MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

1. Active Condition. If not specified as "history of" in this table, a condition must be currently active to be subject to further review. For purposes of this enclosure, "active" means that the applicant is currently under treatment for the condition, or that the applicant is currently under observation for possible worsening or recurrence of the condition, or that the condition is currently present.

2. History. As used in this enclosure, the term "history of" means a previous diagnosis or treatment of a medical condition by a healthcare provider, even once in the applicant's life, unless otherwise specified in this table. It includes all active and present medical conditions.

3. Significant Functional Impairment. As used in this enclosure, the term "significant functional impairment" means that the medical condition impairs the applicant's ability to fully perform the physical abilities listed in enclosure (2), or that it otherwise interferes with the ability of the applicant to fully perform the duties and responsibilities of the credential.

4. Status Reports, Evaluation Reports and Consultations. All time frames specified with respect to the evaluation data listed in this table are measured from the date that the application is received by the Coast Guard. For example, if the table calls for a medical test that is no more than 90 days old, the test should have been completed no more than 90 days before the date that the application for the credential is received by the Coast Guard.

   For most conditions, this table does not contain a specific time frame as to how old a status report, evaluation report or consultation (of whatever type) may be. For all active conditions (as defined in paragraph 1 above), the status report, evaluation report or consultation should have been completed no more than one year prior to the date the application is received by the Coast Guard.

   For conditions that are not active but for which the table indicates that a "history of" the condition should be reported (as defined in paragraph 2 above), the appropriate time frame, if not specified in the table, depends on what is medically relevant given the individual circumstances of the applicant's condition. Medical providers should contact NMC if they have any questions about how recent a status report, evaluation report or consultation should be. *See* 46 CFR 10.205(d)(4).

5. Other conditions. Any medical condition or physical impairment not otherwise specified in this enclosure which may cause significant functional impairment or sudden incapacitation, or which might otherwise compromise shipboard safety, including required response in an emergency situation, may be subject to further review. Any medical condition or physical impairment not otherwise specified in this enclosure which may result in gradual deterioration of performance of duties, or which otherwise poses a threat to the health and safety of the applicant or others, may be subject to further review.

6. Medications, Vitamins and Dietary Supplements. Mariners should not perform a safety sensitive function on any vessel while under the influence of any substance that may negatively impact their performance. To that end, mariners are strongly

warned that some prescription medications, over-the-counter medications, vitamins and dietary supplements, alone or in combination with other substances, may adversely affect an individual's ability to perform critical functions and place the individual at risk of sudden incapacitation. Mariners are strongly advised to seek the advice of a physician before taking any medications, vitamins, or dietary supplements.

Mariners should read and follow the manufacturer's warnings and directions, and the warnings and directions of their own physicians, in order to minimize the risk of adverse affects. Notwithstanding, little is known about the effects of some supplements and their interaction with other substances. Therefore, the risks associated with their use cannot be determined. See enclosure (4).

7. Alternate Evaluation Data. At the time of publication of this NVIC, the evaluation data listed in this table is what the Coast Guard recommends should be submitted for each condition. Submission of other than the recommended evaluation data may result in processing delay.

   Documentation of evaluation data specified in this table for all applicable medical conditions subject to further review should be submitted with each application, unless otherwise specified by the NMC. Mariners, including first class pilots and those individuals "serving as" pilots (as well as Great Lakes pilots) who are required to submit annual physical examinations to the Coast Guard, may be issued a letter by the NMC specifying the extent of the evaluation data, if any, that should be submitted to the Coast Guard for any medical conditions that have been previously reported to, and evaluated by, the NMC.

   The Coast Guard will consider alternative approaches proposed by applicants regarding substitution of evaluation data for the recommended evaluation data listed in this table, if the alternative approach satisfies the requirements of the applicable statutes and regulations. If you wish to discuss alternative approaches, you should contact the NMC Medical Evaluations Branch, which is responsible for implementing this guidance. Contact information for the NMC Medical Evaluations Branch is listed in paragraph 8 on page 5 of the NVIC.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
HEAD, FACE, NECK, AND SCALP		
1	Fistula of neck, either congenital or acquired, including tracheotomy	Copies of all pertinent consultations, CT/MRI reports (and films, if available); plus if surgery has been done, copies of the operative and pathology reports; if malignant, an oncology evaluation as well.
2	Deformities of the face or head that may interfere with the proper fitting and wearing of respiratory protection	Copies of all pertinent consultations, CT/MRI reports (and films, if available) and quantitative respiratory fit testing; plus if surgery has been done, copies of the operative and pathology reports; if malignant, an oncology evaluation as well.
3	History of tumor within the last 5 years	Local expansion and impingement on adjacent structures is the initial manifestation of most of these tumors. The extensive resection and resultant loss of structures vital for speech, swallowing (and control of secretions) and equipment fit will be important post-therapy concerns in medical certification of affected mariners. Appropriate candidates for waiver are those mariners whose tumors have been completely removed in a manner that has not disturbed the surrounding structures needed to perform duties. Impairment of speech, secretion control, and equipment fit are not considered favorably for waiver. Confirmation of the histology is necessary. In addition, documentation of return of function of "quality" speech, swallowing/control of secretions, and equipment fit are required. Basel cell carcinomas with only local excisions do not require this evaluation.
MOUTH AND THROAT		
4	Any malformation or condition, including stuttering, that impairs voice communication	Refer for speech pathology consult.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
EARS		
5	Acute or chronic disease that may disturb equilibrium	Document hearing loss, labyrinthine dysfunction, and facial nerve weakness or paralysis. Audiology (to include speech discrimination in each ear) and neurology evaluations are required. Surgical and pathology reports are also required if applicable.
6	Mastoid Fistula	Document hearing loss, labyrinthine dysfunction, and facial nerve weakness or paralysis. Audiology (to include speech discrimination in each ear) and otolaryngology evaluations are required. Surgical and pathology reports are also required if applicable.
7	Mastoiditis, acute or chronic	Document hearing loss, labyrinthine dysfunction, and facial nerve weakness or paralysis. Audiology (to include speech discrimination in each ear) and otolaryngology evaluations are required. Surgical and pathology reports are also required if applicable.
8	History of Acoustic Neuroma	A request for waiver may be submitted 6 months after successful removal of the tumor provided the sequelae are within acceptable limits. Specifically, the tumor should have been 2.5 cm diameter or less; unilateral, postoperative vertigo should have completely resolved; and any damage to cranial nerves should allow full eye movement without strabismus or tracing deficit and acceptable mask sealing. Psychomotor performance should be within normal limits. Document hearing loss, labyrinthine dysfunction, and facial nerve weakness or paralysis. Audiology (to include speech discrimination in each ear), neurology and neurosurgery evaluations are required. Surgical and pathology reports are also required.
9	Otitis Externa or Otitis Media that may progress to impaired hearing or become incapacitating	Document hearing loss, labyrinthine dysfunction, and facial nerve weakness or paralysis. Audiology (to include speech discrimination in each ear) and otolaryngology evaluations are required. Surgical and pathology reports are also required if applicable.
10	History of episodic disorders of dizziness or disequilibrium within the last 10 years	Document hearing loss, labyrinthine dysfunction, and facial nerve weakness or paralysis. Audiology (to include speech discrimination in each ear) and neurology evaluations are required. Surgical and pathology reports are also required if applicable.
EYES, GENERAL		
11	Monocular vision	See Enclosure (4). Uncompensated monocular vision is generally not waiverable. Contact NMC for guidance. Note: Applicant should be at best corrected visual acuity before evaluation.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
12	Ophthalmic pathology reflecting a serious systemic disease (e.g., diabetic and hypertensive retinopathy)	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
13	Any other acute or chronic pathological condition of either eye or adnexa that interferes with the proper function of an eye	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
14	Diplopia	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
15	Pterygium occluding 50% of the cornea and affecting central vision	If less than 50% of the cornea and not affecting central vision; if more than 50% requires ophthalmology consultation, to include refraction measurement and visual acuity, visual field test battery, corneal topography, slit lamp examination.
16	Refractive Surgery within past 6 months	Ophthalmology consultation, to include refraction measurement and visual acuity, corneal topography, slit lamp examination looking at the quantity, quality, and extent of incisions, contrast sensitivity testing. Provide completed, type and date of procedure, statement as to any adverse effects or complications (halo, glare, haze, rings, etc.). Note: Waiver package should be submitted at least, i.e. not sooner than, 4 weeks after the surgery, with a minimum of two stable visual acuities measured, at least two weeks apart.
17	Chorioretinitis; Coloboma	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
18	Corneal Ulcer or Dystrophy	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
19	Optic Atrophy or Neuritis	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology to include neurology consultation to rule out multiple sclerosis, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
20	Retinal Degeneration or Detachment	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
21	Retinitis Pigmentosa	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
22	Papilledema or Uveitis	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy. In addition provide applicable documentation regarding presence of associated diseases causing uveitis, such as sarcoidosis, ankylosing spondylitis, tuberculosis, syphilis and toxoplasmosis. These conditions should be excluded and the following initial studies should be completed: CXR, Syphilis Serology, PPD, Lyme serology, HLA B 27, Angiotensin Converting Enzyme, and ANA.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
23	Glaucoma (treated or untreated) or Increased Intraocular Ocular Pressure (IOP)	Waivers may be granted if visual field loss is minimal and IOP is controlled at normal levels without miotic drugs. Miotic drugs are incompatible with night operations due to the inability of the pupil to dilate to admit sufficient light. Ophthalmology consultation is required anytime there is one or more documented IOPs > or equal to 22 mmHg; there is an IOP difference between the eyes of 4 mmHg or greater; there is a optic nerve cup-to-disc ratio > 0.5 or an asymmetrical cup-to-disc ratio between the eyes with a difference of > 0.2; or a visual field deficit is suspected; and when there is a recent change of visual acuity, ocular trauma, uveitis, or iritis. Optometrist or ophthalmologist should confirm the IOP with applanation tonometry. Opththalmology IOPs should be documented from a Goldman's applanation tonometer, not from a non-contact tonometer "puff test" or Tono-pen, and should be obtained in the AM and PM for two days. Consultation reports should include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, and gonioscopy. If a low IOP of 7 mm Hg or less is confirmed by Goldman applanation tonometry an ophthalmology consultation should be obtained. FOLLOW-UP: Mariners with proven glaucoma should be evaluated quarterly at least for the first year of treatment unless the consultant ophthalmologist specifies less frequent. If the mariner is determined to have elevated IOP with suspected glaucomatous changes, he or she should be measured and evaluated every 6 months by an ophthalmologist or optometrist for those mariners labeled with ocular hypertension or glaucoma suspect. If the mariner has elevated IOP without any suspected glaucomatous changes, opthalmological evaluation should be conducted annually.
24	Macular Degeneration	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
25	Macular Detachment	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
26	History of Tumors	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
27	Vascular Occlusion	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
28	Retinopathy	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
29	Disparity in size or reaction to light (afferent pupillary defect) or nonreaction to light in either eye, acute or chronic due to pathologic condition	Neurophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.
30	Nystagmus	Neurology consultation. If nystagmus has been present for a number of years and has not recently worsened, it is usually necessary to consider only the impact that the nystagmus has upon visual acuity. If visual acuity is affected, submit ophthalmology consultation.
31	Synechiae, anterior or posterior	Ophthalmology consultation, to include dilated fundus examination, legible drawings of bilateral optic discs noting mathematical estimates of the cup-to-disc ratio, and optic disc, report of slit lamp examination, visual field test battery, confirmation of the exclusion of underlying systemic pathology, confirmation that visual acuity meets standards, presence of color vision abnormalities, and gonioscopy.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
32	Absence of conjugate alignment in any quadrant	Ophthalmology consultation, to include any history of ambliopia (lazy eye) or diplopia, any patching of one/both eyes, or previous eye surgery, and include the following tests: full ocular muscle balance testing, Verhoeff vision testing apparatus (VTA), or Randot depth perception testing, testing for diplopia in the nine cardinal directions, pupillary exam, cover test (both near and far), alternate cover test, near point of conversion (NPC), red lens test, Maddox Rod test, Worth four-dot exam, and AO vectograph.
33	Inability to converge on a near object	Ophthalmology consultation, to include measurement of convergence insufficiency distance.
34	Paralysis with loss of ocular motion in any direction	Ophthalmology consultation, to include any history of ambliopia (lazy eye) or diplopia, any patching of one/both eyes, or previous eye surgery, and include the following tests: full ocular muscle balance testing, Verhoeff vision testing apparatus (VTA), or Randot depth perception testing, testing for diplopia in the nine cardinal directions, pupillary exam, cover test (both near and far), alternate cover test, near point of conversion (NPC), red lens test, Maddox Rod test, Worth four-dot exam, and AO vectograph.
LUNGS AND CHEST		
35	Asthma symptoms requiring emergency treatment in the past 2 years	Internal medicine and/or pulmonology consultation to include complete pulmonary function testing (PFT). Baseline, post bronchodilator, and methacholine/provocative testing results. Examiner statement on applicant's asthma severity class according to National Asthma Education and Prevention Program Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma (http://www.nhlbi.nih.gov/health/prof/lung/asthma/practgde.htm). Examiner statement addressing any sudden severe exacerbations, severe persistent or moderate persistent asthma, any hospitalizations or intubations for exacerbations, or recurrent oral steroid use for exacerbations. Note: Non-sedating antihistamines including loratadine or fexofenadine may be used while underway, after adequate individual experience has determined that the medication is well tolerated without significant side effects.
36	Chronic bronchitis, emphysema, or COPD	Internal medicine and/or pulmonology consultation to include pulmonary function testing (PFT) with bronchodilator challenge, chest x-ray or CT to exclude bullae, and EKG. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
37	Abscesses	Internal medicine and/or pulmonology consultation to include pulmonary function testing (PFT), imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition.
38	Mycotic Disease	Internal medicine and/or pulmonology consultation to include pulmonary function testing (PFT), imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition.
39	Tuberculosis or Untreated Latent Tuberculosis Infection (LTI)	Internal medicine and/or pulmonology consultation with documentation of complete recovery from infection, including post-convalescent negative sputum cultures, if applicable, CXR. Note: Applicants with LTI and no evidence of disease receiving treatment do not require a waiver. Active TB is not waiverable until 6 months after treatment is completed.
40	Fistula, Bronchopleural, to include Thoracostomy	Internal medicine and/or pulmonology consultation to include pulmonary function testing (PFT), imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition.
41	Lobectomy with loss of functional capacity	Internal medicine and/or pulmonology consultation to include pulmonary function testing (PFT), copies of operative reports. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.
42	Pulmonary Fibrosis	Internal medicine and/or pulmonology consultation to include pulmonary function testing (PFT), and imaging studies. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.
43	Sleep Disorders	Submit all pertinent medical information and current status report from a qualified sleep medicine specialist. Include sleep study with a polysomnogram, use of medications and titration study results. If surgically treated, should have post operative polysomnogram to document cure or need for further treatment.
44	Acute fibrinous pleurisy	Internal Medicine and/or pulmonology consultation to include pulmonary function testing (PFT), imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
45	Empyema	Internal Medicine and/or pulmonology consultation to include pulmonary function testing (PFT), copies of operative reports, imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.
46	Pleurisy with effusion	Internal Medicine and/or pulmonology consultation to include pulmonary function testing (PFT), imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.
47	Pneumonectomy	Thoracic surgery consultation with status report, CXR, PFTs, copies of operative reports. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.
48	History of tumors or cysts of the lung, pleura or mediastinum within the last 5 years	Oncology consultation with status report, CXR, PFTs, copies of operative reports if history of surgery. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value.
48a	History of malignant tumors of the breast within the last 5 years	Oncology consultation with status report, diagnostic imaging studies and copies of operative reports if history of surgery.
49	Sarcoid, if more than minimal involvement or if symptomatic	Submit all pertinent medical records, pulmonology consultations to include characteristics and severity of symptoms, names and dosages of medications and side effects. Contact NMC for guidance.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
50	Traumatic pneumothorax within past 3 months or history of spontaneous or recurrent non-traumatic pneumothorax	Chest x-ray, thin-cut CT scan demonstrating full lung expansion, PFTs, copy of operative report and thoracic surgery consult if surgically treated. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than 75% predicted value. Note: A history of a single episode of spontaneous pneumothorax is considered disqualifying for medical certification until there is x-ray evidence of resolution and until it can be determined that no condition that would be likely to cause recurrence is present (i.e., residual blebs). An applicant who has sustained a repeat pneumothorax normally is not eligible for certification until surgical interventions are carried out to correct the underlying problem. A person who has such a history can be evaluated 3 months after the surgery.
51	Bronchiectasis	Internal Medicine and/or pulmonology consultation to include pulmonary function testing (PFT), imaging studies, if applicable, operative/pathology/microbiology studies, if applicable, current treatment, and documentation of resolution or stability of the condition. Exercise stress ECG with pulse oximetry is required to assess pulmonary function during exertion if FVC or FEV1 are less than75% predicted value.
HEART		
52	Symptomatic Bradycardia (<50 bpm)	Exercise rhythm strip. If unable to achieve HR >100 BPM or double resting HR then GXT and 24-hour Holter monitor are required. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
53	Left Bundle Branch Block	Cardiology consultation, PA and lateral CXR, GXT, echocardiogram, and exercise radionuclide scan. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
54	Acquired Right Bundle Branch Block	Cardiology consultation, PA and lateral CXR, GXT, echocardiogram, and exercise radionuclide scan. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
55	Implanted Pacemaker	Cardiology consultation, PA and lateral CXR, GXT, echocardiogram, and exercise radionuclide scan. Detailed reports of surgical procedures as well as cerebral and coronary arteriography and other major diagnostic studies are of prime importance; evaluation of pacemaker function to include description and documentation of underlying rate and rythym with the pacer disabled or at its lowest setting, programmed pacemaker parameters, surveillance record, and exclusion of myopotential inhibition and pacemaker induced hypotension, powerpack data including beginning of life (BOL) and elective replacement indicator/end of life (ERI/EOL). Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
56	Premature Atrial Contractions	If PAC frequency of occurrence is > 10 of any 50 beats, 10% of any one hour, or 1% of 24 hours of monitoring, or applicant is symptomatic cardiology consultation, 24-hour Holter monitor, echocardiogram, and GXT are required. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
57	Premature Ventricular Contractions	If PVC frequency of occurrence is > 10 of any 50 beats, 10% of any one hour, or 1% of 24 hours of monitoring, or applicant is symptomatic cardiology consultation, 24-hour Holter monitor, echocardiogram, and GXT are required. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
58	2nd Degree AV Block Mobitz I	Cardiology consultation, PA and lateral CXR, GXT, and exercise radionuclide scan. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
59	2nd Degree AV Block Mobitz II	Cardiology consultation, PA and lateral CXR, GXT, and exercise radionuclide scan. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
60	3rd Degree AV Block	Cardiology consultation, PA and lateral CXR, GXT, and exercise radionuclide scan. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
61	Preexcitation Syndrome	Cardiology consultation, 24-hour Holter monitor, GXT and echocardiogram. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
62	History of Radio Frequency Ablation	3-month wait, then cardiology consultation, 24-hour Holter monitor, GXT and echocardiogram. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
63	History of Supraventricular Tachycardia (3 or more consecutive non-ventricular ectopic beats)	Cardiology consultation, 24-hour Holter monitor, GXT, TFTs, and echocardiogram. If evidence of abnormalities exercise radionuclide scan and cardiac catheterization are required and surgical/ablative procedure reports if performed. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
64	History of syncope, greater than one episode, within the last 5 years	Cardiology consultation, neurology consultation, 24-hour Holter; bilateral carotid US.
65	History of Atrial Fibrillation within the last 5 years	Document previous workup for CAD and structural heart disease, to include cardiology consultation addressing use of anticoagulants and functional capacity, 24-hour Holter monitor, GXT and echocardiogram. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
66	Chronic Atrial Fibrillation	Cardiology consultation addressing use of anticoagulants and functional capacity, 24-hour Holter monitor, GXT and echocardiogram. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
67	Paroxysmal/Lone Atrial Fibrillation	Cardiology consultation addressing use of anticoagulants and functional capacity, 24-hour Holter monitor, GXT and echocardiogram. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
68	History of Angina Pectoris	Cardiology consultation, hospital admission summaries if applicable, coronary catheterization report, statement of functional capacity, blood chemistries, including total cholesterol, HDL, LDL, and triglycerides, echocardiogram with Doppler flow study, maximal myocardial perfusion exercise stress test no sooner than 6-months post event.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
69	History of Myocardial Infarction	Cardiology consultation, hospital admission summaries if applicable, coronary catheterization report, statement of functional capacity, blood chemistries, including total cholesterol, HDL, LDL, and triglycerides, echocardiogram with Doppler flow study, maximal myocardial perfusion exercise stress test no sooner than 1 month post event. Note: Acceptable treatment of applicants includes all Food and Drug Administration approved diuretics, alpha-adrenergic blocking agents, beta-adrenergic blocking agents, calcium channel blocking agents, angiotension converting enzyme (ACE inhibitors) agents, and direct vasodilators. Centrally acting agents (e.g. reserpine, guanethidine, guanadrel, guanabenz, and methyldopa) are usually not acceptable. The use of flecainide is unacceptable when there is evidence of left ventricular dysfunction or recent myocardial infarction.
70	History of Atherectomy; CABG; PTCA; Rotoblation; or stent	Cardiology consultation, hospital admission summaries if applicable, coronary catheterization report, statement of functional capacity, blood chemistries, including total cholesterol, HDL, LDL, and triglycerides, echocardiogram with Doppler flow study, maximal myocardial perfusion exercise stress test no sooner than 1 month post event, 6 months for CABG.
71	Hypertension, systolic BP > 160 or diastolic BP > 100, with or without medication	ECG, serum chemistries, lipid profile, UA, documentation of family history of CAD, DM, hypertension, CVA, hyperlipidemia, and renal disease. Note: An initial reading exceeding 160/100 should be confirmed by three blood pressure readings separated by at least 24 hours each. Acceptable treatment of applicants includes all Food and Drug Administration approved diuretics, alpha-adrenergic blocking agents, beta-adrenergic blocking agents, calcium channel blocking agents, angiotension converting enzyme (ACE inhibitors) agents, and direct vasodilators. Centrally acting agents (e.g. reserpine, guanethidine, guanadrel, guanabenz, and methyldopa) are usually not acceptable.
72	History of Valvular Disease, non-specified	Cardiology consultation, GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.
73	Aortic and Mitral Insufficiency	Cardiology consultation, GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor. Note: GXT should be Bruce Protocol to at least 8 METS with a functional cardiac stress test. Pharmacologic Stress Tests are not acceptable.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
74	History of Valve Replacement	Cardiology consultation addressing cardiac function, evidence of embolic phenomena, arrythmias, structural abnormalities, or ischemia. GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor, INR values for 6 months prior to application, copy of operative report.
75	History of Valvuloplasty	Cardiology consultation, GXT, 2-D M-mode echocardiogram with Doppler flow study, 24-hour Holter monitor, and copy of operative report.
76	History of Heart Transplant	Generally not waiverable. Contact NMC for guidance.
77	Cardiac decompensation or cardiomyopathy	Cardiology consultation, GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor.
78	Congenital heart disease accompanied by cardiac enlargement, ECG abnormality, or evidence of inadequate oxygenation	Cardiology consultation addressing cardiac function, evidence of embolic phenomena, arrhythmias, structural abnormalities, or ischemia. GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor.
79	CHF, Hypertrophy or dilatation of the heart	Cardiology consultation, GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor.
80	Pericarditis, endocarditis, or myocarditis	Cardiology consultation addressing cardiac function, GXT, 2-D M-mode echocardiogram with Doppler flow study and 24-hour Holter monitor, and documentation of resolution or stability of the condition.
81	Anti-tachycardia devices or implantable defibrillators	Generally not waiverable. Contact NMC for guidance.
VASCULAR SYSTEM		
82	History of Aortic Aneurysm, Abdominal or Thoracic	Surgery and cardiology consultations, hospital admission summaries and operative reports if applicable, coronary catheterization report, statement of functional capacity, blood chemistries, including total cholesterol, HDL, LDL, and triglycerides, echocardiogram with Doppler flow study, maximal myocardial perfusion exercise stress test.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
84	Symptomatic Arteriosclerotic Vascular disease	Cardiology consultation, hospital admission summaries if applicable, coronary catheterization report, statement of functional capacity, blood chemistries, including total cholesterol, HDL, LDL, and triglycerides, echocardiogram with Doppler flow study, maximal myocardial perfusion exercise stress test.
85	Buerger's Disease	Internal Medicine consultation to include documentation of normal extremity function and exercise tolerance.
86	Thrombophlebitis	Internal Medicine consultation to include documentation of normal exercise tolerance.
ABDOMEN, VISCERA AND ANUS CONDITIONS		
87	Cirrhosis- Alcoholic	Internal medicine or gastroenterology consultation with status report, to include history of encephalopathy; LFTs, albumin; bilirubin; and CBC. See also medical conditions 186 and 186a.
88	Cirrhosis- Non-Alcoholic	Internal medicine or gastroenterology consultation with status report, to include history of encephalopathy; LFTs, albumin; bilirubin; and CBC.
89	History of acute Hepatitis A, B, or E	Internal medicine or gastroenterology consultation with status report, to include history of encephalopathy; LFTs, albumin; bilirubin; and CBC. Note: Not disqualifying if 6 months have elapsed since onset, LFTs have returned to normal, and applicant is asymptomatic. For acute hepatitis B, HB surface antigen should have cleared
90	History of chronic Hepatitis B	Internal medicine or gastroenterology consultation with status report, to include history of encephalopathy; LFTs, albumin; bilirubin; and CBC, liver biopsy, hepatitis replication studies (HBeAg and HB DNA).
91	History of acute Hepatitis C	Internal medicine or gastroenterology consultation with status report, hepatitis replication studies (RNA viral load testing).
92	History of chronic Hepatitis C	Internal medicine or gastroenterology consultation with status report, to include history of encephalopathy; LFTs, albumin; bilirubin; and CBC, liver biopsy, hepatitis replication studies (RNA viral load testing).
93	History of Liver Transplant	Internal medicine or gastroenterology consultation with status report, to include history of encephalopathy; LFTs, albumin; bilirubin; and CBC, name and dosage of drugs and side effects.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
94	History of Colon/Colorectal Cancer within the last 5 years	Oncology consultation documenting staging, histologic diagnosis, TMN tumor stage, any post-operative therapies, operative/ pathology reports, results of restaging, and CEA and CBC.
95	History of Other Gastrointestinal Malignancies within the last 5 years	Oncology consultation documenting staging, histologic diagnosis, TMN tumor stage, any post-operative therapies, operative/ pathology reports, results of restaging, and CEA and CBC.
96	History of Gastrointestinal Bleeding	Internal medicine or gastroenterology consultation with confirmation that applicant is free of symptoms, endoscopic or other evidence that the bleeding source has healed, copies of operative reports if applicable.
SKIN DISEASES		
97	Collagen Vascular Diseases causing significant functional impairment	Dermatology consultation, documenting use of medications, ability to wear protective equipment, and ability to perform duties.
98	Skin Diseases causing significant functional impairment	Dermatology consultation, documenting use of medications, ability to wear protective equipment, and ability to perform duties.
99	History of Malignant Skin Tumors within the last 5 years	Dermatology consultation documenting staging, histologic diagnosis, Breslow depth, tumor stage, any post-operative therapies, ability to wear protective equipment, ability to perform duties, and operative/ pathology reports. Malignant melanoma requires CXR, other imaging studies, if appropriate, and laboratory tests. Basel cell carcinomas with only local excisions do not require this evaluation.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
100	Neurofibromatosis with Central Nervous System involvement	Dermatology consultation, documenting use of medications, ability to wear protective equipment, and ability to perform duties. Neurology consult.
GENITAL-URINARY SYSTEM		
101	Renal Replacement Therapy/Dialysis	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, and treatment plan. Note: Chronic dialysis is generally not waiverable. Contact NMC for guidance.
102	History of Renal Transplant	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes,, operative report, and discharge summary, etiology of primary renal disease, evaluation of graft versus host disease, CBC, BUN, creatinine.
102a	Chronic Renal Insufficiency or Chronic Renal Failure (Glomerilar Filtration Rate (GFR) < 30 mL/min	Nephrology consultation, BUN, Ca, PO4, creatinine, GFR, electrolytes, and treatment plan. Note: Chronic dialysis is generally not waiverable. Contact NMC for guidance.
103	Acute Nephritis	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, and treatment plan.
104	Chronic Nephritis	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, and treatment plan.
105	Nephrosis	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, and treatment plan.
106	Bladder Cancer within the last 5 years	Oncology or urology consultation documenting staging, histologic diagnosis, tumor stage, any post-operative therapies, operative/ pathology reports, results of restaging, and abdomen-pelvis CT scan, cystoscopy, and contrast study of urinary tract.
107	History of Neoplasms of the kidneys, bladder, or genitourinary tract within the last 5 years	Oncology or urology consultation documenting staging, histologic diagnosis, tumor stage, any post-operative therapies, operative/ pathology reports, results of restaging, and abdomen-pelvis CT scan, cystoscopy, and contrast study of urinary tract.
108	History of Prostatic Carcinoma within the last 5 years	Oncology or urology consultation documenting staging, histologic diagnosis, tumor stage (Gleason grade), any post-operative therapies, operative/ pathology reports, results of restaging, and abdomen-pelvis CT/MRI reports, bone scan reports, and PSA, including post-op PSAs. Document applicant's physical limitations, bladder competence, and any medications.
109	Polycystic Kidney Disease	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, head MRI or MRA, and treatment plan.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
110	Pyelitis, Pyelonephritis or Pylonephrosis	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, and treatment plan.
111	DELETED	INTENTIONALLY BLANK.
112	Hydronephrosis with impaired renal function	Nephrology consultation, BUN, Ca, PO4, creatinine, electrolytes, and treatment plan.
113	Renal Calculus - Multiple Episodes or Retained Stones	Urology consultation, BUN, Ca, PO4, creatinine, electrolytes, imaging studies, if appropriate, and treatment plan. Note: Ureteral stent is acceptable if functioning without sequela.
114	Ureteral or Vesical Calculus-with or without stent	Urology consultation, BUN, Ca, PO4, creatinine, electrolytes, imaging studies, if appropriate, and treatment plan. Note: Ureteral stent is acceptable if functioning without sequela.
115	History of Gender Reassignment	Complete medical history and records to determine that there is no medical, psychiatric, or psychological condition. Medical disqualification is considered appropriate during the time of hormonal manipulation until such time as there is a stabilization of the physiological response on maintenance medication.
MUSCULOSKELETAL		
116	Amputations at or proximal to the metatarsal or metacarpal joints, or any amputation of a thumb or multiple digits on the same extremity	Physical medicine, occupational medicine or orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion at joints adjacent to amputation, pain), medications with side effects and all pertinent medical reports. Note: When prostheses are used or additional control devices are installed in a vessel to assist the amputee, the credential(s) will be limited to require that the devices (and, if necessary, even the specific vessel) must always be used when acting under the authority of the credential(s).
117	Progressive atrophy of any muscles	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
118	Deformities, either congenital or acquired causing significant functional impairment and/or interfering with the ability to wear required personal protective equipment	Physical medicine, occupational medicine or orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
119	Limitation of motion of major joint causing significant functional impairment	Physical medicine, occupational medicine or orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
120	Neuralgia or Neuropathy, chronic or acute causing significant functional impairment	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
121	Sciatica causing significant functional impairment	Neurology or orthopedic consultation to include sufficient documentation to exclude specific causes of back pain, functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
122	Osteomyelitis, acute or chronic, with or without draining fistula(e) causing significant functional impairment	Orthopedic consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
123	Tremors causing significant functional impairment	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
124	Osteoarthritis causing significant functional impairment	Rheumatology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies. Note: Waiver considered for an applicant who is taking aspirin, ibuprofen, naproxen, similar nonsteroidal anti-inflammatory drugs (NSAID), or COX-2 inhibitors; however, the applicant should present evidence documenting that the underlying condition for which the medicine is being taken is not in itself disabling and the applicant has been on therapy (NSAID) long enough to have established that the medication is well tolerated and has not produced adverse side effects.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
125	Rheumatoid Arthritis and Variants causing significant functional impairment	Rheumatology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies. Note: Waiver considered for an applicant who is taking aspirin, ibuprofen, naproxen, similar nonsteroidal anti-inflammatory drugs (NSAID), or COX-2 inhibitors; however, the applicant should present evidence documenting that the underlying condition for which the medicine is being taken is not in itself disabling and the applicant has been on therapy (NSAID) long enough to have established that the medication is well tolerated and has not produced adverse side effects.
126	Acute Polymyositis	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
127	Dermatomyositis	Rheumatology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies. Note: Waiver considered for an applicant who is taking aspirin, ibuprofen, naproxen, similar nonsteroidal anti-inflammatory drugs (NSAID), or COX-2 inhibitors; however, the applicant should present evidence documenting that the underlying condition for which the medicine is being taken is not in itself disabling and the applicant has been on therapy (NSAID) long enough to have established that the medication is well tolerated and has not produced adverse side effects.
128	Lupus Erythematosus	Internal medicine consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
129	Periarteritis Nodosa	Internal medicine consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
130	Ankylosis, curvature, or other marked deformity of the spinal column causing significant functional impairment	Submit a status report to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical reports.
131	History of Intervertebral Disc Surgery within the last 5 years	Orthopedic, physical medicine or neurosurgery consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects, all pertinent medical studies, restrictions and prognosis.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
132	Cerebral Palsy, Muscular Dystrophy, Myasthenia Gravis, or other Myopathies	Neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
133	Other disturbances of musculoskeletal function, congenital or acquired causing significant functional impairment	Orthopedic, physical medicine or neurology consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects, all pertinent medical studies, restrictions and prognosis. Note: The paraplegic whose paralysis is not the result of a progressive disease process is considered in much the same manner as an amputee.
134	Symptomatic herniation of intervertebral disc	Orthopedic, physical medicine or neurosurgery consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects, all pertinent medical studies, restrictions and prognosis.
135	History of recurrent symptomatic back pain causing significant functional impairment within the last 5 years	Orthopedic, physical medicine or neurosurgery consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects, all pertinent medical studies, restrictions and prognosis. Note: "Significant functional impairment" is defined on p. 1 of this enclosure.
136	Scar tissue that involves the loss of function causing significant functional impairment	Orthopedic or physical medicine consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
LYMPHATICS		
137	History of Hodgkin's Disease Lymphoma within the last 5 years	Oncologist / hematologist consultation documenting staging, histology, past and present treatment(s) together with report of recent CT scans of the chest and abdomen.
138	History of Leukemia, Acute and Chronic - All Types within the last 5 years	Oncologist / hematologist consultation documenting staging, histology, past and present treatment(s).

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
139	History of Chronic Lymphocytic Leukemia within the last 5 years	Oncologist / hematologist consultation documenting staging, histology, past and present treatment(s).
140	Adenopathy secondary to Systemic Disease or Metastasis within last 5 years	Oncologist / hematologist consultation documenting staging, histology, past and present treatment(s).
141	Lymphedema causing significant functional impairment	Orthopedic or surgery consultation to include functional status (degree of impairment as measured by strength, range of motion, pain), medications with side effects and all pertinent medical studies.
142	History of Lymphosarcoma within the last 5 years	Oncologist / orthopedic consultation documenting staging, histology, past and present treatment(s).
NEUROLOGIC		
143	History of Cerebral Thrombosis	Neurology consultation to include brain MRI, bilateral carotid ultra sound, and cerebral angiography.
144	History of Intracerebral or Subarachnoid Hemorrhage	Neurosurgical consultation and confirmation of successful obliteration of the vascular anomaly, neurologic and neuropsychologic evaluations, reports of MRI or CT scan to confirm absence of hydrocephalus.
145	History of Transient Ischemic Attack	Neurology consultation to include brain MRI, bilateral carotid ultra sound, echocardiogram to include bubble-contrast and cerebral angiography.
146	History of Intracranial Aneurysm	Neurosurgical consultation and confirmation of successful obliteration of the vascular anomaly, neurologic and neuropsychologic evaluations, reports of MRI or CT scan to confirm absence of hydrocephalus.
147	History of Arteriovenous Malformation	Neurosurgical consultation and confirmation of successful obliteration of the vascular anomaly, neurologic and neuropsychologic evaluations, reports of MRI or CT scan to confirm absence of hydrocephalus.
148	Intracranial Tumor within the last 5 years	Oncologist / hematologist consultation documenting staging, histology, past and present treatment(s) report of CT scans and post-operative reports and radiation treatment(s) if applicable. Pituitary tumors also require endocrinology consultation.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
149	History of Pseudotumor Cerebri	Submit all pertinent medical records, neurologic report, name and dosage of medication(s) and side effects. Note: An applicant with a history of benign supratentorial tumors may be considered favorably for a waiver after a minimum satisfactory convalescence of 1 year.
150	DELETED	INTENTIONALLY BLANK
151	Landry-Guillain-Barre Syndrome	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies as indicated including documentation of extremity functional status (degree of impairment as measured by strength, range of motion, pain).
152	Myasthenia Gravis	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies as indicated including documentation of extremity functional status (degree of impairment as measured by strength, range of motion, pain).
153	Multiple Sclerosis	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, including recent MRI, as indicated including documentation of extremity functional status (degree of impairment as measured by strength, range of motion, pain). Functional testing as indicated in enclosure (2).
154	Dystonia Musculorum Deformans	Obtain medical records and neurology consultation, complete neurological evaluation with appropriate laboratory and imaging studies, as indicated including neuro-psychological testing. Functional testing as indicated in enclosure (2).
155	Huntington's Disease	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing. Functional testing as indicated in enclosure (2).
156	Parkinson's Disease	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing. Functional testing as indicated in enclosure (2).
157	Wilson's Disease	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing. Functional testing as indicated in enclosure (2).

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
158	Gilles de la Tourette Syndrome	Obtain medical records and neurology consultation, complete neurological evaluation with appropriate laboratory and imaging studies, as indicated including neuro-psychological testing. Functional testing as indicated in enclosure (2).
159	Alzheimer's Disease	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
160	Dementia	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
161	Slow viral diseases i.e., Creutzfeldt - Jakob's Disease	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
162	History of recurrent headaches of any type that have associated symptoms which can cause sudden incapacitation such as visual disturbances, photophobia, difficulty concentrating, nausea/vomiting, ataxia, paresis, or vertigo	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects.
163	Hydrocephalus, secondary to a known injury or disease process; or normal pressure	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
164	History of Brain Abscess	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
165	History of Encephalitis	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
166	History of Bacterial Meningitis within the last 5 years	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
167	Neurosyphilis	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
168	History of disturbance of consciousness without identifiable cause within the last 5 years	Neurology consultation with complete neurological evaluation and appropriate laboratory and CT, MRI, and EEG studies, as indicated.
169	History of Seizure Disorder, excluding Febrile Seizures prior to age 5	Submit all pertinent medical records, neurology consultation, to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects. Note: Contact NMC for guidance.
170	DELETED	INTENTIONALLY BLANK.
171	History of transient loss of nervous system function(s) without identifiable cause, e.g. transient global amnesia	Neurology consultation with complete neurological evaluation and appropriate laboratory and CT, MRI, and EEG studies, as indicated including neuro-psychological testing.
172	Trigeminal Neuralgia	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects.
173	History of Head Trauma within the last 10 years associated with: Epidural or Subdural Hematoma; Focal Neurologic Deficit; Depressed Skull Fracture; or Unconsciousness or disorientation of more than one hour following injury	Neurology consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing. Submit all pertinent medical records, current status report, to include pre-hospital and emergency department records, operative reports, neurosurgical evaluation, name and dosage of medication(s) and side effects.
174	Meniere's Disease	Neurology consultation, to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects, otolaryngology and audiology consults.
175	Acute Peripheral Vestibulopathy	Neurology and otolaryngology consultations, to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
176	Nonfunctioning Labyrinths	Neurology and otolaryngology consultations, to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects.
177	Vertigo or Disequilibrium	Neurology and otolaryngology consultations, to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects.
178	Orthostatic Hypotension causing Vertigo or Disequilibrium	Neurology and otolaryngology consultations, to include characteristics, frequency, severity, associated with neurologic phenomena, name and dosage of medication(s) and side effects.
179	Sleep Apnea, Central Sleep Apnea, Narcolepsy, Periodic Limb Movement, Restless Leg Syndrome or other sleep disorders	Submit all pertinent medical information and status report. Include sleep study with a polysomnogram, use of medications and titration study results. If surgically treated, should have post operative polysomnogram to document cure or need for further treatment.
PSYCHIATRIC		
180	Adjustment Disorders	Psychiatrist or clinical psychologist clinical status report documenting the diagnosis (DSM Axis I) and addressing any disturbances of thought, recurrent episodes, and psychotropic medication(s) to include documenting the period of use, name and dosage of any medication(s) and side-effects used for less than 6 months and discontinued for at least 3 months. Note: Waivers considered if medications used for less than 6 months and discontinued for at least 3 months.
181	Attention Deficit Disorder	Psychiatrist or clinical psychologist clinical status report documenting the diagnosis (DSM Axis I) and addressing any disturbances of thought, recurrent episodes, and psychotropic medication(s) to include documenting the period of use, name and dosage of any medication(s) and side-effects.
182	Bipolar Disorder	Psychiatrist or clinical psychologist clinical status report documenting the diagnosis (DSM Axis I) and addressing any disturbances of thought, recurrent episodes, and psychotropic medication(s) to include documenting the period of use, name and dosage of any medication(s) and side-effects.
183	Dysthymic or Bereavement Disorder	Psychiatrist or clinical psychologist clinical status report documenting the diagnosis (DSM Axis I) and addressing any disturbances of thought, recurrent episodes, and psychotropic medication(s) to include documenting the period of use, name and dosage of any medication(s) and side-effects.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
184	Clinical Depression	Psychiatrist or clinical psychologist clinical status report documenting the diagnosis (DSM Axis I) and addressing any disturbances of thought, recurrent episodes, and psychotropic medication(s) to include documenting the period of use, name and dosage of any medication(s) and side-effects.
185	Psychotic Disorder	Contact NMC for guidance.
186	History of substance or alcohol abuse, as defined in current DSM, within the last 5 years	For issuance of credentials, an evaluation report completed within the last year, including a determination that the individual is safe to work, from a DOT-qualified SAP, physician certified by American Society of Addiction Medicine, or any other addiction specialist accepted by the Coast Guard, and reports from the rehabilitation clinic/center (if any). Contact NMC if you have any questions regarding acceptable addiction specialists. For applicants with a history of substance abuse within the last 5 years, if they are renewal and/or raise in grade applicants who have been subject to the dangerous drug testing requirements in 46 CFR Part 16 for at least three years prior to the date of application, and if they have no verified non-negative test results (i.e. positive, adulterated, substituted, or refusal) for the entire time that they have held the credential being renewed and/or raised in grade, no evaluation data should be submitted. If a non-negative test result has been reported to the Coast Guard at any time that the applicant has held the credential being renewed and/or raised in grade, the applicant should submit the evaluation data specified for issuance of credentials.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
186a	History of substance or alcohol dependence as defined in current DSM	For issuance of credentials, an evaluation report completed within the last year, including a determination that the individual is safe to work, from a DOT-qualified SAP, physician certified by American Society of Addiction Medicine, or any other addiction specialist accepted by the Coast Guard, and reports from the rehabilitation clinic/center (if any). Should have at least 90 days of documented abstinence before applying for a credential. Contact NMC if you have any questions regarding acceptable addiction specialists. For applicants with a history of substance dependence, if they are renewal and/or raise in grade applicants who have been subject to the random dangerous drug testing requirements in 46 CFR Part 16 for at least five years prior to the date of application, and if they have no verified non-negative test results (i.e. positive, adulterated, substituted, or refusal) for the entire time that they have held the credential being renewed and/or raised in grade, no evaluation data should be submitted. If a non-negative test result has been reported to the Coast Guard at any time that the applicant has held the credential being renewed and/or raised in grade, the applicant should submit the evaluation data specified for issuance of credentials.
187	History of Suicide Attempt within the last 5 years	Psychiatrist or clinical psychologist clinical status report documenting the diagnosis (DSM Axis I) and addressing any disturbances of thought, recurrent episodes, and psychotropic medication(s) to include documenting the period of use, name and dosage of any medication(s) and side-effects.
188	Organic mental disorders that cause a cognitive defect	Psychiatric consultation with complete neurological evaluation and appropriate laboratory and imaging studies, as indicated including neuro-psychological testing.
BLOOD AND BLOOD-FORMING TISSUE DISEASE		
189	Anemia with hemoglobin < 10.0 grams per deciliter	Submit an internal medicine or hematology consultation with clinical history of the condition and medications, including diagnosis and course. Include a CBC with reticulocyte count, electrophoresis in cases of thalassemia and hemoglobinopathies. (In the case of sickle cell trait, the electrophoresis should document hemoglobin A > hemoglobin S) Hemoglobin A2 quantification in cases of beta-thalassemia trait, serum iron, TIBC, and serum ferritin in cases of thalassemia trait.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
190	Hemophilia	Submit an internal medicine or hematology consultation with clinical history of the condition, including diagnosis and course. Include a CBC with reticulocyte count.
191	Other disease of the blood or blood-forming tissues causing significant functional impairment	Submit an internal medicine or hematology consultation with clinical history of the condition, including diagnosis and course. Include a CBC with reticulocyte count, electrophoresis in cases of thalassemia and hemoglobinopathies. (In the case of sickle cell trait, the electrophoresis should document hemoglobin A > hemoglobin S) Hemoglobin A2 quantification in cases of beta-thalassemia trait, serum iron, TIBC, and serum ferritin in cases of thalassemia trait.
192	Polycythemia	Submit an internal medicine or hematology consultation with clinical history of the condition, including diagnosis and course.
ENDOCRINE DISORDERS		
193	Diabetes Mellitus requiring Insulin or history of DKA	Internal Medicine consultation documenting interval history, blood pressure and weight, evaluation of fasting plasma glucose; and, two current HgA1C's (<8.0) separated by at least 90 days, the most recent no more than 90 days old, ophthalmology consultation, graded exercise test.
194	Diabetes requiring Oral Medication	Internal Medicine consultation documenting interval history, blood pressure and weight, evaluation of fasting plasma glucose; and, two current HgA1C's (<8.0) separated by at least 90 days, the most recent no more than 90 days old, ophthalmology consultation.
195	Addison's Disease	Endocrinology consultation with status to include names and dosage of medication(s) and side effects.
196	Cushing's Disease or Syndrome	Endocrinology consultation with status to include names and dosage of medication(s) and side effects.
197	Hypoglycemia, whether functional or a result of pancreatic tumor	Internal Medicine consultation documenting interval history and GTT to document response to glucose load (Blood glucose and symptoms).
198	Hyperthyroidism	Endocrinology or internal medicine consultation, ophthalmology consultation, and recent (within the previous 90 days) thyroid panel to include as a minimum TSH and Free T4.

MEDICAL CONDITIONS SUBJECT TO FURTHER REVIEW

No.	MEDICAL CONDITION	RECOMMENDED EVALUATION DATA
HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
199	Acquired Immunodeficiency Syndrome (AIDS)	Infectious disease consult documenting viral load determination by polymerase chain reaction (PCR), CD4 lymphocyte count, CBC, cognitive function test battery, and LFTs.
200	Human Immunodeficiency Virus (HIV)	Infectious disease consult documenting viral load determination by polymerase chain reaction (PCR), CD4 lymphocyte count, CBC, cognitive function test battery, and LFTs.
ALLERGIES		
201	Angioneurotic Edema or Anaphylaxis	Allergy consult documenting of all allergy history and symptoms along with history of desensitization and immunotherapy treatments. Medical records of previous treatments are also required. Note: Mariners issued waivers for this condition must have injectable epinephrine and diphenhydramine conveniently available.