty units reporting to 18th Air Force include the following:
Dover AFB, Del. - 436th Airlift Wing
Dyess AFB, Texas - 317th Airlift Group
Fairchild AFB, Wash. - 92nd Air Refueling Wing
Incirlik AB, Turkey - 385th Air Expeditionary Group
Joint Base Andrews, Md. - 89th Airlift Wing
Joint Base Charleston, S.C. - 437th Airlift Wing
Joint Base Lewis-McChord, Wash - 62nd Airlift Wing
Joint Base McGuire-Dix-Lakehurst, N.J. - 305th Air Mobility Wing
Little Rock AFB, Ark. - 19th Airlift Wing
MacDill AFB, Fla. - 6th Air Mobility Wing
McConnell AFB, Kan. - 22nd Air Refueling Wing
Scott AFB, Ill. - 375th Air Mobility Wing
- 618th Air and Space Operations Center (Tanker Airlift Control Center)
Travis AFB, Calif. - 60th Air Mobility Wing

Photos

18th Air Force shield

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The 618 AOC serves as AFTRANS' air operations center, planning and directing tanker and transport aircraft operations around the world.

History
Organized on March 28, 1951, at Donaldson AFB, S.C., and assigned to Tactical Air Command, the primary mission of the 18th Air Force (Troop Carrier) was training troop carrier crews. Immediately after activation, it began to provide trained troop carrier crews and other personnel for the Korean War.

Redesignated as 18th Air Force on June 26, 1951, it quickly became involved with numerous activities including troop movements in the continental United States, defense early warning (DEW) line operations in numerous Allied nations, and support of U.S. efforts at the South Pole in Antarctica.

During this period, there were 16 troop carrier wings assigned to 18th Air Force flying C-45, C-46, C-47, C-54, C-82, C-119, C-122, C-124 and C-130 aircraft. Additionally, some wings flew H-19 and H-21 helicopters as well as the L-5, L-16 and L-20.

As part of the implementation of the Single Manager Airlift Service concept for the Air Force, 18th Air Force moved on Sept.1, 1957, to Waco, Texas, and transferred its troop carrying aircraft to the Military Air Transport Service (MATS). The command received other combat units as it assumed command responsibilities for all TAC bases and organizations in the south central and western states. During the short time 18th Air Force was in Waco, assigned wings flew KB-29, KB-50, F-84, F-100 and F-101 aircraft.

Eighteenth Air Force had hardly settled into its new home and mission when it was inactivated. On Jan. 1, 1958, 18th Air Force was inactivated and all personnel and equipment were transferred in place to the newly reactivated 12th Air Force.

Since its reactivation in 2003 as AMC's only numbered air force, the 18th Air Force has led the global mobility enterprise in a vast array of missions with global impact. Besides playing a prominent role in Iraq and Afghanistan airlift, airdrop, aeromedical evacuation and air refueling missions, the command conducted humanitarian assistance and disaster relief operations in Haiti, Pakistan and Japan, as well as refueling operations supporting the United Nations' no fly zone over Libya.

As they have throughout the command's history, the people and aircraft of the 18th Air Force continue to work hard to deliver the promise of global reach for America.

(Current as of Feb 2014)

Point of Contact
18th Air Force Public Affairs Office; 709 Ward Dr, Ste 248; Scott AFB, IL 62225, DSN 779-0483 or (618) 229-0483.
email: 18.af.pa@us.af.mil

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FACT SHEET

U.S. Air Force Fact Sheet
SCOTT AIR FORCE BASE

About Scott AFB
Scott Air Force Base is a global mobility and transportation hub for the Department of Defense. The base is home to several command and control elements that represent logistics for the United States military in air, over land and across the sea in a true joint environment that brings together the Army, Navy, Air Force, Marines and Coast Guard members--active duty, Guard and Reserve! Team Scott partners are collectively responsible not only for managing the global mobility missions around the world, but also aeromedical evacuation, senior leader airlift and aerial refueling capabilities for the Air Force and DoD.

Scott AFB is home to some of the nation's most important organizations--including U.S. Transportation Command, Air Mobility Command, the 618th Air and Space Operations Center (Tanker Airlift Control Center), and Air Force Network Integration Center, which are just a few of the 30 partner units stationed here. It's also one of four bases in the Air Force to host both a Reserve unit, the 932nd Airlift Wing, and an Air National Guard unit, the 126th Air Refueling Wing.

375th Air Mobility Wing
The 375th Air Mobility Wing is the installation's host wing. It is made up of four groups--the 375th Operations; Mission Support; Medical and Communications Groups--as well as 14 staff agencies.

Mission
The mission of the 375th AMW is to provide mission-ready Airmen and capabilities to enable rapid global mobility.

Vision
The vision of the 375th AMW is to be the Air Force's premier mission execution and support platform.

We will be the role model for streamlined operations, mission and community partnerships, innovative and cost-effective capabilities, and superior customer service; powered by professional Airmen and a culture of integrity,

375th Operations Group - The 375th Operations Group is comprised of three airlift squadrons, an air refueling squadron, an operations support squadron, an aeromedical evacuation squadron which extends over three operating locations, and a combat flight inspection Detachment. It executes all three of Air Mobility Command's core capabilities (airlift, air refueling, and aeromedical evacuation) by providing operational support airlift with C-21A aircraft at three U.S. and one deployed location; DV special airlift missions via an association with Air Force Reserve Command's 932nd Airlift Wing; global air refueling support via an association with the Air National Guard's 126th Air Refueling Wing; and operates aeromedical evacuation systems on seven air mobility platforms for inter/intra-theater casualty movement.

Additionally, the group develops emerging technology procedures for integration into U.S. Air Force flight operations and conducts worldwide combat flight inspections on Federal Aviation Administration-owned aircraft. Finally, the group has responsibility for C/NC-21A aircraft maintenance, operations support for deployment of combat-ready aircrews and aircraft

worldwide, and all airfield operations and management, including air traffic control of the joint-use Scott AFB/Mid America Airport called home by three flying wings.

375th Mission Support Group - The 375th Mission Support Group provides base-level support to all organizations assigned to Scott. The units that belong to the group provide a variety of services to the base community. The group is composed of five squadrons: the 375th Civil Engineer Squadron, the 375th Force Support Squadron, the 375th Security Forces Squadron, the 375th Logistics Readiness Squadron, and the 375th Contracting Squadron.

375th Medical Group - The 375th Medical Group supports the 375th Air Mobility Wing in the global reach mission by providing, expanding, and deploying medical capability for contingency taskings. The medical group trains 60 personnel annually through four specialty training programs and sustains the readiness skills of more than 850 active duty and Air Reserve Component personnel. In addition to the medical group's readiness mission, it provides health services for more than 60,000 beneficiaries of the Team Scott community and the surrounding areas, as well as 1,500 aeromedical patients. The medical group is accredited by the Accreditation Association for Ambulatory Health Care, American Dental Association, and College of American Pathologists and has affiliations with the American Hospital Association, and American Medical Association. The group is comprised of four squadrons: the 375th Aerospace Medicine Squadron, the 375th Medical Operations Squadron, the 375th Medical Support Squadron, and the 375th Dental Squadron.

375th Communications Group - The 375th Communications Group enables combat power for the 375th Air Mobility Wing in its global reach mission by providing command, control, communications and computer support to DoD, TRANSCOM, AMC, 18th Air Force, SDDC, AFNIC, three flying wings, 31 tenant units and direct support to the 618th Air and Space Operations Center's global mission. The group consists of two squadrons and a direct-reporting flight with more than 600 military and civilian personnel who help direct, control and enhance the command and control capabilities for Scott AFB. The two squadrons are 375th Communications Squadron and 375th Communications Support Squadron and the Plans and Resources Flight is the direct reporting flight.

375th Staff Agencies - The wing staff agencies are the historian, protocol, public affairs, inspector general, command post, legal office, safety, comptroller, equal opportunity, sexual assault prevention and response officer, the Inspector General, chapel, and the AFSO21 office. These agencies provide trusted counsel to the installation commander.

PARTNER UNITS

The 375th Air Mobility Wing hosts some of the nation's most important organizations - including U.S. Transportation Command, Military Surface Deployment and Distribution Command, Air Mobility Command, 18th Air Force, the Air Force Network Integration Center, Defense Systems Information Agency, the Air Force Reserve's 932 Airlift Wing, and the Air National Guard's 126th Air Refueling Wing.

U.S. Transportation Command - United States Transportation Command is responsible for creating and implementing world-class global logistics solutions in support of the President, Secretary of Defense and combatant commander assigned missions. TRANSCOM, one of 10 combatant commands, provides common-user and commercial air, land and sea transportation; terminal management; and aerial refueling to support the global deployment, employment, sustainment and redeployment of U.S. forces. TRANSCOM serves as the Distribution Process Owner and Mobility Joint Force Provider and provides Department of Defense global patient movement.

Military Surface Deployment and Distribution Command - The Military Surface Deployment and Distribution Command's (SDDC) mission is to provide global surface deployment and distribution services to meet the nation's objectives. SDDC executes command and control of all global surface movement of DoD equipment, cargo, vehicles, and household goods, and operates 24 worldwide seaports. SDDC achieves success in deploying and sustaining more than 90 percent of the DoD's equipment and supplies by leveraging the capability of

commercial industry and other military services.

Air Mobility Command - Air Mobility Command's (AMC) mission is to provide global air mobility ... right effects, right place, right time. The command also plays a crucial role in providing humanitarian support at home and around the world. AMC Airmen--active duty, Air National Guard, Air Force Reserve and civilians--provide airlift and aerial refueling for all of America's armed forces. Many special duty and operational support aircraft and stateside aeromedical evacuation missions are also assigned to AMC.

18th Air Force - The 18th Air Force is charged with tasking and executing all air mobility missions. As part of its warfighting role, the 18th Air Force commands assigned forces, presents air mobility forces (airlift and air refueling) and supports forces to the combatant commanders through USTC. The 18th Air Force commander acts as the Air Force's Transportation commander and Joint Force Air Component commander when so designated. The 618th Air and Space Operations Center, also located at Scott, functions as the hub for planning and directing tanker and transport aircraft operations worldwide. Created to centralize command-and-control responsibilities, the 618th AOC plans, schedules and tracks tanker, airlift and aeromedical evacuation airlift worldwide to efficiently and effectively accomplish AMC's Global Reach mission. The 618th AOC reports to 18th Air Force.

Air Force Network Integration Center - The Air Force Network Integration Center (AFNIC), located at Scott AFB, Ill., is a direct reporting unit to Air Force Space Command. As the leader in shaping, provisioning, sustaining, and integrating the AF enterprise network, AFNIC enables assured cyberspace capabilities for the Air Force. AFNIC has a shared responsibility to evolve the Air Force Network (AFNet) into a single integrated network environment with seamless, integrated systems, applications, and capabilities. AFNIC further helps ensure the confidentiality, integrity, and availability of critical information for the warfighter in support of AF priorities. AFNIC communicates, collaborates and coordinates with other AF organizations and domain experts to develop "speed of need" cyberspace net-centric concepts, architectures, as well as tactics, techniques, and procedures. Additionally, AFNIC leverages emerging cyber technologies to meet requirements for current and future air, space and cyberspace operations; allowing the AF to complete the sphere of information dominance. Approximately 900 military, civilian and contractor cyber professionals are assigned performing the AFNIC mission.

Defense Information Systems Agency - Defense Information Systems Agency - Continental United States (DISA CONUS) Field Command is headquartered in Bldg. 3189 and employs more than 850 military members, civilians and contractors. The DISA CONUS Field Command is also the home of the DISA NetOps Center CONUS (DNC CONUS). DISA CONUS is manned 24/7 to ensure customers at Scott and every Air Force Base, Army Post, Marine Camp, Naval Station, and DoD Agency around the world have access to their command and control, direct operational support, telecommunications information and technology services.

932nd Airlift Wing - The mission of the 932nd Airlift Wing is to provide first-class, worldwide, safe and reliable airlift for congressional/military leaders and their staffs, flying C-40 and C-9C aircraft. They maintain these aircraft for VIP special assignment missions. The wing equips, trains, and organizes a ready force of citizen airmen to support and maintain all facets of air base operations involving infrastructure and security. The wing also provides worldwide medical services to the warfighter from the front line to continental United States fixed medical treatment facilities.

126th Aerial Refueling Wing - The 126th Air Refueling Wing provides aerial refueling and airlift support to enhance the U.S. Air Force capability to accomplish its global mission. It also provides aerial refueling support to the U.S. Navy, U.S. Marine Corps, and allied aircraft. It owns and operates the KC-135R Stratotanker. During peacetime, the 126 ARW receives direction from the adjutant general, the governor of Illinois, and the National Guard Bureau. Upon federal mobilization, the wing is assigned to AMC, or specifically the 18th Air Force, to augment active duty forces during national emergencies or war.

635th Supply Chain Operations Wing - The 635th Supply Chain Operations Wing (635

SCOW) is the first responder to the Air Force Supply Chain. It is responsible for conducting time-critical operational spares execution and supply chain command and control for warfighters around the globe. This is done through its two groups. The 635th Supply Chain Operations Group at Scott AFB, IL is responsible for strategic and tactical airlift aircraft, rotary-winged aircraft, and tanker aircraft. The 735th Supply Chain Operations Group located at Langley AFB, VA is responsible for all fighter aircraft, bomber aircraft, and special mission aircraft. In total, the 635 SCOW manages supply chain operations for over 4100 aircraft.

Current as of March 2014

375TH MISSION SUPPORT GROUP

Posted 1/16/2013 Printable Fact Sheet

The 375th Mission Support Group provides base-level support to all organizations assigned to Scott. The units that belong to the group provide a variety of services to the base community. The group is composed of five squadrons.

The **375th Civil Engineer Squadron** is responsible for operating, maintaining, and repairing all base facilities and utilities worth an estimated $3.1 billion. The squadron's diverse mission includes cradle-to-grave management of all contract construction projects, community planning, fire and emergency services, accompanied and unaccompanied housing management, natural, capital and asset management, asset optimization, emergency management and explosive ordnance disposal. Through the Prime Base Engineer Emergency Force Team, they deploy anytime, anywhere in support of Air Force contingency operations worldwide.

The **375th Force Support Squadron** provides quality of life services to the men and women of Scott, their families, plus the local community and surrounding seven-state region. They also provide personnel, services, manpower, education, training, family support, and enlisted professional enhancement to the military, civilian, and family members assigned to Scott during peacetime and contingency operations. The squadron organizes and executes the entire personnel portion of the deployment machine--training, processing, deployment and redeployment--resulting in a well-trained, rapid-response, war-ready force that keeps boots on the ground in theater and our homeland secure. In addition, it maintains the highest level of readiness for global deployment and in-theater mission support through Prime Readiness in Base Service Teams.

Photos 1 of 5

Firefighters from the 375th Civil Engineer Squadron remove begin to remove their gear after an aircraft egress exercise on the flightline Aug. 3 at Scott. The gear used in this type of scenario includes Aircraft Personal Proximity Gear and a breathing apparatus. (U.S. Air Force photo/2nd Lt. Benjamin Garland)

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The **375th Logistics Readiness Squadron** provides a wide variety of logistics services encompassing vehicle operations support, vehicle maintenance, personal property and freight movement, passenger travel--commercial and Air Mobility Command Patriot Express--and aerial port (military airlift) passenger, cargo and fleet services. They also provide aircraft and vehicle fuel support to all Team Scott and base visitors. The 375th LRS also provides base support to include: Equipment management, stock control and the war readiness element. The munitions section maintains accountability for all operational, training and mobility requirements for munitions. The squadron also serves as the wing's focal point for contingency planning, deployment and execution.

The **375th Contracting Squadron** provides fully trained contingency contracting officers to support deployed commanders. The squadron accomplishes this by purchasing and managing base-wide operational contracts totaling more than $99 million annually for U.S. Transportation Command, Air Mobility Command, the 375th Air Mobility Wing and other assigned tenant organizations. In addition, 375th CONS manages the $25 million government purchase card program, providing support, and training to roughly 700 cardholders and almost 300 billing officials. Contracting serves as a key business advisor to the wing commander and creatively uses best-value tools to tailor acquisition solutions and innovatively, yet practically, help the base customers accomplish their wide-range of missions.

The **375th Security Forces Squadron** provides security and law enforcement services to the Scott community while meeting worldwide mobility requirements. Their motto is "Defensor Fortis," which means "Defenders of the Force." The unit also provides combat arms and expeditionary combat skills training to Team Scott members. They provide biometric registration of base personnel, visitor control, police services, resource protection, confinement and investigations support to the Scott community and military working dog support to other federal law enforcement agencies. With a continuous mobility commitment, 375th Security Forces members represent the 375th Air Mobility Wing around the world.

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Tenant units

- U.S. Transportation Command
- 18th Air Force
- 618th Tanker Airlift Control Center
- 932nd Airlift Wing
- 126th Air Refueling Wing
- Air Force Network Integration Center
- Defense Information Sys Agency
- Surface Deployment and Distribution Command
- Scott Composite Squadron - Civil Air Patrol
- E-Command Post
- Federal Voting Assistance Program
- Air Force Voting

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- Defense Information Sys Agency
- Surface Deployment and Distribution Command
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American College of Cardiology Foundation's NCDR **ACTION Registry®-GWTG™ Platinum Performance Achievement Award** for 2013, 2014 and 2015.

HSHS St. Elizabeth's Hospital consistently followed the treatment guidelines in ACTION Registry-GWTG™ for eight consecutive quarters in ACTION Registry-GWTG Premier and met a performance standard of 90% for specific performance measures to receive this 2015 award.

Named a **2015 Partner for Change Award winner** by Practice Greenhealth. The Partner for Change Award recognizes health care facilities that continuously improve and expand upon their commitment to minimizing their environmental footprint by incorporating sustainability into their day-to-day practices.

Top 10 "Best Value Hospital™" in Illinois from Verras Healthcare International

"Top Performer on Key Quality Measures®" Recognition from The Joint Commission for exemplary performance in using evidence-based clinical processes.

Named a **2014 Guardian of Excellence Award winner** by Press Ganey Associates, Inc. The Guardian of Excellence Award recognizes top-performing facilities that consistently achieved the 95th percentile of performance in Clinical Quality.

Illinois Performance Excellence (ILPEx) 2013 Bronze Award for "Commitment to Excellence." This award is given to organizations throughout the state who adopt and demonstrate continuous quality improvement practices. Learn more at www.ilpex.org.

Named one of the nation's **50 Top Cardiovascular Hospitals for three years (2013, 2014, and 2015),** by Truven Analytics (formerly Thomson Reuters). Visit 100tophospitals.com for a complete list of winners and information on this study.

"Top Performer on Key Quality Measures®" Recognition from The Joint Commission for exemplary performance in using evidence-based clinical processes.

Mission: Lifeline® Receiving Center, Silver (2013) and Bronze (2012) Level Recognition Award for excellent care for myocardial infarction (heart attack) patients.

ACTION Registry®-GWTG™ 2012 Recognition Program Silver Achievement Award for excellent care of STEMI and Non-STEMI patients.

Sterile Processing Department has received an award from 3M for providing the highest standard of care when it comes to the sterile processing of surgical instruments and implantables.

Mayor designates National Home Care and Hospice Month - Belleville Mayor Mark Eckert recently signed proclamations designating...

OUR HISTORY

Serving the region with Respect, Care, Competence and Joy since1875

In 1844, a Franciscan priest named Fr. Christopher Bernsmeyer, OFM, founded an order of religious women, the Sisters of Charity. The sisters had a simple mission: to help the needy and provide care for the sick in their homes. By 1880, the name for this order of sisters had changed to the Hospital Sisters of the Third Order of St. Francis.

In 1875, three sisters embarked on a 28 day journey from their Motherhouse in Muenster, Germany to begin a health care mission in Belleville. An old school house of St. Peter's parish was quickly renovated into a hospital and convent. With its primitive equipment, the small hospital had barely enough room for the sisters and, in case of emergency, six patients. For the next five years, the sisters' lived in the hospital, focusing on nursing the sick in their homes.

By 1880, their mission was growing and the little schoolhouse could no longer accommodate the growing number of patients. So the sisters built a larger hospital — one that would house 58 patients — on the grounds where St. Elizabeth's stands today. Many additions and renovations followed until the 1950s, when most of the original structure was razed and replaced with beautiful, new state-of-the-art facilities.

Belleville and the surrounding area, meanwhile, continued to grow. Serious epidemics, from scarlet fever to polio, were brought to St. Elizabeth's for care. The hospital kept pace with changes in health care and new technologies, building a reputation as a leader in health care for Southern Illinois.

Since its completion in 1954, St. Elizabeth's Hospital has more than quadrupled in size, with the addition of medical office buildings and other health care facilities. With outpatient facilities in communities like O'Fallon and Mascoutah, the hospital continues to look for ways to make health care more accessible and convenient. The hospital now partners with the HSHS Medical Group, Prairie Heart Institute and Healogics Wound Care to provide an integrated patient care experience across all of Southern Illinois.

With all the changes and growth over the past 139 years, the mission of the founding sisters remains unchanged: To reveal and embody Christ's healing love for all people through our high quality Franciscan health care ministry. Their mission was to provide care for the sick and needy with a spirit of respect, care, competence and joy.

St. Elizabeth's Hospital is an affiliate of Hospital Sisters Health System.

Saint Elizabeth of Hungary, Our Patron Saint

The life of Elizabeth of Hungary, Patroness of our Hospital, is characterized by her love of the poor and her work for social justice. She was born in 1207, daughter of the king of Hungary and the niece of St. Hedwig. At the young age of 16, she learned about Francis of Assisi and his deep compassion and care for the poor. She heard how he left behind a life of affluence and security to work with the poor. She heard how he overcame his fear of leprosy when he was moved to embrace and kiss a leper, and then went to their slum-like quarters to care for them.

Moved by his story, Elizabeth dedicated her life to the care of the sick, especially the poor. When her husband died, she joined the Third Order of St. Francis of Assisi, made up of lay men and woman dedicated to helping to care for the poor. At the age of 19, she used her personal wealth to build a 28 bed hospital, specifically to care for the poor. Twice daily she would go to the hospital, bringing the sick food and helping to care for their needs. Before Elizabeth died, at the young age of 23, she built her second hospital thus demonstrating her full commitment to caring for the needs of the sick.

This same Franciscan compassion and care that moved Elizabeth to help the sick guides the work we do each day.

SURGICAL SERVICES

Experienced surgeons. The latest techniques.

Our highly trained and experienced surgeons perform surgical and non-surgical procedures in a variety of areas and represent a wide range of specialties, including:

- Cardiothoracic
- Ear, nose and throat
- Endoscopy (upper and lower)
- General Surgery
- Gynecology
- Neurosurgery
- Orthopedic
- Pulmonary
- Plastic Surgery
- Podiatry
- Pain management
- Urology
- Vascular

Our Surgery Suites

Your surgical team will perform your surgery using the latest technology and least invasive procedures possible in one of our 16 new surgery suites.

Anesthesia

Board-certified anesthesiologists and certified registered nurse anethetists provide excellent anesthesia care.

Registration

If you are Pre-Registered:

You will receive a telephone call from our staff prior to your visit to gather insurance and other information. When you arrive at St. Elizabeth's, report directly to the third-floor surgical unit.

Behavioral Healthcare
Cancer Care
Emergency Care
Heart Care
Home Care
Hospice
Hospitalist Services
Laboratory
Mother Child Center
O'Fallon Medical Building
Outpatient Infusion Services
Pain Management
Pastoral Care
Physical Therapy
Radiology/Imaging
Rehabilitation Unit
Sleep Disorders Center
Stroke
Support Groups
Surgical Services
Outpatient Surgery
UrgiCare
Wound Care Center

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Mayor designates National Home Care and Hospice Month - Belleville Mayor Mark Eckert recently signed proclamations designating...

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An Affiliate of Hospital Sisters Health System

The religious community of Hospital Sisters of the Third Order of St. Francis was founded in Telgte, Westphalia, Germany in 1844. A Franciscan priest, Father Christopher Bernsmeyer, OFM, sought the assistance of five German women in order to minister to the needs of the sick poor in the area.

In 1875, 20 Sisters came to America as missionaries from Germany. Over the years, their numbers and works multiplied. Hospital Sisters Health System became a primary vehicle for reaching the sick in America.

The Hospital Sisters Health System is the thirteenth largest acute care hospital system in the United States with 14 hospitals throughout Illinois and Wisconsin. Corporate headquarters and the motherhouse of Hospital Sisters of the Third Order of St. Francis (sponsor of St. Elizabeth's Hospital) are located in Springfield, Illinois. View our Annual Report.

- Sacred Heart Hospital, Eau Claire, Wisconsin
- St. Anthony's Memorial Hospital, Effingham, Illinois*
- St. Clare Memorial Hospital, Oconto Falls, Wisconsin
- St. Francis Hospital, Litchfield, Illinois
- St. Joseph's Hospital, Breese, Illinois*
- St. Joseph's Hospital, Chippewa Falls, Wisconsin
- St. Joseph's Hospital, Highland, Illinois*
- St. John's Hospital, Springfield, Illinois
- St. Mary's Hospital, Decatur, Illinois
- St. Mary's Hospital, Streator, Illinois
- St. Mary Hospital Medical Center, Green Bay, Wisconsin
- St. Nicholas Hospital, Sheboygan, Wisconsin
- St. Vincent Hospital, Green Bay, Wisconsin

** Indicates Southern Illinois Division*

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Our Mission
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St. Elizabeth's Teaching Hospital

Mayor designates National Home Care and Hospice Month - Belleville Mayor Mark Eckert recently signed proclamations designating...

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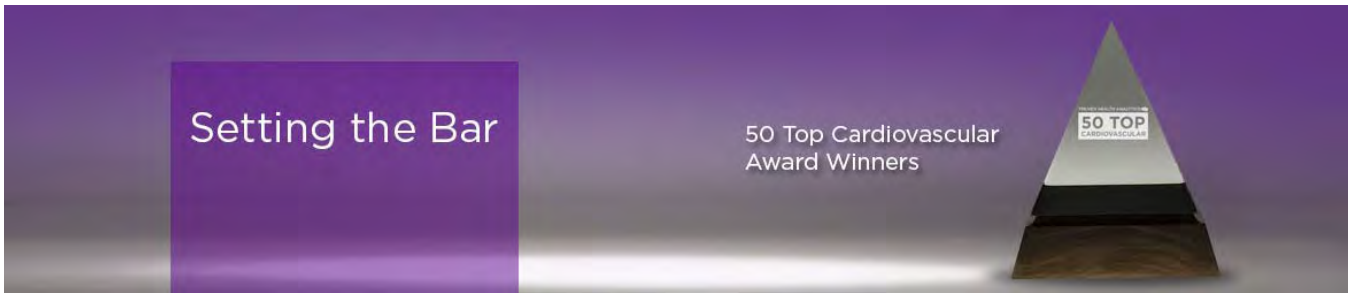

2015 50 Top Cardiovascular Hospitals

Teaching Hospitals With Cardiovascular Residency Programs

Teaching Hospitals Without Cardiovascular Residency Programs

Hospitals

(http://www.allenhospital.org/)Banner Boswell Medical Center (http://www.bannerhealth.com/Locations/Arizona/Banner+Boswell+Medical+Center/_Banner+Boswell+M
Decatur Memorial Hospital (http://www.dmhcares.org/)

Genesis Medical Center (http://www.genesishealth.com/)

JFK Medical Center (http://jfkmc.com/home/index.dot)
MacNeal Hospital (http://www.macneal.com/Home.aspx)

Memorial Regional Hospital (http://www.mhs.net/)

Mission Hospital (http://www.mission-health.org/)

Mount Auburn Hospital (http://www.mountauburnhospital.org/)

(http://www.memorialhermann.org/)Phoenix Baptist Hospital (http://www.abrazohealth.com/facilities/phc

Saint Thomas West Hospital (https://www.sths.com/west/Pages/default.aspx)

St. Cloud Hospital (http://www.centracare.com/locations/st-cloud-hospital/)

St. Elizabeth's Hospital (http://www.steliz.org/)
St. Joseph's Hospital and Medical Center (http://www.stjosephs-phx.org/index.htm)
St. Luke's Boise Medical Center (http://www.stlukesonline.org/boise/)

St. Luke's Hospital (http://www.crstlukes.com/)

St. Mark's Hospital (http://www.stmarkshospital.com/)

St. Vincent Healthcare (http://www.svh-mt.org)

Sutter Medical Center, Sacramento (http://www.suttermedicalcenter.org/)

Tucson Medical Center (http://www.tmcaz.com)

Virginia Hospital Center (http://www.virginiahospitalcenter.com/)

Community Hospitals

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100 Top Hospitals (/studies-winners/100-top-hospitals/)

50 Top Cardiovascular (/studies-winners/50-top-cardiovascular/)

15 Top Health Systems (/studies-winners/15-top-health-systems/)

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(/winners-exclusives/)

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50 Top Cardiovascular Hospitals (/Portals/2/assets/TOP_50CardioStudy2014_web.pdf)

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| **Login (http://100tophospitals.com/login?returnurl=%2fstudies-winners%2f50-top-cardiovascular%2fyear%2f2015)**

ACCREDITATIONS

HSHS St. Elizabeth's Hospital has been awarded the following accreditations

Joint Commission -St. Elizabeth's Hospital is accredited by The Joint Commission- the nation's preeminent hospital accreditation body. This accreditation, which was recently renewed in September 2013, is granted following Joint Commission's evaluation of the hospital's performance in patient safety, quality of care and other key areas.

Chest Pain Center Accreditation - St. Elizabeth's Hospital is accredited by the Society of Chest Pain Centers, a professional organization focused on improving care for patients with acute coronary syndromes and teaching the public to recognize and react to the early symptoms of a possible heart attack.

Echocardiography Accreditation - St. Elizabeth's Hospital is accredited by the Intersocietal Accreditation Commission (IAC), which grants accreditation to those facilities that are found to be providing quality patient care, in compliance with national standards through a comprehensive application process including detailed case study review.

EDAP, Emergency Department Approved for Pediatrics, is a designation from the Illinois Department of Public Health noting the Emergency Department is equipped to care for critically ill or injured patients and is designed specifically for children. Staff are specially trained to care for the special needs of children in an emergency setting.

Emergent Stroke Ready Hospital, is a designation from the Illinois Department of Public Health noting that St. Elizabeth's Hospital is adhering to written emergency stroke protocols and has the ability, 24 hours a day, 365 days a year to provide immediate, advanced stroke treatments and interventions.

Intersocietal Commission for the Accreditation of Vascular Laboratories - St. Elizabeth's Hospital Vascular Laboratory achieved accreditation by the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL) for its commitment to providing a high level of patient care and quality testing for the diagnosis of vascular disease.

CARF - St. Elizabeth's 40-bed in-patient rehabilitation unit is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), a nonprofit organization conducts thorough evaluations of rehabilitation centers to ensure they conform to nationally recognized service standards, meet rigorous guidelines for service and quality, and focus on delivering the most favorable results for their patients.

Sleep Center Accreditation - The Southern Illinois Sleep Disorders Center at St. Elizabeth's Hospital is accredited by the American Academy of Sleep Medicine. It is the first accredited sleep center in Southern Illinois and one of only five accredited sleep centers in the St. Louis metro area.

Laboratory Accreditations - The hospital's Pathology Lab is certified by the College of American Pathologists and licensed by CMS. The Blood Gases Lab is certified by COLA, a physician-directed organization that promotes excellence in laboratory medicine and patient care.

Vascular Lab - The Vascular Lab at St. Elizabeth's Hospital, which treats patients for vascular diseases, is accredited by the Intersocietal Commission for the Accreditation of Vascular Laboratories.

American College of Radiology (ACR) Accreditation for our mammography program.

Additional Accreditations

Outpatient Therapy

- IL Workman's Comp
- MO Workman's Comp

Accreditations
Awards

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MEMORANDUM FOR RECORDS

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS 375TH AIR MOBILITY WING (AMC)

10 Dec 15

MEMORANDUM FOR RECORD

FROM: 375 FSS/FSVS

SUBJECT: CPR and AED Training For FAC 1 and FAC 2

1. The purpose of this memorandum is to provide training dates for both FAC 1 and FAC 2 in regards to CPR/AED certification. FAC 1 accomplished training with on or about October 8th, 2015. This was a scheduled appointment that occurred on one of our Wing training days. FAC 2 received training in CPR and AED in June 2014 with an expiration of June 2016.

2. Aditionally, all sign-in sheets and tests administered were submitted to Red Cross by to be processed for certification. FAC 1 and other attendees are also waiting for currency cards to be produced by 375 MDG.

3. If you have any questions, please contact me at DSN , commercial , or by e-mail at

, 2d Lt, USAF
Chief, Fitness and Sports

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

7 December 2015

MEMORANDUM FOR RECORD

FROM: GROUND ACCIDENT INVESTIGATION BOARD LEGAL ADVISOR

SUBJECT: Review of Videotape of Member of Concern's Pushup and Sit-up Component of His Fitness Assessment Test, 26 October 2015

1. This memorandum provides a statement of my review of the Scott AFB fitness assessment cell (FAC) video of pushup and sit-up components of the physical fitness test (PFT) completed by Member of Concern (MOC) on 26 October 2015.

2. The Scott AFB FAC videotapes all push and sit-up components of PFT tests in order to document an Airman's PFT performance. The video recording produced is proprietary information and the Scott AFB does not have an ability to copy the video recording onto a non-proprietary program. As such, the Ground Investigation Board recorded a video of the video broadcasting through the proprietary video machine. This video of the video recording will be provided to HQ AMC/JA as an attachment to the Post-Investigation Memorandum.

3. On 26 October 2015, MOC arrived to the Scott AFB FAC to complete his pushup and sit-up portion of his PFT. MOC was paired up with another Air Force member who counted MOC's pushup and sit-ups. MOC completed push-ups first and then completed the sit-up portion of his PFT. On the video, MOC appeared to be healthy and did not appear to have physical difficulties completeing the test, other than the normal exertion associated with completing maximum effort on an PFT. The video does not record sound; however, at no point in the video did it appear that MOC complained to FAC personnel about the test or his inability to physically complete the components of his PFT.

, Maj, USAF
Legal Advisor

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

9 December 2015

MEMORANDUM FOR RECORD

FROM: Ground Accident Investigation Board (GAIB)

SUBJECT: Personnel Records Review of Member of Concern (MOC)

1. On 9 December 2015, I conducted a review of the MOC's personnel records. The following is a selection of accolades from his Enlisted Performance Reports

a. "Instructed at McGhee-Tyson; hosted grad via VTC/17 bases/237 students--led largest ALS class in AF history." - Force Development Flight Chief (375 FSS), December 2014;

b. "Instructed 1.1K curriculum hrs; taught 83 students/awd'd 830 CCAF crdts--shaped 14 awd winners/2 Levitows." - Airman Leadership School Commandant, April 2015

c. "Professionally instructed 368 hrs/4 classes; 71 Airmen awd'd 710 CCAF credits—Scott #1 AMC/CCAF grads". - 375th Force Support Squadron Commander (375 FSS/CC), May 2013

d. "Led 60 vols at St Louis Stray Rescue; walked dogs/cleaned pens--provided aid to 180 abandoned/abused dogs." - Force Development Flight Chief (375 FSS), April 2012

e. "Dlvrd showcase spt to monthly Wg/CC fitness challenge; provided PA/music sys—boosted morale for 1K prsn". – 375th Communications Squadron Cyber Operations Flight Commander (375 CS), June 2011

f. "Led radio network switch install; expanded coverage by 40%--enabled robust C2 support link during convoys". - 375th Communications Squadron Qual;ity Assurance Flight Chief, June 2010

g. "Professionally represented Team Scott as Base Honor Guardsman; devoted five mos--49 details, 29 as NCOIC." - 375th Communications Squadron Flight Operations Superintendent, June 2009

h. "Engaged in Unit Compliance Inspection; overhauled Safety/T.O. pgm--effort led to overall "Excellent" rating." - 375th Communications Squadron Flight Operations Superintendent, June 2009

i. "Led TACAN mx after catastrophic lightning strike; restored < 3 hrs--saved over $200K/total replacement cost." - 375th Communications Squadron OIC , Engineering and Airfield Sytems, May 2008

j. "Top notch leader! Led four contractors during ILS shelter power system modifications; completed 1 day early." - 375th Communications Squadron, Ground Communications Section Chief, July 2007

k. "Oversaw Principal User Processor removal and decommissioning: reutilized equipment—saved Wing $63K." - 375th Communications Squadron, Ground Communications Section Chief, June 2006

l. "Unselfishly volunteered 15 hours in search of missing Missouri child; scouted approximately 120 acres." - 375th Communications Squadron, Maintenance Controller, June 2005

2. MOC also earned numerous decorations to include two Air Force Achievement Medals and three Air Force Commendation Medals, one while deployed in support of Iraqi Freedom from November 2009-May 2011.

3. Direct questions regarding this memorandum to the undersigned.

MICHAEL J. WOOD, Colonel, USAF
President

Prehospital Care Report Summary

MedStar Ambulance, Inc.

Date:10/26/2015 **Call #:**30702 **Booklet:**85394149 **Branch:** Scott AFB **Time Zone:**America/Chicago

Call Information:

Disposition: MOC
Unit #:
Run Type to Scene:
Incident Facility:
Incident Location:

Incident Type:

Receiving Facility:
Facility Address:
Destination Type:
Dest. Reason:
Registration #

Loaded Mileage:
Crew Members:

Moved to Amb By:

Call Origin:
Online Facility:
Online Physician:

# Patients Transported In My Unit:	1
# Patients at Scene:	1
Call Received:	07:15:09
Dispatched:	07:15:17
En Route:	07:15:33
On Scene:	07:19:11
Patient Contact:	07:21:00
Left Scene:	07:35:28
At Destination:	07:48:18
Transfer of Care:	N/A
In Service:	08:15:14
Time On Scene:	16 Min
Time to Destination:	33 Min
Total Time of Run:	60 Min

Patient Information:

Name: MOC
Address:
Phone:
Email:
SSN: MOC
Driver License:

DOB: MOC
Gender: MOC
Age: MOC
Weight: MOC **Broselow:**

Other Contact Info
Name: **Phone:** **Cell Phone:**
Relationship:

Current Meds: None
Env Allergies: NKA
Med Allergies: NKDA
Patient Physician:
Advanced Directives:
PMH: None
Comment:

Comments:
Comments:
Comments:

Payer Information:

Priority: **Name:** **Type:** **Policy #:** **Group #:**
Policy Holder: , , Apt , **Phone:** **DOB:**
Relationship of Patient to Insured:

Recurring Scheduled Transports - Medical Need/History:

Primary Condition:
Secondary Condition:
Bed Confined **Behavioral** **Other**

Airway Monitoring

Physical Limitations:

Paralysis	Amputations	Fractures / Dislocations
Paresis (Includes Weakness)	Contractures	Other Physical Limitations
Wounds		

Clinical:

Medical Need: Required Stretcher

Onset Date/Time: 10/26/15
Dispatch Reason (EMD):

Chief Complaint:
Provider Impression:
Mechanism of Injury:
Protocol 1: **Protocol 2:**

Assessments:

Time	Employee	Type	Summary
		ABC	Airway: Patent Breathing: Quality: Lung Sounds: Left: Lung Sounds: Right: Skin Color: Skin Temperature: Condition: Edema: Cap Refill:
		Head To Toe	Head and Neck: Left Eye: Right Eye:
		Neurological	AVPU:

Vitals:

Time	Employee	Summary
		Rhythm 1: Rhythm 2:
07:21:00		Pulse: Resp: Pain:
07:21:00		Glasgow Coma Score:
07:28:00		BP: Pulse: Resp: SPO2: Blood Sugar: Pain:
07:35:00		Glasgow Coma Score:
07:40:00		BP: Pulse: Resp: SPO2: Pain:

Treatments/Medications:

Time	Employee	Summary
07:21:00		Treatment- Assessment-Paramedic Attempts: Success:

	Level: Comments:	
07:28:00	**Treatment- Pulse Oximetry** Attempts: Success: Level: Comments:	
07:28:00	**Treatment- Cardiac Monitor** Attempts: Success: Level: Comments:	
07:28:00	**Medication Oxygen-NRB** Dose: Unit: Route: Attempts: Success: Level:	
07:29:00	**Treatment- Blood Glucose Analysis** Attempts: Success: Level: Comments:	
07:31:00	**Treatment- 12 Lead ECG-Obtain** Attempts: Success: Level: Comments:	
07:33:00	**Treatment- 12 Lead ECG-Transmitted** Attempts: Success: Level: Comments:	
07:36:00	**Medication Normal Saline flush** Dose: Unit: Route: Attempts: Success: Level:	
07:36:00	**Treatment- Venous Access-Extremity** Attempts: Success: Level:	
07:37:00	**Medication Normal Saline** Dose: Unit: Route: Attempts: Success: Level:	

Supply

Qty	Supply

EKG Device Incident Number:

FlexFields:

FlexField	Value
IV Details -	
IV Size	
IV Site	
Attempts	

Narrative History Text:

VITALS:

TREATMENT:

IV DETAILS

MEDICATION:

Unable to Sign:

Authorized Representative:

Authorized Representative Signature:
Secondary Documentation:
Secondary Documentation Signature:
Comment:

Auth Signature: **Privacy Sig:** **Unable to Sign:** **Refused to Sign:**

Signature Image(s):
Authorization Signature

Receiving RN / MD Signature - RN - 10/26/2015 12:45

Technician Signature - - 10/26/2015 12:58

Technician 2 Signature - - 10/26/2015 12:59

Authorized Representative Signature - - 10/26/2015 12:45

Technician 2 - - 10/26/2015 12:59

On Scene Condition Code:

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

PERSONAL DATA – PRIVACY ACT OF 1974 (5 U.S.C. § 552a)

26 February 2016

MEMORANDUM FOR RECORD

FROM: Ground Accident Investigation Board President

SUBJECT: Personnel Qualifications for Treating Physicians Involved in 26 Oct 15 GAIB

1. I reviewed publicly available resources to assess the training, licensure, certifications and credentials of the physicans involved in the care of the Member of Concern (MOC) for the Ground Accident Investigation Board for the Fitness Assessment Test Fatality on 26 October 2015.

2. MOC's primary attending physician was credentialed at St.Elizabeth's Hospital, attended medical school and residency at the University of Missouri-Columbia, was board certified in family practice, and currently licensed in Illinois (through 2017) and Missouri (through 2016). All other physicians treating MOC at various times were appropriately licensed and privileged.

3. The Board made multiple attempts to contact the treating physicians but were not able to compel them to meet with the Board IAW AFI 51-503 paragraph 6.8.5.1.

4. St. Elizabeth's is a teaching hospital affiliated with Saint Louis University Family Medicine Residency Program and Scott AFB's family practice residency program. St Elizabeth's is located approximately 11 miles from Scott Air Force Base.

MICHAEL J. WOOD, Colonel, USAF, MC, FS
President

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HEADQUARTERS AIR MOBILITY COMMAND

16 Feb 2016

MEMORANDUM FOR RECORD

FROM: Ground Accident Investigation Board President

SUBJECT: Policies on Sickle Cell Trait (SCT) in US Armed Services

1. I reviewed publicly available resources to assess for any differences in policy regarding SCT in the different branches of the US Armed Services. Currently, each military service has its own policy for SCT testing.

MICHAEL J. WOOD Colonel, USAF, MC, FS
President

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

PERSONAL DATA – PRIVACY ACT OF 1974 (5 U.S.C. § 552a)

26 February 2016

MEMORANDUM FOR RECORD

FROM: Ground Accident Investigation Board President

SUBJECT: Scott AFB FAC Policy on FA Injury Notification

1. On 26 October 2015, there was no specific training or policy at Scott AFB for any other notification to leadership other than the e-mail at the time of the mishap.

MICHAEL J. WOOD, Colonel, USAF, MC, FS
President

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