Appendix A to Notification
[Refers to para 6]

भारतीय वायु सेना
Indian Air Force

MEDICAL STANDARDS FOR AIR FORCE COMMON ADMISSION TEST (AFCAT- 01/2026) FOR FLYING BRANCH AND GROUND DUTY (TECHNICAL AND NON-TECHNICAL) BRANCHES/ NCC SPECIAL ENTRY FOR COURSES COMMENCING IN JANUARY 2027

General Instructions

1. In this section, standardized guidelines for the physical assessment of candidates for commissioning through AFCAT into flying and ground duty branches in the IAF are elaborated. The purpose of these guidelines is to lay down uniform physical standards and to ensure that the candidates are free of health conditions that may hamper or limit their performance in the respective branch. The guidelines enumerated in this section are meant to be applied in conjunction with the standard methods of clinical examination.

2. All candidates during their induction should meet the basic physical fitness standards which will enable them to proficiently undergo the training and the subsequent service in varied climatic and work environments. A candidate will not be assessed physically fit unless the complete examination shows that he/ she is physically and mentally capable of withstanding the severe physical and mental strain for prolonged periods. The requirements of medical fitness are essentially the same for all branches, except for aircrew in whom the parameters for visual acuity, anthropometry and certain other physical standards are more stringent.

3. The medical standards spelt out pertain to initial entry medical standards. Continuation of medical fitness during training will be assessed during the periodic medical examinations held at NDA/ AFA prior to commissioning. They are not exhaustive, in view of the vast spectrum of diseases. These standards are subject to change with the advancement in the scientific knowledge and change in working conditions of Armed Forces.

4. **Laboratory and Radiological Investigations for Special Medical Board**

4.1. **Hematology**: Complete Haemogram (Haemoglobin estimation, Total Leucocyte Count with Differential Leucocyte Count, Platelet Count).

4.2. Hb Electrophoresis will be carried out in candidates for commissioning to exclude Haemoglobinopathies.

4.3. **Biochemistry:** Liver function test (LFT), Renal Function Test (RFT), Blood glucose estimation (Fasting and two hours after 75 g anhydrous glucose/82.5 g glucose monohydrate loading), Lipid profile.

4.4. Urine Routine Examination (RE) and Microscopic Examination (ME).

4.5. ECG.

4.6. **Radiology:** -

4.6.1. Radiograph Chest PA view in all candidates.

4.6.2. Radiograph Lumbosacral Spine: AP and Lateral views in all candidates.

4.6.3. In addition to the above radiographs, Cervical Spine - AP and Lateral views, Dorsal Spine - AP and Lateral views will be carried out in all candidates being assessed **for flying duties.**

4.6.4. USG Abdomen and Pelvis.

4.6.5. Any other additional investigation deemed necessary will be conducted during the Appeal stage.

General Physical Assessment

5. Every candidate, to be fit for the Air Force, must conform to the minimum standards laid down in the succeeding paragraphs. The physical parameters should fall within the acceptable ranges and should be proportionate.

6. The residual effects of old fractures/ injuries are to be assessed for any functional limitation. If there is no effect on function, the candidate can be assessed fit. Following categories should be meticulously assessed:

6.1. **Spine Injuries**. Cases of old fractures of spine are unfit. Any residual deformity of spine or compression of a vertebra will be cause for rejection.

6.2. **Nerve Injuries**. Injuries involving the trunks of the larger nerves, resulting in loss of function, or neuroma formation, which causes pain significant tingling, indicate unsuitability for employment in flying duties.

6.3. **Keloids**. The presence of large or multiple keloids will be a cause for rejection.

6.4. **Surgical Scars.** Minor well-healed scars for e.g as resulting from any superficial surgery do not, per se, indicate unsuitability for employment. Extensive scarring of a limb or torso that may cause functional limitation or unsightly appearance should be considered unfit.

6.5. **Birth Marks**. Abnormal pigmentation in the form of hypo or hyper-pigmentation is not acceptable. Localized, congenital mole/ naevus, however, is acceptable provided its size is <10 cm. Congenital multiple naevi or vascular tumours that interfere with function or are exposed to constant irritation are not acceptable.

6.6. **Subcutaneous Swellings.** Lipoma will be considered fit unless the lipoma is causing significant disfigurement/ functional impairment due to the size/ location. Neurofibroma, if single will be considered fit. Multiple neurofibromas associated with significant *Café-au-lait* spots (more than 1.5 cm size or more than one in number) will be considered unfit.

6.7. **Cervical Rib**. Cervical rib without any neuro-vascular compromise will be accepted. Meticulous clinical examination to rule out neuro-vascular compromise should be performed in such cases. This should be documented in the Medical Board proceedings.

6.8. **Cranio-facial Deformities**. Asymmetry of the face and head or uncorrected deformities of skull, face or mandible which will interfere with proper fitting of oxygen mask, helmet or military headgear will be considered unfit. Major deformities even after corrective surgery will be considered unfit.

6.9. **History relating to Operations.** A candidate who has undergone an abdominal operation involving extensive surgical intervention or partial/ total excision of any organ is, as a rule, unfit for service. Operation involving the cranial vault with any residual bony defect will be unfit. Major thoracic operations will make the candidate unfit.

Measurements and Physique

7. **Chest Shape and Circumference.** The chest should be well proportioned and well developed. Any chest deformity likely to interfere with physical exertion during training and performance of military duties or adversely impact military bearing or are associated with any cardio-pulmonary or musculoskeletal anomaly are to be considered unfit. Minimum acceptable chest circumference in male candidates for commissioning is 77 cm. The chest expansion must be at least 05 cm for all categories of candidates. For the purpose of documentation, any decimal fraction lower than 0.5 cm will be ignored, 0.5 cm will be recorded as such and 0.6 cm and above will be recorded as 01 cm.

8. **Height**.

8.1. **Ground Duty Branches**. The minimum height for entry into ground duty branches is as follows:-

8.1.1. Male – 157 cm.

8.1.2. Female - 152 cm.

Note 1:- In case of candidates of Lakshadweep ethnicity, the minimum acceptable height is reduced by 02 cm (155 cm for males and 150 cm for females). For Gorkhas and individual belonging to North-Eastern regions of India and hilly regions of Uttarakhand, the minimum acceptable height will be 05 cm less (152 cm for males and 147 cm for females).

Note 2:- Candidates of North East and Hilly states ethnicity includes Gorkhas, Kumaonis, Garhwalis, Assamese and those belonging to the states of Nagaland, Manipur, Mizoram, Meghalaya, Arunachal Pradesh, Tripura, Sikkim and hilly areas of Uttarakhand.

8.2. **Flying Duty Branches**. The minimum height (both male and female) for entry into flying duty branches is as follows:-

8.2.1. Pilots, Flight Test Engineers (FTE) and WSO of Su 30 MKI - **162 cm**.

8.2.2. Officers and airmen who apply for aircrew duties, other than F(P), FTE duties and WSO of Su-30 MKI - **157 cm**.

9. **Sitting Height, Leg Length and Thigh Length**. Acceptable measurements of leg length, thigh length and sitting height for such aircrew will be as under:-

9.1.	**Sitting height**	Minimum	-	81.5 cm
		Maximum	-	96.0 cm
9.2.	**Leg Length**	Minimum	-	99.0 cm
		Maximum	-	120.0 cm
9.3.	**Thigh Length**	Maximum	-	64.0 cm

10. **Body Weight Parameters**

10.1. The acceptable weight range for candidates is given at **Annexure 1** (Male candidates) and **Annexure 2** (Female candidates) to this chapter. Candidates outside the given weight range for their age and height will not be acceptable.

Annexure 1

(Refers to para 8 & 10 to Appendix A)

WEIGHT FOR HEIGHT CHART: MALES (AT ENTRY)

Height (cm)	Minimum Weight (Kg)	Maximum Weight (Kg)		
		Age at last birthday Below 20 yrs	Age at last birthday 20 to 25 yrs	Age at last birthday Above 25 yrs
152	40	53	55	58
153	40	54	56	59
154	40	55	57	59
155	41	55	58	60
156	41	56	58	61
157	42	57	59	62
158	42	57	60	62
159	43	58	61	63
160	44	59	61	64
161	44	60	62	65
162	45	60	63	66
163	45	61	64	66
164	46	62	65	67
165	46	63	65	68
166	47	63	66	69
167	47	64	67	70
168	48	65	68	71
169	49	66	69	71
170	49	66	69	72
171	50	67	70	73
172	50	68	71	74
173	51	69	72	75
174	51	70	73	76
175	52	70	74	77
176	53	71	74	77
177	53	72	75	78
178	54	73	76	79
179	54	74	77	80
180	55	75	78	81
181	56	75	79	82
182	56	76	79	83
183	57	77	80	84
184	58	78	81	85
185	58	79	82	86
186	59	80	83	86
187	59	80	84	87
188	60	81	85	88
189	61	82	86	89
190	61	83	87	90
191	62	84	88	91
192	63	85	88	92
193	63	86	89	93
194	64	87	90	94
195	65	87	91	95
196	65	88	92	96
197	66	89	93	97
198	67	90	94	98
199	67	91	95	99
200	68	92	96	100

Annexure 2

(Refers to para 8 & 10 of Appendix A)

WEIGHT FOR HEIGHT CHART: FEMALES (AT ENTRY)

Height (cm)	Minimum Weight (Kg)	Maximum Weight (Kg)		
		Age at last birthday Below 20 yrs	Age at last birthday 20 to 25 yrs	Age at last birthday Above 25 yrs
147	37	45	48	51
148	37	46	48	51
149	37	47	49	52
150	37	47	50	53
151	37	48	50	54
152	37	49	51	54
153	37	49	51	55
154	38	50	52	56
155	38	50	53	56
156	39	51	54	57
157	39	52	54	58
158	40	52	55	59
159	40	53	56	59
160	41	54	56	60
161	41	54	57	61
162	42	55	58	62
163	43	56	58	62
164	43	56	59	63
165	44	57	60	64
166	44	58	61	65
167	45	59	61	66
168	45	59	62	66
169	46	60	63	67
170	46	61	64	68
171	47	61	64	69
172	47	62	65	70
173	48	63	66	70
174	48	64	67	71
175	49	64	67	72
176	50	65	68	73
177	50	66	69	74
178	51	67	70	74
179	51	67	70	75
180	52	68	71	76
181	52	69	72	77
182	53	70	73	78
183	54	70	74	79
184	54	71	74	80
185	55	72	75	80
186	55	73	76	81
187	56	73	77	82
188	57	74	78	83
189	57	75	79	84
190	58	76	79	85
191	58	77	80	86
192	59	77	81	87
193	60	78	82	88
194	60	79	83	88
195	61	80	84	89

Cardiovascular System

11. **Pulse**. Persistent sinus tachycardia (> 100 bpm) as well as persistent sinus bradycardia (< 60 bpm) are unfit. In case bradycardia is considered to be physiological, the candidate can be declared fit after evaluation by Medical specialist/cardiologist.

12. **Blood pressure**. An individual with systolic blood pressure greater than or equal to 140 mmHg and/or diastolic blood pressure greater than or equal to 90 mmHg shall be rejected.

13. **Cardiac Murmurs**. Evidence of organic cardiovascular disease will be cause for rejection. Diastolic murmurs are invariably organic. Short systolic murmurs of ejection systolic nature and not associated with thrill and which diminish on standing, especially if associated with a normal ECG and chest radiograph, are most often functional.

14. **ECG**. Any ECG abnormality detected at SMB/Recruitment Medical Examination will be a ground for rejection. Benign ECG abnormalities like incomplete RBBB, T wave inversion in inferior leads, T inversion in V1 to V3 (persistent juvenile pattern), LVH by voltage criteria (due to thin chest wall) may exist without any structural heart disease. Echocardiography should be performed in all such cases to rule out an underlying structural heart disease and opinion of Senior Advisor (Medicine)/Cardiologist should be obtained.

15. **Congenital Cardiac Anomalies**. All congenital cardiac anomalies will be declared unfit.

16. **Cardiac surgery and interventions.** Candidates with history of cardiac surgery/ intervention in the past will be considered unfit.

Respiratory System

17. **Pulmonary Tuberculosis.** Any residual scarring in pulmonary parenchyma or pleura, as evidenced by a demonstrable opacity on chest radiogram will be a ground for rejection. Old treated cases with no significant residual abnormality can be accepted if the diagnosis and treatment was completed more than two years earlier.

18. **Pleurisy with Effusion**. Any evidence of pleural thickening will be a cause for rejection. At the time of appeal, these cases will be subjected to detailed evaluation with appropriate investigations by Pulmonologist/Medical Specialist.

19. **Bronchitis**. History of repeated attacks of cough/wheezing/bronchitis may be manifestations of chronic bronchitis or other chronic pathology of the respiratory tract. Such cases will be assessed unfit and will be subjected to detailed evaluation with appropriate investigations at the time of appeal by Pulmonologist/Medical Specialist.

20. **Bronchial Asthma**. History of repeated attacks of bronchial asthma/wheezing/ allergic rhinitis will be a cause for rejection.

21. **Radiographs of the Chest**. Definite radiological evidence of disease of the lungs, mediastinum and pleurae are criteria for declaring the candidate unfit.

22. **Thoracic Surgery**. Candidate with history of any major surgery of the thorax will be considered unfit.

Gastrointestinal System

23. **Head to toe examination.** Presence of any sign of liver cell failure (e.g. loss of hair, parotidomegaly, spider naevi, gynaecomastia, testicular atrophy, flapping tremors etc) and any evidence of malabsorption (pallor, nail and skin changes, angular cheilitis, pedal edema) will entail rejection.

24. **Gastro-Duodenal Disabilities.** Any past surgical procedure involving partial or total loss of an organ (other than vestigial organs/gall bladder) will entail rejection.

25. **Diseases of the Liver.** If past history of jaundice is noted or any abnormality of the liver function is suspected, full investigation is required for assessment. Candidates suffering from viral hepatitis or any other form of jaundice will be rejected. Such candidates can be declared fit after a minimum period of 6 months has elapsed provided there is full clinical recovery; HBV and HCV status are both negative and liver functions are within normal limits. History of recurrent jaundice and hyperbilirubinemia of any nature is unfit.

26. **Disease of the Spleen.** Candidates who have undergone partial/ total splenectomy are unfit, irrespective of the cause for operation.

27. **Anterior abdominal wall EPID including femoral hernia.**

27.1. **Fit**. After 24 weeks of surgery (open as well as laparoscopic) provided there is no recurrence or post-op complications.

27.2. **Unfit**.

27.2.1 All current or operated cases of incisional hernia.

27.2.2. All cases of current anterior abdominal wall hernia.

Inguinal Hernia.

27.3. **FIT**. After 01 year of hernia repair surgery (open as well as laparoscopic) provided there is no recurrence or post-op complications.

27.4. **Unfit**. All cases of current inguinal hernia.

28. **Abdominal Surgery.** A candidate with well-healed scar post conventional abdominal surgery (except appendicectomy through right iliac fossa incision, refer par 36.2) will be considered fit after 24 weeks provided there is no potential for any recurrence of the underlying pathology, no evidence of incisional hernia and the condition of the abdominal wall musculature is good.

29. **Anorectal Conditions**. The examiner should do a digital rectal examination and rule out haemorrhoids, sentinel piles, anal skin tags, fissures, sinuses, fistulae, prolapsed rectal mass or polyps.

29.1. **Fit**.

29.1.1 After rectal surgery for polyps, haemorrhoids, fissure, fistula, ulcer or pilonidal sinus, provided there is no residual/recurrent disease.

29.1.1.1. Anal Fissure, Hemorrhoids: After 12 weeks of surgery.

29.1.1.2. Pilonidal Sinus: After 12 weeks of surgery.

29.2. **Unfit**.

29.2.1. Rectal prolapse even after surgical correction.

29.2.2. Active anal fissure/External Skin tags.

29.2.3. Hemorrhoids (external or internal).

29.2.4. Anal Fistula.

29.2.5. Anal or rectal polyp.

29.2.6. Anal stricture.

29.2.7. Fecal incontinence.

30. **Ultrasonography of Abdomen**

30.1. **Liver**.

30.1.1. **Fit**.

30.1.1.1. Normal echo-anatomy of the liver, CBD, IHBR, portal and hepatic veins with liver span not exceeding 15 cm in the mid- clavicular line.

30.1.1.2. Solitary simple cyst (thin wall, anechoic) upto 2.5 cm diameter provided that the LFT is normal and hydatid serology is negative.

30.1.1.3. Hepatic calcifications to be considered fit if solitary and less than 01 cm with no evidence of active disease like tuberculosis, sarcoidosis, hydatid disease or liver abscess based on relevant clinical examinations and appropriate investigations.

30.1.2. **Unfit**.

30.1.2.1. Hepatomegaly more than 15 cm in mid-clavicular line.

30.1.2.2. Fatty liver.

30.1.2.2.1. Grade 1 Fatty liver with abnormal LFT.

30.1.2.2.2. Grade 2 and 3 Fatty Liver.

30.1.2.3. Solitary cyst > 2.5 cm.

30.1.2.4. Solitary cyst of any size with thick walls, septations, papillary projections, calcifications and debris.

30.1.2.5. Multiple hepatic calcifications or cluster greater than 01 cm.

30.1.2.6. Multiple hepatic cysts of any size.

30.1.2.7. Any haemangioma irrespective of the size and location.

30.1.2.8. Portal vein thrombosis.

30.1.2.9. Evidence of portal hypertension (Portal Vein >13 mm, collaterals, ascites).

31. **Gall Bladder.**

31.1. **Fit**.

31.1.1. Normal echo-anatomy of the gall bladder.

31.1.2. **Post Laparoscopic Cholecystectomy**. After eight weeks, provided LFT and histopathology are within normal limits.

31.1.3. **Post Open Cholecystectomy**. After 24 weeks, provided LFT and histopathology are within normal limits and in the absence of incisional hernia as confirmed on USG Abdomen.

31.2. **Unfit**.

31.2.1. Cholelithiasis or biliary sludge.

31.2.2. Choledocolithiasis.

31.2.3. Polyp of any size and number.

31.2.4. Choledochal cyst.

31.2.5. Gall bladder mass.

31.2.6. Gall bladder wall thickness > 05 mm.

31.2.7. Septate gall bladder.

31.2.8. Persistently contracted gall bladder on repeat USG.

31.2.9. Incomplete Cholecystectomy.

31.3. **Non-visualized Gall Bladder on USG**. Will be considered unfit. They will be considered fit during appeal, if agenesis of gall bladder is confirmed on Magnetic Resonance Cholangio-Pancreatography (MRCP), in the absence of any other abnormality of the biliary tract.

32. **Spleen.**

32.1. **Unfit.**

32.1.1. Spleen more than 13 cm in longitudinal axis (or if clinically palpable).

32.1.2. Any Space Occupying Lesion in the spleen.

32.1.3. Asplenia.

32.1.4. Candidates who have undergone partial/ total splenectomy are unfit, irrespective of the cause of operation.

33. **Pancreas.**

33.1. **Unfit**.

33.1.1. Any structural abnormality

33.1.2. Space Occupying Lesion/Mass lesion.

33.1.3. Features of chronic Pancreatitis (Calcification, ductal abnormality atropy)

34. **Peritoneal Cavity.**

34.1. **Unfit**.

34.1.1. Ascites.

34.1.2. Solitary mesenteric or retroperitoneal lymph node > 01 cm. (Single retroperitoneal LN < 01 cm and normal in architecture may be considered fit).

34.1.3. Two or more lymph nodes of any size

34.1.4. Any mass or cyst.

35. Major Abdominal Vasculature (Aorta/ IVC). Any structural abnormality, focal ectasia, aneurysm and calcification will be considered as unfit.

36. **Appendicectomy.**

36.1. **Laparoscopic Appendicectomy** will be assessed for post-operative fitness after a minimum period of **four weeks**. Candidates will be considered fit if:-

36.1.1. Post-operative site scars are well healed.

36.1.2. Scars are supple.

36.1.3. Histopathological report of appendix is available.

36.1.4. USG confirmation of absence of port site incisional hernia.

36.2. **Open Appendicectomy** (appendicectomy through right iliac fossa incision only) will be assessed for post-op fitness after a minimum period **12 weeks**. Candidates will be considered fit, if :-

36.2.1. Wound has healed well.

36.2.2. Scar is supple and non-tender.

36.2.3. Histopathological report of appendix is available.

36.2.4. USG confirmation of absence of surgical site incisional hernia.

Urogenital System

The fitness criteria to be followed are as follows:-

37. **Undescended testis (UDT)/ Orchidectomy.**

37.1. **Unfit**.

37.1.1 If the testis cannot be palpated (unilateral or bilateral) even after examination of the candidate in squatting position.

37.1.2. Bilateral orchidectomy due to any cause such as trauma, torsion or infection is unfit.

37.2. **Fit**.

37.2.1. Operatively corrected UDT at least four weeks after surgery, provided after surgical correction, the testis is normal in location and the wound has healed well.

37.2.2. Unilateral orchidectomy for benign cause, provided other testis is normal in size, fixation and location.

38. **Atrophic Testis.**

38.1. **Unfit**. Bilateral atrophied testis.

38.2. **Fit**. Unilateral atrophic testis for benign cause, provided other testis is normal in size, fixation and location.

39. **Varicocele.**

39.1. **Unfit**. All grades of current varicocele.

39.2. **Fit**. Post-operative cases of varicocele with no residual varicocele and no post-op complications or testicular atrophy after eight weeks of surgery.

40. **Hydrocele.**

40.1. **Unfit**. Current hydrocele on any side.

40.2. **Fit**. Operated cases of hydrocele after eight weeks of surgery, if there are no post-op complications and wound has healed well.

41. **Epididymal Cyst/ Mass, Spermatocele.**

41.1. **Unfit** – Current presence of cyst / mass

41.2. **Fit**. After 08 Weeks of Post-operative well healed cases with no recurrence and only when benign on histopathology report.

42. **Epididymitis/ Orchitis.**

42.1. **Unfit** – Presence of current orchitis or epididymitis/ tuberculosis.

42.2. **Fit** After treatment, provided the condition has resolved completely.

43. **Epispadias/ Hypospadias.**

43.1. **Unfit** – All are unfit, except glanular variety of hypospadias and epispadias, which is acceptable.

43.2. **Fit** – Post-operative cases at least 08 weeks after successful surgery, provided recovery is complete and there are no complications.

44. **Penile Amputation.** Any amputation will make the candidate unfit.

45. **Phimosis.**

45.1. **Unfit** – Current phimosis, if tight enough to interfere with local hygiene and voiding and/ or associated with Balanitis Xerotica Obliterans.

45.2. **Fit** – Operated cases will be considered fit after 04 weeks of surgery, provided wound is fully healed and no post-op complications are seen.

46. **Meatal Stenosis**

46.1. **Unfit** – Current disease, if small enough to interfere with voiding.

46.2. **Fit** – Mild disease not interfering with voiding and post-operative cases after a period of 04 weeks of surgery with adequately healed wound and no Post Operative complications.

47. Stricture Urethra, Urethral Fistula. Any history of / current cases or post-op cases are unfit.

48. Sex reassignment surgery/ Intersex condition. Unfit

49. Nephrectomy. All cases, irrespective of the type of surgery (Simple/ radical/ donor/ partial/ RFA/ cryo-ablation) are unfit.

50. Renal Transplant Recipients. Unfit

51. Urachal Cyst :08 Weeks (To be declared fit in the absence of any remnant)

52. Cases of Bladder diverticulum will be declared as Unfit.

53. **Urine Examination.**

53.1. **Proteinuria.** Proteinuria will be a cause for rejection, unless it proves to be orthostatic.

53.2. **Glycosuria.** When glycosuria is detected, a blood sugar examination (fasting and after 75 g glucose) and glycosylated Hb is to be carried out, and fitness decided as per results. Renal glycosuria is not a cause for rejection.

53.3. **Urinary Infections.** When the candidate has history or evidence of urinary infection it will entail full renal investigation. Persistent evidence of urinary infection will entail rejection.

53.4. **Haematuria.** Candidates with history of haematuria will be subjected to full renal investigation.

54. **Glomerulonephritis.**

54.1. Acute: In this condition there is a high rate of recovery in the acute phase, particularly in childhood. A candidate who has made a complete recovery and has no proteinuria may be assessed fit, after a minimum period of one year after full recovery.

54.2. Chronic: - Candidate with chronic glomerulonephritis will be rejected.

55. **Renal Calculi:** Irrespective of size, numbers, obstructive or non-obstructive,history of renal calculi (history or radiological evidence) will render a candidate Unfit.

56. Sexual Transmitted Diseases and Human Immuno Deficiency Virus (HIV). Seropositive HIV status and/ or evidence of STD will entail rejection.

57. Ultrasonography of the Abdomen - Urogenital System

58. **Kidneys, ureters and urinary bladder**

58.1 **Unfit**

58.1.1. Congenital structural abnormalities of kidneys or urinary tract

58.1.1.1. Unilateral renal agenesis.

58.1.1.2. Unilateral or bilateral hypoplastic/ contracted kidney of size less than 08 cm.

58.1.1.3. Malrotation of kidney.

58.1.1.4. Horseshoe kidney.

58.1.1.5. Ptosed kidney.

58.1.1.6 Crossed fused/ ectopic kidney.

58.1.2. Simple single renal cyst of more than 1.5 cm size in one kidney.

58.1.3. Complex cyst/ polycystic disease/ multiple or bilateral cysts.

58.1.4. Renal/ ureteric/ vesical mass.

58.1.5. Hydronephrosis or Hydroureteronephrosis.

58.1.6. Calculi - Renal/ Ureteric/ Vesical.

58.1.7. Calyectasis

58.2 **Fit**

58.2.1. Solitary, unilateral, simple renal cyst <1.5 cm provided the cyst is peripherally located, round/ oval, with thin smooth wall and no loculations, with posterior enhancement, no debris, no septa and no solid component.

Endocrine System.

59. Any history suggestive of endocrine disorders will be a cause for rejection.

60. **Clinical Examination**. Any clinical evidence of endocrine disease will be unfit.

61. All cases of thyroid swelling are unfit. Fitness of such cases will be decided during appeal medical board after evaluation with appropriate investigations.

62. Candidates detected to have Diabetes Mellitus will be rejected. A candidate with a family history of Diabetes Mellitus will be subjected to blood sugar (Fasting and after two hours of 75 g of anhydrous / 82.5 g monohydrate Glucose load) and HbA1c evaluation, which will be recorded.

Dermatological System.

63. **Relevant History and Examination**. Candidates who give history of sexual exposure to a Commercial Sex Worker (CSW) and have evidence of healed penile sore in the form of a scar must be declared permanently unfit, even in absence of an overt STD, as these candidates are likely 'repeaters' with similar indulgent promiscuous behavior.

64. **Assessment of Diseases of the Skin.** Acute non-exanthematous and non-communicable diseases, which ordinarily run a temporary course, need not be a cause of rejection. Diseases of a trivial nature, and those, which do not interfere with general health or cause incapacity, do not entail rejection.

65. Certain skin conditions are apt to become active and incapacitating under tropical conditions. An individual is unsuitable for service if he has a definite history or signs of chronic or recurrent skin disease. Some of such conditions are described below:-

66. **Palmoplantar Hyperhydrosis**. Some amount of Palmoplantar Hyperhydrosis is physiological, considering the situation that recruits face during medical examination. However, candidates with significant Palmoplantar Hyperhydrosis should be considered unfit.

67. **Acne vulgaris** Mild (Grade I) acne consisting of few comedones or papules, localized only to the face may be acceptable. However, moderate to severe degree of acne (nodulocystic type with or without keloidal scarring) or involving the back should be considered unfit.

68. **Palmoplantar Keratoderma** Any degree of palmoplantar keratoderma manifesting with hyperkeratotic and fissured skin over the palms, soles and heels should be considered unfit.

69. **Ichthyosis vulgaris** Ichthyosis involving the upper and lower limbs, with evident dry, scaly, fissured skin should be considered unfit. Mild xerosis (dry skin) could be considered fit.

70. Candidates having any keloid should be considered unfit.

71. Clinically evident onychomycosis of finger and toe-nails should be declared unfit, especially if associated with nail dystrophy. Mild degree of distal discoloration involving single nail without any dystrophy may be acceptable.

72. Giant congenital melanocytic naevi, greater than 10 cm should be considered unfit, as there is a malignant potential in such large sized naevi.

73. Single corns/ Warts/ Callosities will be considered fit, three months after successful treatment and no recurrence. However, candidates with multiple warts/ corns/ callosities on palms and soles or diffuse palmoplantar mosaic warts, large callosities on pressure areas of palms and soles should be rejected.

74. Psoriasis is a chronic skin condition known to relapse and/or recur and hence should be considered unfit.

75. **Vitiligo**. Those having vitiligo must be made unfit. On appeal, segmental vitiligo under the covered parts may be accepted.

76. A history of chronic or recurrent episodes of skin infections will be cause for rejection. Folliculitis or sycosis barbae from which there has been complete recovery may be considered fit.

77. Individuals who have chronic or frequently recurring episodes of a skin disease of a serious or incapacitating nature e.g. eczema are to be assessed as permanently unfit and rejected.

78. Any sign of Leprosy will be a cause for rejection. All peripheral nerves should be examined for any thickness of the nerves and any clinical evidence suggestive of leprosy is a ground for rejection.

79. Naevus depigmentosus and Beckers naevus may be considered fit. Intradermal naevus, vascular naevi are to be made unfit.

80. Pityriasis Versicolor is to be made unfit. They can be made fit on appeal, if completely treated.

81. Any fungal infection of any part of the body will be unfit. They can be made fit on appeal, if completely treated.

82. Scrotal Eczema may be considered fit on recovery.

83. Canities (premature graying of hair) may be considered fit if mild in nature and no systemic association is seen.

84. Intertrigo may be considered fit on recovery.

85. All STDs are unfit.

86. Scabies may be considered fit only on recovery.

87. Alopecia areata single and small (<2 cm in diameter) lesion on scalp can be accepted. However if multiple, involving other areas or having scarring, the candidate should be rejected.

88. **Gynaecomastia**: Candidates to be considered fit after 12 weeks of post-operative period if: -

88.1. There is a well healed surgical wound with no residual disease.

88.2. No Post Operative complication.

88.3. Surgical scar should be sufficiently matured and unlikely to cause any problems during military training.

88.4. Normal general physical examination.

88.5. Endocrine workup is normal

89. **Polymazia** Candidates to be considered fit after 12 weeks of Post-Operative period if thethere is no Post Operative complication with a well healed surgical wound and no residual disease.

Musculoskeletal System and Physical Capacity

90. **Spinal Conditions:** Past medical history of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the candidate from successfully following a physically active life, is a cause for rejection for commissioning. History of recurrent lumbago/ spinal fracture/ prolapsed intervertebral disc and surgical treatment for these conditions will entail rejection.

91. Clinical Examination. Normal thoracic kyphosis and cervical/ lumbar lordosis are barely noticeable and not associated with pain or restriction of movement.

91.1. If clinical examination reveals restriction of spine movements, deformities, tenderness of the spine or any gait abnormalities, it will be considered unfit.

91.2. Gross kyphosis, affecting military bearing/ restricts full range of spinal movements and/or expansion of chest is unfit.

91.3. When scoliosis is noticeable or any pathological condition of the spine is suspected, radiographic examination of the appropriate part of the spine needs to be carried out. Scoliosis is unfit, if deformity persists on full flexion of the spine, when associated with restricted range of spine movements or when due to an underlying pathological cause.

91.4. **Spina Bifida**. The following markers should be looked for, on clinical examination and corroborated with radiological evaluation:-

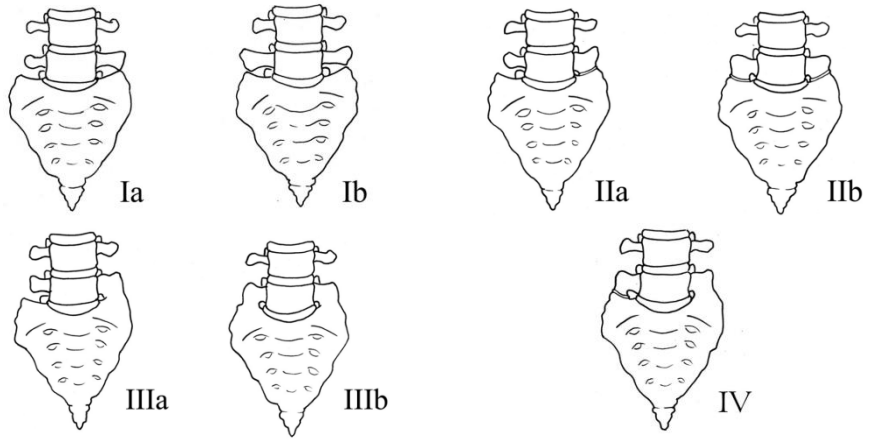
91.4.1. Congenital defects overlying the spine eg, hypertrichosis, skin dimpling, haemangioma, pigmented naevus or dermal sinus.

91.4.2. Presence of lipoma over spine.

91.4.3. Palpable spina bifida.

91.4.4. Abnormal findings on neurological examination.

92. **Castellvi Classification for Lumbosacral Transitional Vertebra (LSTV)**.



Castellvi Classification for LSTV

92.1. **Type I**. Enlarged and dysplastic transverse process (at least 19 mm in width in craniocaudal dimension).

92.1.1. **I a**. Unilateral.

92.1.2. **I b**. Bilateral.

92.2. **Type II**. Pseudoarticulation of the transverse process and sacrum with incomplete lumbarisation/sacralistion (enlargement of the transverse process with pseudoarthrosis).

92.2.1. **II a**. Unilateral.

92.2.2. **II b**. Bilateral.

92.3. **Type III**. Transverse process fuses with the sacrum and there is complete lumbarisation or sacralisation (enlarged transverse process with complete fusion).

92.3.1. **III a**. Unilateral.

92.3.2. **III b**. Bilateral.

92.4. **Type IV**. Type II on one side and type III on the contralateral side.

93. Spinal Conditions Unfit for Air Force Duties (Both Flying and Ground Duties)

93.1. **Congenital/Developmental Anomalies**.

93.1.1. Wedge Vertebra.

93.1.2. Hemivertebra.

93.1.3. Anterior Central Defect.

93.1.4. Cervical Ribs (Unilateral/Bilateral) with demonstrable neurological or circulatory deficit.

93.1.5. Spina Bifida. All types are unfit except in sacrum and LV5 (if completely sacralised).

93.1.6. Loss of Cervical Lordosis with neurological deficit.

93.1.7. Assessment of Scoliosis. Idiopathic scoliosis upto 10 degrees for Lumbar Spine and 15 degrees for Dorsal Spine will be acceptable provided:-

93.1.7.1. Individual is asymptomatic.

93.1.7.2. No history of trauma to spine.

93.1.7.3 No chest asymmetry/shoulder imbalance or pelvic obliquity in the lumbar spine.

93.1.7.4. There is no neurological deficit.

93.1.7.5. No congenital anomaly of the spine.

93.1.7.6. There is absence of syndromic features.

93.1.7.7. ECG is normal.

93.1.7.8. No deformity exists on full flexion of the spine.

93.1.7.9. No restriction of range of movements

93.1.7.10 No organic defect causing structural abnormality.

93.1.8. Atlanto-occipital and Atlanto-axial anomalies.

93.1.9. Incomplete block vertebra at any level.

93.1.10. Complete block vertebra **at more than one level**. (Single level is acceptable. Annotation is to be made in AFMSF-2).

93.1.11. **Lumbosacral Transitional Vertebra (LSTV)**. Unilateral sacralisation or lumbarisation (complete or incomplete) and Bilateral incomplete sacralisation or lumbarisation (LSTV- Castellvi Type II a and b, III a and IV).

Bilateral Complete Sacralisation of LV5 and Bilateral Complete Lumbarisation of SV1, LSTV Castellvi Type III b, Type I a and b are acceptable (Annotation is to be made in AFMSF-2).

93.1.12. Spondylolysis/Spondylolisthesis.

93.1.13. Intervertebral Disc Prolapse.

93.1.14. Schmorl's Nodes at more than one level.

93.2. **Traumatic Conditions**

93.2.1. Spondylolysis/ Spondylolisthesis

93.2.2. Compression fracture of vertebra

93.2.3. Intervertebral Disc Prolapse

93.2.4. Schmorl's Nodes at more than one level

93.3. **Infective**

93.3.1. Tuberculosis and other Granulomatous disease of spine (old or active)

93.3.2. Infective Spondylitis

93.4. **Autoimmune**

93.4.1. Rheumatoid Arthritis and allied disorders

93.4.2. Ankylosing spondylitis

93.4.3. Other rheumatological disorders of spine e.g Polymyositis, SLE and Vasculitis

93.5. **Degenerative**

93.5.1. Spondylosis

93.5.2. Degenerative Joint Disorders

93.5.3. Degenerative Disc Disease

93.5.4. Osteoarthrosis/ osteoarthritis

93.5.5. Scheuerman's Disease (Adolescent Kyphosis)

93.6. **Any other spinal abnormality, if so considered by the specialist.**

Conditions affecting the assessment of upper limbs

94. **Amputations and Deformities of Upper limbs.** Deformities of the upper limbs or their parts will be cause for rejection. Candidate with an amputation of a limb or any part of limb including fingers will not be accepted for entry.

95. **Fingers and Hands**. Deformities and limitations to movements will be considered unfit.

95.1. **Polydactyly**. Can be declared fit 12 weeks post- operative, if there is no bony abnormality on radiograph, wound is well healed, scar is supple and there is no evidence of neuroma on clinical examination.

95.2. **Simple Syndactyly**. Can be declared fit 12 weeks post-operative, if there is no bony abnormality on radiograph, wound is healed, scar is supple and webspace is satisfactory.

95.3. **Complex syndactyly**. Unfit.

95.4. **Hyperextensible finger joints**. All candidates shall be thoroughly examined for hyperextensible finger joints. Any extension of fingers bending backwards beyond 90 degrees shall be considered hyperextensible and considered unfit. Other joints like knee, elbow, spine and thumb shall also be examined carefully for features of hyper-laxity/hypermobility. Although the individual may not show features of hyperlaxity in other joints, isolated presentation of hyperextensibility of finger joints shall be considered unfit because of the various ailments that may manifest later, if such candidates are subjected to strenuous physical training.

95.5. **Mallet Finger**. Loss of extensor mechanism at the distal interphalangeal joint leads to Mallet finger. Chronic mallet deformity can lead to secondary changes in the proximal inter-phalangeal (PIP) and metacarpo-phalangeal (MCP) joint which can result in compromised hand function. Normal range of movement at distal inter-phalangeal (DIP) joints is 0-80 degree and PIP joint is 0-90 degree in both flexion and extension. In Mallet finger, the candidate is unable to extend/straighten distal phalanx of fingers completely.

95.1. Candidates with mild condition ie, less than 10 degree of extension lag without any evidence of trauma, pressure symptoms and any functional deficit must be declared fit.

95.2. Candidates with fixed deformity of fingers will be declared unfit.

96. **Wrist.** Painless limitation of movement of the wrist will be assessed according to the degree of stiffness. Loss of dorsiflexion is more serious than loss of palmar flexion.

97. **Elbow.** Slight limitation of movement does not bar acceptance provided functional capacity is adequate. Ankylosis will entail rejection. Cubitus Valgus is said to be present when the carrying angle (angle between arm and forearm in anatomical posture) is exaggerated. In absence of functional disability and obvious cause like a fracture mal-union, fibrosis or the like, a carrying angle of upto 15º in male and 18º in female candidates would be made fit.

98. **Hyperextension at elbow joint:** Individuals can have naturally hyperextended elbow. This condition is not a medical problem, but can be a cause of fracture or chronic pain especially considering the stress and strains military population is involved in. Also, the inability to return the elbow to within 10 degrees of the neutral position is impairment in the activities of daily living.

98.1. Measurement modality: Measured using a goniometer

98.2. Recommendation: Normal elbow extension is 0 degrees. Up to 10 degrees of hyperextension is within normal limits if the patient has no history of trauma to the joint. Anyone with hyperextension more than 10 degrees should be unfit.

99. Cubitus Varus of > 5 degree will be unfit.

100. Cubitus Recurvatum:. Cubitus recurvatum>10 degrees is unfit

101. Shoulder Girdle. History of recurrent dislocation of shoulder with or without corrective surgery will be unfit.

102. Clavicle. Non-union of an old fracture clavicle will entail rejection. Mal-united clavicle fracture without loss of function and without obvious deformity are acceptable.

Conditions affecting the assessment of lower limbs

103. Hallux valgus with angle >20 degrees and first-second metatarsal angle of >10 degrees is unfit. Hallux valgus of any degree with bunion, corns or callosities is unfit.

104. Hallux rigidus is unfit for service.

105. Isolated single flexible mild hammer toe without symptoms may be accepted. Fixed (rigid) deformity or hammer toe associated with corns, callosities, mallet toes or hyperextension at meta-tarso-phalangeal joint (claw toe deformity) are to be rejected.

106. Loss of any digits/ toes entails rejection.

107. Deformities of the lower limbs or their parts will be cause for rejection. Candidate with an amputation of a limb or any part of limb including toes will not be accepted for entry.

108. **Pes Planus (Flat feet)**

108.1. If the arches of the feet reappear on standing on toes, if the candidate can skip and run well on the toes and if the feet are supple, mobile and painless, the candidate is acceptable.

108.2. Rigid or fixed flat feet, gross flat feet, with planovalgus, eversion of heel, cannot balance himself on toes, cannot skip on the forefoot, tender painful tarsal joints, prominent head of talus will be considered unfit. Restriction of the movements of the foot will also be a cause for rejection. Rigidity of the foot, whatever may be the shape of the foot, is a cause for rejection.

109. Pes Cavus and Talipes (Club Foot). Mild degree of idiopathic pes cavus without any functional limitation is acceptable. Moderate and severe pes cavus and pes cavus due to organic disease will entail rejection. All cases of Talipes (Club Foot) will be rejected.

110. Ankle Joints. Any significant limitation of movement following previous injuries will not be accepted. Functional evaluation with imaging should be carried out wherever necessary.

111. Knee Joint. Any ligamentous laxity is not accepted. Candidates who have undergone ACL reconstruction surgery are to be considered unfit.

112. Genu valgum (knock knee) with intermalleolar distance > 5 cm in males and > 8 cm in females will be unfit.

113. Genu varum (bow legs) with intercondylar distance >7 cm will be considered unfit.

114. Genu Recurvatum. If the hyperextension of the knee is within 10 degrees and is unaccompanied by any other deformity, the candidate should be accepted as fit.

115. True lesions of the hip joint or early signs of arthritis will entail rejection.

Healed Fractures

116. **Intra-Articular Fractures**. All intra-articular fractures especially of major joints (shoulder, elbow, wrist, hip, knee and ankle) with or without surgery, with or without implant shall be considered unfit.

117. **Extra-Articular Fractures**.

117.1. All extra-articular fractures with post-operative implant in-situ shall be considered unfit and will be considered for fitness after minimum of 12 weeks of implant removal.

117.2. Nine months will be the minimum duration for considering evaluation following extra-articular injuries of all long bones (both upper and lower limbs) post injury which have been managed conservatively. Individual will be considered fit if there is:-

117.2.1. No evidence of mal-alignment/mal-union.

117.2.2. No neuro-vascular deficit.

117.2.3. No soft tissue loss.

117.2.4. No functional deficit.

117.2.5. No evidence of osteomyelitis/sequestra formation.

118. Peripheral Vascular System

119. Varicose Veins. All cases with active varicose veins will be declared unfit. Post-op cases of varicose veins also remain unfit.

120. Arterial System. Current or history of abnormalities of the arteries and blood vessels e.g. aneurysms, arteritis and peripheral arterial disease will be considered unfit.

121. Lymphoedema. History of past/ current disease makes the candidate unfit.

Central Nervous System

122. **History of Mental Illness**. A candidate giving a history of mental illness/psychological afflictions will be rejected.

123. **Family History of Psychological Disorders**. When a history of nervous breakdown, mental disease, or suicide of a near relative is obtained, a careful investigation of the personal past history from a psychological point of view is to be obtained. Any evidence of even the slightest psychological instability in the personal history or present condition must entail rejection.

124. **Family History of Epilepsy**. If a history of epilepsy is obtained in a near relative, then the candidate must be made unfit and subjected to a detailed evaluation with appropriate investigations at the time of appeal.

125. **Severe or 'Throbbing' Headache and Migraine**. A candidate with migraine, which was severe enough to make him/her consult a doctor, will be a cause for rejection. Even a single attack of migraine with visual disturbance or Migrainous epilepsy is to be made unfit.

126. **Fits and Convulsions**. History of epilepsy in a candidate is a cause for rejection. Seizures may masquerade as 'faints' and therefore the frequency and the conditions under which 'faints' took place must be elicited. Such attacks will be made unfit, whatever their apparent nature. An isolated fainting attack calls for enquiry into all the attendant factors to distinguish between syncope and seizures. Complex partial seizures, are criteria for making the candidate unfit.

127. **Heat stroke**. History of repeated attacks of heat stroke, hyperpyrexia or heat exhaustion bars employment for Air Force duties, as it is an evidence of a faulty heat regulating mechanism. A single severe attack of heat effects provided the history of exposure was severe, and no permanent sequelae were evident is, by itself, not a reason for rejecting the candidate.

128. **Head Injury or Concussion**. A history of severe head injury/fracture of the skull/ history of intracranial damage or any residual bony defect in the calvaria is a cause for rejection. Presence of burr holes will be cause for rejection.

129. **Psychosis**. All candidates who are suffering from psychosis are to be rejected. Drug dependence in any form will also be a cause for rejection.

130. **Psychoneurosis**. Mentally unstable and neurotic individuals are unfit for commissioning. Juvenile and adult delinquency, history of nervous breakdown or chronic ill-health are causes for rejection.

131. **Organic Nervous Conditions**. Any evident neurological deficit will call for rejection.

132. **Tremors**. Persistent tremors even after reassuring the candidate will be unfit. On appeal only pathological tremors will render the candidate unfit.

133. **Stammering**. Candidates with stammering will be declared unfit. Stammering will be made unfit, even if it is first detected during the time of appeal medical board.

134. Any history of mental disorder in the family or in the candidate himself/herself or signs of intellectual, emotional or conduct disorders or symptoms of psychosomatic disorders should be made unfit and subjected to detailed evaluation and appropriate investigations at the time of appeal by the psychiatrist.

135. **Hyperstosis Frontalis Interna** will be considered fit in the absence of any other metabolic abnormality.

Ear, Nose and Throat

136. **Nose and Para-nasal Sinuses**.

136.1. **External Deformity of Nose or Deviated Nasal Septum**.

136.1.1. Unfit - Gross external deformity of nose causing cosmetic deformity or obstruction to free breathing as a result of a marked septal deviation.

136.1.2. On appeal - Post corrective surgery with residual mild deviation with adequate airway patency will be acceptable after four weeks post-surgery.

136.2. **Septal Perforation**- Unfit

136.2.1. On appeal - Any anterior septal perforation/posterior septal perforation > 01 cm in the greatest dimension is a ground for rejection. A septal perforation which is associated with nasal deformity, nasal crusting, epistaxis and granulation irrespective of the size is a ground for rejection.

136.3. Atrophic rhinitis- Unfit.

136.4. Any history/clinical evidence suggestive of allergic rhinitis/vasomotor rhinitis are to be declared Unfit

136.5. Any infection of the para-nasal sinuses is to be declared Unfit. Such cases may be accepted following successful treatment at the Appeal Medical Board.

136.6. **Nasal polyposis**. Unfit (treated or untreated).

137. **Oral Cavity**.

137.1. **Unfit**.

137.1.1. Current/operated cases of leukoplakia, erythroplakia, submucous fibrosis, ankyloglossia and oral carcinoma.

137.1.2. Current oral ulcers/growths and mucous retention cysts.

137.1.3. Trismus due to any cause.

137.1.4. Cleft palate, even after surgical correction.

137.2. **Fit**.

137.2.1. Completely healed oral ulcers after four weeks post-surgery with proven benign histopathology.

137.2.2. Operated cases of mucus retention cyst with no recurrence and proven benign histology. Evaluation in these cases must be done after minimum four weeks post-surgery.

137.2.3. Sub-mucous cleft of palate with or without bifid uvula not causing Eustachian tube dysfunction may be accepted by ENT specialist, provided PTA, tympanometry and speech are normal.

138. **Pharynx and Larynx**. The following conditions are unfit:-

138.1. Any ulcerative/mass lesion of the pharynx.

138.2. Candidates in whom tonsillectomy is indicated. Such candidates may be accepted minimum four weeks after successful surgery provided there are no sequelae and histology is benign.

138.3. Cleft palate.

138.4. Any disabling condition of the pharynx or larynx causing persistent hoarseness or dysphonia.

138.5. Chronic laryngitis, vocal cord palsy, laryngeal polyps and growths.

139. **Eustachian Tube Dysfunction**. Unfit- Obstruction or insufficiency of Eustachian tube function.

140. **Tinnitus**. Unfit

141. **Susceptibility to Motion Sickness**. Specific enquiry must be made for any susceptibility to motion sickness. An endorsement to this effect must be made in AFMSF-2. Such cases will be fully evaluated and, if found susceptible to motion sickness, **they will be rejected for flying duties**. Any evidence of peripheral vestibular dysfunction due to any cause will entail rejection.

142. **Hearing loss**. The following are not acceptable: -

142.1. Hearing acuity below 600 cm in CV or FW.

142.2. The audiometric loss greater than 20 db, in frequencies between 250 and 8000 Hz on PTA.

143. **External Ear**. The following defects of external ear must be declared unfit:-

143.1. Gross deformity of pinna which may hamper wearing of uniform/personal kit/ protective equipment, or which adversely impacts military bearing.

143.2. Cases of chronic otitis externa.

143.3. Any condition (ear wax, atresia/narrowing of external auditory meatus or neoplasm, exaggerated tortuosity of the canal, bony growth of external auditory canal) preventing a proper visualization of the tympanic membrane.

143.4. Granulation or polyp in external auditory canal.

144. **Middle Ear**. The following conditions of middle ear will entail rejection:-

144.1. **Otitis Media**. Current Otitis Media of any type will entail rejection. If evidence of healed chronic otitis media (in the form of tympanosclerosis/scarred tympanic membrane affecting only pars tensa part of tympanic membrane) and all operated cases of tympanoplasty/Myringotomy will be assessed by ENT specialist. They will be acceptable if Pure Tone Audiometry (PTA) and Tympanometry are normal**.** On appeal, a trial of decompression chamber may be carried out, if indicated, for aircrew, ATC/FC, submariners/divers.

144.2. Any type of TM perforation or healed perforation/retraction in pars flaccida of the tympanic membrane is unfit.

144.3. Marked retraction or restriction in TM mobility on pneumatic otoscopy.

144.4. Tympanometry showing patterns other than Type ‘A’ tympanogram.

144.5. Any implanted hearing devices eg, cochlear implants, bone-anchored hearing aids etc.

144.6. After middle ear surgeries viz, stapedectomy, ossiculoplasty, any type of mastoidectomy.

145. **Miscellaneous Ear Conditions**. The following ear conditions will entail rejection: -

145.1. Otosclerosis.

145.2. Meniere's disease.

145.3. Vestibular dysfunction including nystagmus of vestibular origin.

145.4. Bell's palsy following ear infection.

OPHTHALMIC SYSTEM

146. **Clinical Examination findings**.

146.1. Candidates, who are wearing spectacles or found to have defective vision, should be properly assessed. All cases of squint are unfit.

146.2. **Ptosis**.

146.2.1. Candidates, who meet the following criteria are **Fit**.

146.2.1.1. Mild ptosis.

146.2.1.2. Clear visual axis.

146.2.1.3. Normal visual field.

146.2.1.4. No sign of aberrant degeneration/head tilt /Horner's Syndrome.

146.2.2. Rest all cases - **Unfit**

146.2.3. On appeal - Candidates who have undergone surgical correction may be considered fit provided one year has elapsed post-surgery with no recurrence, the above-mentioned criteria are met and upper eyelid is not more than 02 mm below the superior limbus.

146.3. **Exotropia**. Unfit.

146.4. **Anisocoria**. If size difference between the pupils is >01 mm, candidate will be considered unfit.

146.5. **Heterochromia irides**. Unfit

146.6. **Sphincter tears**. Can be considered fit, if size difference between pupils is <01 mm, pupillary reflexes are brisk with no observed pathology in cornea, lens or retina.

146.7. **Pseudophakia**. Unfit

146.8. **Blepharitis**. Candidates with blepharitis, particularly with loss of eyelashes, must be rejected.

146.9. **Ectropion/Entropion**. These cases are to be made unfit. On appeal, mild ectropion and entropion which in the opinion of ophthalmologist will not hamper day to day functioning in any way, may be made fit.

146.10. **Pterygium**. All cases of pterygium are to be made unfit. On appeal, regressive non-vascularised pterygium occupying ≤ 1.5 mm of the peripheral cornea may be made fit by Eye Specialist after measurement on a slit lamp.

146.11. **Nystagmus**. All cases of nystagmus are to be made unfit except for physiological nystagmus.

146.12. Naso-lacrymal duct occlusion producing epiphora or a mucocele entails rejection.

146.13. Active Uveitis (iritis, cyclitis and choroiditis) will be grounds for rejection. Candidates giving a history of this condition should be made unfit.

146.14. **Cornea**.

146.14.1. Unfit

146.14.1.1. Corneal scars/opacities

146.14.1.2. Any candidate with progressive corneal disorders viz, Corneal dystrophies, Keratoconus, Keratoglobus, any corneal degenerations.

146.14.1.3. Any active corneal disorder.

146.14.2. On appeal corneal scars are acceptable if it does not interfere with vision.

146.15. **Lenticular opacities**. – Unfit

On appeal

146.15.1. **Unfit**- Any lenticular opacity that is causing visual deterioration or is in the visual axis or central area of 04 mm around the pupils is unfit. The propensity of the opacities not to increase in size or number should also be a considered.

146.15.2. **Fit -** Small stationary lenticular opacities in the periphery like congenital blue dot cataract, not affecting the visual axis/visual field (should be less than 10 in number and central area of 04 mm should be clear).

146.16. **Optic Nerve Drusen**. Unfit.

146.17. **High Cup - Disc ratio**. Unfit, if any of the following conditions exist:-

146.17.1. Inter-Eye asymmetry in cup disc ratio > 0.2.

146.17.2. Retinal Nerve fibre Layer (RNFL) defect seen by RNFL analysis on Optical Coherence Tomography (OCT).

146.17.3. Visual Field defect detected by Visual Field Analyser.

146.18. Migraine with visual symptoms are not a strictly ocular problem and should be assessed in accordance with para-124.

146.19. As tests for night blindness are not routinely performed, a certificate to the effect that the individual does not suffer from night blindness will be obtained in every case. Certificate should be as per **Annexure 3** to this chapter. A proven case of night-blindness is unfit.

146.20. Restriction of movements of the eyeball in any direction and undue depression/prominence of the eyeball are unfit.

146.21. **Retinal lesions**. A small healed chorio-retinal scar in the retinal periphery not affecting the vision and not associated with any other complications will be considered fit.

Similarly, a small lattice in periphery with no other complications will be made fit. **Any lesion in the central fundus will be made unfit.**

146.22. **Lattice degeneration**.

146.22.1. The following lattice degeneration will render a candidate unfit:-

146.22.1.1. Single circumferential lattice extending more than two clock hours in either or both eyes.

146.22.1.2. Two circumferential lattices, each more than one clock hour in extent in either or both eyes.

146.22.1.3. Radial lattices.

146.22.1.4. Any lattice with atrophic hole/flap tears (Unlasered).

146.22.1.5. Lattice degeneration posterior to equator.

146.22.2. Candidates with lattice degeneration will be considered fit under the following conditions: -

146.22.2.1. Single circumferential lattice without holes of less than two clock hours in either or both eyes.

146.22.2.2. Two circumferential lattices without holes each being less than one clock hour in extent in either or both eyes.

146.22.2.3. Post-laser delimitation, single circumferential lattice, without holes/flap tear, less than two clock hours extent in either or both eyes.

146.22.2.4. Post-laser delimitation, two circumferential lattices, without holes/flap tear, each being less than one clock hour extent in either or both eyes.

146.23. **Keratoconus**. Keratoconus is unfit.

147. **Visual Acuity/Colour Vision**. The visual acuity and colour vision requirements are detailed in **Annexure 4** to this chapter. Those who do not meet these requirements will be rejected.

148. **Myopia**.

148.1. Unfit, if outside the prescribed visual limits.

148.2. Unfit even if the corrected visual acuity is within the acceptable limits when:-

148.2.1. There is a strong family history of high myopia, and that the visual defect is recent onset.

148.2.2. If physical growth is still expected.

148.2.3. If the fundus appearance is suggestive of progressive myopia.

149. **Refractive Surgeries**. The disposal of candidates who have undergone Keratorefractive Surgeries (PRK, LASIK, Femto LASIK, SMILE or equivalent procedures) for commissioning in the Air Force in all branches is as follows :-

149.1. **Fit**

149.1.1. Candidates for IAF meeting the visual requirements for the branch as laid down in Appendix D to para **146.** Residual refraction after such procedure should not be more than +/- 1.0 D Sph or Cyl for branches where correctable refractive errors are permitted.

149.1.2. Keratorefractive Surgery must not have been carried out before the age of 20 years.

149.1.3. At least 12 months must have elapsed post uncomplicated stable Keratorefractive Surgery with no history or evidence of any complication.

149.1.4. The axial length of the eye must not be more than 26 mm as measured by IOL master.

149.1.5. The post Keratorefractive Surgery corneal thickness as measured by a corneal Pachymeter must not be less than 450 microns.

149.2. **Unfit**

149.2.1. Radial Keratotomy (RK) surgery for correction of refractive errors

149.2.2. Individuals with high refractive errors (> 6 D) prior to Keratorefractive Surgery.

150. **Cataract Surgeries**. Candidates having undergone cataract surgery with or without IOL implants will be declared unfit.

151. **Other Eye Surgeries**. Candidates having undergone any invasive surgeries viz, Implantable Collamer Lens (ICL), Trabeculectomy, Glaucoma surgeries with or without implants, Corneal Collagen Crosslinking with Riboflavin (C3R), INTACS, any intra ocular injections, retinal surgeries etc, will be declared unfit.

Ocular Muscle Balance

152. Individuals with manifest squint are not acceptable for commissioning.

153. The assessment of latent squint or heterophoria in the case of aircrew will be mainly based on the assessment of the fusion capacity. A strong fusion sense ensures the maintenance of binocular vision in the face of stress and fatigue. Hence, it is the main criterion for acceptability.

153.1. **Convergence (as Assessed on RAF rule)**.

153.1.1. **Objective Convergence**.

153.1.1.1. Up to 10 cm- Fit.

153.1.1.2. More than 10 cm - Unfit.

153.1.2. **Subjective Convergence (SC)**. This indicates the end point of binocular vision under the stress of convergence. If the subjective convergence is more than 10 cm beyond the limit of objective convergence, the fusion capacity is poor. This is specially so when the objective convergence is 10 cm and above.

153.2. **Accommodation**. In the case of myopes, accommodation should be assessed with corrective glasses in position. The acceptable values for accommodation in various age groups are given in Table 1.

Table 1 -Accommodation Values – Age wise

Age in years	17-20	21-25	26-30	31-35	36-40	41-45
Accommodation (in cm)	10-11	11-12	12.5-13.5	14-16	16-18.5	18.5-27

154. Ocular muscle balance is dynamic and varies with concentration, anxiety, fatigue, hypoxia, drugs and alcohol. The above tests should be considered together for the final assessment. Standards for assessment of Ocular Muscle Balance are detailed in **Annexure 5** to this chapter.

155. Any clinical findings in the media (cornea, lens, vitreous) or fundus, which is of pathological nature and likely to progress will be a cause for rejection. This examination will be done by slit lamp and ophthalmoscopy under mydriasis.

Annexure 3

[Refers to para 146.19 of Appendix A (Ophthalmology standards)]

CERTIFICATE REGARDING NIGHT BLINDNESS

Name with initials_____ Batch No. _____ Chest No _____

I hereby certify that to the best of my knowledge, there has not been any case of night blindness in our family, and I do not suffer from it.

Date: (Signature of the candidate)

Countersigned by

(Name of Medical Officer)

Annexure 4

[Refers to para 147 of Appendix A (Ophthalmology standards)]

VISUAL STANDARDS FOR CANDIDATES AT INITIAL ENTRY

Ser No.	Med Cat	Branch	Maximum Limits of Refractive Error	Visual Acuity (VA) with Limits of Maximum Correction	Colour Vision
1.	A1G1	F(P) including WSOs/CSOs, Flying Branch Cadets at NDA and AFA	**Hypermetropia**: + 1.5 D Sph **Manifest Myopia**: Nil **Astigmatism**: + 0.75 D Cyl (within +1.5 D Max) **Retinoscopic Myopia**: Nil	6/6 in one eye and 6/9 in other, correctable to 6/6 both eyes only for Hypermetropia	CP-I
2.	A4G1	Adm/ATC/FC/ WS	**Hypermetropia**: +3.5 D Sph **Myopia**: -3.50 D Sph **Astigmatism:** ± 2.50 D Cyl	Correctable to 6/6 in each eye. Wearing of glasses will be compulsory when visual acuity is below 6/6	CP-II
3.	A4G1	AE(M)/ AE(L)	**Hypermetropia**: +3.5 D Sph **Myopia**: -3.50 D Sph **Astigmatism:** ± 2.50 D Cyl	Corrected visual acuity must be 6/6 in each eye. Wearing of glasses will be compulsory when advised.	CP-II
4.	A4G1	Met	**Hypermetropia**: +3.5 D Sph **Myopia**: -3.50 D Sph **Astigmatism:** ± 2.50 D Cyl	Corrected visual acuity must be 6/6 both eyes. Wearing of glasses will be compulsory.	CP-II
5.	A4G1	Accts/ Lgs/ Edn	**Hypermetropia**: +3.5 D Sph **Myopia**: -3.50 D Sph **Astigmatism:** ± 2.50 D Cyl	Corrected visual acuity must be 6/6 both eyes. Wearing of glasses will be compulsory.	CP-II

Note: -

1. Ocular muscle balance for personnel covered in Ser No. 1 and 2 must conform to Appendix C to this Chapter.

2. The Sph correction factors mentioned above will be inclusive of the specified astigmatic correction factor. A minimum correction factor upto the specified visual acuity standard can be accepted.

Annexure 5

(Refers to para 154 of Appendix A)

STANDARD OF OCULAR MUSCLE BALANCE FOR FLYING DUTIES

Ser. No.	Test	Fit
1	Maddox Rod Test at 06 m	Exo - 06 Prism D Eso - 06 Prism D Hyper - 01 prism D Hypo - 01 prism D
2	Maddox Rod Test at 33 cm	Exo -16 Prism D Eso - 06 Prism D Hyper - 01 Prism D Hypo - 01 Prism D
3	TNO Test or Titmus Fly Test	All of BSV grades
4	Convergence	Up to 10 cm
5	Cover Test for Distance and Near	Latent divergence/convergence recovery rapid and complete

Haemopoietic System

156. All cases of anemia (<13 g/dL in males and <12 g/dL in females) will be declared unfit during SMB.

157. All candidates with evidence of hereditary haemolytic anaemias (due to red cell membrane defect or due to red cell enzyme deficiencies) and haemoglobinopathies (Sickle cell disease, Beta-Thalassaemia: Major, Intermedia, Minor, Trait and Alpha Thalassaemia etc) are to be considered unfit for service.

158. Candidates with history of haemophilia or von Willebrand's disease are to be declared unfit. Candidates with clinical evidence of purpura or evidence of thrombocytopenia are to be considered unfit. Cases of Purpura Simplex (simple easy bruising), a benign disorder seen in otherwise healthy women, may be accepted.

159. **Monocytosis**. Absolute monocyte counts greater than 1000/cumm or more than or equal to 10% of total WBC is to be deemed unfit.

160. **Eosinophilia**. Absolute eosinophil counts greater than or equal to 500/cumm is deemed unfit.

161. Haemoglobin more than 16.5 g/dL in males and more than 16 g/dL in females will be considered as Polycythemia and deemed Unfit.

Dental Fitness Standards

162. **Dental Standards**.

162.1. Candidate must have a total minimum of 14 dental points and the following teeth must be present in the upper jaw in good functional opposition with the corresponding teeth in the lower jaw.

162.1.1. Any four of the six anterior.

162.1.2. Any six of the ten posterior.

162.2. The above dental standards are to be followed and candidates who do not conform to the laid down standards will be rejected.

163. **Extra Oral Examination**.

163.1. **Gross Facial Examination**. Presence of any gross asymmetry or soft/hard tissue defects/scars or if any incipient pathological condition of the jaw is suspected, it will be a cause of rejection.

163.2. **Functional Examination**.

163.2.1. **Temporo-Mandibular Joint (TMJ)**. TMJs will be bilaterally palpated for tenderness and/or clicking. Candidates with symptomatic clicking and/or tenderness or dislocation of the TMJ on wide opening will be rejected.

163.2.2. **Mouth Opening**. A mouth opening of less than 30 mm measured at the incisal edges will be reason for rejection.

164. **Guidelines for Awarding Dental Points in Special Situations**.

164.1. **Dental caries**. Teeth with caries that have not been restored or teeth associated with broken down crowns, pulp exposure, residual root stumps, teeth with abscesses and/or sinuses will not be counted for award of dental points.

164.2. **Restorations**. Teeth having restorations that appear to be improper/broken/discolored will not be awarded dental points. Teeth restored by use of inappropriate materials, temporary or fractured restorations with doubtful marginal integrity or peri-apical pathology will not be awarded dental points.

164.3. **Loose Teeth**. Loose/mobile teeth with clinically demonstrable mobility will not be awarded dental points. Periodontally splinted teeth will not be counted for award of dental points.

164.4. **Retained Deciduous Teeth**. Retained deciduous teeth will not be awarded dental points.

164.5. **Morphological Defects**. Teeth with structural defects which compromise efficient mastication will not be awarded dental points.

164.6. **Periodontium**.

164.6.1. The condition of the gums, of the teeth included for counting dental points, should be healthy iepink in colour, firm in consistency and firmly resting against the necks of the teeth. Visible calculus should not be present.

164.6.2. Individual teeth with localized periodontitis (swollen, red or infected gums or those with visible calculus) will not be awarded dental points.

164.6.3. Candidates with severe periodontal disease (generalized calculus, extensive swollen and red gums, with or without exudates), shall be rejected. If periodontal disease is not severe and the teeth are otherwise sound, the candidate may be accepted if in the opinion of the Dental Officer, he/she can be cured by simple periodontal therapy excluding extraction.

164.7. **Malocclusion**. Candidates with malocclusion affecting masticatory efficiency and phonetics shall not be selected. Teeth in open bite will not be awarded dental points as they are not considered to be in functional apposition. Candidates having an open bite, reverse

overjet or any visible malocclusion will be rejected. However, if in the opinion of the Dental Officer, the malocclusion of teeth is not hampering efficient mastication, phonetics, maintenance of oral hygiene or general nutrition or performance of duties efficiently, then candidates will be declared fit. The following criteria have to be considered in assessing malocclusion:-

164.7.1. **Edge to Edge Bite**. Edge to edge bite will be considered as functional apposition.

164.7.2. **Anterior Open Bite**. Anterior open bite is to be taken as lack of functional opposition of involved teeth.

164.7.3. **Cross Bite**. Teeth in cross bite may still be in functional occlusion and may be awarded points, if so.

164.7.4. **Traumatic Bite**. Anterior teeth involved in a deep impinging bite which is causing traumatic indentations on the palate will not be counted for award of points.

164.8. **Hard and Soft tissues**. Soft tissues of cheek, lips, palate, tongue and sublingual region and maxilla/mandibular bony apparatus must be examined for any swelling, discoloration, ulcers, scars, white patches, sub mucous fibrosis etc. All potentially malignant lesions will be cause for rejection. Clinical diagnosis for sub-mucous fibrosis with or without restriction of mouth opening will be a cause of rejection. Bony lesion (s) will be assessed for their pathological/physiological nature and commented upon accordingly. Any hard or soft tissue lesion will be a cause of rejection.

164.9. **Orthodontic Appliances**. Fixed orthodontics lingual retainers will not be considered as periodontal splints and teeth included in these retainers will be awarded points for dental fitness. Candidates wearing fixed or removable orthodontic appliances will be declared unfit.

164.10. **Dental Implants**. Implants and Implant Supported Prosthesis will not be awarded any dental points. In the case of ex-serviceman applying for re-enrolment, dental points will be awarded for removal dental prosthesis.

164.11. **Fixed Partial Dentures (FPD)/Implant supported FPDs**. FPDs will be assessed clinically and radiologically for firmness, functional apposition to opposing teeth and periodontal health of the abutments. If all parameters are found satisfactory, dental points will be awarded for the natural tooth (abutments).

Note:- Any prosthesis, removable/fixed or implant borne, the natural tooth/teeth in that component will be awarded dental points.

165. **The Following will be Criteria for Declaring a Candidate Unfit**:-

165.1. **Oral Hygiene**. Poor oral health status in the form of gross visible calculus, periodontal pockets and/or bleeding from gums will render candidate unfit.

165.2. **Candidates Reporting Post Maxillo-Facial Surgery/Maxillofacial Trauma**. Candidates who undergo cosmetic or post-traumatic maxillofacial surgery/trauma will be UNFIT for at least 24 weeks from the date of surgery/injury whichever is later. After this period, if there is no residual deformity or functional deficit, they will be assessed as per the laid down criteria.

165.3. Candidate with dental arches affected by advanced stage of generalized active lesions of pyorrhoea, acute ulcerative gingivitis, and gross abnormality of the teeth or jaws or with numerous caries or septic teeth will be rejected.

Assessment of Women Candidates

166. **History**. Detailed menstrual and obstetric history, in addition to general medical history, must be taken and recorded. If a history of menstrual, obstetric or pelvic abnormality is given, an opinion of gynaecologist is to be obtained.

167. **General Medical and Surgical Standards.**

167.1. Any lump in the breast will be a cause for rejection. Cases of fibroadenoma breast after successful surgical removal may be considered fit with the opinion of a surgical specialist and a normal histopathological report.

167.2. Galactorrhoea will be cause for unfitness. Fitness after investigation/ treatment may be considered based on merits of the case and opinion of the concerned specialist during AMB.

167.3. Amazia, Polymazia and Polythelia (Accessory nipple) will be considered unfit during SMB. Operated cases of Polymazia/Polythelia will be considered fit after 12 weeks of post-operative period after excision, if there is a well healed surgical wound and no post-operative complications.

168. **Gynaecological Examination**. Any abnormality of external genitalia will be considered on merits of each case.

168.1. Following conditions are acceptable:-

168.1.1. Congenital elongation of cervix which comes up to introitus.

168.1.2. Arcuate type of congenital uterine anomaly.

168.2. Following conditions will entail rejection:-

168.2.1. Amenorrhoea will be grounds for rejection. Such candidates will be investigated, and fitness will be considered on merits after examination and investigations during AMB.

168.2.2. Severe menorrhagia or/and severe dysmenorrhoea.

168.2.3. Stress urinary incontinence.

168.2.4. Congenital elongation of cervix or complete prolapse which comes outside the introitus even after corrective surgery. (Complete prolapse of uterus will be a cause for rejection. Minor degree, after surgical correction, may be considered for fitness on merits.)

168.2.5. Acute or chronic pelvic infection, Endometriosis and Adenomyosis.

168.2.6. Disorders of sexual differentiation.

168.2.7. Significant hirsutism especially with male pattern of hair growth.

168.3. Any other gynaecological condition not covered above will be considered on merits of each case by Gynecologist.

Pregnancy

169. Current pregnancy would be a cause for rejection. The minimum period after which the candidate will be reviewed for appeal post pregnancy would be as follows: -

169.1. **Vaginal delivery**. 24 weeks after an uncomplicated vaginal delivery.

169.2. **MTP/Abortion**. Minimum four weeks and up to 12 weeks.

169.3. **Caesarean section**. 52 weeks after uncomplicated caesarean section delivery.

170. The individual would then be examined by the Gynaecologist and assessed regarding her fitness. In cases wherein more than six months have elapsed, after the initial medical examination, the candidate would be subjected to repeat complete medical examination as per the existing regulations.

171. **Ultrasonography of Lower Abdomen and Pelvis for Women Candidates**. This would be done as per existing orders: -

171.1. **Fit**.

171.1.1. Single small fibroid uterus (03 cm or less in diameter) without symptoms.

171.1.2. Unilocular clear ovarian cyst less than 06 cm in diameter.

171.1.3. Congenital elongation of cervix (which comes up to introitus).

171.1.4. Arcuate uterus type of congenital uterine anomaly.

171.1.5. Minimal fluid in Pouch of Douglas.

171.2. **Unfit**.

171.2.1. Candidates with fluid in Pouch of Douglas with internal echoes.

171.2.2. **Uterus**. Absence of uterus or any congenital structural abnormality, except Arcuate uterus.

171.2.3. **Fibroids**.

171.2.3.1. Multiple fibroids more than two in number, with larger one > 15 mm in size.

171.2.3.2. Single fibroid larger than 03 cm in size.

171.2.3.3. Any fibroid causing distortion of endometrial cavity.

171.2.4. **Adenomyosis**.

171.2.5. **Adnexa**.

171.2.5.1. Simple ovarian cyst 06 cm or more in size.

171.2.5.2. Complex ovarian cyst of any size.

171.2.5.3. Endometriosis.

171.2.5.4. Hydrosalpinx.

171.3. During Appeal Medical Board/Review Medical Board, unfit candidates will be subjected to specific investigations and detailed clinical examination. Fitness for specific conditions will be decided as given below: -

171.3.1. Fluid in POD with internal echoes will be assessed with TLC, DLC and C- Reactive Protein. Senior Adviser (Obs and Gynae) to opine on fitness.

171.3.2. Endometrial thickness > 15 mm or residual echogenic shadows in endometrial cavity. Senior Adviser (Obs and Gynae) to opine on fitness.

172. **Medical Fitness after Laparoscopic Surgery or Laparotomy**. Candidates reporting after undergoing cystectomy or myomectomy will be accepted as fit, if the candidate is asymptomatic, ultrasound pelvis is normal, histopathology report of removed tissue shows benign pathology and per operative findings are not suggestive of endometriosis. Fitness to be considered after laparoscopic surgery once the wound has healed fully. Candidate will be considered FIT after caesarean section and laparotomy after one year of the surgical procedure.

Annexure 6

[Refers to para 9.4.2.1. of Appendix A]

SELF CERTIFICATION CERTIFICATE (ONE FOR EACH TATTOO) BY CANDIDATES FROM TRIBAL COMMUNITIES WITH PERMANENT BODY TATTOO(S)

1. I, _____ (Name of Candidate). Son/Daughter of _____ (Name of Father/Mother/Guardian as applicable) _____ (Date of Birth) hereby give an undertaking that I belong to _____ Tribe from _____ area of _____ state and * I do not have any permanent body tattoo on my body/* I have _____ no of permanent body tattoo (s) inked on my body as follows (one for each tattoo) (*strike out whichever is not applicable):-

Photograph of Tattoo	**Details of Tattoo**
(Post card size to be pasted here duly signed by the candidate with name. Please do not use staple pins/clips	Size of Tattoo (in Cms) Language (if Applicable) Significance of Tattoo (if Applicable)

2. I am enclosing Certificate (s) as per Appendix B, in original, for permanent body tattoo(s) on my body, duly signed as per instructions.

3. I hereby declare that besides the tattoo(s) as referred in Para 1 of Appendix A above, I will not have any other permanent body tattoo(s) in future if I am selected to undergo pre-commissioning training.

4. The above information given by me is true and correct to the best of my knowledge and belief.

5. I understand and is aware that misrepresentation of any facts/concealment of any information regarding permanent body tattoo(s) will lead to cancellation of my candidature at any stage from commencement of the selection process for which I shall be solely responsible.

Place:

_____
(Signature of the Candidate)
Name, Entry & AFSB Batch No.

Date:

Annexure 7

[Refers to para 9.4.2.2. of Appendix A]

CERTIFICATE (ONE CERTIFICATE FOR EACH TATTOO) FOR PERMANENT BODY TATTOO IN RESPECT OF CANDIDATES FROM TRIBAL COMMUNITIES

1. This is to certify that _____ (Name of Candidate) whose date of birth is _____ the son/daughter of _____ (Name of Father/Mother/Guardian as applicable) and belongs to _____ (Name of the Tribe) Community of _____ (Name of the District) in the state of _____ (Name of the State).

2. It is certified that the permanent body tattoo(s) inked on the following parts of the body of _____ (Name of the Candidate) is/are as per existing customs and traditions of _____ Tribe and is prevalent as on date:-

2.1.

2.2.

3. Post card size photograph of each of the tattoo as given in Paragraph 2 of Appendix B above is certified to be true and correct and annexed herewith for future reference/ record hereafter:-

Photograph of Tattoo	**Details of Tattoo**
(Post card size to be pasted here duly signed by the candidate and official issuing this certificate with respective names. Please do not use staple pins/clips	Size of Tattoo (in Cms) Language (if Applicable) Significance of Tattoo (if Applicable)

Note- Separate photograph of each tattoo with details and description will be separately furnished and each page will be duly attested by the Authority.

Place:

Affix round stamp

(Signature with Name, Designation and Stamp of DC/DM of SDM of the District/Tehsil)OR
(Signature with Name, Designation if any and Address of Chairman/Secretary of Senior Member of the Tribe to which the candidate belongs to with their Stamp).

Date: