F.No. 16(3)/2023/D(Pen/Pol)/Vol-II
Government of India
Ministry of Defense
Department of Ex-Servicemen Welfare
D(Pension/Policy)

New Delhi dated 21.09.2023

To

The Chief of the Defence Staff
The Chief of the Army Staff
The Chief of the Naval Staff
The Chief of the Air Staff

Subject : Entitlement Rules for Casualty Pensionary Awards to the Armed Forces Personnel – 2023 and Guide to Medical Officers-2023 – reg.

Sir,

I am directed to say that the President is pleased to decide that with effect from 21st September, 2023 and in supersession of all previous orders/rules on the subject, the Entitlement Rules-2023 and Guide to Medical Officers-2023 set out in Appendix-I and Appendix-II respectively to this letter shall apply in cases of disablement or death of service personnel.

2. This issues with the concurrence of Ministry of Defence (Finance) vide their I.D Note No. 10(03)/2023/Fin/Pen dated 20.09.2023.

yours faithfully

(B L Meena)
Under Secretary to the Govt. of India

Copy to :-

1. The Secretary (Def/Fin)
2. The CGDA
3. DGAFMS
4. The PCDA(P), Prayagraj
5. The PCDA (N), Mumbai
6. The Jt. CDA (AF), Subroto Park, New Delhi
7. The Director of Audit
8. AGPS/AHQ
9. DPP&R, Air HQ/DPA, Air Hqrs,
10. DPA, Naval Hqrs.

Appendix -I
(Refer to Ministry of Defence letter
No. 16(3)/2023/D(Pen/Pol)/Vol-II
dated 21.09.2023

ENTITLEMENT RULES FOR CASUALTY PENSION AND DISABILITY COMPENSATION AWARDS TO ARMED FORCES PERSONNEL, 2023

1. **Title.** These Rules shall be called the Entitlement Rules for Casualty Pension and Disability Compensation Awards to Armed Forces Personnel, 2023 and supersedes the Entitlement Rules for Casualty Pensionary Awards to Armed Force Personnel, 2008.

2. (i) These Rules shall be read in conjunction with the following documents as amended from time to time: -

(a) Pension Regulations for the Army, 2008.

(b) Navy (Pension) Regulations, 1964.

(c) Pension Regulations for the Air Force, 1961.

(d) Guide to Medical Officers (Military Pension), 2023 and subsequent amendments, if any.

(e) Government of India, Ministry of Defence policy letters on the subject issued from time to time.

(ii) **Superseding Clause.** These Rules shall supersede all previous Entitlement Rules for Casualty Pensionary Awards to Armed Forces Personnel. Where any provision in these rules is found contrary to the provisions of any previously existing rules, regulations or policies, on the subject of Casualty Pensionary Awards, the provisions given in these rules shall take precedence.

3. **Extent of Application.**

(a) These Rules shall apply to all Officers, JCOs, WOs, OR and equivalent ranks in other services including officers, JCOs, WOs and OR of the Territorial Army, when embodied, called out or attached as the case may be.

(b) These Rules do not apply in cases where disablement or death, on which the claim to casualty pensionary awards is based, took place

(i) During the period 3rd September, 1939 to 31st March, 1948, which will be dealt with in accordance with the entitlement criteria laid down in **Annexure I**; and

(ii) During the period of emergency post-1948 which will be dealt with in accordance with **Annexure II** to these Rules.

(c) Cases of death/ disablement of Cadets (Direct), due to causes attributable to or aggravated by military training shall be governed under the provisions contained in the Ministry of Defence letter No 1(5)/ 93/ D (Pen – C) dated 16th April, 1996, amended from time to time in so far as entitlement of ex-gratia is concerned. However, the claims for ex-gratia award shall be governed in accordance with these Rules. A copy of the letter dated 16th April 1996 is appended as **Annexure III** to these Rules.

4. **Definitions** :Unless the context otherwise dictates, the following terms shall mean as under: -

(a) **Categories of Disabilities.** For the purpose of determining the casualty pension and disability compensation for death or disability which is attributable to or aggravated by military service, the circumstances shall be broadly classified from Category A – E as specified in Paragraph 4.1 of Government of India, Ministry of Defence Letter No 1 (2)/ 97/ D (Pen – C) dated 31 Jan 2001.

(b) **Disability.** 'Disability' means a condition of a person resulting in long term physical, mental, intellectual or sensory impairment which in interaction with barriers, hinders full and effective participation in society, equally with others. In respect of Armed Forces personnel, a 'Disability' also means a functional impairment that inhibits an individual from effectively discharging duties of a military nature or to be provided an alternate employment within the service, even though the individual may otherwise be fit to participate normally in civil society. Two such Illustrations (though not an exhaustive list of the same) could be as given below: -

(i) Amputation of the index finger of the dominant arm, thereby precluding operation of the trigger of a personal weapon.

(ii) Personnel affected with seizure, who cannot be issued weapons or detailed on sentry duties.

(c) **Entitlement.** Entitlement is the determination by the Competent/ Appellate Authority, after considering both medical and non-medical evidence, as to whether or not a wound. Injury or any bodily disability has been influenced in its onset or course by conditions of military service or is a War Injury. Disabilities that fall under Categories 'B', 'C', 'D' or 'E' are called "Accepted Disabilities" and those that fall under Category 'A' are 'Rejected Disabilities'.

(d) **Assessment.** The term "assessment" defines the process of evaluating the functional impairment suffered by an individual following a disability or disabilities in terms of percentage, for the purpose of calculating disability compensation. Assessment shall be determined by the competent medical authority on the basis of a physical examination of the individual.

(e) **Disability Pension.** A Disability Pension is a monthly composite pension comprising of a Service Element and Disability Element, each calculated separately, as a defined percentage of the last reckonable emoluments. There shall be no condition of minimum qualifying service for earning Service Element.

(f) **Liberalized Disability Pension.** Liberalized Disability Pension is a monthly composite pension comprising of a Service Element and a Disability Element, each calculated separately, as a defined percentage of the last reckonable emoluments, where the aggregate of Service Element and Disability Element shall in no case be less than 80 per cent of the last reckonable emoluments.

(g) **War Injury Pension.** A War Injury Pension is a composite monthly pension comprising of a Service Element and a War Injury Element, each calculated separately, as a defined percentage of the last reckonable emoluments.

(h) **Invalid Pension.** Invalid Pension is a monthly pension equal to the Retiring Pension as on the date of invaliding out of service.

(i) **Impairment Relief.** Impairment Relief is a monthly disability compensation, calculated as a defined percentage of the last reckonable emoluments, awarded to Armed Forces personnel who are retired or discharged from service voluntarily or otherwise with a disability sustained under circumstances accepted as Category 'B' or 'C' and assessed not less than 20 per cent. 'Impairment Relief' shall hereinafter replace the term 'Disability Element' in as far as disability compensation to Armed Forces personnel who are retired or discharged from service. This is not a pension and shall cease upon the demise of the recipient.

(j) **Liberalized Impairment Relief.** Liberalized Impairment Relief is a monthly disability compensation, calculated as a defined percentage of the last reckonable emoluments, awarded to Armed Forces personnel who are retired or discharged from service voluntarily or otherwise with a disability sustained under circumstances accepted as Category 'D' and assessed not less than 20 per cent. 'Liberalized Impairment Relief' shall hereinafter replace the term 'Liberalized Disability Element' in as far as disability compensation to Armed Forces personnel who are retired or discharged from service. This is not a pension and shall cease upon the demise of the recipient.

(k) **War Injury Relief.** War Injury Relief is a monthly disability compensation, calculated as a defined percentage of the last reckonable emoluments, awarded to Armed Forces personnel who are retired or discharged from service voluntarily or otherwise with a disability sustained under circumstances accepted as Category 'E' and assessed not less than 20 per cent. 'War Injury Relief' shall hereinafter replace the term 'War Injury Element' in as far as disability compensation to Armed Forces personnel who are retired or discharged from service. This is not a pension and shall cease upon the demise of the recipient.

(l) **Constant Attendance Allowance.** A Constant Attendance Allowance is a monthly allowance (revised from time to time), paid in addition to Disability Pension/ Liberalized Disability Pension/ War injury Pension or Impairment Relief/ Liberalized Impairment Relief/ War injury Relief, only to Armed Forces personnel whose degree of impairment has been assessed at 100 per cent. This is not a pension and shall cease upon the demise of the recipient.

(m) **Capitalized Impairment Relief/ Liberalized Impairment Relief/ War Injury Relief.** A Capitalized Impairment Relief/ Liberalized Impairment Relief/ War Injury Relief (to be hereinafter referred in short as 'Capitalized Impairment Relief' in these rules) is the commuted present value of the future payout of an accepted Impairment Relief/ Liberalized Impairment Relief/ War injury Relief calculated by adopting the current commutation tables. The provision of Broad Banding shall not apply for calculating the percentage of impairment for the award of 'Capitalized Impairment Relief'. The terms Capitalized Impairment Relief/ Liberalized Impairment Relief/ War Injury Relief shall replace the terms Lump-Sum Compensation in Lieu of Disability Element/ Liberalized Disability Element/ War injury Element.

(n) **Special Family Pension.** Special Family Pension is a monthly pension, calculated as a defined percentage of the last reckonable emoluments, awarded to the Next-of-Kin of an Armed Forces personnel whose death occurs in circumstances accepted as Category 'B' or 'C'.

(o) **Liberalized Family Pension.** Liberalized Family Pension is a monthly pension, calculated as a defined percentage of the last reckonable emoluments, awarded to the

Next-of-Kin of an Armed Forces personnel whose death occurs in circumstances accepted as Category 'D' or 'E'.

(p) **Ex-Gratia Lump Sum Compensation in Cases of Invalidment.** A one-time Ex-Gratia Lump-Sum Compensation is paid to Armed Forces personnel who are invalided from service on account of a disability held attributable to or aggravated by military service or a war injury, at a fixed rate (that is revised from time to time) for 100 per cent impairment, to be proportionally reduced for lesser degree of impairment up to a minimum of 20 per cent. The provision of Broad Banding shall not apply for calculating the percentage of impairment for the award of Ex-Gratia Lump Sum Compensation.

(q) **Ex-Gratia Lump-Sum Compensation to Next-of-Kin of Deceased Armed Forces Personnel.** An Ex-Gratia Lump-Sum Compensation is paid to the Next-of-Kin of Armed Forces personnel who die under circumstances clearly specified in the relevant policy letter on this subject (duly amended from time to time), at rates specified against each circumstance (duly amended from time to time). However, the aggregate of all Government relief provided for the same circumstance of death of the Armed Forces personnel, shall not exceed a the specified maximum amount of Ex-Gratia Lump-Sum Compensation payable (duly amended from time to time)

(r) **Monthly Ex-Gratia.** Monthly Ex-Gratia is paid to Cadets who are invalided from military training at a monthly rate that is revised from time to time. This is not a pension and shall cease upon the demise of the recipient.

(s) **Ex-Gratia Disability.** Ex-Gratia Disability Award is paid to Cadets who are invalided from military training with a disability held attributable to or aggravated by military training, in addition to Monthly Ex-Gratia, at a monthly rate (that is revised from time to time) for 100 per cent impairment to be proportionally reduced for lesser degree of impairment up to a minimum of 20 per cent. This is not a pension and shall cease upon the demise of the recipient. The provision of Broad Banding shall not apply for calculating the percentage of impairment for the award of Ex-Gratia Disability Award.

5. **Invaliding from Service.**

(a) Invaliding out of service is a condition precedent to considering an individual's case for the award of Disability Pension, subject to such disability being sustained under circumstances that is accepted by the Competent/ Appellate Authority as Category 'B' or 'C'.

(b) Liberalized Disability Pension or War Injury Pension may be awarded if the impairment has been sustained under the circumstances that is accepted by the Competent/ Appellate Authority, as Category 'D' or 'E' respectively.

(c) Armed Forces personnel who are invalided out of service with a disability sustained under circumstances that is accepted by the Competent/ Appellate Authority as Category 'A' are eligible for the award of Invalid Pension, subject to their completing 10 years reckonable service or being declared medically unfit for service both in the military as well as civil.

(d) Only those Armed Forces personnel who are placed in medical classification SHAPE – 5 and boarded out of service by a Competent/ Appellate Authority on the recommendations of an Invaliding Medical Board, before completing their terms of engagement, shall be treated as invalided out of service.

(e) JCOs/ WOs/ OR and equivalent rank in other services who are placed permanently in a medical category other than SHAPE – 1 or equivalent and are discharged because (i) no alternative employment suitable to their low medical category can be provided, or, (ii) they having been retained in alternative employment, are discharged before the completion of their engagement, shall be deemed to have been invalided out of service.

(f) Retired officers who are not granted re-employment or JCOs/ WOs/ OR who are not granted extension of service, beyond their prescribed term of engagement, for not meeting the laid down medical standards, shall not be deemed to have been invalided from service.

(g) Cadets whose training is terminated and who are boarded out on the orders of the Competent Authority, solely on account of a wound, injury or any medical condition shall also be deemed to have been invalided from military training.

6. **Retention in Service Despite Disability.**

(a) Armed Forces personnel who are not invalided out but retained in service despite a Disability or a War Injury, shall be eligible to be considered by the Competent/ Appellate Authority for the award of a 'Capitalized Impairment Relief' on the basis of a Retention cum Impairment Assessment Board, to be held immediately after the decision to retain the individual in service is taken, subject to the disability or war injury being assessed at 20 per cent or more 'For Life'.

(b) The percentage of impairment for the purpose of calculating the 'Capitalized Impairment Relief', shall be the actual percentage of impairment assessed by the Retention cum Impairment Assessment Board and the provision of Broad Banding of assessment shall not apply to such cases.

Illustration: The amount of 'Capitalized Impairment Relief' where an Armed Forces personnel who is retained in service despite the 'Accepted Disability' which is assessed at 40 per cent in Category B, and who is aged 40 years and was drawing a Basic Pay of ₹41,100 (₹35,900 + MSP ₹5200) per month on the date of sustaining the disability (injury/ disease), shall be as under:-

$41{,}100 \times \frac{30}{100} \times \frac{40}{100} \times 12 \times 9.075 = Rs5{,}37{,}095$, Where,

$$Impairment Relief for 100\% = \frac{30}{100}$$

$$Assessed impairment = \frac{40}{100}$$

$$No of Months \in Year = 12$$

$$Commutation Factor = 9.075$$

(c) 'Capitalized Impairment Relief', once paid, shall be treated as full and final settlement of all service liabilities with respect to that disability or war injury and the individual shall have no further claim for any disability compensation for the same disability or war injury or an option to return the lump-sum so paid to him/ her. Such disability or war injury shall also not qualify for the award of any pensionary benefit or relief subsequently.

(d) The medical classification awarded by a Retention cum Impairment Assessment Board shall also be 'For Life' and cannot be reviewed.

(e) Armed Forces personnel who forgo the 'Capitalized Impairment Relief' offered to them, at the time of their retention in service despite a disability, shall be eligible to be considered by the Competent/ Appellate Authority for the award of Impairment Relief/ Liberalized Impairment Relief/ War Injury Relief for that disability or war injury in respect of which the 'Capitalized Impairment Relief' was originally offered. Retention in service order will be a mandatory document either to admit Capitalized Impairment Relief at the time of retention in service or Impairment Relief/Liberalized Impairment Relief /War Injury Relief in lieu of that at the time of discharge/retirement on completion of terms of engagement.

(f) Such Impairment Relief/ Liberalized Impairment Relief/ War injury Relief shall be paid in addition to their Retiring Pension/ Retiring Gratuity or Service Pension/ Service Gratuity, at the time of their retirement, release or discharge on fulfilling their terms of engagement, completion of tenure, attaining the age for retirement/ discharge or on taking Pre-Mature Retirement or discharge on own request.

(g) The entitlement and assessment having already been settled by the Competent/ Appellate Authority based on the Retention cum Impairment Assessment Board, Impairment Relief/ Liberalized Impairment Relief/ War injury Relief shall be paid on the basis of the same.

7. **Medical Tests at Entry.**

(a) The main purpose of medical tests at entry stage is to assess the fitness of the candidate for enrolment in service as per the standards laid down and revised from time to time, by the Army, Navy and Air Force, based on their requirements. Despite significant advancement in medical technology, it is not feasible at the stage of entry into service, to detect all diseases present in an individual like:-

(i) Hidden, latent or clinical conditions.

(ii) Certain hereditary or congenital disorders.

(iii) Diseases related to age that manifest later in life.

(iv) Certain constitutional and other congenital diseases which manifest later in life irrespective of service conditions.

(b) The mere fact that a disease has manifested during military service does not per se establish attributability to or aggravation by military service.

8. **Causal Connection.**

(a) Establishment by the Competent/ Appellate Authority, of a causal connection between the disability/ impairment or death of an Armed Forces personnel and military service is an essential pre-requisite for the award of Disability Pension, Impairment Relief, Capitalized Impairment Relief or Special Family Pension. Consequently, these awards are subject to adjudication of claims and are also eligible for two appeals against rejection. These casualties would ordinarily fall under Category 'B' or 'C'.

(b) Casualties that are accepted and confirmed by the Competent Authority as having been sustained under circumstances specified in Categories 'D' or 'E' are not subject to adjudication/ appeals. Liberalized Disability Pension, Liberalized Impairment Relief, War

Injury Pension, War injury Relief, or the appropriate 'Capitalized Impairment Relief' shall be paid directly by the Pension Sanctioning Authority, based on the casualty report and the percentage of assessment. In case of death of the Armed Forces personnel under Category 'D' or 'E', Liberalized Family Pension shall be paid to the Next-of-kin.

9. **Post Discharge Claims.**

(a) Cases in which a disease did not actually lead to the Armed Forces personnel's discharge from service but arose within seven years thereafter, may be recognized as **attributable** to service, if it can be established by the Competent Medical Authority that the impairment caused by the disease is a delayed manifestation of a pathological process set in motion by service conditions obtaining prior to discharge and that if the impairment had manifested during service, the individual would have been invalided out of service on this account. Such cases shall be eligible to be considered for the award of Impairment Relief/ Liberalized Impairment Relief/ War Injury Relief.

(b) Determination of entitlement and assessment of impairment in respect of Post Discharge Claims shall be on the basis of a Post Discharge Medical Board, to be sanctioned by the office of Directorate General of Armed Forces Medical Services.

(c) Where an invalided Armed Forces personnel in receipt of a Disability Pension, Liberalised Disability Pension or War Injury Pension dies subsequently, and it cannot, from a strictly medical point of view, be definitely established that the death was solely due to the disability in respect of which such pension was awarded: -

(i) The benefit of doubt in determining attributability for the award of Special Family Pension or Liberalised Family Pension, should go to the family of the deceased, if death occurs within seven years from the date of his/ her invaliding from service, unless there are other factors adversely affecting the claim; and

(ii) If death takes place more than seven years after the date of the individual's invalidment from service, the benefit of doubt shall go to the State.

(iii) In cases where an individual outlives a normal span of life, i.e., where death takes place at the age of 60 or above, the death should be held to be due to normal causes and not due to military service.

Notes:

(1) Death of an Armed Forces personnel receiving Disability/ Liberalized Disability/ War Injury Pension, whose disability has been accepted on the basis of aggravation, may also be accepted as due to military service under Rule 9 (c) above, if the last assessment of impairment was 50 per cent or above. If the last accepted assessment of impairment was less than 50 per cent, death should not be regarded as due to military service.

(2) For this purpose, the assessment of impairment shall be the actual assessment made by the medical board and no Broad Banding shall be applied.

(3) The above procedure will apply when death is clearly established as due to the disability in respect of which Disability Pension, Liberalised Disability Pension or War Injury Pension was awarded. If this is not the case, the identification of the cause of death with the disability will first be determined in accordance with the provisions of the Guide to Medical Officers. If the identity can be conceded thereunder, the procedure in the preceding sub-paragraph will be followed for determining the further point whether entitlement to Special Family Pension or Liberalised Family Pension can be conceded in a case where an impairment was aggravated by service.

(4) Impairment or Death occasioned by an injury Post retirement/ discharge shall not be eligible to be considered for any casualty pensionary award, as service factors are not responsible for the same.

10. **Duty.** For the purposes of these Rules, a person subject to the disciplinary code of the Armed Forces shall be treated on 'duty': -

(a) When performing an official task or a task the failure to perform which would constitute an offence triable under the disciplinary code applicable to him/ her.

(b) When moving from one place of duty to another place of duty, irrespective of the mode of transportation.

(c) During the period of participation in recreation and other unit/ sports activities organized or approved by service authorities and during the period of traveling in relation thereto.

Notes:

(1) Personnel of the Armed Forces participating in local/ national/ international sports tournaments as members of service teams or mountaineering expeditions or other adventure activities organized by service authorities, with the approval of Service HQs, shall be deemed to be 'on duty' for the purpose of these Rules.

(2) Personnel of Armed Forces participating in sports tournaments or in privately organized mountaineering expeditions of indulging in other adventure activities as a hobby or interest, in their individual capacity, shall not be considered to be 'on duty' for the purposes of these Rules, even though prior permission of the competent service authorities may have been obtained by them.

(3) Injuries sustained by personnel of the Armed Forces in impromptu games and sports which are organized by or with the approval of the local service authority and death or disability arising from such injuries will be regarded as having occurred 'on duty' for the purpose of these Rules.

(4) The Personnel of the Armed Forces deputed for training at courses conducted by the Himalayan Mountaineering Institute, Darjeeling and other similar institutes shall be treated at par with personnel attending other authorized professional courses or exercise for the Defence Services for the purpose of grant of disability compensation/ family pension on account of disability/ death sustained during the courses.

(d) When proceeding on leave/ valid out pass from his duty station to his leave station or returning to duty from his leave station on leave/ valid out pass.

Notes:

(1) An Armed Forces personnel while travelling between his place of duty to leave station and vice-versa is to be treated on duty irrespective of whether he has availed railway warrant/ concession vouchers/ cash TA etc., or not for the journey. This would also include journey performed from leave station to duty station in case the individual return early.

(2) The occurrence of injury should have taken place in reaching the leave station from duty station or vice-versa using the commonly available/ adopted route and mode of transport.

(e) When travelling by a reasonable mode from one's official residence to and back from the appointment place of duty, irrespective of the mode of conveyance (whether private or provided by the Government).

(f) Death or injury which occurs when an individual is not strictly 'on duty' e.g. on leave, including cases of death/ disability as a result of attack by or action against extremists or anti-social elements may also be considered attributable to service provided that it involved risk, which was due to is belonging to the Armed Forces and that the same was not a risk faced by a civilian. Death and disability due to personal enmity is not attributable.

Note: For the purpose of these Rules, leave shall include casual leave/ Study Leave. Leave shall not be treated as 'duty' except in situations mentioned above.

11. **Attributability**.

(a) **Injuries**. In respect of accidents or injuries, the following rules shall be observed: -

(i) Injuries sustained when the individual is 'on duty', as defined, shall be treated as attributable to military service, provided a causal connection between the injury and military service is established.

(ii) In cases of self-inflicted injuries while 'on-duty', Attributability shall not be conceded unless it is established that service factors were responsible for such action.

Note: Cases of suicide shall not be eligible to be considered for the award of any casualty pensionary award.

(b) **Diseases**: For acceptance of a disease as attributable to military service, the following two conditions must be satisfied simultaneously: -

(i) that the disease has arisen during the period of military service, and,

(ii) that the disease has been caused by the conditions of employment in military service like active operations, high altitude, extreme cold/ hot climate, extreme physical exertion and other specified exposures for e.g. to infections, chemicals and ionizing radiation.

(c) Diseases arising due to infection contracted in service and fulfilling above mentioned criteria, other than that transmitted through sexual contact, shall merit an entitlement of attributability. Where the disease may have been contracted prior to enrollment or during leave, the incubation period of the disease will be taken into consideration on the basis of its clinical course as determined by the Competent Medical Authority.

(d) If nothing at all is known about the cause of the disease and the presumption of the entitlement is not rebutted, attributability should be conceded on the basis of the clinical picture and current scientific medical application based upon standard text books

prescribed by the Government Medical Colleges affiliated to IMA/ MCA and not merely on research articles.

(e) When the diagnosis and/ or treatment of a disease was faulty, unsatisfactory or delayed due to exigencies of service, disability caused due to any adverse effects arising as a complication therein shall be conceded as attributable to military service. This however, does not apply for known adverse effects of treatment/ drugs which are the standard of care and the individual has been made aware of the risk to benefit aspect of the treatment being offered.

12. **Aggravation**.

(a) An impairment shall be conceded as aggravated by military service if its onset is hastened or its subsequent course is worsened by specific conditions of military service, such as being posted in places of extreme climatic conditions or being exposed to environmental factors that adversely affect any pre-existing medical condition e.g, Fields, Operations, High Altitudes etc.,

(b) Extreme exertion caused by various military activity, impact of exceptional stress or strain of military service and conditions that inhibit an individual from following through on medical advice such as dietary restrictions are some conditions that merit a consideration of entitlement on the basis of aggravation of a pre-existing medical condition.

(c) The curative outcomes achieved through medical treatment in service hospitals and the sheltered appointments provided to the individual to prevent worsening of a medical condition shall also be taken into account while contemplating award of entitlement on the basis of aggravation. Where a pre-existing medical condition has shown improvement with treatment, aggravation shall not be conceded.

13. **Competent Authorities**.

(a) **Attributability/ Aggravation**.

(i) **Injury Cases**. The decision regarding whether an impairment caused by an injury is to be held attributable to military service, both in cases of invalidment or retirement/ discharge shall be taken by the Service HQ in respect of officers and cadets and by the Officer in Charge Records in case of JCOs/ WO/ OR based on an assessment of the circumstances leading to the injury and the rules, regulations and policies on the subject that are currently in force.

(ii) **Disease Cases**. The decision regarding whether an impairment caused by a disease is to be held attributable to or aggravated by military service, both in cases of invalidment or retirement/ discharge shall be taken by the Service HQ in respect of officers and cadets and the Officer in Charge Records in case of JCOs/ WO/ OR. The decision shall be taken on the basis of the findings of an Invaliding Medical Board, Retention cum Impairment Assessment Board or Release Medical Board, read in conjunction with the Guide to Medical Officers and duly accepted by the Competent/ Appellate Authority, as the case may be, based on rules, regulations and policies on the subject that are currently in force.

(b) **Assessment**.

(i) The assessment with regard to percentage of impairment in both injury and disease cases as recommended by the Invaliding Medical Board, Retention cum Impairment Assessment Board or Release Medical Board, read in conjunction with the Guide to Medical Officers and duly accepted by the Competent/ Appellate Authority, as the case may be, shall be treated as final and 'For Life', except in the cases of impairments that are not of a permanent nature, unless the individual himself requests for a one time review.

(ii) Where the impairment is due to more than one medical condition, a composite assessment of the degree of impairment shall be made by reference to the combined effect of all medical conditions in addition to separate assessment for each medical condition. In case of overlapping medical conditions, the composite assessment of impairment will not be the sum of individual medical conditions. After accounting for the percentage of the first medical condition, the percentage of every subsequent medical condition shall be calculated against the total after discounting its assessment from 100 per cent, or the remainder thereof. The composite assessment of impairment shall be the sum of the percentages of individual accepted medical conditions calculated in this discounted manner. This is based on the principle that no person can be more than 100 per cent disabled.

Illustration:

If an individual has three 'Accepted Disabilities' assessed as follows: -

Disability A = 30%

Disability B = 20%

Disability C = 10%

The net impairment is calculated as follows: -

$$30\% + (100-30\%)\,20\% + (70-14)\,10\%$$

$$30\% + 14\% + 5.6\% = 49.6\%$$

The total impairment will thus be Broad Banded to 50 per cent for the purpose of awarding Impairment Relief.

(c) **Re-Assessment of Disability**. There shall be no periodical review of the assessment of impairment determined by an Invaliding Medical Board, Retention cum Impairment Assessment Board or Release Medical Board, except those impairments which are not of a permanent nature. In such cases, there shall be only one re-assessment of the percentage by a Re-Assessment Medical Board. The percentage of disability assessed/ recommended by the Re-Assessment Medical Board shall be final and 'For Life', unless the individual himself asks for a one-time Review Medical Board.

14. **Death Cases**.

(a) **Due to Injury**. Decision regarding whether a death due to injury is to be held attributable to military service shall be taken by the Service HQ in respect of officers or cadets and the Officer in Charge Records in respect of JCOs/ WOs/ OR, as the case may be, based on the circumstances leading to the death due to injury and the rules, regulations and policies on the subject that are currently in force.

(b) Deaths due to an injury sustained post retirement or discharge from military service shall not be eligible for raising a claim for casualty pensionary award.

(c) **Due to Disease.** Decision regarding whether a death due to a disease is to be held attributable to or aggravated by military service shall be taken by the Service HQ in respect of officers or cadets and the Officer in Charge Records in respect of JCOs/ WOs/ OR, as the case may be, based on the medical opinion rendered by the Director General Armed Forces Medical Services or such medical authorities prescribed by him/ her.

15. **Exercise of Delegated Powers and Confirmation.**

(a) Powers of adjudication of claims for Casualty Pensionary Awards have been delegated to the respective Service HQ vide Government of India, Ministry of Defence letter No 4684/ DIR (PEN)/ 2001 dated 14 Aug 2001.

(b) Where in doubt, the medical opinion of the Director General Armed Forces Medical Services or such medical authorities prescribed by the him/ her may be obtained. In case of any variance, the decision of the Competent/ Appellate Authority shall be treated as final.

(c) Cases that are accepted for the award of casualty pensionary award shall be forwarded to the authority one level higher than the Competent Authority for scrutiny and confirmation.

16. **Category 'D' and 'E'.** Where death/ disability occurs under the circumstances that fall within Categories 'D' or 'E' the following procedure shall be followed: -

(a) The Service HQ is the Competent Authority to accept a casualty as having occurred under circumstances specified under Categories 'D' or 'E'.

(b) In such cases the award of Liberalized Disability Pension, War Injury Pension, Liberalized Impairment Relief, War Injury Relief and Liberalized Family Pension shall be decided by the Pension Sanctioning Authority based on the casualty report published by the Competent Authority concerned.

17. **Appeals.**

(a) **First Appeal.** A person who is not satisfied with the decision of the Competent Authority in rejecting their Initial Claim for Disability Pension, Capitalized Impairment Relief, Impairment Relief or Special Family Pension, may prefer a First Appeal through their respective record office, to the Chairman Appellate Committee for First Appeal, within six months from the date of issue of the Government Sanction Letter rejecting the initial claim, which would then be considered by. The decision of the Chairman Appellate Committee for First Appeal for upholding the First Appeal will be based on consensus amongst the members of the committee.

(b) **Second Appeal.** A person who is not satisfied with the decision of the Chairman Appellate Committee for First Appeal in rejecting their First Appeal for Disability Pension, Capitalized Impairment Relief, Impairment Relief or Special Family Pension, may prefer a Second Appeal through their respective record office, Chairman Second Appellate Committee on Pension, within six months from the date of issue of the Government Sanction Letter rejecting their First Appeal. The decision of the Chairman Second Appellate Committee on Pension for **both upholding or rejecting** the Second Appeal will be based

on consensus amongst the members of the committee. Cases where there is no consensus among the members of the Second Appellate Committee on Pension will be submitted by the Chairman of the committee to the Department of Ex-Servicemen Welfare, Ministry of Defence for examination and obtaining the final decision on the second appeal from the Hon'ble Raksha Rajya Mantri.

(c) No appeals are applicable in respect of casualty pension or disability awards related to Category 'D' or 'E' cases.

18. **Medical Boards Related to Casualty Pensionary Awards.** The following medical boards shall be held in respect of casualty pensionary awards to Armed Forces personnel: -

(a) **Invaliding Medical Board.** An Invaliding Medical Board shall be held in respect of Armed Forces personnel who are recommended by medical authority for invaliding out of service, solely on medical grounds. The following procedure shall be followed: -

(i) Invaliding Medical Board shall be held in the nearest Military Hospital where a Senior Specialist of the department concerned with the medical condition of the personnel being invalided is available.

(ii) The proceedings of an Invaliding Medical Board is subject to confirmation by: -

(aa) DGMS (Army/ Navy/ Air) in respect of officers.

(ab) Designated medical Staff officer at Area/ Sub Area Headquarters or equivalent appointment in the Navy and Air Force in respect of Personnel Below Officer Rank.

(iii) Competent Authority to approve invalidation out of service shall be as follows:-

(aa) **Officers and Cadets.** Adjutant General or equivalent appointment in Navy and Air Force in respect of officers (Non-appeal cases) and Raksha Rajya Mantri (Appeal cases).

(ab) **JCOs/ WOs/ OR.** Officer in Charge Records or equivalent appointments in the Navy and Air Force in respect of (Non-appeal cases) and Army Commander or equivalent appointment in Navy and Air Force (Appeal cases).

(b) **Retention cum Impairment Assessment Board.** A Retention cum Impairment Assessment Board shall be held in respect of Armed Force personnel who are placed in Low Medical Category 'For Life' to decide on their retention/ invaliding out of service and the award of disability compensation. The following procedure shall be followed: -

(i) Armed Forces Personnel whose medical condition is determined by a Reclassification Medical Board to have reached finality, or whose medical condition is subject to progressive deterioration or who are continued remained in permanent Low Medical Category over two reclassification cycles or four years, whichever is earlier, shall be classified Low Medical Category (For Life).

(ii) Such personnel shall be considered either for invaliding or retention in service by a Retention cum Impairment Assessment Board.

(iii) Personnel who are recommended for invaliding shall be placed in SHAPE – 5 and assessed by the Competent Medical Authorities.

(iv) Once their invalidation out of service is approved by the Competent Authority, they shall be considered for the award of Disability Pension, Liberalized Disability Pension, War Injury Pension or Invalid Pension, depending upon the Category of disability.

(v) Personnel who are recommended to be retained in service despite a disability shall be considered by the Competent Authority for the same and if their retention is approved shall be issued a Retention in Service Order.

(vi) On the authority of the Retention in Service Order the initial claim of such personnel shall be considered for the award of 'Capitalized Impairment Relief', depending upon the Category of disability and subject to the degree of impairment being not less than 20 per cent and in case the same is forgone,Impairment Relief/Liberalized Impairment Relief/War Injury Relief may be admitted at the time of discharge/retirement based on this Retention in Service Order.

(vii) Retention cum Impairment Assessment Board shall be held in any Service hospital commanded by a Brigadier or equivalent in other services. The Presiding Officer of the Board shall be the Commandant of the Service Hospital.

(viii) The findings of a Retention cum Impairment Assessment Board shall be approved along the respective medical chain. However, it shall be confirmed only by the Major General (Medical) or equivalent in other services in the respective Command Headquarters. Retention cum Impairment Medical Board shall not be confirmed by the Area/ Sub-Area Headquarters.

(ix) Retention cum Impairment Assessment Board of officers of the rank of Colonel and above or equivalent in other services will be held in a hospital outside their Area of Responsibility.

(x) Personnel whose claim is rejected on account of their impairment having been declared under Category 'A' (i.e held neither attributable to nor aggravated by military service) or assessed less than 20 per cent, may continue in service but shall not be eligible for any compensation for the impairment.

(xi) Personnel placed in Low Medical Category (For Life) shall not be medically upgraded. The individual shall undergo Annual Medical Examination or Periodic Medical Board as applicable every year and shall be retained in the same medical classification, unless, based on specialist opinion a change in COPE (Army)/ SA (Navy)/ AG (Air Force) Code is envisaged.

(xii) Personnel whose Retention cum Impairment Assessment Board has been held shall render a certificate accepting that their medical classification is 'For Life' and no upgrading or change in assessment is applicable in respect of that impairment and no aggravation in respect of the instant medical condition can be claimed on account of their being retained in service.

(xiii) Where the award of Capitalized Impairment/ Liberalized Impairment/ War Injury Relief has been rejected by the Competent/ Appellate Authority, an individual

may prefer an appeal to the Chairman Appellate Committee for First Appeal or Chairman Second Appellate Committee for Pension, as the case may be.

(c) **Release Medical Board.** A Release Medical Board shall be held at the time of retirement, release or discharge of an Armed Forces personnel with a medical condition for which he/ she has been placed in a Low Medical Category (Temporarily/ Permanently/ For Life).Temporary and Permanent category under LMC will not be eligible for Impairment Relief/Liberalized Impairment Relief/War Injury Relief, however, LMC for life may be eligible for the same, subject to conduct of Impairment cum Assessment Medical Board in the past and issuance of Retention in Service Order and if the Armed Forces personnel has forgone Capitalized Impairment Relief. The Release Medical Board shall be held in a hospital outside their area of responsibility in respect of officers of the rank of Brigadier (equivalent in the Indian Navy and Air Force) and above and at the dependent Military Hospital in respect other personnel.

(d) **Post Discharge Medical Board.** A Post Discharge Medical Board is held where a Post Discharge Claim is allowed by the Director General of Armed Forces Medical Services. The following procedure is to be followed: -

(i) A Post Discharge Claim can only be preferred in respect of a disease that was not present at the time of an Armed Forces personnel's retirement, release or discharge from service.

(ii) It can be preferred within seven years from the date of invaliding (in respect of death cases) and retirement, release or discharge (in respect of disability cases).

(iii) It can be preferred only in respect of a disease that can be held attributable to military service.

(iv) In respect of death cases, a Post discharge Claim for Special Family Pension or Liberalized Family Pension can only be processed in respect of an individual who was in already in receipt of Disability Pension, Liberalized Disability Pension or War Injury Pension.

(v) A Post Discharge Claim shall be forwarded to the office the Director General of Armed Forces Medical Services who shall scrutinize the case from the point of eligibility before sanctioning a Post Discharge Medical Board.

(vi) Post Discharge Medical Board shall be held at Base Hospital Delhi Cantonment and the proceedings shall be confirmed by the Director General Hospital Services or Senior Consultants (Medicine/ Surgery) in the office Directorate General of Armed Forces Medical Services.

(e) **Re-Assessment Medical Board.** Re-Assessment Medical Board is applicable only in respect of individuals who have been awarded Disability Pension, Liberalized Disability Pension, War Injury Pension, Impairment Relief or War Injury Relief in respect of an impairment whose assessment is limited only to a specified period. The following procedure shall be followed: -

(i) An individual who has been awarded a disability compensation for specified period only, shall report to the nearest Military Hospital for a Re-Assessment Medical Board before the expiry of the validity of the assessment.

(ii) Since service factors cease to have an effect on an individual post retirement or discharge, any subsequent increase in percentage of assessment in respect of a disability held aggravated by military service at the time of invaliding, retirement or discharge cannot be linked to service conditions. However, percentage of assessment in attributable cases may be revised upward based on Re-Assessment Medical Board.

(iii) A disability claim that was untenable at the time of retirement/ discharge, on the grounds of being held Neither Attributable to nor Aggravated by military service or being assessed less than 20 per cent cannot be revived post retirement on the basis of a Re-Assessment Medical Board.

(iv) Re-Assessment Medical Board shall also not be applicable in respect of those personnel who have been paid Capitalized Impairment/ Liberalized Impairment/ War injury Relief on the basis of a Retention cum Impairment Assessment Board.

(v) A Re-Assessment Medical Board, where due, shall not require a sanction.

(vi) However, Re-assessment Medical Board that is overdue shall only be allowed on the basis of a Time-Bar Sanction

(vii) Where rate of disability compensation is required to be revised on the basis of a Re-Assessment Medical Board, the same shall be sanctioned only by the competent authority after due financial scrutiny.

(viii) Based on the sanction, Pension Sanctioning Authority shall issue a Corrigendum Pension Payment Order duly revising the disability compensation as per the new assessment.

(ix) Where a Re-Assessment Medical Board has reduced the assessment of an impairment less than 20 per cent, the disability compensation shall cease to be paid. However, Service Element or other pension that the individual may be eligible to may continue to be paid.

(f) **<u>One Time Review Medical Board</u>.** A One Time Review Medical Board may be held on the request of an individual who is not satisfied with the assessment of the degree of his/ her impairment where the disability is held **attributable** to military service. The following procedure shall be followed: -

(i) An individual with a disability held attributable to military service, may seek a One Time Review Medical Board to re-assess his/ her degree of impairment as determined by an Invaliding Medical Board, Retention cum Impairment Assessment Board, Release Medical Board or a Post Discharge Medical Board.

(ii) A One Time Review Medical Board shall be sanctioned by the office of the Director General Armed Forces Medical Services on the basis of an application made in this regard by the individual through his/ her record office.

(iii) An individual can exercise this option only once in his/ her lifetime.

(iv) A One Time Review Medical Board shall be held at Army hospital (Research and Referral).

(v) Any revision of assessment of impairment by the One Time Review Medical Board, shall be approved by the Competent Authority after due financial scrutiny before forwarding the same to the Pension Sanctioning Authority for issue a corrigendum Pension Payment Order.

(g) **Appeal Medical Board.** An Appeal Medical Board may be sanctioned by the office of the Director General of Armed Forces Medical Services while considering the First or Second Appeal of an individual, if in their opinion, the Invaliding Medical Board, Retention cum Impairment Assessment Board, Release Medical Board or a Post Discharge Medical Board has erred in its findings. The following procedure is to be followed: -

(i) During the consideration of an Appeal (First or Second) if the medical member of the appellate committee from the office of the Director General of Armed Forces Medical Services feels that the findings of the Medical Board placed on record is not correct, he/ she may sanction a First or Second Appeal Medical Board to physically examine the individual.

(ii) A First or Second Appeal Medical Board shall be held at Base Hospital Delhi Cantonment. The members of the Appeal Medical Board shall be detailed from the office of the Brigadier Armed Forces Medical Services (Pension).

(iii) The findings of the Appeal Medical Board shall be final and 'For Life; unless the individual exercises his/ her option for a One Time Review Medical Board, if not already exercised.

(iv) The Appellate Committees are not bound to sanction an Appeal Medical Board unless they find an inconsistency vis-à-vis the Guide to Medical Officers.

19. **Scope of Medical Boards.** All medical boards related to casualty pensionary awards shall limit their scope to the following: -

(a)Thoroughly evaluating the medical condition of the individual.

(b)Determining and specifying any disability.

(c)Assessing the degree of impairment caused by the disability.

(d)Noting detailed factors/ justification that support or refute any claim for entitlement of disability compensation.

20. Medical boards shall not opine on the element of 'entitlement', which shall be left to be determined by the Competent/ Appellate Authority based on these rules read in conjunction with the Guide to Medical Officers.

21. **Time Barred Cases.** The following time barred cases may be considered on the basis of a Time Bar Sanction accorded by the Competent Authority who has been delegated the powers to accord the same: -

(a) **Appeals.** Appeals that are submitted after more than six months, but less than five years, from the date of issue of the Government Sanction Letter rejecting an Initial Claim or a First Appeal. Award of casualty pensionary awards or disability compensation in respect of Time Barred Appeals, if accepted, shall be effective only from the date of the delayed appeal. Under No circumstances shall an appeal time barred beyond five years be considered by either Appellate Committees.

(b) **Release Medical Boards**. A delay of two years from the date of retirement, release or discharge.

(c) **Re-Assessment Medical Board**. A delay equal to the period of validity of original assessment or five years, whichever is earlier.

(d) **Initial Claim for Award of all Forms of Casualty Pensionary Awards**. Claims delayed beyond five years.

Annexure-I

WARTIME RULES

No. 106123/4/P.P.3(a)
General Headquarters
Adjutant General's Branch
GHQ APO
New Delhi, 25th November, 1946

To

Headquarters All Commands, Divisions,
Brigades, Areas and Sub Areas
with sufficient copies for distribution to all medical officers,

Instructions for Medical Officers called upon to Sign Death Certificates and for Medical Boards.

MEMORANDUM

1. New rules on entitlement to pensions were introduced for the Indian Army by A.I. (I) 43/45. Medical Boards will be held in accordance with these instructions which will be simplified or amended from time to time as may be found necessary. While not comprehensive, they are intended to be a guide so that medical officers may be enabled to give immediate effect to the alterations brought about by the new rules. Medical Officers should appreciate that not only has the old criteria been discarded but that the whole approach to the question of attributability has been changed and the changes explained below entail more accurate medical recording on their part and a more accurate appreciation of the various findings in each case.

2. Terms employed under the new rules - Hitherto the word "attributable" had an artificial meaning covering both "directly attributable" and "Materially aggravated". In that sense, it has now been replaced by "due to" and "attributable" replace "directly attributable" as meaning "caused by".

The word "materially" and the words "to a material extent" have been omitted in reference to aggravation. Under the new rules worsening to any extent by service will be regarded as aggravation. The Ministry of Pensions test of the existence of aggravation in this sense will now apply to the Indian Army, namely there is held to be "aggravation" where effective service is found to have caused a degree of worsening in a previously existing condition resulting in discharge from service on account of that condition.

3. New method of approach to the question of entitlement- Though the principle that there must be a causal connection between the disability or cause of death and service is still preserved the question of supporting evidence is to be approached from a new angle. The Government of India will give full weight to two presumptions arising out of the fact that the man is accepted for service during the present war in a certain medical category. These presumptions are:-

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...Letter dated 20 Jan 1972 addressed to DPSMG.

(1) That at the time of acceptance he was fit for the kind of service demanded of a man in that medical category, and

(2) That in the event of his subsequently being discharged from the service on medical grounds any deterioration in his health which has taken place is due to his service.

While the medical services are not directly concerned with the making of these artificial presumptions, in future they must bear them in mind, since, in cases which, in their opinion, should be regarded as not attributa le to military service, it will be nosessaryyto record evidence sufficient to rebut one or both of these presumptions.

Presumption (1) itself does not lead to any conclusion of entitlement but approach to Presumption (2) will be affected as pr-esumption (1) stands or falls. It is, therefore, necessary to record any evidence available which may affect Presumption (1). This may take the form of radiological or other evidence that the disease was of long standing or there may be evidence in the individual's medical history sheet or other medical documents. The history given by the individual on first admission to hispital may also be of importance.

Presumption (2) is the vital one. Unless there is contrary evidence attributability must be conceded. This contrary evidence may take the form of showing,

(1) that no deterioration in health, persisting to date of discharge, occurred during service; or

(2) that, where there has been persisting deterioration, the presumption that such deterioration is due to service is not well founded.

The mere fact that an individual has been invalided does not necessarily mean that his health has deteriorated during service. The disability may have been discovered soon after joining and the individual discharged in his own interest in order to prevent deterioration. In such a case there may even have been worsening during service, but if treatment given before discharge restored the individual to his normal condition so that his discharge was on grounds of expediency to prevent a recurrence, no lasting damage was inflicted by service and there is no ground for conceding attributability. Again an individual may be found to be so weak mentally that it is impossible to make him an efficient soldier, this does not establish that his condition has worsened during service but only that it is worse than was realised on enrolment.

On the other hand, where there has been deterioration attributability must be conceded under presumption (2) unless there is evidence indicating that the presumption is not well founded. There may be direct evidence of the contraction of disability otherwise than by service, e.g. by infection whil

at home on leave, and even then the question of aggravating by subsequent service will have to be considered. The difficulty will be greatest in those diseases regarded as constitutional and naturally progressive. Deterioration must be accepted as due to service unless there is evidence to the contrary including as evidence a consensus of medical opinion regarding the particular disability or the group of disabilities to which it belongs. It will thus be seen that a claim to pension will not be rejected unless presumption (2) is shown to be ill founded by written or other reliable evidence or such a consensus of medical opinion as amounts to reliable evidence.

In other words, the Government of India must be satisfied that there are reasonable grounds before any case is rejected and it will be for the medical officers concerned with the case to put forward all the medical evidence available which may have a bearing on the final decision.

4. Procedure to be adopted by Medical Boards:- It is obvious that with the new approch to the question of attributability, the present method of completing the invaliding roll must be considerably altered. At present, there are not sufficient particulars recorded regarding many of those invalided from service on account of disease to allow of a correct decision on entitlement to pension under the new criteria. It should be realised that all cases will be subject to review and it may be necessary to reverse the decision in those cases recommended for rejection of the claim to pension where the supporting evidence is insufficient. Phrases such as "equally common in civil life" will no longer have any force and should not be used except in cases of diseases which run their course independently of external circumstances; see paragraph 6(c) below. Until it is found possible to issue a revised form of invaliding roll IAFY-1948, the procedure therefore will be as follows:-

(i) On page 5 of the invaliding roll, the medical officer-in-charge of the case should first of all give a concise history of invaliding disability as complete as possible clearly specifying the station of origin, e.g. field service area or peace station. The duration of the disability and the circumstances in which it arose may have a vital bearing on the case. Such particulars may possibly be obtained from the individual documents. The medical notes made when the individual first fell ill are of special importance as not only do they frequently show the pathological state of the disease when it first came to notice enabling a deduction to be made as to its probable duration but they often contain a statement as to the history prior to that date. Such information may be of more value than statements made at the time of invalidment when the question of a disability pension has arisen. Where relevant a short note should be added regarding defects noted

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on enrolment, family history, other illness during or prior to service. This all important history of the case should be followed by ;

(ii) The diagnosis of the disability, about which there should be no serious doubt and an exact description of the clinical conditions present. This description should not necessarily be detailed but should make clear any features likely to assist the board informing an opinion on the question of attributability and on the assessment of disablement. Notes on laboratory, X-ray findings etc., should be included when necessary and specialists reports on the case may be of value. Where the medical officer-in-charge of the case have considered that the individual was non-co-operative or has retarded his cure or that he was malingering, a note to that effect should invariably be recorded for the information of the board.

(iii) Finally, whether there was neglect, delay, faulty technique or lack of reasonable skill in service medical treatment, or the exigencies of service, before, during or after the treatment could be held to have caused or aggravated the condition, these should be recorded as on these grounds alone a presumption of aggravation through service may be made if deterioration thereby resulted.

(iv) On page 6 of IAFY-1948. In addition the words "in the hope of obtaining pension or gratuity" should be deleted from question (8). Bearing in mind that decisions contrary to the opinion of the medical board may be given on on review, the percentages of disablement should be carefully assessed in all cases and entered at question (5).

5. Death certificates.- IAFA-393 part III in which the medical officer records his opinion regarding attributabil should likewise in future contain more details of the cause of death. As a rule, not only the immediate cause of death but also the underlying disease should be noted. In the case of infectious disease it may be relevant to note the incubation period of the particular disease, eg. when the individual may have contracted the disease while on leave or prior to enrolment. It is specially importar

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in death cases to note whether neglect, delay, faulty technique or lack of reasonable skill** in service medical treatment can be held responsible for untoward outcome, or the exigencies of service before, during or after the treatment can be held to have caused or hastened death. The presumption already referred to will apply equally in cases of death. It should be clearly stated whether the individual died overseas or in India in a hospital or at home as a result of disease contracted overseas, or whether he died in a peace station of disease contracted in such station.

**N.B.--Should a recognised complication of the normally accepted methods of treatment properly prescribe and administered, occur, then that complication is regarded as NOT attributable to service.

6. Notes on common diseases.-- It may be advisable at a later date in issue detailed guidance regarding certain diseases. In the meantime the following notes may in some cases, be helpful. They contain the ideas of the Ministry of Pensions formed from their experience in applying the new principles in the U.K. The Ministry of Pensions state that the position regarding psychoneourosis is not yet sufficiently clear to make a pronouncement so that medical officers should use their own discretion in expressing an opinion on attributability in such cases for the present.

(a) Common diseases known to be affected by exposure to weather.--Diseases such as Bronchitis, rheumatism and nephritis-- indeed most diseases of the respiratory system, joints and kidneys are affected by climatic conditions and here the man's condition has worsened during service, the presumption that this worsening was caused or aggravated by service would be well founded, unless the service was of such short duration or the conditions of service were so good that it would be quite unreasonable to grant entitlement to pension.

(b) Common diseases known to be affected by stress and strain.-- If the individual has given reasonable service in a branch of the service where physical effort or other strain can be assumed the presumption that deterioration is due to service can be regarded as well founded. This refers particularly to pulmonary tuberculosis and certain heart conditions. It may be that in an exceptional case the man has been engaged on sedentary duties and the presumption would not then usually apply.

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(c) Diseases which run their course independently of external circumstances.-- There are certain diseases which would have run the same course whether the member had been in the Forces or not. Such cases if equally common in civil life will not be accepted as aggravated by war service unless it is clear that owing to the exigencies of his service the man did not receive medical treatment of a satisfactory character and standard or such treatment was so delayed as to be less effective than it should have been.

(d) Injectious diseases.-- Death or disablement resulting from infectious disease other than venereal disease contracted during service will be regarded as attributable to military service. Where the disease may have been contracted prior to enrolment or during leave, the question of determining the incubation period in a particular case will arise and an opinion on this point should be expressed.

(e) Venereal diseases.-- Presumption (2) is not regarded as applying in the case of venereal disease, having regard to the way in which the disease is normally acquired; similarly the question of onus of proof does not arise. Cases of veneral disease or later manifestations of sequelae thereof will, therefore, only be accepted as attributable.-

(i) If the disease has been contracted in the course of duty e.g., by a doctor or medical orderly.

(ii) If, having contracted disease during service, the man after treatment has returned to full duty and has been subjected to such strain as has produced one of the after-effects of the disease sooner than would normally have been the case.

(iii) If, having contracted the disease prior to enrolment, the man has been subjected to such strain as has produced or hastened a later manifestation of the disease.

Note 1. --For the purposes of (b) and (c), the strain must be due to service and of such a degree as is unlikely to be met in civil life, and it must be clear that the later manifestation was in fact produced or hastened

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by that strain. If, however, the man had reached an age when such a manifestation could be expected, the case is difficult for acceptance.

Note 2.-- A member engaged on clerical duties would not normally be subjected to any such strain, and it may be taken as axiomatic, that no sedentarily employed man could establish a claim to pension save in the most exceptional circumstances.

(iv) If the disease is due to heredity and the latter manifestation is produced or hastened by conditions of the man's service (the normal considerations as to giving the benefit of doubt apply).

(v) If the disease existed before enrolment and death results from treatment given with a view to making the man an efficient soldier.

(vi) If the disease was contracted during service and death results from faulty technique in treatment.

NOTE 1.--In case of disease contracted during service should the man advance the argument that owing to the exigencies of his service he did not receive treatment when he ought to have received it, such argument will be treated with reserve.

NOTE 2.-- "Faulty technique in treatment" implies the use of drugs obviously wrong or contra-indicated, an unreasonably low or high dosage, procedures not generally recognised as correct or the lack of proper precautions.

Medical Boards will always record their opinion with reasons in support, as to whether the disease is congenital or was contracted before or after enrolment.

The general principle underlying the provisions of this sub-para is that when the disease is either hereditary or contracted by sexual contact either before or during service, entitlement for the disease itself can never be granted. Such entitlement can only be given

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for a later manifestation or sequela of the disease which has been precipitated or whose onset has been hastened by the stress of service in the the Army.

(f) Service employment similar to civil employment.-- Where the man's employment in the service, e.g., a lorry driver, is the same as his pre-service civil employment, and it is clear that there has been deterioration during service, the similarity of employment is not a sufficient ground for rejecting a claim to pension on the plea that the risks to health were not increased by service. That would be equivalent to giving the same weight to the possibility of deterioration in civil life as to the fact that deterioration took place in the service. This argument cannot be maintained. Where, however, the disease is one that could not be influenced by employment as, e.g. a clerk, the case is different.

7. In conclusion, it is necessary to reiterate that where a medical officer considers that a case is not attributable to military service, the evidence on which the opinion is based must be clearly stated whether this takes the form of certain facts peculiar to the case or well known features regarding the disease in question.

8. G.H.Q. memoranda Nos 106122/1/AG 14(b), dated 20th July 1944 and 106123/3/P.P.3(a) dated 6th July 1945, are hereby cancelled.

Annexure-II

CLASSIFICATION OF DISEASES

A. Diseases affected by climatic conditions

1. Pulmonary tuberculosis
2. Pulmonary oedema
3. Pulmonary tuberculosis with pleural effusion
4. Tuberculosis(non-pulmonary)
5. Bronchitis
6. Pleurisy, Emphysema, Lung abscess; and Bronchiectasis
7. Lobar Pneumonia
8. Nephritis(acute and chronic)
9. Otitis media
10. Rheumatism(acute and chronic)
11. Arthritis
12. Myalgia
13. Lumbago
14. Local effects of severe col climate-i.e.,frost bite, trench foot and chilblains
15. Effects of hot climate-i.e., heat stroke and heat exhau

B. Diseases affected by stress and strain

1. Psychosis and Psychoneurosis
2. Hypertension(BP)
3. Pulmonary tuberculosis
4. Pulmonary tuberculosis with pleural effusion
5. Tuberculosis(non-pulmonary)
6. Mitral stenosis
7. Pericarditis and adherent pericardium
8. Endocarditis
9. Sub-acute bacterial endocarditis, including infective endocarditis
10. Mycarditis(acute and chronic)
11. Valvular diseases
12. Myocardial infarction, and other forms of IHD
13. Cerebral haemorrhage and cerebral infarction
14. Peptic ulcer

C. Diseases affected by dietary compulsions

1. Infective hepatitis(Jaundice)
2. Diseases of stomach and duodenum
3. Worm infestation and particularly guinea worm and round worm infections
4. Gastritis
5. Food poisoning, especially due to tinned food

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Annexure-II

ENTITLEMENT RULES FOR THE DISABILITY AND SPECIAL FAMILY PENSIONARY AWARDS IN RESPECT OF ALL RANKS OF THE ARMED FORCES DURING EMERGENCY

Period of Emergency	Government of India letter
8 Sep 62 to 9 Jan 68	- A/01927/AG/PS-4(a)/9948/Pen-C dated 26 Dec 62
3 Dec 71 to 31 Mar 72 25 Mar 71 to 31 Mar 72 (Op Cactus Lily)	- A/01927/AG/PS-4(a)/11130/Pen-C dated 16 Dec 71
15 Aug 71 to 31 Mar 72 (Naval personnel)	- PN/3948/1191/Pen-C dated 1 Feb 72

Entitlement to disability or family pensionary awards in respect of all ranks of the Armed Forces eligible for pension under the Military Rules, disablement or death, shall be accepted as due to service, if -

(a) the disablement is due to a wound, injury or disease, which-

(i) is attributable to service; or

(ii) existed before or arose during service and has been, or remains aggravated thereby.

(b) the death was due to or hastened by -

(i) a wound or injury or disease which was attributable to service; or

(ii) the aggravation by service of a wound, injury or disease which existed before or arose during service.

2. In dealing with these cases, the benefit of reasonable doubt will be given to the claimant. The entitlement shall be denied only if it can be established beyond reasonable doubt that the conditions mentioned above are not fulfilled.

3. Where an injury or disease, which led to discharge or death during service, was not noted in a medical report or other appropriate enrolment papers prepared at the time of commencement of the individual's service, fulfilment of the conditions mentioned in para 1 above may be accepted unless there is a positive evidence to the contrary.

4. Where there is no note in contemporary official records of a material fact on which the claim is based, other reliable corroborative evidence of that fact may be accepted.

N.B. - "Service" means service in the Armed Forces during emergency rendered anywhere in India.

Special proforma should be attached to the BMB proceedings of all cases to provide additional information vide DGAFMS letter No. 16033/PS MP-MS/71 Pen dated 28 Jan 1972 addressed to DGAFMS

Rule and the above meanings

Gastric ulcer
Duodenal ulcer
Nutritional disorders

Diseases affected by training, marching prolonged standing etc.

1. Tetanus, erysipelas, septicaemia and pyaemia etc. resulting from injuries
2. Ankylosis and acquired deformities resulting from injuries
3. Post traumatic epilepsy and other mental changes resulting from head injuries
4. Internal derangements of knee joint
5. Deformities of feet
6. Osteoarthritis of spine and lower limb joints
7. Burns sustained through petrol, fire, kerosene oil etc. leading to scars and various deformities and disabilities
8. Hernia
9. Varicose veins

Environmental Diseases

1. Diseases contracted in the course of official duty of attending to a venereal or septicaemic patient or while conducting a postmortem examination
2. Diseases contracted on account of handling infectious material, poisonous chemicals and radioactive substance

Diseases affected by altitude

1. High altitude pulmonary oedema and pulmonary hypertension
2. Acute mountain sickness
3. Psychosis, Psychoneurosis, suicide
4. Thrombosis

Disease affected by service in Submarines and in diving

1. Acoustic trauma resulting from continuous noise and vibrations
2. Effects of exposure to high levels of toxic gases
3. Droplet infections
4. Neurosis and psychosomatic disorders
5. Effects of barotrauma
6. Decompression sickness
7. Dysbaric osteo-necrosis

.....3

Diseases affected by service in flying duties

1. Otitic barotrauma
2. Altitude decompression sickness
3. Hypoxia
4. Explosive decompression
5. Long duration G

Diseases not normally affected by service

1. Malignant diseases(Cancer and carcinoma)
2. Sarcoma(except in cases of sarcoma of bone with a history of injury, due to service, on the site of development of the growth)
3. Epithelioma
4. Rodent ulcer
5. Lympho-sarcoma
6. Lymphomas except of viral aetiology
7. Leukaemia(except radiation effect)
8. Pernicious anaemia(Addison's disease)
9. Osteitis deformans(Paget's disease)
10. Gout
11. Acromegaly
12. Cirrhosis of the liver-if alcoholic

Eyes

13. Error of refraction
14. Hypermetropia
15. Myopia
16. Astigmatism
17. Presbyopia
18. Glaucoma-acute or chronic-unless there is a history of injury due to service or of disease of the eye due to service.

Annexure I

Annexure-III

No.1(5)/93/D(PEN-C),
Government of India/Bharat Sarkar
Ministry of Defence/Raksha Mantralaya,

New Delhi, dated April,16, 1996.

To

The Chief of the Army Staff,
The Chief of the Naval Staff,
The Chief of the Air Staff,

Subject:-Scheme for grant of Ex-gratia Awards in cases of Death/Disablement of Cadets(direct) due to causes attributable to or aggravated by Military Training.

***

Sir,

I am directed to state that the President is pleased to sanction a scheme for grant of ex-gratia awards in respect of Cadets in the event of death/disablement due to causes attributable to or aggravated by the conditions of military training. The rates and other conditions for grant of these ex-gratia benefits shall be as laid down in the succeeding paragraphs.

2. Ex-Gratia Awards in cases of disablement : In cases of invalidment on medical grounds due to disabilities attributable to or aggravated by the conditions of military training, an ex-gratia award at the rate of Rs.375/- per month for life shall be admissible to the ex-cadets (except Service entry). In addition, a Disability Award on ex-gratia basis shall also be admissible to the ex-cadet at the rate of Rs.600/- per month for 100% disability, during the period of disablement. The amount of disability award shall be proportionately reduced when the degree of disablement is less than 100%. No disability award shall be payable in cases where the degree of disablement is less than 20% or the disablement has not been accepted as attributable to or aggravated by the conditions of military training.

3. Ex.gratia Awards in cases of Death : As per terms and conditions of recruitment, majority of the Cadets such as entries through IMA, Ex-NDA and direct entries etc., are required to be bachelors and they cannot marry during the pre-commission training. However, in cases of entries such as Technical graduate entry/post graduate entry/Short Service Commission(tech.and Non-tech), Entry

contd/-

through the Army Cadet College(ACC) etc., marriage prior to pre-commission training is not a bar. In the event of death of a Cadet due to causes attributable to military training, the following ex-gratia awards shall be payable to the Next of Kin of the deceased Cadet depending on his marital status:-

(i) On death of married Cadet during training, Ex-gratia Award at the rate of Rs.600/-per month shall be admissible to the widow/children of the deceased Cadet. This award shall be payable to the widow until her death or re-marriage (with a person other than the real brother of the deceased Cadet), whichever is earlier. After death or disqualification of tho wid w on account of re-marriage, the ex-gratia award shall be payable to the sons/ unmarried daughters(in the order of seniority in age) till they attain the age of 25 years. In case of unmarried daughter(s), the payment of ex-gratia award shall be stopped on her/their getting married.

In the absence of eligible widow/children, ex-gratia award shall be paid to the dependent parents as per rates given in the para 3(ii) below.

(ii) In case of unmarried/widower cadet with no children, ex-gratia award at the rate of Rs.375/-per month shall be payable to the dependent parent(s) of the deceased Cadet for life. In the absence of partents, the ex-gratia award shall be payable to the dependent brother(s)/unmarried sister(s) in the order of seniority in age, till they attain the age of 25 years. In case of unmarried sister(s), the payment of ex-gratia award shall be stopped on her/their getting married.

(iii) The ex-gratia award shall be payable to only one member of the family at a time.

(iv) In the event of death of an ex-cadet in receipt of disability award under para 2 above, Ex-gratia Awards at the above rates shall be admissible to the family of the deceased cadet provided that the death is caused by the disability sustained during military training which was accepted as attributable to or aggravated by the conditions of military training.

contd/-

4. Constant Attendance Allowance(CAA) : When the degree of disability is assessed at 100% and is accepted as attributable to or aggravated by the conditions of military service, Constant Attendance Allowance at the rate of Rs.300/- p.m. shall be admissible to the ex-Cadet on the recommendation of the Invaliding Medical Board.

5. No ex-gratia award under these instructions shall be payable if the death/disablement is neither attributable to nor aggravated by the conditions of military service/training.

6. Other rules and procedure regarding assessment/re-assessment of disablement and acceptance of disability/death as attributable to or aggravated by conditions of military service/training in cases of cadets shall be the same as for regular Commissioned Officers of the Armed Forces. The procedure for sanction and conditions for grant of ex-gratia awards to the Next of Kin in case of deceased Cadets shall be same as in cases of casualties of regular Commissioned Officers due to attributable causes.

7. Awards under these instructions are being sanctioned purely on ex-gratia basis and the same shall not be treated as pension for any purpose. However, Dearness Relief shall be admissible on the Ex-gratia Awards sanctioned under para 2 & 3 of these instructions.

8. The provisions of this letter shall be applicable in cases of casualties occurring on or after 1.1.86.

9. This issues with the concurrence of the Finance Division of this Ministry vide their U.O.NO.607/Pen/96 dated 9.4.96.

Yours faithfully,

(P.K.KATARIA)
DEPUTY SECRETARY TO THE GOVERNMENT OF INDIA.

Copy to:-

1. JS(Trg.&CAO), JS(G), JS(N), JS(Air).

2. CGDA,New Delhi.

contd/-

3. CCDA(P),Allahabad.
4. CDA(PD), CDA(Navy), Bombay; CDA(Air Force),New Delhi and CDA(O) Pune, CDA(Air Force), Dehra Dun.
5. The Director General of Audit, Defence Services, New Delhi.
6. Army HQ/AG/PS-4.
7. Naval HQ/DPA.
8. Air HQ/DPP&R.
9. Director General of Resettlement.
10. Department of Pension & Pensioners' Welfare.
11. Department of Expenditure(EV Section).
12. Addl.FA(P)/DFAs(Pen),Min.of Def(Fin/Pen).
13. D(Pen-A); D(Pen-C); D(Civ.II); D(GS-VI); D(Res); PG Cell, D(Air-III), D(Navy-I), D(GS-II).
14. Director of Public Relations.
15. Editor-in-Charge, Sainik Samachar.
16. D(Hindi-IV)- for Hindi version.

[illegible] 1972 processed to DESMS.

Appendix-II
(Refer to Ministry of Defence letter
No.16(3)/2023/D(Pen/Pol)/Vol-II
Dated 21.09.2023

Guide to Medical Officers (Military Pensions)-2023 Chapter I - VII

CONTENTS

	Paragraph	Pages
CHAPTER I - GENERAL		1-3
Introduction	1-5	1
Entitlement rules	6	1
Definitions	7	1-2
Function of medical boards	8	2-3
Casual connection	9	3
CHAPTER II – ENTITLEMENT GENERAL PRINCIPLES		4-7
Evidence for entitlement purposes	4	5
CHAPTER III – CLINICAL ASPECTS OF ENTITLEMENTS		8-50
General	1	8
Wound and injuries	2	8
Diseases	5	9-12
Appx 'A' to Chapter III GMO 2023	-	13-19
Encls 1 to Appx 'A' to Chap III of GMO 2023	-	20-41
Encls 2 to Appx 'A' to Chap III of GMO 2023	-	42-50
CHAPTER IV – ENTITLEMENT RULES 2023 (Under revision)		51
CHAPTER V- MISCELLANEOUS PROVISIONS		52-57
Members who aggravate or retard the cure of a specified medical condition	1	52
Refusal to undergo medical treatment or operation	2-4	52
Unforeseen effects of treatment	5	52-53
Classical sequelae	10	54
Appendix 'A' to Chap V Unwillingness cert for treatment	-	55
Appendix 'B' to Chap V Unwillingness cert of NOK for treatment	-	56
Appendix 'B' to Chap V Unwillingness cert of NOK for treatment	-	57

CONTENTS

Diseases	Paragraph	Pages
CHAPTER VI CLINICAL ASPECTS OF CERTAIN DISEASES		58-90
AIDS	1	58-59
Adrenocortial Insufficiency	2	59
Aplastic Anaemia	3	59
Appendicitis	4	59
Bronchial Asthma	5	59-60
Blank	6	-
Bronchiectasis	7	60
Cardiomyopathy	8	60
Cancer	9	60-62
Blank	10	-
Blank	11	-
Blank	12	-
Cataract	13	62-63
Cerebrovascular Accident (Stroke)	14	63
COPD	15	63
Corns, Callosities and Warts	16	63-64
Cholelithiasis & Cholecystitis	17	64
Cirrhosis of Liver	18	64
Conjuctivitis	19	-
Chronic Degenerative Disease of CNS	20	64-65
Colonic Polyps and Diverticulosis	21	65
Congenital Heart Disease	22	65
Deafness	23	65-66
Diseases of Retina	24	66-67
Demyelinating Disease of CNS	25	67
Diabetes Mellitus	26	67-68

Diseases	Paragraph	Pages
DNS	27	68
Disorders of Cardiac Rhythm and Conduction	28	68
Diseases of Female Reproductive System	29	68-69
Disorders of Immune Dysregulation	30	70
Diseases Peculiar to Naval Service	31	70-72
Eczema/Dermatitis	32	72
Epilepsy/Seizure	33	73
Errors of Refraction	34	73
Glaucoma	35	73
Fibrosis of Lungs	36	73-74
Fistula in Ano	37	74
Goitre	38	74
Gout	39	74-75
Hepatitis	40	75
Hernia	41	75
Haemorrhoids	42	75
Hypertension	43	75-76
Inflammatory Bowel Disease	44	76
Irritable Bowel Syndrome	45	76
Injuries to Oral Cavity	46	-
Coronary Artery Disease (CAD)	47	76
Keratitis	48	76
Musculoskeletal Conditions (Orthopaedics)	49	77
Laryngo-Tracheal Injury	50	77
Neck pain & Back Ache	51	77-78
Leprosy	52	78
Lymphadenitis Neck	53	78
Mental & Behavioural (Psychiatric) Disorders	54	78-79
Oesophageal Stricture	55	-

Diseases	Paragraph	Pages
Osteo-arthritis	56	79
Otitis Media	57	79-80
Otosclerosis	58	80
Pancreatitis	59	80
Paraplegia	60	80
Peptic Ulcer	61	80
Peripheral Neuropathy	62	80-81
Peripheral Vascular Diseases	63	81-82
Pneumonia	64	82-83
Pulmonary Eosinophilia	65	83
Prolapse Rectum	66	83
Psoriasis	67	83
Renal Disorders	68	83-85
Blank	69	-
Blank	70	-
Blank	71	-
Blank	72	-
Blank	73	-
Blank	74	-
Urolithiasis	75	85
Rhinitis	76	-
Chronic Rhinosinusitis	77	85
Spondarthritides	78	85
Squint	79	86
Gonadal Dysufunction (Hypogonadism)	80	86
Tuberculosis	81	86-87
Uveitis	82	87
Valvular Heart Disease	83	87
Vertigo	84	87
New Paragraphs		
Obstructive sleep apnea	85	87-88
Diseases Peculiar to Military Aviation	86	88-89
Disorders of bone	87	89
Dyslipidemia	88	89
Appx to Para 47 Chap VI – Cert by the CO/ Fmn Cdr	-	90

CHAPTER VII

ASSESSMENT

	Paragraph	Pages
Definition	1-2	91
Basis of Assessment	3	91
Definition of Function	4-6	91-92
Principles of Assessment	7-10	92-93
Computation of Assessment	11-14	93
Assessment with Regard to Percentage of impairment	15	93
Reassessment of impairment	16	93-94
Paired Organs	17	94
Composite Assessment	17A	94-95
Ankylosis	17B	95-96
Flail Joints	18	96-97
Defective Vision	19	97-98
Defective Hearing	20	98-101
Diseases of Circulatory System	21	101-108
Diseases of the Digestive System	22	108-111
Assessment of AIDS	23	111
Assessment of Lung Diseases	24	111-112
Assessment of Pulmonary Tuberculosis	25	112-113
Assessment of Chronic Bronchitis	26	113
Assessment of Asthma	27	113
Assessment of Bronchiectasis	28	113
Assessment of Mental & Behavioural (Psychiatric Disorders	29	113
Assessment of Skin Diseases	30	114-115
Assessment of Bone and Specific Injuries	31	115
Assessment of Spinal Deformity	32	115
Assessment of Neck pain & Backache	33	115-116
Assessment for knee injuries	34	116

Diseases	Paragraph	Pages
New Paragraph		
Assessment of Neurological Disorders	35	116-133
Appx I to Para 35 – Assessment proforma for upper extremity	-	134-135
Appx II to Para 35 – Assessment proforma for lower extremity	-	136
Appx III to Para 35 – Average normal Range (degrees) at different joints	-	137
Assessment of Renal Function	36	137-138
Assessment of Endocrine Disorders	37	138-139
Assessment of Spondylarthritis	38	139-140
Assessment Post-Transplant	39	141
Assessment of Haematological Disorders	40	141
Assessment of Burns	41	141-145

CHAPTER I

GENERAL

Introduction

1. The instructions in this book are intended to be a guide to medical officers and medical boards to enable them to approach the issue of entitlement of service personnel to disability or death and special family pensions in the proper perspective in line with extant rules, regulations and policies and efficiently discharge their responsibilities.

2. The disability or death compensation are awarded to Armed Forces personnel and their families respectively under current 'Entitlement Rules for Casualty Pensionary Awards for Armed Forces Personnel' and 'Pension Regulations' if, their bodily impairment or death is held 'Attributable to' or 'Aggravated by' Military Service as per the laid down criteria and meets the Benchmark Assessment parameter set forth in such rules and regulations.

3. The office of the Principal Controller of Defence Accounts (PCDA) (Pensions), Prayagraj is the Pension Sanctioning Authority (PSA) in respect of Commissioned Officers and Personnel Below Officers Rank (PBOR) of the Indian Army and all Defence Civilians serving in Defence Establishment all over the country including Defence Account Department (DAD), General Reserve Engineering Force (GREF) and Coast Guard. PCDA (Navy), Mumbai and CDA (Air Force), New Delhi are the PSA for service officers and PBOR of the Navy and Air Force respectively.

4. The Competent Authority to decide the initial claim for the award of Disability Pension (DP)/ Disability compensation(Monthly Disability Ex-gratia and Special Family Pension (SFP)/ Ordinary Family Pension (OFP) shall be as per the Entitlement rules as amended from time to time, in consultation with their designated Financial Advisors.

5. Service Personnel, Cadets and their families have a right to appeal against the rejection of their Initial Claim or First Appeal for the Award of Disability Pension/ Disability Compensation, Monthly Disability Ex-gratia and Special/ Ordinary Family Pension of the Pension Sanctioning Authority regarding entitlement within six months of the date of communication of such decision. In no case, appeals shall be processed after five years from the date of issue of Govt Sanction Letter on disability.

Entitlement Rules

6. Entitlement of an impairment or death regarded solely due to service rendered will be decided under Entitlement Rules 2023 as promulgated by Ministry of Defence and as amended from time to time. Chapter VII in this Guide on assessment of impairment applies to all cases irrespective of entitlement rules.

Definitions

7. (a) Disability as per RPwD Act of 2016 is defined as along term physical, mental intellectual or sensory impairment which, in interaction with barriers, hinders the full and effective participation of the person in society equally with others. The Act, aimed at promoting and protecting the Rights and Dignity of

persons with disabilities, both lists the medical conditions that are to be treated as disabilities, specifies the parameters for assessment of such disabilities and the benchmark assessment that shall entitle a person to such rights. Disability Compensation (DP/ DE/ Lump sum compensation) to Armed Forces personnel is aimed at fulfilling a service liability in respect of impairment that is clearly established to have been precipitated/ caused by service conditions, this aspect is to be determined by applying the provisions of these guidelines.

(b) *Entitlement.* Is the recognition by Competent/ Appellate Authority, after considering both medical and non-medical evidence that a bodily Impairment has been influenced in its onset or course by the conditions of military service. Such an impairment is called an "Accepted impairment".

(c) *Member.* Means a person who is in the Armed Forces.

(d) *Reasonable Doubt.* Implies that there must be reasons i.e. facts from which the doubt arises. It is the one which influences the decisions arrived at by a reasonable and prudent person when conducting important affairs of his own life. Accordingly, for the purpose of these instructions it will be considered as an alternative favouring a member, which can be supported by rational arguments based on adequate premises and is not merely a strained or fanciful acceptance of vague or remote possibilities.

(e) *Consensus of medical opinion.* Means the views of medical authorities recognized as speaking with authority on the impairment (s) in question in regard to the effect of service conditions on its development.

(f) *Assessment.*The term "assessment" is used for the process of evaluation of functional impairment in percentage for calculation of disability component.

Functions of Medical Boards

8. The function of a medical board is to inform and advise the Competent/ Appellate Authority on the basis of all available records and their own clinical examination concerning :-

(a) The clinical history and conditions of a member on account of an impairment or impairments alleged to be related to service.

(b) The particular evidence on which the boards base their opinion on the relation or otherwise, of an impairment to service.

(c) The degree of permanent or temporary impairment of function produced by a disease/injury with particular reference to the amount of that impairment resulting from service. In cases of reassessment by Re-assessment Medical Boards (RAMB) and Review Medical Boards (Rev MB),the amount of impairment due to extraneous factors and the natural history of illness will have to be separated from those due to service.

(d) The refusal of a member to undergo medical treatment, provided the modality of treatment which was offered, would have cured or improved the

impairment or resulted in arresting further deterioration of the condition would be accounted for appropriate reduction from overall assessment for that impairment.

Causal Connection

9. The establishment of a Causal Connection between a Death/ Bodily Impairment and Military Service, based on evidence, by the Competent/ Appellate Authorities, is an essential pre-requisite for the award of a Death/ Disability Compensation.

Death or bodily impairment may be due to wounds, injury or disease. Evidence of causal connection or otherwise, in cases of disease, can be obtained in various ways. For instance, the person may have declared or admitted at the time of enrolment, that he suffered from the disease previously: or in statements made before or on admission to hospital, he may have explained when he began feeling unwell or out of sorts adding how his time shortly prior to that was spent, thereby giving an indication or clue to the proximate time and circumstances of possible source of exposure. It may be that the consensus of medical opinion is against the acceptance of the particular disease as having caused by conditions of Military Service. That will constitute evidence that it is not attributable to service, but then the onset of the disease may either have been hastened or worsened by specific conditions of Military Service. If the condition deteriorates naturally, and military service does not accelerate the worsening, there will be no case for conceding acceptance on the basis of aggravation. Thus, there is a distinction between a disease contracted in service and one merely worsened by service.

10. Service conditions provide safe environment for a healthy population with a good nutritional and physical background. Acquisition of infection in such circumstances may be the result of a temporary breakdown in the health environment. For accepting a disease as Attributable to Military Service, the Medical/ Competent and Appellate Authorities must satisfy themselves that, the onset of the disease occurred during the period of Military Service and that it was directly caused by the specific conditions of Military Service. A disease caused due to an infection arising whilst in service, other than those that could be transmitted through sexual contact, shall merit consideration of entitlement based on Attributability and where the disease may have been contracted prior to enrolment or whilst on leave, the incubation period of the disease must be taken into consideration, on the basis of the clinical course determined by the Competent Medical Authority. If nothing at all is known about the cause of the disease and the presumption of the entitlement in favour of the claimant is not rebutted attributability should be conceded on the basis of clinical picture and current scientific medical application.
When the diagnosis or treatment of a disease was faulty, unsatisfactory or delayed due to exigencies of service, bodily impairment caused due to any adverse effects arising as a complication shall be conceded as attributable to military service.

Thus, while awarding attributability, circumstances under which infection could have been contracted in service should be clearly spelt out in the history part of the opinion and also elucidated by the board.

CHAPTER - II

ENTITLEMENT: GENERAL PRINCIPLES

1. Although the certificate of a properly constituted medical authority vis-à-vis the bodily impairment, invalidment, discharge or death, forms the basis of compensation payable by the government, the decision to admit or refuse entitlement is not solely a matter which can be determined by the medical authorities alone. It requires the consideration of other circumstances e.g., service conditions, pre-and post-service history, verification of wound or injury, corroboration of statements, collecting and weighing the value of evidence, and in some instance, matters of military law and discipline. Accordingly, Medical Boards should examine cases in the light of the etiology of the particular disease and after considering all the relevant particulars of a case, record conclusions with reasons in support, in clear terms and in a language which the Competent/ Appellate Authorities, would be able to appreciate fully in determining the question of entitlement according to the rules. In expressing their opinion, medical officers should comment on the evidence both for and against the concession of entitlement. In this connection, it is as well to remember that a bare medical opinion without reasons in support will be of no value to the Competent/ Appellate Authorities.

2. Entitlement of Attributability to Military Service in case of Injuries/ Accidents is conceded on the basis of a direct nexus between the Injury/ Accident and Military Service. The twin tests that must be satisfied in such cases are, whether the individual was performing a bonafide military duty, as defined in the Entitlement Rules for Casualty Pensionary Awards for Armed Forces Personnel, at the material time of sustaining the injury and if a direct causal connection between the Injury/ Accident and Military Service has been established on the basis of clear evidence. Service factors must not be unduly implicated for Injuries/ Accidents that can occur in the ordinary course of daily life, to any person, irrespective of environmental conditions, for eg., slipping, tripping, falling, striking one's body/ limbs against objects both animate or inanimate, sprains, muscle pulls etc., unless a specific impetus from service conditions, personnel or equipment is evidenced in precipitating such Injury/ Accident. It is therefore important that the Injury/ Accident is recorded by initiating an Injury Report immediately or at the latest, within the period of first medical treatment/ hospitalization for the same. It must be initiated by the treating medical authority, evidencing both the date and time of occurrence and the immediate circumstances leading to the Injury/ Accident. The report, once initiated may thereafter be finalized by the Competent Authority, based on a thorough Inquiry into the circumstances of the same. Injury Report is a primary document to determine the occurrence and Attributability of an Injury/ Accident and must be initiated in all cases including where injuries are sustained during active operations.

3. If a disease was contracted whilst in Military Service and it is established by evidence that the disease was brought about solely by specific conditions of Military Service, then Attributability is clearly indicated.

A disease is to be considered as Aggravated by Military Service, if evidence indicates that its onset was hastened by specific conditions of Military Service.

If on the other hand, a disease prevalent in the individual pre-enrolment or having its origin in circumstances other than Military Service, stands influenced in its subsequent course by conditions of Military Service, the claim for Death/ Disability Compensation would stand for acceptance on the basis of Aggravation, provided the prevalence of such a disease was brought to the notice of the Medical Authorities in time and the individual has followed through on all medical advice.

Evidence for Entitlement Purposes

4. Opinion on entitlement must be impartially given in accordance with the available scientific evidence as per standard medical text books. Documents, Record of Service, medical and hospitalization documents, Injury Report raised by a medical officer/ specialist at the time of injury or initial admission duly approved by the Competent Authority, Court of Inquiry where required, along with remarks of the formation/ Station Commander, SITREPS, Battle Casualty Report, Part II Order etc., which establish a nexus between the Injury and Military Service are to be considered as evidence. Diseases contracted while in service, other than sexually transmitted diseases, shall merit an entitlement of attributability, if a causal connection is established by the specialist opinion.

5. Evidence to be accepted for the purpose of these instructions should be of a degree of cogency which though not reaching certainty, nevertheless carries high probability.

6. **BLANK**

7. Evidentiary value is attached to the record of a member's condition at the commencement of service, and such record has, therefore, to be accepted unless any different conclusion has been reached due to the inaccuracy of the record in a particular case or otherwise. It is also possible that an impairment may escape detection on enrolment/commissioning due to a non-disclosure of the essential facts by the member, e.g., pre-enrolment history of an injury, disease like epilepsy, mental disorders etc. It may also be due to latency or obscurity of the symptoms at the time of enrolment/commissioning. There may occasionally be direct evidence of the contraction of an impairment, otherwise than by service. In all such cases, though the disease cannot be considered to have been caused by service, the question of aggravation by subsequent service conditions will need examination on a case-to-case basis. Diseases may also not be detected because of lack of sophisticated equipment / techniques available on ground during initial medical examination e.g., Congenital Diseases of the Kidney, Liver, Valvular Heart Disease etc. Therefore, mere fact that a disease has manifested during military service does not establish entitlement by military service.

The following are some of the diseases which may ordinarily escape detection on enrolment/commissioning: -

(a) Certain congenital abnormalities which are latent and only discoverable on full investigations e.g., Congenital Defect of Spine, Spina Bifida, Sacralization, Renal abnormalities, etc.

(b) Certain familial and hereditary disease, e.g., Haemophilia, Congenital Syphilis, Haemoglobinopathies, etc.

(c) Certain diseases of the heart and blood vessels, e.g., Coronary Atherosclerosis, Rheumatic Fever, etc.

(d) Diseases which may be undetectable by physical examination on enrolment, unless adequate history is given at the time by the member, e.g. Gastric and Duodenal Ulcers, Epilepsy, Mental Disorders, HIV, HBV, HCV Infections, etc.

(e) Relapsing and remitting forms of diseases which have intervals of normalcy like, mental disorders, autoimmune disorders, etc.

(f) Diseases which have periodic attacks e.g., Bronchial Asthma, Epilepsy, CSOM, etc.

(g) Diseases which can be masked by taking medications e.g., Seizures, Mental Disorders, Hypertension, Diabetes Mellitus, etc.

8. The question whether the impairment, invalidation, discharge or death of a member has resulted from service conditions, has to be judged in light of the record of member's condition on enrolment/commissioning as noted in service doouments and of all other available evidence both direct and indirect.

In addition to any documentary evidence relative to the member's condition to entering the service and during service, the member must be carefully and closely questioned on the circumstances which led to the manifestation of the disease, the duration, the family history, his pre-service history, etc. so that all evidence in support or against the claim is elucidated.

Medical Boards should ensure that opinion on attributability, aggravation and neither attributable nor aggravated impairments are supported by cogent reasons. The approving, confirming and accepting authorities should also be satisfied that this question/aspect has been dealt with in such a way as to establish a causal relationship with military service and leave no reasonable doubt.

9. On the question, whether any persisting deterioration has occurred, it is to be remembered that invalidation or discharge from service does not necessarily imply that the member's health has deteriorated during service. The impairment may have been discovered soon after joining and the member discharged in his own interest in order to prevent deterioration. In such cases, there may even have been a temporary worsening during service, but if the treatment given before discharge was on grounds of expediency to prevent a recurrence, no lasting damage was inflicted by service and there would be no ground for admitting entitlement. Again, a member may have been invalided from service because of not being mentally strong to make an efficient soldier. This would not mean that his condition has worsened during

service, but only that it is worse than was realized on enrolment in the army. To sum up, in each case the question whether any persisting deterioration is or is not due to service will have to be determined on the available evidence which will vary according to the type of the impairment, the consensus of medical opinion relating to the particular condition and the clinical history.

CHAPTER-III

CLINICAL ASPECTS OF ENTITLEMENT

General

1. Reports of medical boards are the basis of executive action, and will be read by both medical and lay officials, whose duty is to maintain a just and uniform application of the rules. It is, therefore, of the utmost importance that the board's report should be legibly written (especially medical terms or abbreviations) and in an unambiguous language so that the reader may be able to accurately visualize the nature of impairment caused by a medical condition for which a claim for compensation is being raised, and the general constitutional makeup of the member examined. No indication whatsoever should be given to, or in the hearing of, a member being examined, as to the views/ opinion of the members of the board, on the question of entitlement or the extent of assessment of the impairment, caused to the member being examined by a specified medical condition (Functions of various boards related to disability compensation included as Appx 'A' to this chapter).

The copy of board proceedings will not be handed over to the member by the concerned hospital / higher medical authorities. However, a confirmed copy of the Medical Board Proceedings should be made available to the member by the concerned Record Office, along with the letter conveying the decision of the Competent Authority as to the Initial Claim of the member for the award of disability compensation.

Wound and Injuries

2. The question of entitlement, where a wound or injury has resulted from enemy action, The circumstances leading to such a wound or injury entitlement is dependent on an authentic official record of the injury. In such cases attributability is conceded by the Competent Authority, as designated in the Entitlement Rules for Casualty Pensionary Awards for Armed Forces Personnel, only when a direct causal connection between the injury and military service is clearly established by way of evidences such as, a valid Injury Report, statements of witnesses in a Court of Inquiry, SITREP, Battle Casualty (BC) Report, BOMBREP, MORREP, initial and detailed report of an incident, the case sheets of immediate hospitalization for the specified wound or injury etc., initiated by authorities in reasonable proximity and within a reasonable time frame of the occurrence of the wound or injury and not in retrospect. The question of entitlement will be decided by the Competent/ Appellate authority where as the degree of impairment caused by such wound or injury will always be done only by a duly constituted Medical Board, after physically examining the member.

3. **BLANK**

4. Self- inflicted. The determination of a wound or injury as having been self-inflicted, must as a rule be made on the basis of the initial and detailed report and/ or

the proceedings of a Court of Inquiry held to determine the circumstances leading to such a wound or injury and the reports of the Medical Examination and treatment, which are usually available for scrutiny. Cases of self-inflicted wound or injury require special investigation and consideration. The Medical Board should only comment on whether or not the Impairment that is raising a claim for death or disability compensation, was indeed caused as a result of such self-inflicted wounds or injury and whether or not from a medical perspective, specific service factors played a role in the precipitation of such self-inflicted wound or injury and the impairment caused therein. The question of entitlement must however be left open by the Medical Board for the consideration and decision of the Competent/ Appellate Authority.

Diseases

5. Service personnel are constantly under medical review throughout their service. During the period of intensive training and active service a person may undergo strenuous physical activity, exposure and hardships. Such strenuous activity and exposure may have an influence on the onset or course of a medical condition leading to an impairment. It is possible that persons weakened by such proven hardships may contract infections or latent infections within them may become manifest. In such cases attributability is conceded when the medical condition caused by such infections manifests while in service and there is evidence that military service conditions have directly caused the disease.

6. In considering, whether a particular disease has been caused due to service, it is necessary to relate the established facts in the aetiology of the disease and of its normal development to the effect that any specific condition of service, e.g., extreme physical exertion, climate, may have had on its manifestation. Regard in such cases must be paid to the time factor. The effects of exposure or other compulsions of services would usually be expected to manifest themselves not long afterwards; and if the impairment does not come under notice for a considerable time after the member was removed from such harsh or potentially stressful environmental conditions, as to affect the medical condition, there would be doubt that the disease had indeed arisen as a direct outcome of the specified service conditions.

7. In order to come to a decision as to the question of entitlement, the board must be satisfied as to the diagnosis of the medical condition and the specified impairment caused by it. It is therefore, of the utmost importance that the evidence, documentary or otherwise, on which the diagnosis is based should be critically considered and any reasons for doubt clearly indicated, so that further investigations by special tests or observation may be carried out if practicable.

8. The reported or alleged conditions of service which may have influenced the origin and development of the medical condition must be critically examined, and information from the member sought on matters of doubt. The Medical Board should study relevant information recorded in the AFMSF-15, AFMSF-16 available to them before coming to their conclusions.

9. To establish the causal relationship between the diseases and military service, relevant conditions have been brought out in Chapter VI with a view to assisting the boards in arriving at uniform decision in individual cases. However, Chapter VI is not all encompassing and certain diseases / ailments may not have

been covered therein. Opinion on such occasions shall be provided based on current medical literature published in standard text books and evidence available to the medical board (e.g., Valid and duly approved Injury report initiated at the time of injury or at the time of initial hospitalization and not in retrospect).

10. The effect on function should be described so as to make apparent from what normal activities the examinee is inhibited from undertaking. The terms slight, moderate or severe, without qualifications, are insufficient. Physical examination, whilst primarily directed to the condition for which compensation is sought, must also be sufficiently comprehensive to reveal the existence of other injuries, disease or defects.

11. Wounds and injuries should be described with anatomical precision and appropriate measurements. It is important to insert right or left; front or back; upper or lower and such terms as fracture of leg should not be used. The use of diagrammatic sketches to show the position of scars, distance from the nearest fixed bony point should be noted, this will simplify description and facilitate subsequent consideration of the case. All scars, even those not connected with wounds or injuries received during service, should be recorded. In describing conditions in which either the upper or lower limbs are involved the effect on function is of paramount importance.

12. Particular care should be taken to avoid the use of vague or ambiguous terms of diagnosis such as "debility", "second degree constitution", "anaemia" etc., which have a varied aetiology, without specification of the cause of the symptoms. The diagnosis should be recorded as per the International Classification of Diseases (ICD) code.

13. The board should ensure the diagnosis recorded in the AFMSF-15, AFMSF-16 is as per the ICD code (The revised AFMSF-16 & 17 with their instruction for filling are enclosed as enclosures to Appendix A of this chapter).

14. To have a correct appreciation of the case and to bring out the above-mentioned facts, the following suggestions are made:-

(a) The opinion of the board on entitlement of the disease must be justified so as to make it comprehensible by the executive and appellate authorities.

(b) Where a disease is opined to exist before enrolment/commissioning, adequate reasons must be stated to as to why it was not or could not be detected at the time of enrolment/commissioning.

(c) Reasons must be stated as to why the disease or impairment is attributable to or aggravated or otherwise by military service in conjunction with the accompanying medical record/specialist opinion. Detailed justification without ambiguity should be given and the opinion furnished should stand the scrutiny of courts especially where death or impairment is neither attributable nor aggravated due to military service.

(d) Medical Boards at the time of discharge when recording their opinion as to causation, degree of impairment and fitness for service will be careful

not to allow their decisions to be influenced by the proceedings of the previous Medical Boards. RMB/IMB will remain empowered to alter the opinion of any earlier medical board.

(e) Guidelines on the conduct and processing of Release/Invalidment Medical Board proceedings are issued from time to time by the O/o DGAFMS and must be adhered to. A schematic diagram is enclosed as Appx A to this chapter on the sequence of relevant medical boards related to disability compensation.

(f) Specialist opinion should be detailed, legible, show proper application of mind and derive logical conclusions. While rendering opinion, specialists should ensure that:-

(i) They are well conversant with the Guide to Medical Officers as and when revised from time to time.

(ii) The date and place of detection of the impairment should always be mentioned based on documentary evidence.

(iii) The initial presentation, treatment given and the progression of the disease whether the individual has improved / deteriorated while in service and whether treatment and drug dosage had to be changed should be recorded in a chronological order.

(iv) Possible aetiological factors of the diseases whether infective/ degenerative/ inherited/ immunological/ iatrogenic etc., should be brought out clearly.

(v) Presence or absence of relevant modifiable risk factors and co-morbidities must be mentioned.

(vi) The course of the impairment since detection should be summarised. The opinion furnished must not be ambiguous and should be able to stand the scrutiny of the court.

(vii) Present condition of the individual, commenting on the condition as improved, deteriorated or stable.

(viii) Degree of functional loss to be assessed by the specialist in the opinion and an assessment calculation sheet will be enclosed along with the opinion for verification by the President Medical Board, but the final percentage of impairment will be endorsed by the board after verification.

(g) Assessment of Impairment. The assessment of impairment by RMB/IMB should be justified as per provisions of Chapter VII, Guide to Medical Officers. If a disease entity is not covered in the above chapter, it should be evaluated as per guidelines for disability evaluation in the Right of Persons with Disabilities Act 2016, ICF(WHO) 2002 and application of current medical knowledge.

(h) Every attempt should be made to initiate the injury report soon after the patient's admission to hospital/ at the time of initial down gradation of classification. The fact that injury report has been initiated, should be clearly mentioned in the medical case sheet with the date of its initiation.

BRIEF SUMMARY OF RELEVANT MEDICAL BOARDS FOR DISABILITY COMPENSATION

1. The composition and disposal of Medical Boards is governed by Chapter VIII of Regulation for the Medical Services of the Armed Forces (RMSAF) as amended from time to time and relevant Service Orders issued by the Service Chiefs. A brief overview describing the types and functions of the medical boards relevant for Disability compensation is reproduced below.

2. The important functions of relevant medical boards are as under:

S No	Board	Forms as revised from time to time	Functions
1	Classification Medical Board	AFMSF-15	(a) When a disease or an injury occurs to a member and would require greater convalescence period for the member to improve than hospital admission combined with sick leave. The board is held to downgrade their medical classification temporarily with an intent to provide them sheltered appointment with restrictions to prevent any worsening of the medical condition due to service conditions. (b) The entitlement (attributability /aggravation/ NANA) is also endorsed by the board. (c) The assessment is endorsed only if the board feels that the medical condition is of a permanent nature and will require long duration of follow up and downgrades the member in permanent low medical classification.
2	Reclassification Medical Board	AFMSF-15	(a) The board is held to review the member who has been placed in lower medical classification after the stipulated time endorsed by the previous board. (b) The board can upgrade, downgrade or observe the member further in same the medical classification depending upon their clinical status.

			(c) The assessment is endorsed only if the board places the member in a low medical classification permanently. (d) This board does not comment on the entitlement of the medical condition.
3	Disability Compensation Medical Board(DCMB)	AFMSF-15	(a) This is a special board convened for an impairment which is attributable or aggravated due to military service and greater than the benchmark, within three months of it becoming permanent with no scope for it to improve or deteriorate further, even if the member of the Armed Forces is retained in service continues to serve till retirement or discharge. (b) The board can be convened at any Command Hospital of the three services or at Army Hospital (R&R)/Base Hospital Delhi Cantt once the member opts for it within a period of three months at the time of retention. (c) This special board will be presided over by Commandant and members will be Conslt/Sr Adv of Medicine and Surgery of these hospitals. The board proceedings are submitted to MGs Med & Equivalents of Comd HQ for approval and will be confirmed by DGsMS of the respective services.
4	Invalidment Medical Board(IMB)	AFMSF-16	(a) The board is ordered when a member is to be invalidated out of service on medical grounds before the completion of terms of service. (b) The proceedings of this board determine the eligibility of the member for Disability pension. (c) The board comments on both entitlement and assessment of the Disability. (d) There is no benchmark disability percentage for ordering this board as it is based upon functionality of the member for the service to which

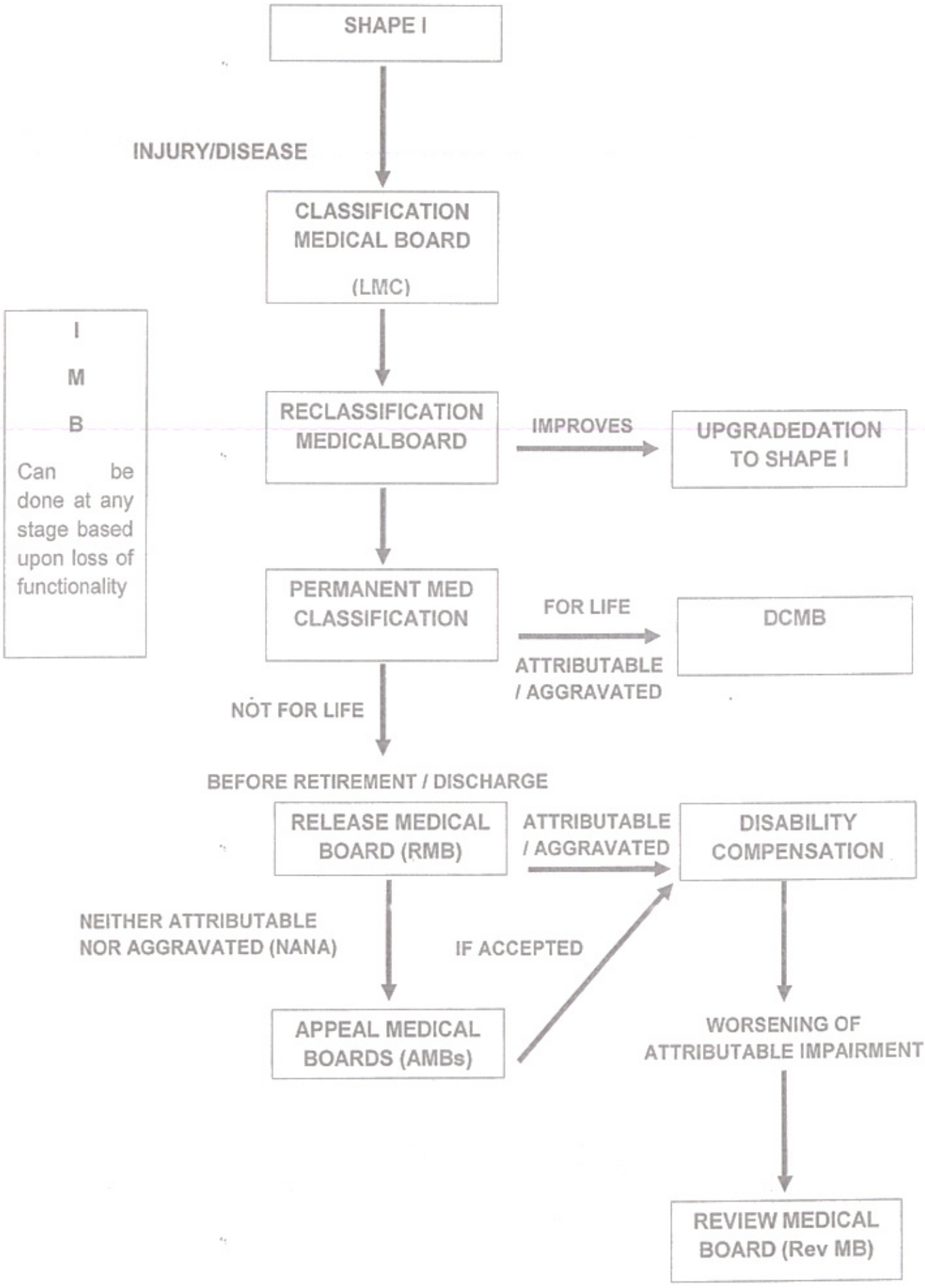
			he was enrolled or commissioned for. (e) Even if the assessment of impairment is minor but makes the member incapable of performing the task that he was enrolled for are adequate grounds for invalidment. (f) The board has to provide detailed justification without ambiguity with cogent reasons based upon evidence weather the disability is entitled (attributable/ aggravated) or neither attributable nor aggravated due to military service. (g) The assessment of functional impairment is to be done as per Chapter VII of GMO as amended from time to time. (h) The board will be approved by one echelon higher and will be confirmed by MGs Med Command &equivalents. (j) DGsMS of the respective Service would be the accepting authority in case of Offrs.
5	Release Medical Board(RMB)	AFMSF-16	(a) This board is done for all members who are being discharged/retiring(weather voluntarily or otherwise) from service after completing the terms of engagement in low medical classification and conducted at service hospitals. The conduct of the board for officers above the rank of Col & equivalents will be outside their area of responsibility as per Entitlement Rules of 2023. (b) The proceedings of this board determine the eligibility of the member for compensation on account of impairment attributable or aggravated by service. (c) The board comments on both entitlement and assessment of the impairment. (d) The board has to provide detailed justification without ambiguity with cogent reasons based upon evidence weather the disability is

			entitled (attributable/ aggravated) or neither attributable nor aggravated due to military service. (e) The impairments for which compensation has been paid by DCMB are not considered for final composite assessment ascribable to military service. (f) The assessment of functional impairment is to be done as per Chapter VII of GMO as amended from time to time. (g) The composite percentage of assessment done by the board is not the arithmetic sum of impairments and has to be an exact percentage with no rounding off. (h) The board is approved one echelon higher and the assessment is to be treated as final unless the member asks for a one-time final review. (j) The confirming authority for Lt Gens & equivalents are DGsMS of the respective services. (k) The board is confidential and will be forwarded to the member after inttial adjudication by the respective Service HQs.
6	Re-Assessment Medical Board(RAMB)	AFMSF-17	(a) The board is conducted at the nearest service hospital to the veteran for impairments which have not attained finality at the time of Release Medical Board and are likely to improve with time after discharge. (b) The board can only comment upon the assessment and the assessment is given by the board for life. (c) If the board gets delayed the sanction of the board is accorded by Service HQ and by the DGsMS under the powers delegated by the DGAFMS. (d) The board will also endorse the

			assessment for the intervening period if there is a delay.
7	Appeal Medical Boards (1st& 2nd AMBs)	AFMSF-16	(a) These boards are sanctioned by the O/o DGAFMS on the appeal by the member/veteran against the findings of the RMB. (b) It is granted if the medical member of the appellate committee feels that the entitlement given by the RMB is not appropriate. (c) Appeal medical boards can change both the entitlement as well as the assessment percentage given by the RMB. (d) Composition of the board is as per the directions of the MoD as amended from time to time. (e) The boards are conducted at Base Hospital Delhi Cantt.
8	Review Medical Board(RevMB)	AFMSF-17	(a) Veterans can apply for a one-time final Review Medical board if the impairment is attributable to military service and it is felt that the assessment done by the Release Medical Board was inappropriate or the impairment has worsened meriting a higher assessment. (b) It is granted by the O/o DGAFMS and conducted at Army Hospital (R&R) Delhi Cantt for veterans residing in Northern regions of India and at AFMC, Pune for veterans residing in Southern regions of India. (c) The board can only change the assessment and does not comment upon the entitlement. (d) The assessment done by the board is final and for life. There is no provision for asking for another review under the existent rules.
9	Post Discharge Medical Board (PDMB)	AFMSF-16	(a) The medical board was being conducted under the provisions of Rule 8 of Entitlement Rules 2008 for veterans who had retired in SHAPE-I and developed an impairment within

			07 years of discharge from service which was attributable to military service like the Second Appeal Medical Board after the sanction of DGAFMS. (b) No provision of this board exists as per Entitlement Rules of 2023.

3. The sequence of various medical boards is summarised in the flow chart as below :



4. The revised AFMSF-16 & 17 (version 2023) are placed as enclosures to this Appendix.

Encls 1 to Appx 'A' to Chap III of GMO 2023

AFMSF-16 (Ver 2023)

Passport size Photograph duly attested by CO

MEDICAL BOARD PROCEEDINGS

INVALIDMENT / RELEASE IN LOW MEDICAL CATEGORY/ APPEAL MEDICAL BOARD (First/Second)/PDC

PART – I

1.Authority for Board Release order : -			2.Place/Hospital		3.Date - __/__/____
4.Name	5. Sex : M/F	6. Service No.	7.Rank	8. Date of Birth __/__/____	9. Contact number & Email ID
10.Unit / Ship	11 .Service*(Army / Navy / Air Force)*		12.Arm / Corps / Branch / Trade	13.Total Service	14.Total Flying Hours / Service Afloat
15.Permanent Address:	16. Name & relation of NOK	17. Date of commissioning/ Enrolment: __/__/____	18. Date of Retirement/ Release __/__/____	19. (a) Record Office -	
20.Identification Marks: (a) (From service I-Card) (b)				21 (a) Height (cm) - (b) Weight (Kg) -	

Signature of Witness .....
Service No.....Rank.....
Date.....

Signature of Individual.....
Service No.....Rank.....
Date.....

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

II

PERSONAL STATEMENT

1. Give details of service. (P= Peace OR F= Field / Operational / Sea service) *

*(Copy of paramount card and Part –II orders for service in Fd/Mod Fd/CI Ops/HAA/sea service/operational area/Others for the indl undergoing RMB to be att)

S No	From	To	Unit	Place/ Ship	P/F(HAA/Ops/Sea service)/Mod Fd	S No	From	To	Unit	Place/ Ship	P/F(HAA/Ops/Sea service)/Mod Fd
(a)						(b)					
(c)						(d)					
(e)						(f)					
(g)						(h)					

2. (a.) Did you suffer from any impairment before joining the Armed Forces? If so give details and dates.

(b.) Were you previously employed in service? If so, are you in receipt of any disability compensation? Give details.

(c.) Did you take any treatment from any civil or private sources? If so, give details and reasons for taking treatment from civil resources.

(d.) Did you refuse any treatment or surgery? If so, give details and reasons for refusal.

(e.) Did you sustain any injury resulting in impairment? Give ref of injury report and COI. Give reasons for non submission of injury report at the time of injury, if injury report not submitted.

(f.) Did you delay any of your AME/PME or did not carry out AME/PME for any year/age? Is so, give details.

(g.) Did you report for review of your medical cat as per advice of Medical Board? Give details of delayed medical board if any and reasons for the delay.

Signature of Witness .....
Service No.....Rank.....
Date.....

Signature of Individual.....
Service No.....Rank.....
Date.....

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

3. Give particulars of any diseases or injuries from which you are suffering					
Illness/ injury	First Started		Rank of Individual	Where treated	Approximate dates and periods treated (Attach documentary evidence)
	Date	Place			

4. Give details of any incidents during your service, which you think caused or made your impairment worse.

5. Any other information you wish to give about your health

I certify that I have answered as fully as possible all the questions about my service, personal history and that the information given is to the best of my knowledge.

Signature of Witness .....
Service No.....Rank.....
Date.....

Signature of Individual.....
Service No.....Rank.....
Date.....

NOTE: The questions should be answered in the individual's own words. This statement and the data given above will checked from official records as far as possible by the parent Unit/Ship of the individual. **Particulars including identification marks and height from Service identity card and weight measured shall be authenticated by the Commanding Officer (auth to sign not to be delegated).**

Unit Stamp

( )
Signature of CO
No.....
Rank.....
Name.....
Date ...../...../.....

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

PART III
STATEMENT OF COMMANDING OFFICER/COMDT/FMN CDR

1. Date the individual joined your Unit / Ship -
2. Was the individual in Low Medical Category *(Y/N)* _____, If Yes (a) What was / were the impairment(s)? (b) What was the medical category and since when? (Mention date of last Categorization Medical Board) (c) How long has the individual been in low medical category?
3. Was the individual excused any duty? (a) Type of duties excused : (b) Was the individual excused BPET/PPT?
4. Nature of duties in the Unit (Give details)
5. Did the duties involve Severe / exceptional stress and strain? (Give details). (a) Since when (b) On special day/occasions
6. Was the individual living with his family? If so- (a) Since when (b) In Govt accommodation or under own arrangements
7. Was the individual living in Unit lines?
8. Dates of leave over last two years with full leave address.
9. If impairment is due to an infection (a) Any other case in the unit. (b) Is the disease endemic in the town in surrounding areas? (c) Preventive measures taken?
10. In case of Sexually Transmitted Diseases/Immune surveillance (a) When and where was it contacted? (b) Name of Hospital / STD centre where treated. (c) Was surveillance and follow-up treatment completed? (d) If surveillance and follow-up treatment was not completed, state service factors responsible.
11.Documents to be attached by Commanding Officer (Provide ref letter numbers) (Tick the docu att) (a) Injury Report (for injury cases) (b) COI (if applicable) (c) Copy of initial and latest AFMSF 15 (d) Copy of latest AME/PME (e) Copy of release order (f) Certificate by CO prior to onset (in CAD cases) (g) Any other relevant document
Unit / Ship Station — Signature of Commanding officer/Comdt/Fmn Cdr Date — Rank & Name in full

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

PART – IV

ENDORSEMENT BY COMMANDING OFFICER/COMDT/FMN CDR

(1) Details of the indl.

S No.	Nomenclature	Remarks
(a)	Present Med Cat	
(b)	Date of receipt of retirement/release order	
(c)	Date of release/retirement	
(d)	Date of referral to AMA	
(e)	Present loc of unit (P/F/HAA/CI Ops/MF)	
(f)	Deployment of indl to places/units to other units during posting to your unit	

(2) Courses attended

S No.	Course	From	To	Place of course	P/F/MF/HAA/CI Ops

(3) Temp duties in Op areas/Fd areas/HAA/CI Ops

S No.	Temp Duty	From	To	Unit and Place of deployment	P/F/MF/HAA/CI Ops

Signature of indl

Service No.....

Rank .....

Name.....

Date : _ _/_ _/_ _ _ _

Signature of CO

Service No.....

Rank .....

Name.....

Date : _ _/_ _/_ _ _ _

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

PART – V

MEDICAL EXAMINATION

1. (a) Total Nos of Teeth	(b) Missing /Unsaveable teeth	
(b) Total No Defective Teeth	U.R 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 U.L
(c) Dental Points	L.R 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 L.L
(d) Condition of gums	Missing teeth to be indicated by Horizontal line(__) and unsaveable teeth by a cross (x) through the appropriate number	

2. Investigations

3. (a) Physical capacity

(i) Height .....cms (ii) Weight actual..... Kg (iii) Ideal Wt .....Kg (iv) Over weight .....%

(v) Waist .....cms (vi) Chest full expansion.....cm (vii) Range of Expansion.....cms

(b) Skin

(c) Cardio Vascular System

(i) Pulse...../min (ii) BP .....mm/Hg (iii) Peripheral pulsations

(iv) Heart size (v) Sounds (vi) Rhythm

(d) Respiratory System

(e) Gastrointestinal System

(i) Liver Palpable (Y/N) .....cm (ii) Spleen Palpable (Y/N)..... cm

(iii) Hernia/ Hydrocele (Y/N).....(iv) Haemorrhoids (Y/N).....

(f) Central Nervous System

(i) Higher Mental Functions (ii) Speech (iii) Reflexes

(iv)Tremors: Nil/Fine/Coarse. (v) Self Balancing Test : Fairly steady/Unsteady.

4. (a) Locomotor System NAD (b) Spine NAD

5. (a) Distant Vision	R	L	(b) Near Vision	R	L	(c) CP
Without Glasses			Without Glasses			
With glasses			With glasses			

6 (a) Hearing	R	L	Both	(e) Audiometry record

FW	cms	cms	cms	
CV	cms	cms	cms	
(b) Tympanic membrane Intact	Y/N	Y/N		
(c) Mobility (Valsalva)				
(d) Nose, Throat, &Sinuses NAD/				
7. Gynaecological Examination				
(a) Menstrual History		(b) LMP		
(c) No of Pregnancies		(d) No of abortions		
(e) No of Children		(f) Date of last confinement		
(g) Vaginal discharge		(h) Prolapse		
(j) USG Abdomen		(k) Breast		
Remarks Date Signature of MO				

1. Delete what is not applicable. In case any abnormality is detected, delete "*NAD*" and enter findings.

2. This part is to be completed by AMA in case of Release in low medical category, and by ward MO in case of Invalidments.

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

PART VI

STATEMENT OF CASE

1. Chronological list of the diseases/impairment

Diseases/Impairments	Date of origin	Rank of the Indl	Place and unit where serving at the time	Date of initial AFMSF 15 for each disease/impairments

2. Clinical details.
(a) Detailed history:
(b) Personal History:
(To include history of smoking/tobacco chewing, alcohol intake, etc)
(c) Family history:
(To incl history of life style disorders, psy illnesses, hereditary disorders, etc)
(d) Treatment History:
(e) Specialist report (Including History of presenting illness, Clinical Examination, Relevant Investigations, Details of treatment, present condition, Summary and Final Opinion for all diseases and impairments)
(f) Certified that all AFMSF-15 and other hospitalization documents are available incl latest AFMSF – 15. If not so, Give details.

Signature of President Medical board

Note. *Insert the clinical summary sheet between page 7(A) &8, without any folds.*

PART VII
OPINION OF THE MEDICAL BOARD

1. Please endorse diseases/ impairments in chronological order of occurrence

Impairment	Attributable to service *(Y / N)*	Aggravated by service *(Y / N)*	DETAILED JUSTIFICATION
(a)			
(b)			
(c)			
(d)			

Note: 1. A detailed justification regarding the board's recommendations on the entitlement for each disease/ impairment must be provided sequentially especially in NANA cases as per enclosed Appendix 'A'.
2. In case of multiple impairments or inadequate space, do not paste over the opinion, an additional sheet should be attached instead, providing a detailed justification, which is authenticated by the President and all members of the Medical Board.
3. In case the medical board differs in opinion from the previous medical board, a detailed justification explaining the reasons to differ should be brought out clearly.
4. An impairment cannot simultaneously be both attributable to or aggravated by military service, only one or neither of which will apply.

Member Member President

Appendix 'A'

Indl Sig .....
Service No.....Rank.....
Name .....

(As per Note 1 of Part VII of AFMSF – 16)

DETAILED JUSTIFICATION FOR ALL CASES

1. Why is the disease not related to service as per job profile and place of posting.

2. If the disease is constitutional / hereditary / due to the process of ageing etc, why was it not detected at the time of recruitment / commission.

3. The detailed list of documents that have been verified to come to the conclusion that the disease is NANA:

(a) Initial Medical Board (AFMSF – 15) including specialist opinion
(b) Release Medical Board (AFMSF – 16) including specialist opinion
(c) Posting Profile
(d) Job Profile
(e) Medical Case Sheets
(f) Latest AME / PME
(g) Injury Report / C of I proceedings
(h) Certificate by CO prior to onset of disease in certain cardiac conditions
(j) Any others

(k) Board will summarise their findings based upon the above, they will comment upon any hastening in onset or worsening of the disease due to service conditions and not merely mention as per the specialist opinion enclosed.

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

2. (a) Was the disease/impairment attributable to the individual's own negligence or misconduct ? If Yes, in what way?

(b) If not attributable, was it aggravated by negligence or misconduct? If so, in what way and to what percentage of the total disablement?

(c) Has the individual refused to undergo operation / treatment? If so, have the individual's reasons will be recorded. *Note :-In case of refusal of operation/treatment a certificate from the individual will be attached.*

(d) Has the effect of refusal been explained to and fully understood by the individual, viz, a reduction in, or the entire withholding of any disability compensation to which he/she might otherwise be entitled?

(e) Does the Medical Board consider it probable that the operation / treatment would have cured the disease/ impairment or reduced its percentage?

(f) If the reply to (e) is in affirmative, what is the probable percentage to which the disease / disablement could be reduced by operation/treatment?

(g) Does the Medical Board consider individual's refusal to submit to operation / treatment reasonable? Give reasons in support of the opinion specifying the operation/treatment recommended.

(h) Does the individual claim to be suffering from any other disease / injury apart from those listed in Para 3 of Part – II.

3. What is present degree of disease /disablement as compared with a healthy person of the same age and sex? (Percentage will be expressed as Nil or as follows): **5%, 10%, 15% upto 100%. If the assessment given in Ch VII as per RPwD act assessment guideline then exact % will be mentioned. Assessment sheet will be signed by concerned specialist and all members of the medical board to verify its correctness. No rounding off will be done by the board.**

Disease /impairment (As numbered in Para 1 Part VI)	Percentage of disablement	Corresponding para of GMO	Composite assessment for all impairments (Max 100%) with duration	Disability Percentage Qualifying for Disability compensation with duration.	Net Assessment Qualifying for Disability compensation(Max 100%) with duration
(a)					
(b)					
(c)					
(d)					

Note: Assessment of impairments *not mentioned in the Guide to Medical Officers(Mil Pens) is to be done on the basis of best available medical evidence*

4. Is the individual in need of further treatment and, if so, of what nature and for how long is it likely to be required?

5. Does the individual require constant attendant? If so how long?

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

Invalidment / Release in Medical Category .....

Place

Date Member Member Signature of President

APPROVING AUTHORITY
(Not applicable for Navy)

Place Signature

Date Designation

CONFIRMING AUTHORITY
(Not applicable for Navy)

Place Signature

Date Designation

ACCEPTING AUTHORITY
(Not applicable for Navy)

Place Signature

Date Designation

Indl Sig .....
Service No.....Rank.....
Name .....

CERTIFICATE FOR COMMUTATION OF PENSION

The medical board having carefully examined No..... Rank ..... Name .....Unit.....are of the opinion that :

The individual is suffering from ..... but is otherwise in good bodily health and has the prospect of an average duration of life. Commutation of pension in his / her case is therefore, recommended for acceptance.

OR

The individual is suffering from ..... and as the consequence there of he / she is not in good bodily health and does not have the prospect of an average duration of life. The Medical Board therefore, does not recommend acceptance of commutation of pension in his / her case.

OR

The individual is suffering from ..... The medical board is of the opinion that he is not in good bodily health and does not have the prospect of an average duration of life. The medical board however, recommends compliance with his application to be allowed to capitalise a portion of his pension by Rank, on his / her age for the purpose of commutation i.e. his age next birth day should be .....year (s) more than his actual age.

Signature of Individual
Date

Signature of President
Date

Notes.
1. Addition to actual age should be indicated in full years.

2. While furnishing the above certificate, medical board should bear in mind that the recommendation for commutation, or otherwise in pension is not related to the diagnosis as such but the likely effect which the impairment *has on the individual's longevity of life. Impairments, which do not affect longevity, should invariantly be recommended for full commutation of pension as admissible.*

3. However where the impairment *is likely to effect the longevity of an individual the medical board should consider whether commutation should not be recommended at all or recommended with loading of age. In other words, if the* impairment *is so severe that longevity of the individual has been seriously curtailed, they should not recommend commutation of pension at all. If on the other hand, they feel that the longevity of the individual has diminished but, not severely they may determine in imaginary age of the individual which, accept to his existing condition would correspond to the residual longevity and recommend that the age of the individual be reckoned as such. For example in IHD case, if the individual's disease is fully compensated and is without any complications, he may be considered to have normal chances of longevity. However, in case of severe infarction not fully compensated where chances of longevity are not considered to be equal to those of a normal person the board should recommend addition of appropriate number of year / years to the actual age for commutation purposes. This is known as "Loading of age".*

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

EMPLOYABILITY OF ARMED FORCES PERSON RETIRING IN LOW MEDICAL CATEGORY

The inherent stress and strain in the military service has been recognized the world over as Armed Forces personnel stay away from their family during a major portion of service in a regimented lifestyle under a strict disciplinary code in harsh and hostile environmental conditions. Consequently, for personnel serving in such conditions, even common ailments such as hypertension, Diabetes, CAD, minor psychiatric illnesses or psychosomatic disorders are bound to get aggravated by all domestic events such as property disputes, family problems, education of children, etc.

Additionally, the progressive provisions of Section 20 of 'The Rights of Persons with Disabilities Act, 2016' have not been made applicable to the Armed Forces as they are meant to retain a fighting fit profile. Whereas, under the same Act, a civilian Government employee if disabled under any circumstances will be paid full pay and allowances till the age of 60 years and full pension thereafter. Thus, many a times, personnel cannot be retained in service inspite of their being fitter than their civilian counterparts.

Low Medical Category (LMC) in the Armed Forces is for conditions specific to service and is meant for employability restrictions for varied climatic conditions / terrain deployment/active war service/Operational requirements etc. Post retirement, once the stressors of Armed Forces have ceased to exist, the individual would be able to perform routine/regular duties in a normal manner just like any other civilian. However the fitness of the individual to perform duties in any job/employment should be commensurate with the composite assessment of disablement as assessed by the Medical Board. Similarly in case of aircrew invalided / released in medical category A4(P) i.e. permanently unfit for A1, A2 and A3 duties, the certificate should also state that he is unfit for civil aircrew duties but fit for other duties.

Therefore, this fitness certificate of employability as on date of signing is being issued with the specific intent and purpose to convey to all prospective employers regarding the ability of the concerned ex-serviceman, whose particulars and details have been provided below.

FITNESS CERTIFICATE FOR CIVIL EMPLOYMENT

(ONLY TO BE ISSUED FOR RMB AND NOT IN IMB CASES)

To whomsoever it may concern:

1. This is to certify that **No.** ----------, **Rank** ----------, **Name** ---------- ----------, is being discharged from service after completion of full term of service/PMR in Low Medical Category for the following conditions:
   (a)
   (b)
   (c)
   (d)

2. He / She is:

   (a) FIT FOR ALL TYPES OF EMPLOYMENT IN CIVIL.
   (b) FIT FOR ONLY SEDENTARY EMPLOYMENT IN CIVIL.
   (c)FIT FOR ALL EMPLOYMENT NOT INVOLVING HEAVY MACHINERY / MOVING PARTS.
   (d) UNFIT FOR EMPLOYMENT IN CIVIL REQUIRING HIGH PHYSICAL / MENTAL FITNESS.
   (e) FIT FOR ALL TYPES OF CIVIL AIRCREW DUTIES
   (f) ANY OTHER (SPECIFY).

   (AUTH: RMB dated ....., held at .....)

Note: This certificate will be an integral part of Service Book of all Ex-servicemen undergoing RMB. The Service Book copy will be signed by concerned Record Officer quoting authority of RMBwith date.

Member Member President

Indl Sig .....
Service No.....Rank.....
Name .....

PART VIII

ROLL OF JCO/OR PROPOSED TO BE INVALIDED

No.	Information Required	Answers	
1	Army / Navy / Air Force Service Official No.		
2.	Rank Airman, Group and Name *(Name should be hand Printed).*		
3.	Regt. Corps / Ship / Establishment		
4.	Date of birth		
5	Age on enrolment	Years	Days
6.	Date of enrolment		
	Date of advancement to Rank		
	Date of advancement to airman's service		
7.	Height		
8.	Personal appearance *(colour of hair and eyes and identification marks).*		
9.	Permanent home address on being discharged *(to be hand printed).*	Village / Pargana / Tehsil Post Office District	
10.	(a) Substantive rank (s) held during the last 2 years with dates of promotion / advancement.		
	(b) Acting rank held, if any		
11.	Periods with dates of service in each pay *group (if more than one group has been held during the last 2 years of service).*		
12.	Rate of pay last admitted *(in case of non-combatants claiming impairment person under military rules)* and Rule or Order under which admissible.		
13.	Date of discharge *(the date upto which effective pay has been admitted).*		
14.	Service to date of discharge		
15.	Service to date on which Medical Board Proceedings are countersigned by ADGMS Army / DGMS Navy/ DGMS Air.		
16.	Periods not counting as qualifying service for pension (See Rules 195, 196 and 211 of Pension Regulations for the Army, Rules 164 & 181 of Pension Regulations for the Navy and Rules 3 and 8 of para 207-A of pay and Allowances Regulations for Air Force 1942).		

Indl Sig .....
Service No.....Rank.....
Name .....

No.	Information Required	Answers	
17.	Any previous Army, IN or IAF service counting towards pension or gratuity as verified by the Defence Accounts Department *(quote authority).*		
18.	Character		
19.	Whether recommended for the grant of personal allowance of Rs. 50 (in the case of Risaldar Major / Subedar Major who elects to be governed by the old pension code).		
20.	Pension Paying Agency / Treasury / Sub-Treasury from which desirous of drawing pension. Note :-*The place should be one of those mentioned in Financial Regulations of India, Part I Appendix IV (or in Annexures, I & I I& A.F.I. 166/43, in the case of I.A.F. Personnel.*		
21.	Invalid / disability compensation for which recommended.		
Note. *Orders of the competent authority are necessary for deduction in the amount of invalid gratuity / pension and for the grant of gratuity / in the case of those invalided on account of disorders (including insanity) brought on by indulgence in drugs or drink. (Rules 200, 232, 233, 252, 253 and 336 Pension Regulations Part II read with A.I. 5/S/56 as amended by A.I. 12/57: Rules 167, 189, 190 and 193 of Pension Regulations for Navy and N.I. No. 1/S/57 and para 12 of A.F.I. 92/42, sub-paras 12& 13 para 207-A of P&A. Regulations for Air Force 1942 and A.F.I. 5/S/56).*			
22.	Allowances to which entitled when pensioned: - (a) Personal Allowances as Risaldar Major or Subedar Major per mensem (only if a JCO elects to be governed by the old Pension Rules). (b) Allowances in respect of Gallantry Awards or other decorations :- (i)---------- (ii)---------- (iii)---------- (iv)----------	Amount Rs P .	Authority for same
23.	Whether he was granted any pension (Civil or Military) previously. If so, quote No. and date of Pension Circular / Pension Payment Order and the amount of Pension.		
24.	Whether any disability compensation claim has or had been submitted in respect of previous service. If so, with what result *(Quote authority for accepting/rejecting the claim).*		
25.	Name and relationship of next of kin or other person to whom arrears of pension are to be paid on demise of the pensioner.		
Signature or thumb and finger impressions (*in case of illiterate persons only*) of the left hand ofIndl ..... *(to be attested by a Commissioned Officer)*			

Indl Sig .....
Service No.....Rank.....
Name .....

In cases of impairments due to accidents, the officer-in Charge, Records or the Officer Commanding, Unit should certify here
(a) Whether the impairment was sustained according to the information available, while the individual affected was in actual performance of Military / Naval / Air Force duty and if so, what was the nature of such duty and
(b) Whether in his opinion, the impairment was attributable to Field / Military / Naval / Air Force Service and he should state the reasons underlying his opinion as regards attributability.

Certified that ..... will be discharged with effect from ..... *(Dates shown at item 13 on page 12 to be entered).*

I consider the man's refusal to undergo operation / treatment to be reasonable / unreasonable for the following reasons: -

Station:
Dated:
Office

Officer Commanding / Officer-in-Charge, Record

I certify that the particulars given are correct as far as can be ascertained from the records of the Regiment Corps / Ship / Establishment / Air Force and recommend that full / 3/4th pension admissible under rules may be sanctioned.

Station.....
Dated..... :

Officer Commanding / Officer-in-Charge, Record Office

Note :-1 Audit Officers will bring to the notice of the competent authority any abnormal delay between the date on which the Board Proceeding are countersigned by the ADMS Army /DGMS Navy /Air and the date on which the man is discharged by the Officer-in-Charge, Record Office. In case where a Gorkha Rank whose home is in Nepal, is found unfit for further service by a Medical Board and the Proceedings are signed by the ADMS after 15th June, the Officer-in-Charge, Record Office, will record in the above certificate that the man will be retained with him until 15th September and discharged with effect from that day.

2. The Officer-in-Charge Record Office will specify the date of discharge before the claim to pension is submitted to the Audit Office concerned.

3. In the case of Air Force Personnel, the functions of Record Office will be performed by the Directorate of Personnel (Airmen) Air Headquarters.

Indl Sig .....
Service No.....Rank.....
Name .....

RECOMMENDED

Station..... .
Dated .....
Commodore Naval Barrack

Commandant / Commanding Officer
Brigade / Sub-Area

SANCTIONED

Station .....
Dated .....Commandant / Commanding Officer
(See Army Rule 13, Table Item I (ii), II (ii), III (iii) &IV)

FOR USE IN THE DEFENCE ACCOUNTS DEPARTMENT

Invalid
} Pension/compensation admitted
Impairment

Rs. ..... (Rupees .....only) p.m.
vide P.P.O. No ..... dated .....
Serial No :.....

A.A.O. (P) .....A.C.D.A. (P)..... D.C.D.A. (P).....

INSTRUCTIONS :

1. Part VIII will be completed only when it is proposed to invalid a JCO / OR / Sailor / Airman (including M.W.O.).

2. Part VIII will be completed by the Officer-in-Charge, Record Office, after receipt of Medical Board Proceedings but before the submission of the pension claim to the CDA (P).

3. Two copies of this form (duly completed), will be submitted by the Officer-in-Charge, Regt / Corps Record Office to the Staff Officer of the station of assembly of Medical Board of transmission through the Independent Brigade or Area Commander to the Medical Board. In the case of I.N. Sailors, three copies of this form (duly completed) will be submitted by the Commanding Officer Ship / Estd. to Hosp. / Sick Bay where the Medical Board is to be held. In case of M.W.O. / W.O / Airman, two copies of this form (duly completed), will be submitted by the Commanding Officer of the Unit concerned to Medical Board.

4. Claims to Disability Pension/compensation should invariably be accompanied by (a) AFMSF-81 (old IAFM-1231) in case of disablement on account of disease, and (b) IAFY-2006 and proceedings of Court of inquiry (where required under RA Instruction 346), IAFF (P) 23 and Proceedings of Court of Inquiry where required, in case disablement on account of wound or injury.

5. Claims for Disability Pension/compensation, supported in each case by the sheet Roll, will be submitted to the CDA (P) direct, except in the following cases where they will be submitted through the Independent Brigade or Area Commander /Air Headquarters.

(a) Risaldar Majors / Subedar Majors who elect to be governed by the old pension code and who are recommended for the grant of personal allowance of Rs. 50 p.m.

(b) All JCOs / OR / Airmen (including M.W.Os / NCs (E) who are invalided on account of disorders (including insanity) brought on by indulgence in drugs or drink.

GUIDELINES ON FILLING OF AFMSF-16 (VERSION-2023)

1. Part I to IV of AFMSF-16(Ver-2023) is to be filled by the unit of the individual. However, signature with stamp of Presiding officer and members of the medical board needs to be affixed on all pages. It is pertinent that the medical board counter checks the following points in Part I to IV :-

(A) **Part- I** :

(a) Authority of release has been correctly endorsed. Release of the individual at the time of RMB should not be later than 08 months.

(b) Height, weight and identification marks of the individual will be countersigned by the 'CO' of the unit (and this authority should not be delegated to Adjt / 2 IC etc).

(c) Photograph of individual has been attested by the 'CO' of the unit.

(d) Responsibility/onus of getting signature of witness in AFMSF-16 is on the individual and not of the hospital conducting the board.

(B) **Part- II** :

(a) Dates in Column - I match with the respective Part - II order especially those pertaining to service in Field/CI Ops/HAA and equivalent in Air Force and Navy. It should include both names of and type of location i.e. Peace/Field/HAA/CI-Ops/Modified Field /Afloat etc. The unit of the individual is responsible to provide correct dates, place of posting and type of location with respect to Ops. Incomplete info should not be accepted by the medical board.

(b) The columns 2(a) to 2(g) should be filled in either Yes/No and no column should be left blank or filled as NA. Special attention to be given to statement of individual for columns 2(c), 2(d) and 2(e) in case it has some connection to the impairment.

(c) Column 3 is completed using previous medical boards and correctness of same must be ensured.

(d) Column 4 & 5 can be filled as 'NIL RELEVANT' in case there is no information which the individual has to share/disclose.

(C) **Part III** :

(a) Column 1 and 2 shall be filled in Yes/No. In case the reply in Yes, suitable details should be given.

(b) In case the individual is not suffering from STDs, Column 10 can be filled as NA. The board should ensure all relevant documents as given in Column 11 are attached.

(D) **Part IV** :

(a) All columns are to be filled and signatures of individual and CO of unit are endorsed. The CO must ensure that the details of courses attended / temp duty with type of location i.e. Peace/Field/MF/HAA/CI-Ops/Afloat and duration of stay in relation to the onset of the disability be duly mentioned in relevant columns.

2. Part V,VI,VII and VIII (only in cases of IMB) are filled by the medical board. These sections must be filled carefully and cutting, overwriting and use of whiteners should not be made under any circumstances.

(A) Part- V : Part V of the board pertains to medical examination. This is usually done in the MI Room by the AMA or ward MO in case of IMB. Following points should be checked by the board:

(a) Dental examination in column by the board should be done by Dental Officer only. Signature & stamp of the Dental officer should be endorsed.

(b) In column 2, fresh report of investigations (routine) done at the time of RMB, Hemoglobin, TLC, DLC, Urine (routine & microscopic examination), Blood Sugar etc. to be endorsed with respective units of measurement.

(c) It is imperative that the medical officer records the findings of examination carefully. The medical condition leading to impairment of the member is to be endorsed under the column of relevant system, for e.g. - CAD-Cardio Vascular 3(c), Bronchial asthma-3(d), CVA-3(f), PIVD- 4(b) etc.

(d) In case of males, gynaecological examination should be filled as 'NA'.

(e) The medical officer should clearly mention in 'Remarks' column if the individual has or is claiming any other ailment other than those endorsed in earlier boards. Any such ailment claimed should be considered by the medical board having been duly examined by the concerned specialist & if significant opined by the concerned specialist to be placed in low med classification. Followed by a reclassification medical board.

(B) **Part VI** : The impairments in column 1 should be filled in chronological order (in case of more than one impairment) that is from the date of detection. Date of origin/rank of individual / place and unit of individual can be obtained from the previous AFMSF-15. Due care should be taken while filling these dates. Board should record the clinical details of the individual by asking the individual and by perusal of previous specialist opinions and other medical documents. Relevant history (for example of smoking/tobacco/alcohol in cases of diseases like CAD/HTN/CVA/certain malignancies) is important. The president medical board should sign Part VI only once it has been ensured that all relevant AFMSF-15 and other medical documents of individual are available and all dates have been correctly endorsed.

(C) **Part VII** :

(a) Full diagnoses should be written without using any abbreviations along with ICD code of the impairment(s).

(b) Attributability due to military service and Aggravation by military service should be based on :-

(i) Chapter I-VI of GMO as amended from time to time.

(ii) Entitlement Rules of Casualty Pensionary Awards to the Armed Forces Personnel – as amended from time to time.

(iii) Guidelines / policy letters issued from time to time.

(iv) Reasons for Variation of opinion in respect of entitlement (attributability/aggravation) from the opinion of earlier medical boards (AFMSF-15) should be clearly brought out in light of all available evidence.

(v) Appx – 'A' to Part VII : It is pertinent that the board justifies in detail with cogent reasons why the impairment has been conceded as attributable (evidence based causal connection), aggravated (hastened in onset or worsened due to service conditions) or neither attributable nor aggravated due to service (constitutional, hereditary, personal risk factors, obesity), and terms like 'Not connected with service / not covered in GMO/ as per para given in GMO' are to be avoided. Detailed justification should be given using standard text books, GMO, entitlement rules, and to bring out the role of specific service conditions in grant or refusal of entitlement.
In Para 2 of Appx 'A' of Part VII, if the answer is affirmative, the board may endorse *'Though the disease was present it had not manifested at the time of recruitment/commission'*. Similarly, in Para 3, the Board should mark and enclose the relevant documents pertaining to impairment(s) which were verified to come to the conclusion of entitlement of the impairment(s). For e.g. – Court of Inquiry / Injury Report in cases of Injuries, Certificate issued by the CO in CAD etc.

(c) Instructions for filling of Column 2 (a) to (h) of Part VII :

(i) Column 2(a) to 2(c) : The answer can be either Yes/No but not NA.

(ii) Column 2(d) & 2(e) : In case the reply to column 2(c) is affirmative, then this column should be filled in either 'Yes' or 'No'. In case of vice versa, it should be endorsed as 'NA'.

(iii) Column 2(f) : Actual impairment after reduction should be endorsed in case reply to column 2(e) is affirmative.

(v) Column 2(g) : Remarks in this column should be endorsed based on guidelines contained in Chapter V of GMO as amended from time to time.

(vi) Column 2(h) : While filing this column, the board should also recheck individual's statements/MO examination.

Note : Casual approach in filling Columns 2a - 2h as 'NA' or contradictory replies puts the sanctity of board in doubt.

(d) The assessment of disablement by RMB/IMB should be justified as per provisions of Chapter VII, GMO (Military Pension) as amended from time to time. If a disease assessment is not covered in the above chapter, it should be evaluated after referring to literature on the subject and application of current medical knowledge. It should be based upon a measurable parameter indicative of functional assessment. In the second last column of Para 3 of Part VII, the board should endorse only assessment with regard to accepted impairments. The last column of the same should have composite assessment of only accepted impairment(s) with duration. The sum of impairments cannot be their arithmetic sum.

(e) Constant Attendant or Constant Attendant Allowance (CAA) is given for 100% impairment. If the board feels the need for the same, it can recommend for CAA along with duration.

(f) It is the duty of approving / perusing authority to closely monitor and scrutinise the medical board proceedings carefully before approving / perusing them. In case where the confirming authority does not concur with the opinion of the RMB, the precise reasons (s) for the same should be conveyed to the concerned hospital, with a direction to make the necessary amendment(s). An RMB proceeding should be confirmed only when the opinion offered therein is in consonance with the opinion of the confirming authority.

3. **General Guidelines** :

(a) Certificate of Commutation of Pension : The recommendation should be based on the actual condition of the individual at the time of board.

(b) Fitness Certificate for Civil Employment should mention all the impairments being considered at the time of RMB. Fitness for employment in civil to be suitably marked in the given choices based on the condition of the individual at the time of RMB. The certificate is not applicable for IMB cases.

(c) No comments on attributability should be made in RMB in cases of injury in the absence of Injury report. In case of non-availability of injury report, the board should endorse that "No comments can be made as injury report is not available". However, in such cases where board has not commented upon entitlement (attributability) it is mandatory for the board to assess the percentage of impairment and not leave the column of percentage blank.

(d) Specialist opinion should be detailed, legible, show proper application of mind and derive logical conclusions. While rendering opinion, specialist should be well conversant with relevant para in Chapter VI & VII of GMO as amended from time to time and the relevant DGAFMS letters. Possible aetiological factors of the disease whether infective/ degenerative / inherited / immunological / iatrogenic etc. should be brought out clearly. Percentage of impairment will be calculated by the specialist on a separate assessment sheet using the assessment tools given in Ch VII of GMO as amended from time to time based upon the worst parameter used and it will be signed below by the concerned specialist with stamp. The same will be countersigned by all the members of the board as correct after verification. The board will not round off any assessment and exact assessment will be endorsed. The final composite assessment will only be endorsed by the medical board.

(e) Commandant / Commanding Officers of hospitals should ensure that members of board assemble at a designated place and patient should be present for conduct of board and verification of the assessment done by the specialist.

(f) Soft copies of the revised AFMSF-16 (Ver-2023) have been made available by the concerned Dtes Gen and these can be used after resizing the various rows/columns in order to create sufficient space for providing a detailed justification as per the requirements specified in the preceding para of this letter. However, it must be ensured that no paragraph from original AFMSF-16 (Ver-2023) be removed or added by unit / hospital itself even if it has to be endorsed as 'NA'.

Encls 2 to Appx 'A' to Chap III of GMO 2023

A.F.M.S.F-17 (Ver – 2023)

Recent Photograph to be verified, signed & stamped by the concerned Record office

MEDICAL BOARD PROCEEDINGS
REASSESSMENT(RAMB)/REVIEW MEDICAL BOARD(RMB) – ALL RANKS
PART-I
(To be completed by Record Office of the individual)

1. Authority/Sanction letter No and Date of Sanction :-				2. Hospital at which RAMB/RMB is to be conducted:-		3. Date:-
(a) Expiry of Previous award:	(b) Pre 1996 Retiree:	(c) On Court order:	(d) Others (specify reasons):			
4. Name:-		5. Service No.:-		6. Rank:	7. Last Unit:	8. Service (Army/Navy/Air Force):
9. Date of Birth:-		10. Date of Commissioning/ Enlistment/Training:-		11. Date of Release:-		12. Date of expiry of the existing award, if any:-
13. Present address of the individual with mobile number and e-mail address:-				14. Identification marks as per service records :- (i) (ii)		

15. Previous assessment(s) of disablement:

Impairment (s)	Whether the **impairment** was conceded as attributable/aggravated by service or Neither attributable nor aggravated (NANA) (Specify)	Percentage (in words & figures) of assessment				Period of assessment	Authority PC/PPO No
		As recommended by Medical Board		As accepted by the Pension Sanctioning Authority			
		Individual assessment	**Composite assessment**	**Individual assessment**	**Composite assessment**		

16. List of documents to be attached:-
(a) Initial Medical Board (AFMSF-15/15A) including specialist opinion : Yes/No
(b) Release Medical Board (AFMSF-16) including specialist opinion : Yes/No
(c) Any others relevant documents including previous RAMB/RSMB with specialist opinion :Yes/No
(d) All medical documents including hospitalization documents / AME /PME / Cat & Re-cat med board Yes/No
(e) Authenticated service profile mentioning date, place of posting, nature of posting(Field/Peace/HAA Yes/No Hard area/Ashore/CI-Ops)
(f) Any other relevant documents (e.g. Part – II Orders, Court of Inquiry, **Certificate by CO in IHD cases**, Corps Yes/No notification for Field/HAA/CI Ops etc).

Station.....
Date.....
(Round Stamp of the Record Office)

.....
Signature of OIC Records
(Rubber stamp mentioning Rank & Name)

No:
Rank:
Name:

PART – II

CLINICAL DETAILS

(To be completed by Medical Board)

S No	Nomenclature	Remarks
1.	Is the Medical Board satisfied that the person appeared before them is the individual referred to above? (The medical board has to confirm the identity by matching the identification mark & photograph of the indl)	Yes/No
2.	Record of clinical examination (Clinical summary including diagnosis and prognosis to be attached in original)	Yes/No
3.	Further medical treatment:-	
	(a) Is the treatment required and if so. of what nature and duration	Yes/No Duration: For Life/.....yrs
	(b) Has/Does the individual refused/refuse to undergo treatment specified or an operation?	Yes/No
	(c) If answer to the above question at para 3 (b) is 'Yes' then what is the Individual's reason for such refusal? (Unwillingness certificate to been closed as per Appendix 'C' to this AFMSF-17).	Reasons:
4.	Variation in **impairment (s)** since previous medical board:-	
	(a) Has the condition improved/ deteriorated or remained static clinically since the last medical board?	Clinical condition:
	(b) If the condition has improved/cured, give detailed justification.	Assessment: Justification:
	(c) If the condition has deteriorated, the medical board should give appropriate assessment and state with reason in support thereof whether this was due to fwg factors:-	
	(i) Natural course/history of disease	Yes/No. Assessment:
	(ii) Effects of non service factors e.g. during civil/self employment after release	Yes/No. Assessment:
	(iii) Result of individual factors i.e. negligence on the part of individual	Yes/No. Assessment:
	(iv) Extraneous factors e.g. unable to take regular treatment being in remote geographical location	Yes/No. Assessment:
	(v) Interplay of more than one of above factors	Yes/No. Mention the factors: Assessment:
	(vi) Any other reason	Details: Assessment:
5	Special features in the case:- (The medical board should here draw attention to any special feature in the case which has not been brought out in previous reports).	Details:

No:
Rank:
Name:

6. (a) **Assessment of illness(es)/disablement(s) for which RAMB/RMB has been sanctioned (In Words and figures) (Percentage will be expressed as Nil or as follows): 5%, 10%, 15% upto 100%. If the assessment given in Ch VII GMO as per RPwD act assessment guideline then exact % will be mentioned. Assessment sheet will be signed by concerned specialist and all members of the medical board to verify its correctness. No rounding off will be done by the board.**

Medical conditions leading to impairment(s)	Previous Assessment **(Both in words and figures)**	Present Assessment **(Both in words and figures)**	Assessment for disablement due to non-service factors **{As per Para 4(c)}**	Present Assessment **{Column (iii minus iv)}**	Duration of assessment	Composite Net assessment referable to service with duration **(Both in words and figures)**
(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)

6. (b) Assessment of illness(es)/disablement(s) during intervening period (In Words and figures)

Medical conditions leading to impairment(s)	Assessment **(Both in words and figures)**	Duration of Assessment		Composite Net assessment referable to service with duration (if applicable) **(Both in words and figures)**
		Date		
		From	To	

7. **Constant Attendant Allowance:-**

S No	Nomenclature	Remarks
(a)	Constant attendance allowance with duration	Yes/ No Duration: For Life/……yrs
(b)	Give justification	

No:
Rank:
Name:

8. Effects of pensionable **impairment(s)** on functional capacity:-
(Specific clinical data may be recorded in relation to functional capacity)

9. Any other remarks of medical board:-

Signature: President Medical Board.....
(Rank, Name, appointment, Rubber Stamp)

Station.....
board.....

Member1 of medical
(Rank, Name, appointment, Rubber Stamp)

Date.....
board.....

Member 2 of medical
(Rank, Name, appointment, Rubber Stamp)

(Unit Round Stamp)

APPROVING AUTHORITY (ONLY IN RAMB)

Station .....

Signature.....

Date.....

(Rank, Name, appointment, Rubber Stamp)

(Unit Round Stamp)

NOTE:- There should not be any cutting, overwriting or application of whitener in any part of AFMSF-17.

Appx 'A' to AFMSF – 17
(To be attached with AFMSF – 17)

PARAWISE GUIDELINES FOR FILLING OF PART-I OF AFMSF-17 (Ver 2023)

Part-I is to be filled by the Record Office of the individual:-

1. Authority or sanction letter issued by DGAFMS/DGMS is to be enclosed.
2. Name of nearest service hospital where the individual is to report for conduct of Re assessment medical board/Review medical board.
3. Date on which the present AFMSF-17 is being filled by Record Office.
4. Name as per service records.
5. Service No as per service records
6. Rank the individual held at the time of Release Medical Board.
7. Unit where individual was serving at the time of Release Medical Board.
8. Tick the service in which the individual was serving at the time of Release Medical Board.
9. Date of Birth as per service records
10. Date of Commission/Enlistment/Training as per service records
11. Date of Release from service as per service records.
12. Date of expiry of the existing award on assessment of **impairment(s)**.
13. Present address of the individual with mobile number and e-mail address.
14. Identification marks as per service records
15. All **impairments** of the individual while in service including those not under consideration to be mentioned.
16. All the medical documents of the individual as per the list to be attached.

CERTIFICATE BY THE Oi/C RECORDS

I, NO.....Rank.....Name..... Appointment.....have carefully read the above instructions and certify that the information in respect of NO..... Rank..... Name..... Last Unit..... as mentioned in 'Part – I' of AFMSF – 17 (Ver 2023) has been filled diligently and is correct to the best of my knowledge.

( )
Signature of Oi/c Records
No.....
Rank.....
Name.....

Unit Stamp

Date ...../...../.....

Appx 'B' to AFMSF – 17
(To be attached with AFMSF – 17)

PARAWISE GUIDELINES FOR FILLING OF PART-II OF AFMSF-17 (Ver 2023)

Part-II is to be filled by the Medical Board:-

1. Based on photograph, identification marks and Govt issued identity card, identity of the individual should be confirmed.

2. Relevant medical opinion including AFMSF-7A and all medical tests/investigation are to be enclosed. Concerned specialist should be advised to refrain from commenting on percentage of assessment unless asked for by the Medical Board. The specialist should mention, if the condition of the individual (based on clinical parameters) has remained static / improved or deteriorated as compared to his clinical condition at the time of last available medical board.

3. Nature and duration of treatment required in future should be mentioned. Reason for refusal of treatment and the unwillingness certificate should be endorsed as per Appx 'C' to this AFMSF-17.

4. (a) Should be based on current clinical parameters/clinical condition as compared to that in last medical board held.

(b) If current clinical parameters/clinical condition have improved as compared to that at the time of last medical board same must be endorsed with justification.

(c) If clinical parameters/clinical condition have deteriorated as compared to that at the time of last medical board, relevant reason for the deterioration should be given. In case of more than one impairments reasons for deterioration in respect of each one should be marked separately.

5. The medical board should mention any special feature in the case which has not been brought out in previous reports.

6. (a) Column (iii) to (vii) are to be filled up for all impairments for which Reassessment / Review Medical Board has been sanctioned. For the remaining disabilities, column (iii) to (vii) should be scored out with a single line and endorsed with as "Not sanctioned".

(i) All impairments of the individual are to be listed in column (i).

(ii) Percentage will be expressed as Nil or as follows; 5%, 10%, 15% upto 100%. If the assessment given in Ch VII as per RPwD act assessment guideline then exact % will be mentioned. Assessment sheet will be signed by concerned specialist and all members of the medical board to verify its correctness. No rounding off will be done by the board. Percentage of disablement assessed during the previous RMB/RAMB should be endorsed both in words as well as figures.

(iii) Present percentage of assessment should be mentioned separately for each illness/impairment both in words as well as figures.

(iv) Percentage of assessment in cases where clinical condition of the individual has improved as per Para 4(b) must be decreased and where the same has deteriorated as per Para 4(c) must be increased.

(v) Percentage of assessment of impairment(s) referable to service is to be endorsed in column (v) as shown below :-

(aa) Attributable / aggravated by service :- Disablement due to non-service factors (column iv) is to be deducted from present assessment (column iii), since aggravating factors of service cease to play a role after the individual's release from service.

(ab) However, if in case the medical board finds that as per policy guidelines the individual had been under-assessed / over-assessed at the time of Release Medical Board/Reassessment Medical Board (irrespective of whether the impairment has been held as attributable or aggravated) the corrected percentage of disablement must be endorsed in both column (iii) as well as column (v) with due justification.

(vi) Duration of assessment in column (vi) must clearly state duration of assessment such as 'for life' wef date on which the present medical board was held.

(vii) While calculating composite net assessment referable to service, other disabilities not being reviewed / reassessed but have been held attributable to or aggravated by service or for which the individual is in receipt of disability compensation have to be included without changing the previously sanctioned assessment.

6. (b) (i) If the Reassessment/Review Medical Board is held after the expiry of the previous award, assessment for the intervening period should be clearly stated.

(ii) Assessment of **impairment(s)** during intervening period is to be filled by the medical board in terms of MoD, GoI letter No 16(01)/2009-D(Pen/Pol) dt 10 Nov 2010 as amended from time to time.

(iii) Intervening period will be from next day of the date of expiry of existing award of disability assessment percentage made by the last medical board till one day prior to date of current medical board.

7. (a) CAA is to be awarded as per provisions of GMO as amended from time to time. In case CAA is recommended, time period (eg 'for life') should be clearly mentioned.

(b) The Medical Board should consider functionality of the individual as a result of the impairments being considered and give detailed justification for recommending/ not recommending CAA.

8. Functional capacity of the individual should be brought out in details.

9. Any other remarks or comments by the Medical Board may be mentioned here. In case there are no comments 'Nil' should be endorsed and remaining space crossed out with a single line.

10. Names of all the members with stamps and round stamp of unit should be legible.

11. Only RAMB requires to be approved.

Note : -

(i) Individual should be clearly intimated to report to a specific service hospital to obtain opinion by concerned specialist.

(ii) Individual needs to submit an undertaking that he has been following up his impairment in a Service/Govt/Civil hospital in the interim period and he has been regular on his medications / physiotherapy. Copies of such reviews should be attached with the AFMSF-17.

CERTIFICATE BY THE PRESIDENT MEDICAL BOARD

I,No.....Rank.....Name.....
Appointment.....have carefully read the above instructions and certify that the information in respect of No.....Rank..... Name.....Last Unit.....as mentioned in 'Part – II' of AFMSF-17 (Ver 2023) have been filled diligently and correctly to the best of my knowledge.

( )
Signature of President Medical Board
No.....
Rank.....
Name.....

Round Stamp

Date ...../...../.....

Appx 'C' to AFMSF – 17
(To be attached with AFMSF – 17)

UNWILLINGNESS CERTIFICATE FOR TREATMENT(SURGICAL/ MEDICAL)

PART-I

No .....Rank.....Name.....

Last Unit ..... Record Office.....

Diagnosis .....

Treatment refused ..... (specify surgical/medical /investigation procedure in detail).

PART-II

I, No ..... Rank ..... Name .....hereby express my unwillingness for undergoing treatment ..... (specify type of treatment /operation/investigation procedure) which is considered essential by the treating medical officer. The reason for this refusal is ..... The consequences of this refusal to undergo treatment have been explained to me in detail in the language I understand and I accept the same. I also understand that this may have adverse effect on my disability compensation, which may be admissible to me as per pension regulations as amended from time to time.

(Signature of the individual)
No .....
Rank .....
Name .....

Witness No 1

Signature .....
No ----------
Rank ----------
Name ----------
Unit ----------

Witness No 2

Signature .....
No ----------
Rank ----------
Name ----------
Unit ----------

Note:-The witnesses should be serving personnel other than the AMC personnel.

COUNTER SIGNATURE BY THE SPECIALIST GIVING OPINION

Date:

Signatures.....
(Rank, Name, Rubber Stamp)

CHAPTER – IV

BLANK

(ER 2023 IS INCLUDED AS ANNEXURE)

CHAPTER V

MISCELLANEOUS PROVISIONS

Members who Aggravate or Retard the Cure of a specified medical condition

1. In giving their opinion on the above subject, the medical officers and the medical boards should state in detail how exactly the member brought about the retardation of cure or in other words aggravated the disease/said medical condition. The opinion must highlight if the medical condition was aggravated or its cure delayed or inhibited by the member's refusal to undergo treatment or generally follow medical advice. This will assist the Competent/ Appellate Authority in deciding on the question of entitlement for death/ disability compensation.

Refusal to Undergo Treatment

2. In giving their opinion on the subject, the medical officers and the medical board should state in detail, the type of the treatment or surgery/intervention advised, which the member refused to undergo. The record should also show whether it was explained to the member, that there was reasonable probability of cure or the treatment/ surgery/intervention which would have prevented any further aggravation or deterioration of the medical condition or reduced the degree of consequent bodily impairment, so as to enable the Medical Board and the Competent/ Appellate Authority to take appropriate decision on the question of entitlement for death/ disability compensation.

Sometimes, the member may be unwilling for surgery/treatment at the time of presentation but may be willing for surgery/treatment at a later date. In such cases, the member will be placed in appropriate medical classification, however, any deterioration of the medical condition during the period of such conditional refusal should not be considered for the purpose of assessment of the degree of bodily impairment eligible for the purpose of raising a valid claim for death/ disability compensation.

3. All the possible consequences of refusal of surgery/ medical treatment will be explained to the patient in his own language or a language which he fully understands, by the medical officer in charge of the case, in the presence of two witnesses. Further, a certificate stating that he refuses to undergo medical treatment or surgery as advised and that all the consequences of such refusal of treatment have been explained to him and understood by him, should be obtained from the member. However, these cases shall be governed by Regulation 85 of the Pension Regulations for the Army Part I, 2008 as amended from time to time and Appendix V of the same.

4. **BLANK**

Unforeseen Effects of Treatment

5. In giving their opinion with regard to unforeseen effects of treatment, medical officers and the medical boards should keep in mind that:

(a) Complications do arise in certain cases in spite of the utmost care and skill in treatment etc. and this should particularly be borne in mind in cases where the treatment is given in the interest of the member to save their life or improve their physical condition. When an impairment is caused due to any adverse effects arising as a complication of treatment, it shall be conceded as attributable to service. This however, does not apply for known adverse effects of treatment/drugs which are the standard of care and the member has been made aware of the risk to benefit aspect of the treatment being offered.

(b) On the question of negligence, delay or faulty technique or lack of skill. It must be remembered that once a member is in hospital under qualified medical care, there can normally be no delay. Cases in which there was any delay in getting a member admitted to hospital will involve consideration of non-medical issues. For instance, in a case of sexually transmitted disease, the natural tendency is to conceal the disease as much as possible. Similarly, time is required in arriving at a diagnosis in certain cases like malignant diseases, rare diseases or diseases requiring genetic studies or diseases with atypical presentation. This is usually due to the necessity of carrying out observation on the patient, the indefiniteness of signs and symptoms, the elaborate clinical, pathological investigations and tests required to exclude other diagnosis. These investigations may take some time. In such cases, the time usually taken in arriving at a correct diagnosis does not constitute delay.

(c) On the question whether a treatment other than the one administered was also/more appropriate, it is stressed that the treating medical officer is in the best position to judge what particular form of treatment is indicated at any particular moment. Accordingly, in the absence of any strong "Positive" evidence to the contrary, it is reasonable to presume that the treatment given is appropriate to the condition. In this context the provisions of Rule *10 (b) (iv) of ER 2023 are relevant.*

6. Entitlement to compensation cannot be awarded for any death or bodily impairment arising from intemperance in the use of alcohol, tobacco or drugs, similarly sexually transmitted diseases or lifestyle disorders are not related to service conditions. Where alcohol, tobacco or drugs or sexually transmitted diseases have aggravated an accepted bodily impairment, it is necessary to exclude their effect in assessing the impairment ascribable to service conditions.

7. Where, alcoholism is due to the result of a mental disorder leading to discharge, the facts and the conclusions reached should be recorded and the claim should be examined for non-medical issues.

8. It should be borne in mind that alcoholism may have a selective action on the central nervous system, that it may produce symptoms, identical in many respects with those of neurosis or psychosis and the only evidence of alcoholism may be nervous or mental disorder itself. These mental disorders will not merit an entitlement of attributability to or aggravation by military service.

9. **BLANK**

Classical Sequelae

10. Classical sequelae of medical condition or injury may be defined as a pathological condition which is likely to follow the said condition or injury and have a definite connection with it, asunder:

(a) A further manifestation, in another organ or different part of the body, of the same morbid condition as caused by the original disease.

(b) A later or terminal phase of the medical condition, which could not have developed in the absence of previous medical condition.

(c) A medical condition following a wound or injury, which in absence of the injury would not have occurred and is not due to extraneous factors or member's own act.

(d) Classical sequelae are considered attributable to service only when the primary disease was attributable to service.

11. As regards to fresh medical condition that are prima facie classical sequelae, it will be necessary to determine, whether the new condition is in fact a direct outcome of the original condition disease and, further, whether its development is solely referable to the conditions of military service.

APPENDIX 'A' to Chapter-V

UNWILLINGNESS CERTIFICATE FOR TREATMENT (SURGICAL/MEDICAL)

PART-I

No.....Rank.....Name
.....
Unit.....
Diagnosis.....
Treatment refused .....
(specify surgical/medical/investigation).

PART-II

I, No.....Rank..... Name..... hereby express my unwillingness for undergoing treatment.....(specify type of treatment/operation/investigative procedure) which is considered essential by the treating medical officer. The reason for this refusal is .....The consequences of this refusal to undergo treatment has been explained to me in detail in the language I understand and I accept the same. I also understand that this may have adverse effect on my disability pension, which may be admissible to me as per Pension Regulations-1961 (Part-I) at the time of release/invalidment from service.

(Signature of the individual)
No.....
Rank.....
Name.....

Witness No .1
Signature.....
No..... Rank..... Name .....
Unit.....

Witness No.02
Signature.....
No.....Rank.....Name.....
Unit.....

COUNTER SIGNATURE OF MEDICAL OFFICER I/C CASE

APPENDIX 'B' to Chapter-V

UNWILLINGNESS CERTIFICATE OF NOK FOR TREATMENT (SURGICAL/MEDICAL)

PART-I

No.....Rank.....Name.....
.....
Unit.....
Diagnosis.....
Treatment Refused .....
(specify surgical/medical/investigation).

PART-II

I,.....(Name of NOK)..... (specify relationship) of Rank.....Name.....Hereby express my unwillingness for treatment.....(specify type of treatment/operation/investigative procedure) of my.....(specify relationship) which is considered essential by the treating medical officer. The reason for this refusal is .....The consequences of this refusal to undergo treatment has been explained to me in detail in the language I understand and I accept the same. I also understand that this may have adverse effect on my disability pension of my .....(specify relationship), which may be admissible to him/her as per Pension Regulations-2008 (Part-I) at the time of release/invalidment from service.

(Signature of the NOK)
Name.....
Address.....

Witness No .1
Signature.....
No..... Rank..... Name .....
Unit.....

Witness No.02
Signature.....
No.....Rank.....Name.....
Unit.....

COUNTER SIGNATURE OF MEDICAL OFFICER I/C CASE

APPENDIX V

(Referred to in Regulation 85(c) of PRA 2008)

CRITERIA FOR DECIDING WHETHER AN INDIVIDUALS REFUSAL TO UNDERGO MEDICAL TREATMENT OR AN OPERATION FOR HIS DISABILITY ATTRIBUTABLE TO OR AGGRAVATED BY MILITARY SERVICE, IS OR NOT REASONABLE

1. Refusal to undergo medical treatment or an operation may be held be reasonable-

(a) When, in the opinion of the medical authorities it is improbable that such treatment or operation would cure the disability or reduce its percentage or where such treatment or operation may be severe and dangerous to life;

Or

(b) Where, in the opinion of the Officer Commanding Unit, to undergo the operation or the treatment prescribed is opposed to religious or case prejudices of a valid nature and the refusal is the bonafide outcome of such prejudices.

2. Refusal to undergo medical treatment or an operation shall be treated as unreasonable-

(a) When, in the opinion of the medical authorities, it is due to malingering;

Or

(b) When, in the opinion of the Officer Commanding Unit, it is due to desire to avoid further service or to obtain or retain a pension or to receive an enhanced pension.

3. If in the opinion of the Officer Commanding Unit, the individual has grounds not covered above for refusing medical or operative treatment, the case shall be referred to the Area/Independent Sub-Area commander for a decision as to whether the objection is reasonable or not and his decision shall be final.

CHAPTER VI

CLINICAL ASPECTS OF CERTAIN DISEASES

AIDS

1. A viral infection caused by HIV -1, HIV-2 retroviruses and spread amongst people through unsafe sexual practices, sharing unsafe sharps between intravenous drug users (IVDU), transfusion of unscreened, contaminated blood and blood products with HIV. Nosocomial spread due to usage of non-sterile syringes and needles contaminated with HIV. Use of contaminated shaving razors.

Attributability: HIV does not kill by itself but weakens the immune system over a period of time leading to opportunistic infections/malignancy. Medical Boards will examine all evidence to establish a causal relationship between service related factors and exposure to HIV or otherwise. Where a causal relationship with service can be established, attributability may be conceded in the following cases:

(a) Accidental infection by documented contaminated or unscreened blood and blood product transfusions / invasive procedures and instrumentation in a service hospital, after referral to a civil hospital or in an emergency setting.

(b) Health Care Workers engaged in treatment and nursing where a possible causal relationship can be established. (Reference guidelines issued vide para 9(b) Annexure 4 of DGAFMS letter No 5496/DGAFMS DG-3A dated 18 Jun 2001).

The following conditions will not be considered as attributable in relation to HIV infection:

(a) Unsafe sexual practices

(b) Intravenous drug abuse.

HIV Infection with Pulmonary Tuberculosis: Keeping in view the high prevalence of Tuberculosis in India, attributability may be conceded in the following circumstances:

(a) If Pulmonary Tuberculosis was the presenting feature and the individual was found to be HIV positive and CD4 count > 200 cells/ µL subsequently, attributability in such cases should be given to the individual with regards to Tuberculosis.

(b) If the individual had received treatment for Pulmonary Tuberculosis in the past. In such cases there is a strong likelihood that Pulmonary Tuberculosis is due to reactivation or relapse.

(c) Pulmonary tuberculosis developing in an established known case of HIV positivity at a later date should be considered as part of the AIDS complex(CD4.< 200 cells/µL). Extra pulmonary manifestations of Tuberculosis are also common with AIDS complex with CD4 <200 cells/µL. Attributability should not be considered for such cases.

(d) In cases where attributability of Tuberculosis is conceded, two diagnoses will be given viz:

(i) Tuberculosis ICD 011
(ii) AIDS ICD 042

Note: In cases where attributability is not conceded only one diagnosis of AIDS (ICD 042) will be given.

2. **Adrenal Diseases**

Adrenal Insufficiency. Adrenal insufficiency occurs due to infectious adrenalitis, autoimmune adrenalitis, hemorrhagic infarction, metastatic disease, drugs and severe inflammatory disease. Only infections due to service merit attributability.

Cushing's syndrome. Cushing's syndrome may be either corticotrophin (ACTH) dependent or independent. Among all patients presenting with Cushing's syndrome, the most common cause is due to exogenous administration of glucocorticoids. Attributability may be examined if due to glucocorticoids.

Aldosteronism. Apparentmineral corticoid excess syndrome can occur in adults with triazole antifungal and ectopic ACTH syndrome. Aggravation and attributability would be non-admissible in these cases.

Pheochromocytoma. Catecholamine-secreting tumours that arise from chromaffin cells of the adrenal medulla and the sympathetic ganglia are referred to as pheochromocytomas. Most catecholamine-secreting tumours are sporadic. Therefore, aggravation and attributability would be non-admissible in these cases.

3. (a) **Aplastic Anemia.** The condition is caused due to varied causes which include inherited, autoimmune/idiopathic, cytotoxic drugs, radiation exposure, infections& benzene exposure.

Patients on investigations showing evidence of inherited causes like Fanconi gene positivity, telomere shortening, or other germline mutations will not be considered attributable to service. All remaining patients with a definite diagnosis of Aplastic Anemia confirmed by bone marrow studies, with or without a PNH clone and unresponsive to ATG (idiopathic) shall be considered attributable to service as the role of infection acquired due to service conditions cannot be excluded.

(b) **Anemia.** Anemia due to genetic mutations and nutritional deficiencies will neither merit attributability nor aggravation.

4. **Appendicitis**

Appendicitis is the commonest major surgical disease, affecting all ages and both sexes. Obstruction of the appendix lumen resulting in bacterial multiplication causes Acute Appendicitis. Fecoliths, intestinal parasites & sometimes tumours can cause obstruction of lumen.

All cases of Appendicitis will be considered attributable to service being due to infection contracted due to service conditions.

5. **Bronchial Asthma.** Bronchial Asthma is defined by the history of respiratory symptoms such as shortness of breath, chest tightness and cough that

vary over time and in intensity, together with variable expiratory airflow limitation. The disease onset is usually due to genetic and environmental factors and majority are associated with allergic diathesis such as skin allergies, recurrent rhinitis and/or sinusitis.

Persistent exposure to trigger factors due to service conditions in tradesmen and personnel posted to a particular environment for prolonged periods can result in recurrent severe exacerbations or poor control despite adequate treatment.

All cases where poor control or severe exacerbations defined by two or more hospital admissions per year or one ICU admission per year, if established to be due to service-related factors such as exposure to extreme cold climate, fumes due to occupational exposure, deployment or nature of duty, may be regarded as aggravated due to service.

6. **BLANK**

7. **Bronchiectasis.** Bronchiectasis refers to the permanent dilation of the bronchi. It is often a sequel of remote lung disease that develops into a pathological pattern of dilated bronchi, which heightens susceptibility to further lung infections.

Although several cases of Bronchiectasis are post infective including Tuberculosis, many such patients present with no previous history of active infection in past. Cystic fibrosis, immunodeficiency, chronic obstructive pulmonary disease (COPD), asthma, ciliary dyskinesia and congenital are some of the other causes Bronchiectasis.

Aggravation is to be conceded only if bronchiectasis follows pneumonia due to infection or aspiration with an established causal relationship with service.

8. **Cardiomyopathy.** This is a group of diseases of heart muscle that results from a variety of insults such as, genetic defects, cardiac muscle injury, infections and infiltration of myocardial tissue. They are of four types; dilated, hypertrophic, restrictive and arrhythmogenic right ventricular dysplasia.

Dilated cardiomyopathy (DCM) can result from genetic/ familial causes as well as a number of acquired insults which include infections, toxins, drugs like alcohol and lithium, metabolic, and immunologic. Hypertrophic cardiomyopathy (HCM) and arrhythmogenic right ventricular cardiomyopathy are usually familial/ genetic. Restrictive cardiomyopathy can be idiopathic or secondary to radiation, amyloidosis, sarcoidosis, metastatic tumours or inborn errors of metabolism.

Attributability may be conceded only in cases of DCM due to infective etiology.

Aggravation may be conceded only in cases of cardiomyopathies which were detected de novo during active operations or after a continuous tenure of three months in HAA or within three months of de-induction from HAA after a minimum antecedent continuous tenure of three months or after a minimum antecedent continuous service of three months on board a ship or one month in submarine.

9. **Cancer.** The precise cause of cancer is unknown. Cancer is the end result of an interaction of several carcinogenic influences along with intrinsic factors. Carcinogenesis is a multistep process involving sequential or concurrent cellular alterations. Most cancers have a distinct genetic predisposition but infections, chemicals, trauma, diet, occupational exposure and radiation are known causative

agents which initiate/promote the process of carcinogenesis. The following are some of the well-established associations with specific etiological agents:-

(a) **Chemical carcinogens:** A variety of chemicals are known to be involved in both initiation and promotion of carcinogenesis. Common carcinogenic chemicals are alkylating agents (anti-cancer drugs such as chlorambucil, cyclophosphamide, nitrosoureas; other chemicals like β-propiolactone, diepoxybutane), alkylating agents (dimethyl carbamide, acetyl imidazole), polycyclic and aromatic hydrocarbons (benzopyrenes, benzanthracine), aromatic amines and dyes (benzidine, napthylamine), natural plant and microbial products (aflatoxin, betel nuts) and other chemicals like vinyl chloride.

In military service, the exposure to these chemicals is usually seen in personnel working with mineral oils, petrol, diesel, lubricants, hydrocarbon fumes, dyes, paints, insecticides and fungicides. Cancers commonly associated with exposure to chemical carcinogens are:-

(i) Carcinoma urinary bladder
(ii) Renal cell carcinoma
(iii) Carcinoma of renal pelvis

(b) **Diet**: Dietary factors implicated in causation of cancers are excessive consumption of red meat, low intake of fruits and vegetables and contaminated food. Military service per se provides for a healthy balanced diet and does not predispose a member to these malignancies.

(c) **Infections**: Numerous viral infections and certain bacterial infections have been directly implicated as causative factors in various malignancies, however the list is expanding with increasing research in the field. Commonly encountered in malignancies with known infective etiological associations are:

(i) Hepatocellular carcinoma - HBV and HCV

(ii) Carcinoma Nasopharynx – EBV

(iii) Hodgkins Lymphoma (EBV)

(iv) Non Hodgkins Lymphoma- Marginal zone lymphoma, DLBCL, PTCL (H Pylori, EBV, HIV, HHV8)

(v) Multicentric Castleman disease (HHV -8)

(vi) Adult T Cell Leukemia (HTLV-1)

However, confirmation of an infective agent with respect to the malignancy may not always be possible due to subclinical or occult infections, a long lag period between infection and clinical presentation; and lack of diagnostic facilities. Hence, malignancies that have an unequivocal proven known infective etiology with the exception of infection proven to be acquired due to high-risk

behaviour/sexual behaviour/ drug abuse, should be conceded as attributable to service.

(d) **Other Occupational Exposure like Coal dust, Asbestos, Silica and Iron:**

(i) Bronchogenic carcinoma
(ii) Mesothelioma

(e) **Radiation:** Recurrent and prolonged exposure to ionizing radiation as in med personnel and personnel working in nuclear facilities, nuclear powered submarines, is known to be associated with cancers. Commonly encountered cancers associated with ionizing radiation exposure are:-

(i) Astrocytoma
(ii) Skin cancers
(iii) Multiple myeloma
(iv) Thyroid cancers
(v) Acute Leukemia (AML, ALL)
(vi) Chronic Leukemia (CLL)

All cancers where an infective aetiology, exposure to ionising radiation, chemicals due to service conditions is forthcoming, should be conceded as attributable to service.

10. **BLANK**

11. **BLANK**

12. **BLANK**

13. **Cataract**. Cataract is primarily due to degenerative changes in the lens causing defective vision.
The causes of cataract are many: -

(a) Senile cataract

(b) Metabolic disease - Diabetes Mellitus, Hypocalcaemia, Galactosemia

(c) Trauma - Ocular trauma (Open or closed globe injury)
Ionizing Radiation(Radiographer)
Electric shock and Lightning
Prolonged exposure to UV Light (for decades)

(d) Complicated cataract - Secondary to Uveitis, Choroiditis
High myopia
Glaucoma

(e) Complications of Atopic Dermatitis and Psoriasis

Cataract is mostly seen in serving soldiers due to age-related changes in the crystalline lens. These kinds of senile cataracts usually present after the age of 45 years. There exists no clear causal relationship between service conditions and early onset or progression in presenile cataract, and hence are not attributable. Age

related or Senile cataracts continue to be non-attributable to military service as they represent the normal age-related changes in the crystalline lens. In cases of any kind of ocular trauma sustained while on military duty being documented prior to the onset of cataract in the eye, the same should be considered attributable to military service.

14. **Cerebrovascular Accident / Stroke**. Stroke or cerebrovascular accident is a disease of acute onset leading to neurological deficit such as hemiplegia caused by intravascular events. Cerebral infarction following thrombosis and embolism accounts for a large number of cases whereas cerebral haemorrhage is the cause only in a few cases. Atherosclerotic thrombosis is of gradual onset and any permanent neurologic deficit is preceded by TIAs (Transient Ischaemic Attacks).

TIAs result mostly from embolism of thrombus or platelet material from an extra cerebral artery (Internal carotid) and sometimes due to stenosis of a major artery, altering hemodynamics in the event of change of posture and exertion.

Mural thrombus from the heart in IHD and Infective Endocarditis (IE) and ulcerated plaques of atherosclerotic arteries are the principal source of embolism.

Among other causes, service associated trauma and arteritis associated with infections like TB. Service in HAA can precipitate stroke by virtue of hypercoagulable state.

About half of the strokes caused by cerebral hemorrhage are due to subarachnoid hemorrhage from rupture of a berry aneurysm (Circle of Willis) and less commonly due to arteriovenous malformation. Remaining cases of hemorrhage in cerebral substance are due to rupture of small perforating arteries/arterioles weakened by hypertension or atheromatous degenerations which are not due to service conditions.

Cerebral venous thrombosis is a condition where there is thrombosis of the venous sinuses, superficial and/ or deep veins of the brain. These may lead to headache, signs of raised intracranial pressures (ICP), focal neurological deficits, seizures. These may be a result of prothrombotic states resulting whileserving in HAA or within 3 months of de-induction from HAA after a minimum antecedent continuous tenure of three months.

It will be appropriate to award attributability if there is sufficient evidence of infection underlying the disease ortrauma related to service or due to HAA.

15. **COPD**. It is a heterogenous lung condition characterised by persistent, progressive airflow limitation with chronic respiratory symptoms (cough, dyspnoea, sputum production). Most cases of COPD are caused by cigarette smoking in which case the disease will neither be attributable or aggravated by the service conditions. Diagnoses such as chronic bronchitis, emphysema are discontinued as these are covered in COPD.

16. **Corns, Callosities and Warts**. Corns develop due to ingrowths of epidermis after a minor or unrecognized trauma and can be very painful. They are usually present over soles. Callosities develop at the site of continuous friction or pressure and over the feet. It can be due to ill-fitting shoes or long marches. In cases with corns & callosities where definite correlation with service is established,

aggravation is appropriate, provided functional impairment arises on account of the corns/ calluses

Warts over soles and other parts of the body when caused by infection by Human Papilloma Virus which is sexually transmitted hence are not considered attributable to service.

17. **Cholelithiasis & Cholecystitis**. Gall stone disease is most common biliary disease. It is more common in females. Causes of cholelithiasis are-

(a) Metabolic.
(b) Infection which can cause cholecystitis & cholelithiasis.
(c) Bile stasis- due to pregnancy, after truncal vagotomy, long term parenteral nutrition.
(d) Haemolytic disease.

Only cases of acalculous cholecystitis being infection contracted in service will be considered attributable

18. **Cirrhosis of Liver**. This is a condition characterised by architectural distortion of the liver resulting in complications like variceal bleeding, ascites, deranged coagulation profile and hepatic encephalopathy. It is sequelae of various conditions including viral infections (HBV, HDV and HCV), inherited metabolic disorders, hepatic venous outflow obstruction, non-alcoholic steatohepatitis (NASH), alcoholic, autoimmune liver disease and biliary cirrhosis. It may be cryptogenic in some cases.

Attributability should be conceded when antecedent history of infection due to service is evident. Attributability should also be conceded in patients who develop hepatic venous outflow obstruction in HAA or within 03 months of de-induction after antecedent continuous tenure of three months. Cryptogenic cirrhosis may follow unidentified viral infections. Hence, attributability should be conceded in all cases of cryptogenic cirrhosis.

However, cirrhosis related to alcohol, fatty liver, infections due to recreational intravenous drug abuse and sexually transmitted diseases should be conceded neither attributable to nor aggravated by military service.

19. **BLANK**

20. **Chronic Degenerative Diseases of CNS.** Diseases like motor neuron disease, Parkinson's disease, chorea, athetosis and other movement disorders including tremors, Alzheimer's disease and other degenerative dementias are grouped under this category. A variety of possible causes including viral infection, trauma, exposure to toxins and electric shock have been postulated for motor neuron disease but no factual evidence exists to support any of these in typical cases.

In case of chorea the majority falls in Huntington's disease but other causes include post-drug therapy (L-Dopa, phenothiazines etc), viral encephalitis, rheumatic chorea and hyperthyroidism.

The exact cause of Parkinsonism is not known, however repeated trauma e.g., punch drunk syndrome in boxers, encephalitis (Japanese B Encephalitis, lethargica), certain drugs like reserpine, phenothiazine and carbon dioxide poisoning, exposure to certain toxic agents, can lead to Parkinsonism.

Tremors may arise due to metabolic/endocrinal conditions, substance/ toxin exposure/abuse, idiopathic or degenerative causes. Theses may range from mild to disabling in severity.

Alzheimer's disease (AD) and other degenerative dementias of presenile onset is insidious and often in middle life. Genetic factors play a predominant role in genesis of presenile Alzheimer's disease. Care should be taken to exclude other reversible dementias and pseudodementia prior to labelling a person with degenerative dementias like AD.

Attributability will only be appropriate if there is antecedent history of infection or trauma in cases of these chronic neurological conditions.

21. **Colonic Polyps and Diverticulosis**. Colonic polyps arise from a mucosal surface and project into the lumen. These can be benign or malignant. Congenital or familial polyposis will not be considered aggravated due to service conditions.

Diverticulosis of intestine results due to herniations of the intestinal mucosa. It is rare in people who eat a diet which contains natural fibre. Diverticulitis leading to pelvic abscess or peritonitis may be examined for aggravation if due to service factors.

22. **Congenital Heart Disease**. This refers to a group of diseases include left to right shunt lesions, congenital valvular heart disease (such as mitral valve prolapse, bicuspid aortic valve), coarctation of aorta and cyanotic heart diseases. These diseases will be conceded as not attributable to military service as they are present since birth and may have escaped detection at the time of enrolment.

23. **Hearing Impairment**. Hearing loss refers to impairment of hearing, the degree of which may vary from mild to total hearing loss. In the great majority cases of ear disease it is necessary to investigate the condition of hearing and to ascertain whether the hearing impairment if present, is due to involvement of sensorineural apparatus or conduction apparatus. The common causes of conductive deafness are wax, otitis media and otosclerosis.

Hearing impairment is either due to disease of cochlea or auditory fibres in the 8th nerve and its connection in the brain stem.

The common causes are:

(a) Infections: Viral infection e.g. mumps, influenza, cerebrospinal fever, labyrinthitis complicating otitismedia(commonest cause of SN deafness), Ramsay Hunt Syndrome(Herpes-ZosterOticus),TB meningitis.

(b) Ototoxic agents like Tobacco, alcohol (rarely).

(c) Degenerative disease e.g. Multiple sclerosis.

(d) Trauma

(e) Tumours e.g. Acoustic Neuroma

(f) Meniere's Disease

(g) Age associated hearing loss (AAHL) defined to be occurring in members greater than 50 years of age.

Caisson workers, divers, airmen, mountaineers and persons posted in HAA are liable to develop hearing impairment due to labyrinthine injury (haemorrhage, thrombosis or embolism) resulting from sudden compression / decompression and hypercoagulable state.

Medical board should hold that nerve deafness (SNHL) to be due to service only when it is as a result of an attributable service injury or outcome of an infection contracted due to military service.

However, those working in close proximity of gun fire (small arms, grenade, arty guns, bomb blast, and tanks) and in constant exposure to blast of loud noises such as working with aero engines, engine room of ships/submarines, riveters, and factory workers run the risk of noise induced hearing loss. In these cases, intensity, continuity, duration and distance of sound nuisance should be considered before conceding aggravation.

24. **Diseases of Retina**.

All retinal diseases are associated with reduction of acuity of vision, contraction of field of vision, colour blindness and sometimes progress to blindness.

Retinal diseases are divided into broad categories as under:

(a) **Retinal Perivasculitis**. Cases of retinal perivasculitis secondary to confirmed infective etiology during active military duty should be attributable. Aggravation is not to be conceded in any other forms or causes of retinal vasculitis.

(b) **Optic Neuropathy**. Optic neuritis encompasses morphological variants such as retro bulbar neuritis, papillitis, neuro retinitis and optic atrophy. It is a degenerative disease with multiple sclerosis accounting for majority of cases.

The other documented causes for Optic neuropathyinclude sinus infection, head injury, penetrating injury eye, certain drugs (ethambutol, chloramphenicol), tobacco, alcohol, atherosclerotic embolism of artery concerned, cerebral malaria can also cause this. Optic neuropathy may be a complication of SLE and temporal arteritis.

Traumatic, cerebral malaria induced optic neuropathy while on military duty should be held attributable to military service.

(c) **Retinal Detachment**. Retinal detachment is a degenerative disease. Degeneration is either due to lattice degeneration or myopic degeneration. A case of retinal detachment should be considered attributable to military service if there is any associated history of trauma. In all other cases, attributability or aggravation should not to be conceded.

(d) **Degeneration and Dystrophy of Fundus**

(i) **Central Serous Retinopathy**. It is common condition characterized by unilateral localized detachment of sensory retina at macula. About 80% of Central Serous Retinopathy undergo spontaneous recovery and visual acuity is restored within six months.Cases of central serous retinopathy due to infective etiology while on duty to be held attributable. All other causes will not be attributable or aggravated by service.

(ii) **Retinal Vascular Diseases**. Generally associated with Diabetes and Hypertension. Retinal artery occlusion may be due to vegetation from cardiac origin as in infective bacterial endocarditis and thrombus in myocardial infarction. Retinal Vascular Diseases due to infective etiology while on duty to be held attributable. All other causes will not be attributable or aggravated by service.

(iii) **Retinitis Pigmentosa**. It is a generic name for a group of hereditary disorders characterized by progressive loss of photo receptor retinal pigment i.e., rods and cones. Night blindness is the main complaint with loss of acuity of vision. Given the hereditary nature of these disorders, they cannot be held attributable or aggravated due to military service.

(iv) **Maculopathies**. These are seen in myopic and certain toxic maculopathies due to drugs (chloroquine, quinine, chlorpromazine). In case of macular hole and epiretinal membranes, should be given attributability to military service only in documented cases of ocular trauma while on duty.

25. **Demyelinating Diseases of CNS**. Demyelinating diseases of CNS encompass a host of conditions like multiple sclerosis, Guillain-Barre syndrome, acute demyelinating encephalomyelitis, Neuromyelitis spectrum disorders (NMOSD), Central Pontine (CPM) and Extrapontine Myelinosis (EPM),progressive multifocal encephalopathy (PMLE) and slow virus infection.

Acute demyelinating encephalomyelitis (ADEM) follows weeks after exanthem such as measles, chickenpox or after vaccination. Guillain-Barre syndrome may develop during or after virus infection of upper respiratory tract.

Multiple Sclerosis is a disease which is multifactorial due to genetic predisposition and immune dysregulation. Neuromyelitisoptica spectrum disorder (NMOSD) is a rare autoimmune disease. CPM is a monophasic demyelinating disease of the pons and lower midbrain. It most often occurs in association with alcoholic liver disease or correction of hyponatraemia (especially if the hyponatraemia is marked and the correction rapid). Another clinical context in which CPM is increasingly common is in patients with liver transplant, in whom high cyclosporin levels may have a role.

All demyelinating disorders with preceding history of infection, mandatory vaccination in service hospitalonly are to be considered as attributable to service.

26. **Diabetes Mellitus**. The term diabetes mellitus describes diseases of abnormal carbohydrate metabolism that are characterized by hyperglycaemia. It is

associated with a relative or absolute impairment in insulin secretion, along with varying degrees of peripheral resistance to the action of insulin.

Type 1 diabetes results from autoimmune destruction of the pancreatic beta cells, leading to absolute insulin deficiency. Type 2 diabetes is the most common phenotypic form of diabetes in adults characterized by hyperglycaemia and variable degrees of insulin resistance and deficiency. LADA (Latent autoimmune diabetes in adults) is a part of autoimmune diabetes spectrum. However, unlike DM type 1 the progression of beta cell failure is slow. Monogenic diabetes or maturity onset diabetes of the young (MODY) is a clinically heterogeneous disorder characterized by diabetes diagnosed at a young age (<25 years) with autosomal dominant transmission and lack of auto antibodies. Diseases that damage the pancreas, or surgical removal of pancreatic tissue, can also result in diabetes.

There is a known genetic predisposition to Diabetes Mellitus Type 2. The most striking risk factors in most patients who develop type 2 diabetes are increased weight gain and decreased physical activity, each of which increases the risk of diabetes.

Only pancreatogenic diabetes if occurring due to service factors where there is unequivocal evidence of infection, trauma, causing loss of pancreatic function should be considered to be attributable. All other forms of diabetes broadly are not due to service factors and do not merit attributability or aggravation.

27. **DNS**. It is a congenital disease. If acquired during service due to trauma or during an organised game activity like boxing should be treated as attributable.

28. **Disorders of Cardiac Rhythm and Conduction**

These are disorders of electrical conduction of heart. Recurrence of these may result in heart failure, sudden cardiac death (SCD) and syncope.
These disorders are generally not attributable to service. However, if the arrythmia develops due to an infection like viral myocarditis, it may be considered as attributable. Aggravation may be considered only in cases of cardiac arrythmia which was detected de novo after a continuous tenure of 03 months in HAA or within 03 months of de-induction after antecedent minimum continuous tenure of three months.

29. **Diseases of Female Reproductive System**. With the induction of females into Armed Forces, a new scenario has emerged as certain diseases specific to reproductive system can be adversely affected by service conditions. At the time of enrolment, it is mandatory to ascertain certain information pertaining to reproductive system such as date of last menstrual period, regularity of periods, clinical examination and ultrasonography to exclude any pelvic pathology. Certain common diseases of female reproductive system are being discussed here with relevance to service in Armed Forces.

(a) **Disorders of Menstruation**

(i) **Amenorrhoea**. Amenorrhoea (Absence of menstruation) may be primary or secondary:

(aa) Primary amenorrhoea is either due to non-development of genital tract or lesion in hypothalamic-pituitary-ovarian axis. Recommended to be unfit for commissioning in military service.

(ab) Secondary amenorrhoea is commonly caused by pregnancy or lactation. Pathological causes can be lesion in the hypothalamic - pituitary - ovarian - uterine axis. This condition is neither attributable nor aggravated by military service. It can be held attributable to service if secondary to endometrial Tuberculosis due to infection acquired due to military service.

(ii) **Dysfunctional Uterine Bleeding**. It is an endogenous disorder and is neither attributable nor aggravated by service.

(b) **Pelvic Inflammatory Disease**. Pelvic inflammatory disease can be due to endogenous or exogenous infection. If exogenous infection other than STD is proved, attributability is appropriate. Pelvic Tuberculosis is attributable to service.

(c) **Prolapse Uterus**. Prolapse uterus is due to weakness of the uterine supports. Chronic increase in intra-abdominal pressure due to chronic cough, constipation may adversely affect the disease. This condition is neither attributable nor aggravated by service.

(d) **Abortion**. The condition is a temporary disability and is neither attributable nor aggravated by service.

(e) **Stress Incontinence of Urine**. Stress incontinence of urine is involuntary leaking of urine on increasing intra -abdominal pressure. It is caused by loosening of bladder neck supports. It is neither attributable nor aggravated by service conditions.

(f) **Pelvic Endometriosis**. This is an endogenous disorder and neither attributable nor aggravated by service.

(g) **Fibroid Uterus**. This is an endogenous disorder and is neither attributable nor aggravated by service.

(h) **Pelvic Malignancies**. Carcinoma of cervix, endometrium, ovary, vagina, vulva and fallopian tubes may adversely affect the functioning. These are endogenous disorders or due to HPV infection which is sexually transmitted and are to be held neither attributable nor aggravated by service.

(j) **Menopause**. Menopausal symptom may be severe and adversely affect the functioning of the individual. This condition is neither attributable nor aggravated by service.

(k) **Pregnancy Complications**. Any pregnancy complication including ectopic pregnancy, abortions, antepartum haemorrhage, are not attributable to military service as the member is placed in a sheltered appointment after detection of pregnancy.

(l) **Polycystic Ovary Syndrome**. is primarily due to hormonal imbalance and aggravation or attributability should not be admissible in such condition.

30. **Immune mediated Inflammatory Diseases/Disorders of immune Dysregulation**.

Various Immune mediated inflammatory diseases include:

(a) Arthritides

(b) Vasculitides

(c) Connective tissue diseases.

These are autoimmune diseases with some genetic background and environmental triggers.

(a) Arthritis includes Rheumatoid arthritis which can be seropositive or seronegative, other inflammatory arthritis.

(b) Vasculitiides include Large Vessel Vasculitis including Takayasu Aortoarteritis&Giant cell arteritis, Medium Vessel vasculitis like Polyarteritis nodosa, Small vessel vasculitis includingAnti neutrophil cytoplasmic antibodies (ANCA) associated vasculitis like Granulomatosis with polyangiitis (Wegener's), Eosinophilic Granulomatosis with polyangiitis (Churg-Strauss), Microscopic polyangiitis(MPA), IgA vasculitis (Henoch Schnolein Purpura) and various vasculitis secondary to other systemic diseases.

(c) Connective tissue diseases include Systemic Lupus Erythematousus (SLE), Systemic Sclerosis, Sjogrens Syndrome, Idiopathic Inflammatory Myosisits (Dermatomyostitis/polymyositis), Overlap Syndromes and undifferentiated connective tissue diseases. These are characteristically multisystem disease with varied presentations.

All the above-mentioned conditions are neither attributable nor aggravated by service conditions as the members are given sheltered appointment after diagnosis.

31. **Diseases Peculiar to Naval Service**.

(a) **Barotraumas.** Barotraumas are group of disorders occur in divers and submariners due to rapid ascent from depth / rapid descent from surface. Barotraumas are mainly of otitic barotrauma, sinus barotrauma and pulmonary barotrauma. Causes of otitic/sinus barotrauma are eustachian tube blockage/dysfunction due to common cold, faulty ear clearing techniques etc. Pulmonary barotrauma commonly occurs due to breath holding while surfacing/ascending, in case of increase of pressure in lung and counter lung system, due to lack of sufficient air for breathing as a result of loss of mouth piece and breathing from mask space, mouth piece block due to vomitus and pre-existing lung pathology such as healed scar/fibrosis, bullae, cyst etc.

Otitic/Sinus barotraumas commonly manifest with ear/sinus pain to serious manifestation such as vertigo & bleeding through ear/nose due to tissue damage in air sinuses, rupture of eardrum which may be associated with round window blow out in severe cases of middle ear barotrauma.

Severe otitic barotrauma may manifest later with conductive/sensorineural hearing loss.

Pulmonary barotrauma may manifest with pneumothorax/hemopneumothorax, mediastinalemphysema and arterial gas embolism (AGE).Signs and symptoms of Pulmonary barotrauma appear few minutes after coming to surface. Chest pain, breathlessness and haemoptysis and varied CNS symptoms are the common presentation due to air embolism particularly in Cerebral Arterial Gas Embolism (CAGE).

Attributability is appropriate in all such cases.

(b) **Caissons Disease or Decompression Sickness**. Caissons Disease or Decompression Sickness (DCS) is a condition peculiar to divers, submariners and flyers. It is classified as Type 1 (mild) and Type 2 (severe) DCS. It is caused by inert gas such as nitrogen, which is a component of air mixture that we intake, goes into solution in large quantities at great pressure and the same separates out from physical solution in tissues in form of bubbles due to uncontrolled changes in ambient pressure while ascending to surface giving rise to symptoms of body ache of musculoskeletal origin, joints pain, skin rashes, numbness/paraesthesia, unsteadiness of gait to more severe neurological symptoms such as paralysis of limbs, altered sensorium, coma and death.
Attributability may be conceded if the same is acquired while on duty.

(c) **DysbaricOsteonecrosis**. Dysbaric osteonecrosis is a type of avascular necrosis of the bone seen inprofessional divers using compressed air. Frequent exposure to pressure substantially greater than normal atmospheric pressure is known to be associated with death of portion of long bones due to blockage of end arteries by asymptomatic micro bubbles. The pathology is detected during periodic x-ray examination of long bones or incidentally while investigating a case of diving related pathology. The lesions are mainly confined to head, neck and upper shaft of long bones.This condition may lead to increased risk of fracture head & neck of long bones depending on the size of the bony defect. The most commonly involved region is the hip joints. In advanced cases, the individual may have severe functional impairment due to hip joint arthrosis.

Attributability is appropriate in all cases of dysbaric osteonecrosis where other causes of osteonecrosis like Diabetes Mellitus, age related osteoporosis, use of corticosteroids have been ruled out.

(d) **Drowning**. World Health Organisation has redefined drowning in 2002 as a condition leading to respiratory insufficiency due to submersion/immersion in the water/liquid. This condition may occur in members during diving operations and naval training. The outcome of drowning could be fatal or the individual may survive with neurological sequalae.
Attributability is to be conceded if the same happens while on duty and a nexus between drowning and service compulsions is proven.

(e) **Hypothermia.** Humans maintain their core body temperature by balancing heat production and loss. The body temperature must remain at about 37 ± 1°C for a person to be comfortable. Core temp for a diver in the

water, the heat transfer is often greater than normally experienced on land. Divers are prone to hypothermia in high altitude diving, deep diving etc. The core temperatures ranging from 35-33° C is mild hypothermia, 33-30°C is moderate hypothermia and below 30°C is classified as severe hypothermia. The clinical presentation varies from shivering in mild/moderate hypothermia to altered mentation, coma and death due to multisystem involvement in severe hypothermia like Acute Kidney Injury due to rhabdomyolysis. Attributability to be conceded in cases of hypothermia occurs whilst diving ops / training.

(f) **Disorder Related to Abnormal Gas Pressure**.

Hypoxia is a clinical condition encountered by divers while diving. Hypoxia occur because of insufficient/ absence of breathing gas due to reasons such as out of gas from cylinder, malfunction of diving equipment, vomitus in the mouth piece/mask and off mask condition. The symptoms and signs of hypoxia become obvious when the PaO2 drops below 50 mm Hg. If the fall in PaO2 is rapid, then loss of consciousness may be unheralded. With slower falls, an observer may note lack of coordination/poor job performance, fatigue, headache or blurred vision. There are rarely any symptoms to warn the diver of impending unconsciousness from hypoxia under water. Divers may survive with no/ significant neurological deficit.

Oxygen toxicity is a consideration when higher partial pressures of oxygen are used in the inspired gas. Central nervous system toxicity, manifested by convulsions, is potentially lethal in the diver. Pulmonary toxicity is more likely in longer exposure to saturation diving or hyperbaric oxygen therapy. It is characterized by hyperplasia of type II alveolar cells and progressive pulmonary fibrosis. The common symptoms are chest tightness or discomfort, dry cough, shortness of breath etc. The pulmonary function test may reveal reduction in vital capacity. Decrease in vital capacity of more than 10% from base line considered significant. Attributability is to be conceded in all such cases.

32. **Eczema/Dermatitis**. Eczema is an inflammatory response of the skin primarily not infectious or contagious. Reaction is due to many agents such as exogenous factors (irritants/contact) or endogenous factors (biological). A sensitive person may develop eczema due to stimuli encountered because of military service. These include mechanical stimulus of the skin from friction of clothing and chemical and biological irritants in those handling equipment and in also in those engaged in professional work. The friction may occur during marching, PT, military exercise, thermal irritation, from sweating or over reaction of the secretions of the skin. Exposure to cold appears also to be a precipitating factor in some cases.

Any case of exogenous eczema which begins after enrolment, the onset of which is accepted as precipitated by service conditions, must be considered as attributable to service and not merely aggravated. For acceptance of being precipitated by service conditions a demonstrable patch test to a service related offending agent must be carried out and recorded. If it is demonstrated as positive to a factor related to military duty it must be considered attributable.

33. **Seizures/Epilepsy**. This is a disease which may develop at any age without obvious discoverable cause. The persons who develop epilepsy while serving in forces are commonly adolescents with or without ascertainable family history of disease. The onset of epilepsy does not exclude constitutional idiopathic type of epilepsy but possibility of organic lesion of the brain associated with cerebral trauma, infections (meningitis, cysticercosis, encephalitis, TB), cerebral anoxia in relation to continuous service of three months in HAA, cerebral infarction, CVT and haemorrhage, and certain metabolic (diabetes) and demyelinating disease should be kept in mind. However, in certain cases remote symptomatic seizures where the seizures might post-date the initiating event (trauma, infection etc) by weeks to years and the individual might not be in LMC for that disease which are confirmed by radiological evidence of gliosis.

Acceptance is on the basis of attributability if the cause is due to infection or service-related trauma. Past service-related trauma must be confirmed by radiological evidence of gliosis before deciding on entitlement.

34. **Errors of Refraction:**

(a) **Astigmatism**
(b) **Hypermetropia**
(c) **Myopia**

Refractive errors detected or worsened during military service will not be held attributable or aggravated due to military service being constitutional.

35. **Glaucoma**.

(a) Primary Glaucoma is associated with certain risk factors like advanced age, myopia, family history, high intraocular pressure, myopia and ethnicity. By itself, the condition is not attributable to military service.

Juvenile open angle glaucoma is a kind of open angle glaucoma the onset of which occurs prior to the age of 35 years. These cases should not be considered attributable to military service.

(b) **Secondary Glaucoma**. In all cases of secondary glaucoma, attributability will be decided based on whether the initial disease causing the glaucoma was attributable to military service or not. In all cases of service related ocular trauma causing secondary glaucoma, attributability should be given.

36. **Fibrosis of Lungs (Post Infective/ Non-Specific)**. Fibrosis refers to deposition of fibro-collagen to various extent in the Lung parenchyma due to injury/inflammation of lung parenchyma. It may be caused due to:

(a) Infections- Pneumonia, Tuberculosis
(b) Exposure to irritant/toxic gases
(c) Ionising radiation
(d) Aspiration

Fibrosis of lungs is usually focal, static and remains throughout life if the exposure to agent causing fibrosis is removed. Attributability is to be given only if the development of fibrosis is the result of infections, long term exposure to irritants,

radiation due to service conditions. (eg: Fibrosis after kerosene aspiration while on active duty).

37. **Fistula in Ano**. It is a track lined by granulation tissue which connects anal canal or rectum with skin around anus. It usually results from anorectal abscess which burst spontaneously or is opened surgically. It continues to discharge pus off & on. It may also occur following trauma, anal cancer, Crohn's disease and certain specific infections like tuberculosis. It will be considered attributable when it is due to infection or trauma contracted in service.

38. **Goitre & Thyroid Diseases**

(a) **Goitre or Thyroid nodule**.Mere presence of goitre itself does not qualify for aggravation or attributability.

(b) **Hyperthyroidism**. Hyperthyroidism is characterised by increased thyroid hormone synthesis and secretion from the thyroid gland. Several different disorders can cause hyperthyroidism. Graves' disease is the most common cause of hyperthyroidism. It is an autoimmune disorder caused by activating auto antibodies against thyroid-stimulating hormone receptor antibodies.

Toxic adenoma and toxic multinodular goitre are the result of focal and/or diffuse hyperplasia of thyroid follicular cells whose functional capacity is independent of regulation by TSH most commonly due to activating somatic mutations of the genes for the TSH receptor.

Thyroiditis are a group of heterogeneous disorders that result in inflammation of thyroid tissue with transient hyperthyroidism due to release of preformed hormone from the colloid space. This initial presentation is followed by a hypothyroid phase and then recovery of thyroid function in most cases.

Graves' disease is an immunologically and a genetically mediated disease. Hence, does not merit attributability or aggravation due to service factors.

(c) **Hypothyroidism**. Hypothyroidism can result from a defect anywhere in the hypothalamic-pituitary-thyroid axis. In the vast majority of cases, it is caused by thyroid disease (primary hypothyroidism). Much less often it is caused by decreased secretion of thyroid-stimulating hormone (TSH) from the anterior pituitary gland or by decreased secretion of thyrotropin-releasing hormone (TRH) from the hypothalamus. Primary hypothyroidism due to chronic autoimmune (Hashimoto's) thyroiditis, caused by cell and antibody mediated destruction of thyroid tissue is the commonest cause of hypothyroidism. Therefore, does not merit attributability or aggravation due to service factors.

39. **Asymptomatic Hyperuricemia and Gout**

Asymptomatic hyperuricemia is a term applied to settings in which the serum urate concentration is elevated but in which neither symptoms nor signs of monosodium urate (MSU) crystal deposition disease, such as gout, or uric acid renal disease, have occurred. Gout is a disease that occurs in response to the presence of

monosodium urate (MSU) crystals in joints, bones, and soft tissues. It may result in one or a combination of acute arthritis (a gout flare), chronic arthritis (chronic gouty arthritis), and tophi (tophaceous gout).Considering the pathophysiologic mechanism aggravation or attributability should not be admissible due to service conditions.

40. **Chronic Hepatitis**. This may be caused by hepatitis viruses like hepatotropic and non-hepatotropic viruses, autoimmune liver disease, Wilson's disease; drug induced liver disease, alcohol and may also be cryptogenic. Viral infections constitute the single largest group accounting for most cases of hepatitis. The spread of disease in hepatitis associated with HAV and HEV is feco-oral, whereas the spread of hepatitis due to HBV, HCV, and HDV are mostly parenteral, vertical or sexual. Chronic hepatitis is a chronic parenchymal liver disease caused by alcohol, HBV and HCV infection, non-alcoholic steatohepatitis (NASH), drugs and auto-immune hepatitis.

Attributability should be conceded in all infections due to service like accidental infection by documented contaminated or unscreened blood and blood product transfusions / invasive procedures and instrumentation in a service hospital, after referral to a civil hospital or in an emergency setting or in Health Care Workers engaged in treatment and nursing where a possible causal relationship can be established, which have developed chronicity (clinically, biochemically and imaging).Cryptogenic chronic hepatitis of unidentified aetiology should also be conceded as attributable as it may be due to unidentified and occult infections. A carrier state of Hepatitis due to infection acquired due to service should also be conceded as attributable to service.
Hepatitis due to alcohol, secondary to IV drug abuse and STDs should be conceded as neither attributable to nor aggravated by service.

Non Alcoholic Steatohepatitis (NASH) is commonly associated with obesity, hyperlipidemia, insulin resistance/ diabetes, prolonged total parenteral nutrition, or protein energy malnutrition. Attributability should be conceded in patients on prolonged TPN only.

Certain congenital hyperbilirubinemias (Gilberts' syndrome, CrigglerNajar syndrome) can also present with jaundice and mimic hepatitis clinically. Being congenital, these do not merit attributability or aggravation due to service conditions.

41. **Hernia**. A Hernia is a protrusion of a viscus or part of a viscus through an abnormal opening in the walls of a body cavity. Common varieties of abdominal wall hernias are, inguinal, femoral, umbilical, para umbilical, epigastric & incisional.
In young people, there may be a preformed sac that predisposes to indirect inguinal hernias. Connective tissue abnormality may be involved in adult onset hernia. Abnormalities in ultrastructure and physicochemical properties of collagen suggest that hernia is one manifestation of a generalised abnormality in collagen metabolism. Hence, do not merit attributability or aggravation due to service conditions.

42. **Haemorrhoids**. Haemorrhoids are dilated veins occurring in anal canal. Straining, accompanying constipation predisposes to haemorrhoids. Service conditions are neither responsible nor do they aggravate the condition.

43. **Hypertension**. This disease can be either primary or secondary. Primary (earlier known as essential) hypertension is the most frequently encountered form of hypertension in the Armed Forces. Primary hypertension is multi-factorial in etiology, the most common underlying factors being genetic and lifestyle. Hence, it does not normally merit aggravation due to service conditions. Attributability in hypertension

may be conceded if the onset occurs while serving in HAA for at least three continuous months or within three months of de-induction after a minimum antecedent continuous tenure of three months. Aggravation may be examined in cases where there is evidence of worsening of the disease due to induction into HAA after being diagnosed or during active operations / service on board ship for at least three months or submarine for one month.

44. **Inflammatory Bowel Disease (IBD)**. This comprises of ulcerative colitis and Crohn's disease. These diseases are caused by immune mediated damage to the intestinal mucosa and are characterized by unpredictable exacerbations and remissions. Relapses are often associated with emotional stress, inter-current infection or use of non-steroidal anti-inflammatory drugs. The complications of these diseases include Fissure in Ano, intestinal strictures and fistulae. Extra-intestinal complications include ankylosing spondylitis, uveitis, and amyloidosis. Aggravation may be conceded in cases which develop complications due to infections or delay in treatment due to involvement in active operations.

45. **Irritable Bowel Syndrome (IBS)**. Irritable bowel syndrome is a functional gastrointestinal disorder characterized by chronic abdominal pain and altered bowel habits in the absence of an identified cause. The path physiology of IBS remains uncertain. Hence, it should not be conceded as attributable or aggravated by service.

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47. **Coronary Artery Disease (CAD)**. Coronary atherosclerosis results in coronary artery obstruction which may be asymptomatic or may cause chronic stable angina, acute coronary syndrome (unstable angina, myocardial infarction) or sudden death. Sudden cardiac death (SCD) is an unexpected death due to cardiac causes occurring in a short time period in a person with known or unknown cardiac disease. In 4% of sudden deaths, postmortem examination fails to identify a cause; these cases are diagnosed as having sudden arrhythmic death syndrome (SADS).

CAD has multi-factorial causation which includes genetic factors, dyslipidemia, diabetes mellitus, smoking, hypertension etc. is not attributable to service.

Attributability in CAD may be conceded only if the onset of acute coronary syndrome/SCD is while serving in HAA or within three months of de-induction from these areas after a minimum antecedent continuous tenure of three months, or while serving onboard ships for three months/submarine for one month or if the onset is during or within 72 hours of heavy physical exertion requiring >7 METS (Certificate by CO/Fmn Cdr enclosed as Appx) due to service requirements or during active operations.

48. **Keratitis**. Keratitis is an inflammation of cornea with or without ulceration and on healing opacity or opacities may be left which may interfere with vision. It is essentially an infection by various microorganism excited by a number of causes e.g., injury, foreign body exposure (facial nerve palsy), conjunctivitis.

The viruses causing keratitis are usually Herpes and Varicella virus. Bacteria such as Staphylococcus and Pseudomonas can also cause keratitis. Few morphological variants such as interstitial keratitis, phlyctenular keratitis, marginal keratitis are due to hypersensitivity reaction to bacterial toxins (TB, Staphylococcus). Keratitis may also be associated with fungal infection and collagen disorders. Infective Keratitis and its complications should be considered attributable to military service.

49. **Musculoskeletal Conditions** (Orthopaedics). In these conditions, it is essential to trace the medical-occupational history of the impaired person from the original injury, considering the nature of the injury and the attendant circumstances, the effect of treatment over past periods, and the course of the recovery to date. The duration of the initial and any subsequent treatment, period of total/partial incapacity, especially periods reflecting delayed union, non-union, malunion, inflammation, drainage, or operative interventions, should be given close attention to determine aggravation.

Evaluation by X ray, CT Scanand MRI may be done to accurately record the union, extent and direction of angulations, shortening and any secondary/ residual effects of the injury on the adjoining musculature and joints (especially in the lower weight bearing joints) may be related to. Wherever, required a diagnostic arthroscopy may be done to evaluate the extent of cartilaginous, meniscal and ligament injuries.

Attributability is granted if nexus between injury and military service is established.

Aggravation is merited only if the condition has worsened beyond the natural course of the disease at the time of discharge as evidenced by clinical and radiological findings endorsed by both an orthopaedic surgeon and a radiologist, as injuries to the limbs and axial skeletal maybe sustained during training, movement, operations, combat or even while discharging routine military duties.

Musculoskeletal Infections- Infections of the bones, joints, muscles and fascia of the limbs and around the spine are either extrinsic in origin e.g. post-surgical/iatrogenic, after open injuries or penetrating injuries etc or intrinsic in origin e.g. haematogenous spread associated with sepsis or low immunity states. Attributability may be assessed on correlation of the primary causative agent and incubation period, antecedent service conditions and correlation with interventions if any during the course of treatment.

50. **Laryngo-Tracheal Disorders & Vocal Cord Palsy**. Laryngo-tracheal injury is a common injury seen in Armed Forces. This can be due to MT accident, injury due to boxing and wrestling, bullet injury, basketball and also due to diving into a swimming pool. Vocal cord paralysis is a common outcome of such injuries. Vocal cord palsy can also be due to viral laryngitis, complication of thyroid surgery, neck surgery in malignancy. Irradiation of neck may also give rise to vocal cord palsy. Sometimes tracheal stenosis occurs in tracheal injury, burns, post tracheostomy and bullet injury.

Attributability is to be conceded if due to injury on bonafide military duty or infection contracted while in service.

51. **Neck pain & Back Ache**. Neck pain &backache are clinical entities where aetiology is multifactorial. They may or may not be associated with neurological deficit.

Some of the causes are:

(a) Spondylolysis/Spondylolisthesis
(b) Facet joint arthropathy
(c) Ligament hypertrophy/Canal stenosis
(d) Degenerative disc disease
(e) Prolapsed inter vertebral disc (PIVD)
(f) Vertebral fractures/Ligament injuries

These conditions can be demonstrated on imaging of the Spine (X-ray/CT scan/MRI).

Attributability is to be only conceded if there is an established causal & temporal relationship of these conditions with an injury sustained due to military service.

52. **Leprosy**. Leprosy is caused by *Mycobacterium* leprae and occurs in two main forms, tuberculoid and lepromatous. It is characterized by extreme chronicity. Although skin to skin contact with infectious cases may play a role in transmission, there are other modes of transmission also, viz recovery of large number of lepra bacilli from nasal mucosa of reservoir of infection namely lepromatous leprosy, has led to possibility of droplet infection through nose blows, sneezing, coughing etc by lepromatous cases. Also, the lepromatous ulcers in the skin discharge a large number of bacilli.

The incubation period is not definitely known, and various periods have been given by different authorities. There is a long interval between the exposure to infection and the appearance of definite recognizable symptoms of the disease. However, the accumulated evidence indicates that the incubation period is usually not less than 2 years in an adult.

Attributability should be accepted in respect of any individual contracting leprosy after being in service for two years. Cases diagnosed within the first two years of enrolment cannot be considered as attributable to service.

53. **Lymphadenitis (Tubercular)**

It is the most common extra pulmonary manifestation of Tuberculosis which is treatable with standard ATT. Complications of TB Lymphadenitis while on treatment include sinus formation, fistula formation, emergence of new nodes or increased swelling of existing nodes. These, per se do not denote treatment failure and can occur up-to 25-30% of cases both during and after treatment. These usually subside spontaneously with therapy without any major sequala or functional impairment.

54. **Mental and Behavioural (Psychiatric) Disorders**. This group of disorders results from a complex interplay of endogenous (genetic/biological) and exogenous (environmental as enumerated below; psychosocial family dynamics, social support, major life events, lack of support from civil administration due to service factors etc as well as prolonged tenures in HAA etc and those enumerated below) factors. This is true for the entire spectrum of psychiatric disorders.

(a) Attributability will be conceded where the psychiatric disorder occurs when the individual is serving in or involved in:-

(i) Combat area including active counterinsurgency operational area

(ii) Minimum three months continuous tenure in HAA

(ii) Deployment at an extremely isolated post

(iv) Minimum continuous tenure on a afloat platform for three months or one month in a submarine

(v) Catastrophic disasters particularly while providing aid to civil authorities during natural disasters (where one has to handle work in proximity of dead or decomposing bodies).

(b) Attributability should be conceded in all cases of Post Traumatic Stress Disorder (PTSD) in above mentioned service conditions.

(c) Attributability should also be conceded when the psychiatric disorder arises within one year subsequent to severe/grievous injury or illness that are themselves considered attributable to military service.

(d) Aggravation should be conceded in those cases, which were made to serve in HAA after detection of disorders leading to worsening of those subsequent course of the disease.

(d) Psychiatric illness in recruits with prior history of psychiatric illness is neither attributable to nor aggravated by service.

(e) Psychoactive substance and alcohol abuse/dependence are neither attributable to nor aggravated by service.

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56. **Osteoarthritis**. Osteoarthritis is a degenerative joint disease, represents the final common pathway of injury to the articular cartilage. Osteoarthritis can be primary or secondary. The designation of primary or idiopathic osteoarthritis is made when no identifiable predisposing condition could be identified. Osteoarthritis is considered secondary when an underlying cause such as trauma, old intra-articular fracture, ligament injury, or previous deformity, septic arthritis, rheumatoid arthritis, avascular necrosis. The weight bearing joints are more commonly affected such as Knee, Hip, and Spine. However, upper limb joints like shoulder, elbow and wrist joints can also develop arthritis, although their incidence and prevalence are less in comparison to lower limb.

The spectrum of diseases included in this category are:

(a) **Upper limb Joints**:

(i) Shoulder, elbow and wrist

(b) **Lower Limb Joints:**

(i) Osteoarthritis hip, knee, and ankle

Uncongenial climate (cold, damp) and hilly terrain may affect the course of the disease. The disease is generally accepted on the basis of aggravation if the onset is before the age of 50 years in absence of obesity.

57. **Otitis Media**. Otitis media can be classified into acute and chronic, based on extent of inflammatory reaction and the presence or absence of suppuration. It should be noted that an initial non-suppurative condition may proceed to suppurative one and chronicity if neglected or inadequately treated. The common predisposing factors are upper respiratory tract infection and rarely as a manifestation of allergy.

Chronic otitis media may be:

(a) **Active**: When there is pus discharge

(b) **Quiescent**: With intermittent pus discharge for a period less than 6 months.

(c) **Inactive**: Cessation of discharge for six months without resumption. It may reactivate by reinfection.

(d) **Healed**: Total extinction of disease and healing of perforated tympanic membrane.

Chronic suppuration in attic and antrum associated with perforation (attic) and posterior marginal perforation and complications like cholesteatoma and polyp are ominous signs and carries a risk of bone destruction, recurrence after surgery.

If chronic suppurative otitis media originates during service it should be accepted as attributable to service because of infection acquired due to service conditions.

58. **Otosclerosis**. Otosclerosis is hereditary progressive form of conductive or middle ear deafness but it may be associated with an added perceptive or nerve deafness due to involvement of the nervous elements of the cochlea, particularly in the later stages of the disease. If a diagnosis of otosclerosis is established, it is to be held neither attributable nor aggravated due to military service being hereditary in nature and as it may escape detection at the time of enrolment.

59. **Pancreatitis**. Inflammation of pancreas results due to chronic alcoholism, cholelithiasis abdominal surgery, hypercalcemia, hypertriglyceridemia, ERCP, certain drugs, trauma, viral infections e.g. mumps and in few cases genetic or idiopathic.
Attributability can be considered in those cases with preceding history of mumps & trauma due to military service. Alcohol induced pancreatitis is to be considered neither attributable nor aggravated due to service.

60. **Paraplegia.** Non-surgical causes include infectious, parainfectious, demyelination, postvaccinal and vascular.
Attributability should be conceded if the cause is infection/para-infectious etiology like postvaccinal (only for mandated vaccinations at a service hospital) or due to service related injury while on bonafide military duty.

61. **Peptic Ulcer**. Peptic ulcer can occur in stomach, duodenum or at anastomotic sites. The common causes of peptic ulcer are use of non-steroidal anti-inflammatory drug (NSAID) intake and infection with *Helicobacter pylori*. Risk factors include smoking, alcohol intake, undue stress and strain and ingestion of spicy food.
Peptic ulcer should be accepted as neither attributable nor aggravated due to service because of ubiquitous prevalence of H. pylori infection in the country.

62. **Peripheral Neuropathy**. The cause of peripheral neuropathy may be due to infection, post or para-infectious (e.g. Gullian Barre syndrome, leprosy, typhoid),connective tissue diseases (PAN, SLE, rheumatoid arthritis), metabolic(diabetes, hypothyroidism) and hepatic failure.

Attributability is considered in infectious, para or post infectious cases and to those cases which are due to work-related exposure to toxins/chemicals.

Certain compressive neuropathies like carpal tunnel syndrome which can be caused due to frequent, repetitive, small movements with the hands (such as with

typing or using a keyboard), frequent, repetitive, grasping movements with the hands (such as with sports and certain physical activities) if related to occupation/trade related exposures can be considered for aggravation.

63. **Peripheral Vascular Diseases**

(a) **Peripheral Arterial Occlusive Disease (PAOD)**.Clinical features of chronic limb ischemia due to PAOD include intermittent claudication, rest pain, ischemic ulcers or gangrene. Smoking is the single most important risk factor for PAOD, others being hypertension, diabetes, hyperlipidemia, CAD and lack of exercise. Aetiology in the older age group is mainly due to atherosclerosis of the blood vessels. Diabetic micro and macro angiopathy potentiates atherosclerotic involvement. Buerger's Disease (Thromboangitis Obliterans) occurs in the young male smoker, involving the small and medium sized vessels of the extremities. Takayasu's Aorto-arteritis and Giant Cell Arteritis involve the aorta and its major branches. PAOD per se is not attributable to military service.

(b) **Acute Limb Ischemia**. Service in HAA area leads to a Hypercoagulable state which might lead to acute or chronic limb ischaemia. This can occur due to arterial thrombosis, embolism or secondary to aortic dissection and aneurysms. Arterial thrombosis occurring during HAA tenure or in close time association with service up to three months after leaving HAA area after a continuous tenure of three months merits attributability. Ischaemia arising post arterial injury due to service conditions as GSW/splinter injuries/blunt injuries while on active duty are also attributable.

(c) **Vasculitis**. Many inflammatory and vasospastic disorders present with ischemia. These diseases have a systemic nature and include Raynaud's phenomenon due to connective tissue disorders (CTD), and the vasculitides. Majority of the vasculitis have an immunological basis as the underlying cause. Only cases of Raynaud's disease and vascular disorders associated with physical injuries like Frost bite, chill blains due to extreme cold climate due to service conditions merit attributability.

(d) **Arterial aneurysms**. These can be true or false aneurysms. Aortic, peripheral and visceral arterial aneurysmal disease is usually degenerative in aetiology and not attributable. Other causes of aneurysms are collagen disorders, dissections, infective and post traumatic. Atherosclerosis and hypertension are important risk factors which are not attributable to service. Aneurysms secondary to infection/ trauma during active service are attributable.

(e) **Deep Vein Thrombosis (DVT)**. DVT is a result of hypercoagulable state, which may be congenital (thrombophilia) or acquired. Congenital causes include Protein-C & Protein-S deficiency, antithrombin deficiency, Factor V Leiden, dysfibrinogenemias and homocysteinemia and are not attributable. Acquired causes of DVT include prolonged surgery, trauma, immobilisation, malignancy, antiphospholipid syndrome, nephrotic syndrome, sepsis, chronic inflammatory conditions, diabetes and hyperviscosity syndromes. DVT following surgery, trauma, or prolonged immobilisation in a hospitalised patient and continuous flight duration >4 hours is attributable to service. DVT detected while in HAA area due to a hypercoagulable state or

within three months of de-induction after a minimum continuous antecedent tenure of three months is also attributable.

(f) **Chronic Venous Insufficiency (CVI) & Varicose Veins**. CVI is a result of sustained ambulatory venous hypertension due to valvular incompetence; venous out flow obstruction or calf muscle pump failure. Features of CVI include varicose veins, leg oedema, eczema, lipodermatosclerosis and venous ulcers. Secondary varicose veins due to DVT are attributable to military service if the episode of DVT was attributable to service. Primary varicose veins are not attributable to service.

(g) **Miscellaneous Conditions**.

(i) **Thoracic Outlet Syndrome (TOS)**.

Vascular complications occur in 5% of cases of TOS usually due to compression from a cervical rib or band, resulting in subclavian artery aneurysm, thrombosis or distal embolization in upper limbs, Condition is not attributable. Thrombotic episodes involving the arterial and venous beds can occur in arterial and venous TOS (Paget- Schrotters disease) due to rigorous exercise/ HAA exposure.
It is to be considered as neither attributable nor aggravated being a congenital anomaly.

(ii) **Vascular Malformation**. These are congenital and can be high flow lesions (arterio-venous malformations) or low flow lesions (capillary, venous or lymphatico venous malformations). They are neither attributable nor aggravated being a congenital malformation.

(iii) **Arterio Venous Fistulas**. These usually occur as a result of trauma and are attributable if occur due to trauma related to service.

(iv) **Carotid Body Tumour**. This tumour is a paraganglioma/chemodectoma, arising from the carotid body at the carotid bifurcation. They are neither aggravated nor attributable to service.

(h) **Extracranial Carotid Artery Disease**. Atherosclerotic carotid artery stenosis involves the carotid bifurcation, resulting in decreased cerebral circulation, transient ischaemic attacks or stroke. Underlying cause in such cases is atherosclerotic, thus not attributable. However, aggravation can be considered in cases if it occurs in HAA or within one month of leaving HAA.

64. **Pneumonia**. Pneumonia is defined as the inflammation of lung parenchyma caused by microorganisms such as bacteria, viruses and fungi. Pneumonia is common in recruits, immune-compromised and individuals with structural lung disease. Precipitating causes include overcrowding, prolonged hospitalisation, comorbid conditions like Diabetes and harmful consumption of alcohol. The incubation period varies among the agents responsible for causing pneumonia which lasts from 2-7 days. If a serving personnel living in barracks develops pneumonia it is presumed to be due to overcrowding and exposure to incriminating agents under serving conditions. Hence the illness and the resultant fibrosis if any will be attributable to military service. However, if the pneumonia

develops in immune compromised patients or harmful consumption of alcohol, as it is not caused due to military conditions and hence, not attributable.

65. **Pulmonary Eosinophilia**. The eosinophilic lung diseases are a group of disorders characterised by the presence and presumed pathogenetic role of eosinophils. They are mainly represented by the eosinophilic pneumonias, defined by a prominent infiltration of the lung parenchyma by eosinophils, which respond dramatically to corticosteroid treatment and generally heal without significant sequelae. Pulmonary Eosinophilia is attributable to service post infestation/infection acquired in to military service.

66. **Prolapse Rectum**. In complete prolapse of rectum all layers of rectal wall protrude downward through anus. It is more than 4cms in length. Post Traumatic prolapse of rectum will be considered attributable if trauma is established to be due to military service. Many patients have a history of intractable constipation/ chronic diarrhoea in which case it is neither aggravated nor attributable to military service.

67. **Psoriasis**. Psoriasis is a genetically determined disease. A family history is obtained in about 30 per cent of cases. Onset may be spontaneous, or it may be precipitated by infections, especially streptococcal infections. Local trauma may determine the site and occasionally it appears for the first time at the site of a healing wound. Mental and emotional stress are generally regarded as not causative but may give rise to exacerbations. The disease is frequently associated with a type of arthritis very similar to rheumatoid arthritis except that the distal interphalangeal joints are frequently involved and the agglutination test for rheumatoid arthritis is almost invariably negative. The disease being hereditary in nature is neither attributable nor aggravated due to service conditions

68. **Renal Diseases**. The upper urinary tract consists of the kidneys, their vasculature, and the renal parenchyma and its collecting system. The lower urinary tract is composed of the peristaltic ureters from each kidney and the bladder.

Renal diseases predominantly involve the upper urinary tract and are based on syndromes as under:

(a) **Acute Kidney Injury (AKI)**. It is a rapid deterioration in renal function sufficient to result in the accumulation of nitrogenous wastes in the body. An increase of serum creatinine ≥ 0.3 mg/dl developing over < 48 hrs or an increase of ≥50% developing over < 7 days along with or without reduced urine output is defined as acute kidney injury. The kidneys may recover even after severe, dialysis requiring AKI.

(b) **Chronic Kidney Disease (CKD)**. Chronic kidney disease is defined based on the presence of either kidney damage or decreased kidney function for three or more months, irrespective of the cause. Kidney damage refers to pathologic abnormalities in the native or transplanted kidney, whether established via kidney biopsy or imaging studies or inferred from markers such as urinary sediment abnormalities or increased rates of urinary albumin excretion. CKD will also include congenital abnormality of the kidney and urinary tract (CAKUT). Decreased kidney function refers to a decreased glomerular filtration rate (GFR), which is usually estimated (e GFR) using serum creatinine and one of several available equations. A kidney biopsy may reveal evidence of glomerular, vascular, or tubulointerstitial

disease. Patients with a history of kidney transplantation are assumed to have kidney damage whether or not they have documented abnormalities in kidney biopsy or markers of kidney damage.

(c) **Acute Nephritis**. Nephritic inflammation may occur in association with infection, systemic autoimmune disorders, or toxic exposures. The nephritic syndromes may be further subdivided depending on the inflamed structures within the kidney, including vascular, glomerular, and tubulointerstitial; and also, on the time course of progression of the inflammatory process, which may be acute, subacute, or chronic. Rapidly progressive glomerulonephritis (RPGN) is a syndrome arising from a variety of causes and pathologically associated with a proliferation of glomerular parietal epithelial cells and inflammatory cells called cellular crescents surrounding the capillary that, over time, becomes fibrotic and atrophic with global loss of the glomerular tuft.

(d) **ProteinuricState and Nephrotic Syndrome**. Microalbuminuria (30–300 mg/day of albumin excretion) is beneath detection by urinary dipstick protein analysis. Any detectable albuminuria on the dipstick is called overt proteinuria (> 300 mg/day albumin or > 500 mg/day protein)and when detected at the highest level on the strip is consistent with nephrotic proteinuria.Sustained proteinuria >1–2 g/24 h is commonly associated with glomerular disease and needs renal biopsy for confirmatory diagnosis.
Nephrotic syndrome (NS) has three defining features: edema, hypoalbuminemia (<3.5 g/dL), and proteinuria >3.5 g/day.

(e) **Urinary Tract Infections (UTI)**. UTI is an infection in any part of the urinary system. The urinary system includes the kidneys, ureters, bladder and urethra. Most infections involve the lower urinary tract the bladder and the urethra. Women are at greater risk of developing UTI than men.

(f) **Tubule Function Defects**. Majority of diseases are congenital; at times they may be acquired following a disease process.

(g) **Urinary Tract Obstruction**. Obstruction can occur majority in the kidney or downstream leading to uropathy and subsequently leading to nephropathy.

(h) **Asymptomatic Urinary Abnormalities**. Abnormalities detected in routine urinalysis in patients who have no symptoms of the renal or urologic disease are common findings in clinical practice.

Attributability and Aggravation

Acute renal conditions associated with infections, dehydration, trauma to the kidney due to military service are attributable.

Aggravation is examined in relation with service profile at the time of detection of CKD within three months of exposure to the following military service conditions

(a) (Hot &arid region (Max Temp crossing > 45 deg C with arid vegetation) like in deserts.

(b) Cold &arid region (Min Temp falling below -10 deg C with arid vegetation) in HAA.

(c) Continuous tenure onboard a ship for three months or one month in a submarine

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75. **Urolithiasis**. . Stones usually arise because of breakdown of delicate balance between excretion of low soluble material and attempt to conserve water by kidney. The balance is upset by failure of adaptation to combination of factors such as diets, climate, activity and also infection.
The increased frequency of urolithiasis in service population is by the virtue of service due to exposure to difficult terrain, climate, compulsive dietary practice and excessive physical activity. Urolithiasis is attributable to military service when the member has history of recurrent urinary tract infection prior to calculi formation with documented evidence of pyuria in form of pus cells on urine routine examinations and positive urinary culture or it develops post instrumentation.
Aggravation is examined in relation with service profile at the time of detection within three months of exposure to the following military service conditions

(a) Hot &arid region (Max Temp crossing > 45°C with arid vegetation) like in deserts.

(b) Cold &arid region (Min Temp falling below -10°C with arid vegetation) in HAA.

(c) Continuous tenure onboard a ship for three months or one month in a submarine

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77. **Chronic Rhinosinusitis**. Rhinosinusitis is commonly associated with infection, allergy and certain psychosomatic factors. Alteration in temperature, humidity of inspired air and anxiety can precipitate vasomotor rhinitis. Atrophic rhinitis is a disease of uncertain origin. All these may progress to rhinosinusitis, therefore they are neither attributable nor aggravated due to service.

78. **Spondyloarthritides (SpA)** are a group of inflammatory arthritis which consist of ankylosing spondylitis (AS), reactive arthritis, arthritis/spondylitis associated with psoriasis (PsA), and arthritis/spondylitis associated with inflammatory bowel diseases. As per newer criteria they are classified into axial or peripheral spondyloarthritis based on presence of the following in various combinations: Sacroiliitis on imaging, HLA B 27 positivity, inflammatory back pain, arthritis, enthesitis, dactylitis, psoriasis, Crohn's/Ulcerative colitis, uveitis. These are chronic inflammatory disorders that can progress to spinal fusion or involvement of peripheral joints, especially larger joints. These conditions cannot be held attributable to service and due to sheltered appointment do not merit aggravation due to service.

79. **Squint**. Strabismus is a congenital or acquired condition characterised by malalignment of the visual axes. It can be congenital or acquired. The role of convergence insufficiency is evidently documented in worsening of intermittent exotropia and as such, aggravation can be considered in personnel who are employed in duties involving long term monocular use of viewing devices and navigational equipment.

Acquired cases of strabismus like paralytic squint can be considered attributable to military service if due to service-related trauma or infection.

80. **Gonadal Dysfunction (Hypogonadism)**. Hypogonadism in a man refers to a decrease in one or both of the two major functions of the testes: sperm production and testosterone production. These abnormalities usually result from disease of the testes (primary hypogonadism) or disease of the pituitary or hypothalamus (secondary hypogonadism). Mumps orchitis is the infection most closely associated with testicular damage. Attributability will be appropriate when there is evidence of service-related trauma and infection acquired during service.

81. **Tuberculosis**. Infection caused by Mycobacterium Tuberculosis (bacteria) resulting in pulmonary and /or extrapulmonary manifestation.

Microbiologically confirmed TB- biological specimen positive for AFB, positive for MTB in culture, positive for tuberculosis through quality assured rapid molecular test.

Clinically diagnosed TB – who is not microbiologically confirmed but has been diagnosed on the basis of X ray abnormalities, histopathology or clinical signs.

Pulmonary Tuberculosis- involves lung parenchyma or tracheobronchial tree.

Extrapulmonary Tuberculosis- involves organs other than lungs.

Patients with pulmonary and extrapulmonary tuberculosis should be classified as Pulmonary Tuberculosis only. Attributability would be conceded if onset is after 6 months of enrolment in service. If the onset is within 6 months of enrolment in service, the infection was likely acquired before service.

The following case definitions are also included

(a) New case – Patient who was never treated for tuberculosis or had treatment for less than 1 month only.

(b) Recurrent TB case- Patient who have been declared as successfully treated and is subsequently found to have microbiologically confirmed TB.

(c) Treatment after failure- Previously treated for TB whose treatment failed after recent course of therapy.

(d) Treatment after loss to follow up – patient previously treated for TB for more than 1 month and subsequently found to have microbiologically confirmed Tb after being loss to follow up on the previous regimen.

(e) Mono drug resistant TB- Patient whose biological specimen is resistant to one of the antitubercular drugs (INH / Rifampicin/ Pyrazinamide/ Ethambutol).

(f) Polydrug resistant TB- Patient whose biological specimen is resistant to 2 drugs other than INH and Rifampicin

(g) Multidrug resistant TB- Patient whose biological specimen is resistant to INH and Rifampicin

(h) Pre-XDR tuberculosis- Biological specimen that fulfil the definition of multidrug resistant and rifampicin resistant TB (MDR/RR-TB) and which are also resistant to any fluoroquinolone.

(j) XDR Tuberculosis – Biological specimen that fulfil the definition of MDR/RR-TB and which are also resistant to any fluoroquinolone and at least one additional Group A drug (Bedaquiline, Linezolid)

82. **Uveitis**. Uveitis is an inflammation of uveal tract which can be anatomically divided into:

(a) Anterior uveitis affecting iris and anterior part of ciliary body.
(b) Intermediate uveitis affecting ciliary body and periphery of retina.
(c) Posterior uveitis affecting predominantly choroids called retino-choroiditis.
(d) Pan uveitis involving all the layers of uveal tissue

The underlying attributable causes are:

(a) Infection: TB, leprosy, herpes, candida
(b) Trauma: Boxing, organized games and penetrating ocular injury.

83. **Valvular Heart Disease**. This is a group of diseases affecting the valves of the heart. The predominant causes of valvular heart disease in adults are rheumatic, congenital or degenerative heart disease. Rheumatic heart disease (RHD) is due to streptococcal infection acquired in childhood. It cannot be considered as attributable to service. Other cases of valvular heart diseases (congenital/ degenerative) also cannot be considered as attributable to service. However, valve disease developing as consequence of infection contracted during service (like infective endocarditis with sequelae) may be considered attributable.

84. **Vertigo**. The causes of vertigo are as under:

(a) **Central**. Trauma to 8th nerve at the base of brain tumours at cerebellopontine angle (acoustic neuroma) and disseminated sclerosis, posterior inferior cerebellar artery thrombosis.

(b) **Peripheral**. Meniere's disease, vestibular neuronitis,vertebrobasilar insufficiency in cervical spondylosis, labyrinthitis, Diabetes Mellitus, hypertension, drugs(salicylates, quinine, streptomycin, kanamycin) otitis media/complicated chronic otitis media.
Vertigo arising out of infection and trauma related to service should be treated as attributable.

New Paragraphs

85. **Obstructive Sleep Apnea**. OSA is characterized by discrete episodes of absent (apnea) or reduced (hypopnea) breathing, and/or by sustained reductions in

breathing due to upper airway closure during sleep (hypoventilation) compared with wakefulness.

The pathogenesis of OSA involves a complex interaction of factors including altered upper airway anatomy, tissue characteristics, neuromuscular function, sleep-related decrements in upper airway dilator muscle activity, attenuated protective reflexes, and altered ventilatory and arousal responses to chemical and other respiratory stimuli. None of the above factors can be considered attributable or aggravated by military service. Hence, OSA is neither aggravated nor attributable to military service.

86. **Diseases Peculiar to Military Aviation**.

(a) **Altitude Decompression Sickness**. Altitude Decompression Sickness (DCS) occurs as a result of acute exposure to a reduction in ambient pressure (above 18,000 feet). In aviation, rapid/ explosive decompression leading to acute loss of cabin pressure predisposes an individual to develop altitude decompression sickness. Such a condition may also be encountered during training on Explosive Decompression Chamber. It is caused by inert gas such as nitrogen separating out from physical solution in the tissues and circulation in the form of gas bubbles. It can present in a wide variety of ways. Mild DCS manifests as Joint pain, limb pain, cutaneous manifestations (bends) and are self-limiting. On the other hand, severe variant causes cardiovascular, pulmonary and neurologic manifestations. Permanent sequelae arising out of the condition is attributable to service.

(b) **Barotrauma**. Barotrauma is defined as an injury produced by mechanical forces caused by change of pressure on a gas filled space. Following types of barotrauma are encountered in aviation:-

(i) **Otitic Barotrauma**. The traumatic injury to the middle ear and tympanic membrane produced by failure of adequate ventilation of the latter, encountered during rapid descent of an aircraft.

(ii) **Delayed Otitic Barotrauma**. Aircrew breathing 100% oxygen at altitude and during descent to ground level, some hours later, present with ear discomfort and deafness. This phenomenon is due to rapid absorption of oxygen from the middle-ear cavity into the blood and is known as delayed otitic barotrauma.

(iii) **Sinus Barotrauma**. Sinus barotrauma is due to the inability to equalize the pressure within some or all of the paranasal sinuses in response to changes in the ambient air pressure. It is characterized by sharp pain in cheeks or forehead and is known to recur.

(iv) **Barodontalgia**. It occurs as a case of a trapped gas exerting positive or negative pressure on surrounding tissue as a result of the difference between the pressure inside the tooth or the apical root of the tooth in the maxillary sinus and the pressure outside the tooth. The condition is usually self-resolving on descent to ground level but may need intervention in the form of root canal treatment.

(v) **Pulmonary Barotrauma**. The condition occurs due to lung over distension and is a rare consequence of loss of cabin pressure in flight but remains a real risk in hypobaric chamber exposure. However, highly agile aircraft capable of sustaining high +Gzmanoeuvre at high altitude and with life support system which delivers positive pressure breathing has created the circumstances wherein an acute loss of cabin pressure during a $+G_z$manoeuvre could occur while the aircrew's lungs are fully inflated. In addition, performance of Anti G Straining Manoeuvre obstructs free flow of expanding gas from the lungs, thus increasing the risk of pulmonary barotrauma.

Barodontalgia, Otitic and sinus barotrauma usually resolve in due course of time. However, residual tympanic membrane perforation with varying degree of conductive deafness may occur following otitic barotrauma. Pulmonary barotrauma may have serious manifestations. Attributability is to be conceded if barotrauma is sustained in flying or during to hypobaric chamber exposure.

(c) **Ejection/ Crash Related Injuries**. Forces sustained during ejection from an aircraft or during crash landing exposes the spine to considerable axial loading. In addition, the impact forces predispose to numerous types of injuries. These may include, spinal injuries, head injury, limb fractures, joint dislocations, penetrating injuries, flail injuries etc. Attributability is conceded in all types of injuries sustained during ejection/ crash landing/ hard landing/ belly landing.

87. **Disorders of bone**

(a) **Primary Hyperparathyroidism (PHPT)**

The classical symptoms and signs of PHPT are known as the "bones, stones, abdominal moans, and psychic groans." They reflect the combined effects of increased parathormone secretion and hypercalcemia. The abnormalities associated with hyperparathyroidism are nephrolithiasis and bone disease; both are due to prolonged PTH excess. Aggravation or attributability cannot be considered for this condition.

(b) **Osteoporosis**

Osteoporosis is a skeletal condition characterized by low bone mass, which is associated with reduced bone strength and an increased risk of fractures. Osteoporosis occurs most commonly in postmenopausal women. Aggravation or attributability cannot be considered in primary osteoporosis.

88. **Dyslipidemia**

Dyslipidemia is due to hereditary mutations or due to dietary and lifestyle habits. Service factors have no role in either its onset or course of the disease.

Appx to Para 47 Chapter VI

CERTIFICATE BY THE COMMANDING OFFICER/ FMN CDR TO DECIDE ENTITLEMENT BY MED BD IN ACUTE CORONARY SYNDROME/ SUDDEN CARDIAC DEATH

1. This is to certify that No_____ Name_____ Age____ of Unit/Fmn_____ was commissioned/enrolled on and was diagnosed with Acute Coronary Syndrome/ expired due to Sudden Cardiac Death on_____.

2. The individual is / was serving in HAA/CI Ops/ Field/ Peace wef to _____.

3. The individual was in/not in performance of bonafide military duty/ leave/ TD.

4. The following duties involving exceptional physical exertion due to service compulsions were performed by the individual within 72 hours prior to being detected with Acute Coronary Syndrome/ Sudden Cardiac Death.

S No	Date	Time	Details of physical activity	Supporting Documents

5. Was the individual under any exceptional emotional/mental stress due to Service compulsions in the preceding 72 hours? Yes/No

If yes, give details.

Signature of the CO/FmnCdr

Concurred/ Not Concurred

Signature of Higher Fmn HQ

Encls (As applicable)

Unit Part II order (and eqvt) for ToS, Location.

Movement order for TD/LRP/Attachment

Leave certificate

Unit Part I order for PPT, BPET, Organised sports, Route marches, Ex

Any other relevant documents

Note. The certificate is also to be filled in Sudden Cardiac Deaths where the AFMSF-93 Part II and Court of Inquiry are not available.

CHAPTER VII

ASSESSMENT

1. **Definition**
Medical Officers are called upon to evaluate an impairment at the time of medical boards. Assessment is the measure of the functional loss from normal of the member due to the impairment under consideration.

2. The evaluation of an impairment for disability component (element) purposes is called assessment.

3. **Basis of Assessment**.
The purpose of the impairment evaluation is to ensure compensation on equal terms for all members of the Armed Forces of similar status suffering from a like impairment which may be due to injury or a disease. It is estimated by reference to the physical or mental capacity for performance of the necessary functions of a normal life, which would be expected in a healthy person of the same age and sex. It should represent the extent to which the impairment has reduced that functional capacity. It is determined solely on general functional capacity. Consideration should not be given to the member's capacity or incapacity to follow his own or any specific trade or occupation. Assessment should be based on measurement of objective parameters which can be used to quantify the functional loss. Sympathy, sentiments and personal feelings should not come in the way of assessment.

For arriving at a proper assessment of an impairment, it is necessary to elicit a conclusive history, carry out a thorough clinical examination and all relevant laboratory and radiological investigations. It has to be determined whether the impairment is temporary or permanent and also the degree of impairment as it pertains to working capacity. The physical examination and laboratory tests must be relied upon more than ever to substantiate or disprove symptoms and complaints. The evaluation of an impairment based on measurement of function is a sound procedure by means of which a reliable medical opinion may be reached by reason or logic rather than by intuition, conjecture or assumption.

The functional assessment being parameter based and derived from guidelines of assessment based upon RPwD Act of 2016, GARP and other international disease specific guidelines will be provided by the concerned specialist. The specialist will enclose a duly signed assessment calculation sheet along with the findings in his opinion. The assessment will be verified by the President Medical Board. The final assessment of impairment will be endorsed by the medical board.

4. **Definition of Function**
The term "function" is one that is commonly used to denote the usefulness of a part of the body. In stating the extent of loss of function of a part, it has to be found out what the member cannot do. When anatomical or physiological changes have taken place leading to the stiffness, atrophy or pain and the usefulness and the efficiency of the organ are impaired, the extent of this clinical impairment is revealed through physical examinations.

However, the extent of deficiency of functional ability does not correspond to the extent of physical limitation. Limitation of motion by 50 per cent does not mean 50 percent loss of function. The clinical findings must be designated as factors contributing to the loss of function and not measuring it.

5. In analysing the problem of assessment, a thorough examination together with a deterioration of the anatomical or physiological alterations from normal as compared to abnormal physical state of the same age and sex and the effect of such alterations are taken into consideration. In the case of injuries or diseases, the important points to note are:

(a) Quickness of action
(b) Coordination of movements
(c) Strength
(d) Sense of security
(e) Endurance

Expressed negatively, loss of function may be estimated in terms of (a) delayed action; (b) awkwardness; (c) weakness; (d) insecurity; (e) diminished endurance; (f) lowered swift factor and (g) the adverse influence of the conspicuous impairment.

6. The functional factors e.g., in the hand may be stated as (a) quickness and nimbleness of digital action; (b) coordination of fingers and thumb in opposing finger tips to thumb and thumb to fingers and palm; (c) strength of gripping and fist making ability, striking, holding and pushing power; (d) reliability of sensations; and (e) endurance of holding, gripping or pinching.

In respect of leg, foot and toes, the factors would be: (a) quickness, nimbleness, springiness of step and gait (b) coordination of feet and toes in smoothness and steadiness of steps and gait (c) strength or weight-bearing and power of action in standing, walking, running or jumping and (d) reliability or toe, heel or foot action.

In an examination of the back, the gait, deformity, dressing or undressing, sitting down or getting up attitude will have to be taken into consideration, as also muscle spasm. Stiffness of the spine causes movement of the hips prior to that of the spine.

In the hip, the stance or gait or sitting down as in dressing, muscle spasm or rigidity, swelling or atrophy, degree of movement at the hip have to be taken into consideration.

In the knee, the gait, swelling, atrophy, movements painful or free, limitation of such movements have to be considered.

In the foot, the gait, deformity, swelling, movements active and passive, muscle power, weight-bearing on toes and heels, and ankylosis if any, have to be taken into consideration.

In the shoulder, the general appearance, deformity, swelling, atrophy, extent of motion painful or free, will have to be considered, as also any neurological signs. The same applies to elbow, wrist and the hands.

In head injury cases, the peculiar characteristic manner of special coordination of movements, gait, general appearance and behaviour with an examination of the scalp, the eyes, the facial expression along with an examination of the reflexes will have to be considered amongst other symptoms attributed to trauma, such as headache, dizziness, insomnia, nausea, vomiting etc.

Once this distinction is made in the clinical entity of the impairment, the examiner is in a position to evaluate the impairment on the merits of pathological significance.

7. **Principles of Assessment.**

The assessment of an impairment for compensation purposes is the estimate of the degree of impairment it causes, which can properly be ascribed to service. The impairment properly referable to service is assessed slightly differently at the time of discharge from the armed forces.

8. There are various stages of an impairment. These are: treatment period, healing period, temporary or permanent impairment-partial or total. Thus, an impairment may be temporary or permanent.

9. **BLANK**

10. Impairments which necessitate invalidation from service are capable of improvement in due course or are of permanent nature. "Permanent" means persisting for all times, i.e., the impairment is said to be in a permanent state when the condition is unchangeable.

11. **Computation of Assessment**.
In the armed forces, the evaluation of impairment or assessment is made to ensure compensation on equal terms for all members suffering from like disablement. The impairment is to be assessed in multiples of 5, like 5%, 10%, 15% up to 100%If the assessment tool is as per RPwD guideline, then exact % of impairment will be mentioned. There will be no rounding off of assessment by the board. If an impairment is assessed at 100 per cent, a recommendation will invariably be made as to the necessity or otherwise for a constant attendant, bearing in mind that the necessity arises solely from the condition of impairment. If an attendant is recommended, the period for which such attendant is necessary, should also be mentioned.

A member of the armed forces who is in receipt of a disability compensation (element) in respect of an impairment, the degree of which is less than 100 per cent, may be awarded constant attendant allowance if it is certified by the Medical Board why a constant attendant on him is necessary on account of the impairment.

12. **BLANK**

13. It is not always possible to decide what portion of the impairment is due to natural progress and what portion is due to persisting effects of service, aggravation or due to extraneous factors. The medical board will have to decide the issue based on all facts placed before them, their knowledge of the natural history of the particular disease, the circumstances after discharge, on the clinical condition etc.

14. In attributable cases, if death occurs after invaliding, the family is entitled to special family pension if the cause of death is related to the invaliding impairment, irrespective of the degree of the impairment.

15. **Assessment with Regard to Percentage of Impairment**
The assessment with regard to percentage of impairment as recommended by the Invaliding Medical Board, Release Medical Board would be treated as final unless the individual himself requests for review except in case of impairments which are not of permanent nature. The opinion of the Reassessment Medical Board, Appeal Medical Board, which will be constituted by DGAFMS as & when required, will be final.

16. **Reassessment of Impairment**. There will be no periodical reviews by the Resurvey Medical Boards for re-assessment of impairments. In case of impairments adjudicated as being of a permanent nature, the decision once arrived at will be final unless the individual himself requests for a review. In cases of impairments which are not of a permanent nature, there will be only one reassessment of the percentage by a Medical Board to be carried out later within a specified time frame. The percentage of impairment assessed/recommended by the Board will be final

unless the individual himself asks for a review for a condition which is attributable. The review will be carried out by Review Medical Board constituted by DGAFMS.

17. **Paired Organs**.

(a) Where an impairment is due to service exists in one or both of the paired organs such as "eyes, ears, limbs" the condition and degree of impairment if any, should be noted separately for each organ, but the Board's recommendation of an assessment of impairment for compensation purposes, will be based on an estimate of the functional capacity at the time of invaliding, of the paired organs working together.

(b) It may happen that the functional capacity of the combined paired organs is partly due to an accepted impairment and partly due to an impairment unconnected with service. In these cases, the following principles should be observed for the assessment of the impairment:

(i) The first assessment for compensation purposes is made on the total functional capacity of the paired organs working together at the time of invalidation/ discharge and without any deduction on account of "unaccepted components".

(ii) Any subsequent increase in the non-service disablement existing after discharge, whether due to injury or disease, will be excluded from the assessment.

17 A (a) Where there are two or more impairments due to service, compensation will be based on the composite assessment of the degree of impairment. The composite assessment will be reduced in proportion to the degree of overlapping. The exact percentage of the assessment will be mentioned and there will be no rounding off of the assessment by the medical board.

(b) Example is given as under:-

(i) Member 'A' has four impairments – (i) Impairment 1 – 20%, (ii) Impairment 2 – 30%, (iii) Impairment 3 – 20% and (iv) Impairment 4 – 30%. The arithmetic assessment will be 100% (arithmetic sum of individual impairments).

However functionally the member is not 100% impaired as he is ambulant and is able to carry out all his routine functions and activities of daily living. Besides the member was released in low medical category, there by indicating that he was also able to perform his mil duties in a sheltered appointment.

Method of Calculation: The composite impairment as per the suggested method will be calculated as follow –

Impairment (i) 20%

Impairment (ii) 100-20 = 80 X 30/100
= 24%

Impairment (iii) 100-(20+24) = 56 X 20/100
= 11.2%

Impairment (iv) 100 – (20+24+11) = 45 X 30/100
= 13.5 %

Composite Assessment - 20+24+11.2+13.5 = 68.7%

(c) The calculation method of normal impairment and war injury is different and assessment of impairments including both i.e. normal and war injury are assessed as composite. The calculation of compensation values in cases where War Injury Element and Disability Element both exist should be carried out as follows, Firstly, the composite assessment for all accepted impairments shall be derived. The higher element i.e. War Injury Element (WIE) shall be deducted from composite assessment and paid in full, irrespective of the percentage of assessment. The remainder shall be calculated as the normal Disability Element (DE). The minimum assessment criterion shall not be applicable in such cases as the net assessment reckonable for WIE and DE together is more than 20%.

Example is given as under :-

An individual has two impairments (i) Gun Shot Wound (attributable to service) assessed as 40% for life and (ii) Hearing loss aggravated by service. assessed at 20% for life. The composite assessment for the two would be 50% for life. The War Injury Element of the composite will be granted in full i.e. 40% and the remainder 10% of composite calculated for impairment (ii).

17B **Ankylosis**: To be assessed as per assessment of RPwD for locomotor disabilities given in Para 35 (viii):- The assessment of Upper extremity joints (shoulder, Elbow, Wrist) will include: Range of motion grading of severe (different for each joint), coordination activities as well as inclusion of dominant right or left upper limb. In assessment of lower extremity joints (Hip, Knee, Ankle) inclusion of stability criteria & shortening if present along with the above mentioned aspects will also be assessed.

17B.1. **Guidelines for Evaluation of Permanent Physical Impairment in Persons with Amputation (Amputees):**

Basic Guidelines: (a) In cases of multiple amputees, the % of permanent impairment is to be computed by using the combining formula: a+b (90-a)/ 90 (a = higher value, b = lower value). (b) If the stump is unfit for fitting the prosthesis additional weightage of 5% should be added to the value. (c) Any complication in form of stiffness of proximal joint, neuroma, infection, etc., should be given up to a total of 10% additional weightage. (d) Involvement of dominant upper limb (right upper limb in majority of individuals) in acquired amputation should be given 10% additional weightage

No. Level of Upper Limb Amputation	**% of permanent impairment in relation to that specific limb**
1. Fore-quarter amputation	100
2. Shoulder Disarticulation	90
3. Trans Humeral (Above Elbow) upto upper 1/3 of arm	85
4. Trans Humeral (Above Elbow) upto lower 1/3 of arm	80
5.Elbow Disarticulation	75
6. Trans Radial (Below Elbow) upto upper 1/3 of forearm	70
7.Trans Radial (Below Elbow) upto lower 1/3 of forearm	65
8. Wrist Disarticulation	60

9. Hand through carpal bones	55
10. Thumb through C.M. or through 1st MC joint	30
11. Thumb disarticulation through metacarpo phalangeal Joint or through proximal phalanx 25	
12. Thumb disarticulation through inter phalangeal joint or through distal phalanx 15	
13. Amputation through Proximal phalanx or Disarticulation through MP joint of	
Index finger	15
Middle finger	5
Ring finger	3
Little finger	2
14. Amputation through Middle phalanx or Disarticulation through PIP joint of	
Index finger	10
Middle finger	4
Ring finger	2
Little finger	1
15. Amputation through Distal phalanx or disarticulation through DIP joint of	
Index finger	5
Middle finger	2
Ring finger	1
Little finger	1
17.4 Lower Limb Amputations:	
No. Level of Lower Limb Amputation % of permanent impairment in relation to that specific limb	100
1. Hind quarter	90
2. Hip Disarticulation	85
3. Trans Femoral (Above knee) up to upper 1/3 of thigh	80
4. Trans Femoral (Above knee) upto lower 1/3 of thigh	75
5. Through Knee	70
6. Trans Tibial (Below Knee) up to upper 1/3 of leg	60
7. Trans Tibial (Below Knee) up to lower 1/3 of leg	55
8. Through Ankle	50
9. Syme's	40
10. Upto mid-foot (proximal to tarso-metatarsal joints level)	30
11. Upto fore-foot (distal to tarso-metatarsal joints level)	
12. All toes	20
13. Loss of first toe	10
14. Loss of second toe	4
15. Loss of third toe	3
16. Loss of fourth toe	2
17. Loss of fifth toe	1

18. **Flail Joints.**

Flail joints are more disabling than the ankylosed joints. Where there is abnormal mobility, the assessment of both upper and lower limb will be higher than that of ankylosis. Any improvement due to skilled orthopaedic treatment will call for corresponding reduction in assessment. The assessment will be done as per

locomotor disability Para 35 (viii). Range of motion of joints & coordinated activities for Arm component & stability component for lower extremity should be taken into consideration for assessing disability. If weakness of muscle leads to flail joint then strength of muscles to be added to the assessment. Additional points for pain/ deformity/ loss of sensation to be added as per assessment guidelines of RPwD Act 2016.

19. **Defective Vision.**

The documentation and assessment of visual impairment is to be done as per the current national guidelines for RPwD Act of 2016.

1. Definition of visual impairment

(a) "Blindness" means a condition where a person has any of the following conditions, after best correction—

(i) Total absence of sight; or
(ii) Visual acuity less than 3/60 or less than 10/200 (Snellen) in the better eye with best possible correction or
(iii) Limitation of the field of vision subtending an angle of less than 10 degree.

(b) "Low-vision" means a condition where a person has any of the following conditions, namely: —

(i) Visual acuity not exceeding 6/18 or less than 20/60 up to 3/60 or up to 10/200 (Snellen) in the better eye with best possible corrections; or
(ii) Limitation of the field of vision subtending an angle of less than 40 degree up to 10 degrees

The documentation of best corrected visual acuity using glasses/ contact lenses should be ensured. In cases of poor/low vision, the examination should carefully document visual acuity as Hand movements/ Finger counting/ Light perception using recommended examination techniques. The field of vision should be additionally evaluated since certain diseases like Glaucoma are associated with visual field damage even with a good central visual acuity.

The assessment of visual impairment (based on best corrected visual acuity in each eye and the binocular field of vision) is as under.

Matrix for Assessment of Visual Impairment

Left Eye (Best corrected visual glasses) BCVA

		6/6 to 6/18	6/24	6/36	6/60	3/60	2/60	1/60	HMCF to PL negative
Right Eye (Best corrected visual glasses) BCVA	6/6 to 6/18	0%	10%	10%	10%	20%	30%	30%	30%

	6/24	10%	40%	40%	40%	50%	60%	60%	60%
	6/36	10%	40%	40%	40%	50%	60%	60%	60%
	6/60	10%	40%	40%	40%	50%	60%	60%	60%
	3/60	20%	50%	50%	50%	70%	80%	80%	80%
	2/60	30%	60%	60%	60%	80%	90%	90%	90%
	1/60	30%	60%	60%	60%	80%	90%	90%	90%
	HMCF to PL negative	30%	60%	60%	60%	80%	90%	90%	100%

Field of Vision around centre of fixation

Left eye		<40° to 20°	<20° to 10°	<10°
Right eye	<40° to 20°	40%	50%	60%
	<20° to 10°	50%	70%	80%
	<10°	60%	80%	100%

20. **Assessment of Hearing Loss**.

As per the current national guidelines for RPwD act of 2016
Definition of hearing loss

(a) "Deaf" means person having 70dB hearing loss in speech frequencies in both ears.

(b) "Hard of hearing" means person having 60dB to 70dB hearing loss in speech frequencies in both ears.

Guidelines for Assessment : Measurement Air Conduction Thresholds(ACT):

(a) ACT is to be measured using standard Pure Tone Audiometry by an Audiologist for Right Ear and Left Ear separately.

(b) In case of non-reliable ACT, addl tests recommended are Immittance and Speech audiometry or Auditory Brain stem Response (ABR) Testing.

Computation of Percentage of Hearing Impairment:

Monaural Percentage of Hearing Impairment

(i) Calculate Pure tone average of ACT for 500 Hz, 1000 Hz, 2000Hz, 4000Hz for Right Ear and Left ear separately (when ever there is no response at any frequency ACT is to be considered as 95dB).

(ii) Monaural percentage of hearing impairment is to be calculated as per the ready reckoner given below separately for Right Ear and Left Ear.

Monaural PTA in dB	% of Impairment	Monaural PTA in dB	% of Impairment
0 to 25	0	61	41.71
26	1	62	43.42
27	1	63	45.13
28	1	64	46.84
29	1	65	48.55
30	1	66	50.26
31	1	67	51.97
32	1	68	53.68
33	1	69	55.39
34	2	70	57.1
35	3	71	58.81
36	4	72	60.52
37	5	73	62.23
38	6	74	63.94
39	7	75	65.65
40	8	76	67.36
41	9	77	69.07
42	10	78	70.78
43	11	79	72.49
44	12	80	74.2
45	13	8	75.91
46	14	82	77.62
47	15	83	79.33
48	16	84	81.04
49	17	85	82.75
50	18	86	84.46
51	19	87	86.17
52	20	88	87.88
53	21	89	89.59
54	22		

55	23	90	91.3
56	24	91	93.01
57	25	92	94.72
58	26	93	96.43
59	27	94	98.14
60	40	95	100

Percentage of Hearing Impairment

Percentage of Hearing Impairment =

(Better ear % of hearing impairment X 5)+(Poorer ear % of hearing impairment)

6

Assessment for Other ENT Conditions

(a) **Laryngo-Tracheal Disorders & Vocal Cord Palsy**

Impairment to be calculated as per "The Gazette of India, Extraordinary, Part 2, Section 3, sub-section (ii), RPwD act 2016 dt 05 Jan 2018."

The verbal output of person should be evaluated using either Perceptual Speech intelligibility rating scale (AYJNISHD, 2022) and percentage of Speech Intelligibility Affected (SIA) to be measured based on score as given below:

(i) Voice Test

(ii) Consensus Auditory Perceptual Evaluation of Voice (CAPE-V) or Dysphonia Severity Index (DSI) can be

Score	Percentage of Speech Intelligibility Affected **(SIA) %**
1	0-15
2	16-30
3	31-39
4	40-55
5	56-75
6	76-89
7	90-100

(iii) used for measuring percentage of Overall Voice Clarity Affected**(OVCA)** which includes roughness, breathiness, strain, pitch and loudness. Average score to be given weighted for the percentage of overall voice clarity affected

Score	Percentage of overall voice clarity affected **(OVCA)**
1	0-15
2	16-30
3	31-39
4	40-55
5	56-75

6	76-89
7	90-100

(iv) **Percentage of Speech Impairment=**

$$2 \times \frac{\text{Upper range of percentage of SIA+ Upper range of percentage of OVCA}}{3}$$

(b) **Assessment in Chronic Otitis Media**

Impairment will be assessed as per the functional hearing loss.

(c) **Assessment of Rhinitis**

If there is associated bronchial asthma, then impairment to be assessed as for bronchial asthama.

(d) **Assessment of Sinusitis**

Rhinosinusitis with nasal polyps leading to anosmia bilateral - 20%

Invasive fungal sinusitis beyond sinuses- As per the assessment of anatomical system involved.

(e) **Assessment of Vertigo**

Compensated peripheral vestibular dysfunction will be assessed not to have any reckonable impairment. In uncompensated situations, assessment of impairment will be done as per neurological deficit in balance function.

21. **DISEASES OF CIRCULATORY SYSTEM**.

Assessment of the degree of disablement in cardiovascular diseases should be broad based and should take into account the functional status, left ventricular function, the cardiac rhythm, objective assessment of ischaemia (morphological characteristics as assessed by echo cardiographic/ angiographic evaluation and treatment modality offered.

(a) **Assessment for Valvular Heart Disease**.

Valvular Heart Disease should be assessed in a composite manner on the basis of functional status, left ventricular function, the cardiac rhythm, objective assessment of morphological characteristics of valves as evaluated by echocardiography and treatment modality offered.

The total impairment will be a combination of impairment assessed due to reduced exercise tolerance in METS or as per cardiac failure assessment and due to other impairment specifically due to valvular heart disease.

Step 1

Assess the exercise capacity as per the METS table (Table 5), calculate the impairment as per the table for the age and sex (Table 6 and Table 7).

Step 2

If the assessment exercise capacity can't be done due to limitation of activity or there are features of cardiac functional impairment as per imaging assessment,the individual can be assessed based on the table on cardiac failure.(Table 1)

Step 3
Assess the impairment specific to valvular heart disease as per Table 4.

Step 4
Total impairment due to valvular heart disease will be obtained by adding impairment from step 3 to the higher impairment value between step 1 or step 2

Table 1

Heart Failure Assessment Table	
Impairment %	**Criteria**
05	No symptoms
20	EF 35-50% despite therapy for HFrEF and Grade II diastolic dysfunction for HFpEF, Moderate LVH with symptoms
30	EF <35% despite therapy for HFrEF and ≥ Grade III diastolic dysfunction for HFpEF, Marked LVH with symptoms or Refractory /Resistant to drugs, LVAD, MCS, on ICD or CRT device based therapy.

Table 2

Valvular Heart Disease Impairment Table	
Impairment %	**Criteria**
Nil	Asymptomatic Mitral valve prolapse or Aortic sclerosis, bicuspid aortic valve
05	Asymptomatic Valvular heart disease other than above
10	Asymptomatic Valvular heart disease with history of successful valve replacement, repair, valvotomy, not requiring anticoagulation, without evidence of heart failure
15	Asymptomatic Valvular heart disease with history of successful valve replacement, repair, valvotomy, requiring anticoagulation, without evidence of heart failure

(b) **Cardiomyopathy**

Assessment in cardiomyopathies will be as below:

The total impairment will be the higher of impairment assessed due to reduced exercise tolerance in METS as per table or due to cardiac failure table as per the table above.

Step 1
Assess the exercise capacity as per the METS table (Table 5), calculate the impairment as per the table for the age and sex (Tables 6 &7).

Step 2

If the assessment exercise capacity can't be done due to limitation of activity or there are features of cardiac functional impairment as per imaging assessment the individual can be assessed based on the table on cardiac failure (Table 1).

Step 3
Total impairment due to cardiomyopathy will be obtained by selecting one value from either step 1 or step 2 (whichever is higher).

(c) **Assessment of Rhythm and Conduction Disorders**

The total impairment will be a combination of impairment assessed due to reduced exercise tolerance in METS as per table or cardiac failure as per table above (whichever is higher) and due to other impairment specifically due to cardiac arrythmia as shown in the table below:

Step 1
Assess the exercise capacity as per the METS table (Table 5), calculate the impairment as per the table for the age and sex (Table 6 &7).

Step 2
If the assessment exercise capacity can't be done due to limitation of activity or there are features of cardiac functional impairment as per imaging assessment the individual can be assessed based on the table on cardiac failure (Table 1).

Step 3
Assess the impairment specific to cardiac arrythmia as per the table given below.

Step 4
Total impairment due to cardiac arrythmia will be obtained by adding impairment from step 3 to the higher impairment between step 1 or step 2

Table 3

Cardiac Arrythmia Assessment Table	
Impairment	Criteria
05%	Asymptomatic arrythmia/ asymptomatic post RFA or medication
15%	Symptomatic arrythmia/Need for pacemaker/Device
20%	Symptomatic arrythmia with LV dysfunction

(d) **Assessment for CAD**

The total impairment will be a combination of impairment assessed due to reduced exercise tolerance in METS as per the chart or due to cardiac failure table as per the table above (whichever is higher) and due to other impairment due to CAD as shown in the table below.

Step 1
Assess the exercise capacity as per the METS table (Table 5), calculate the impairment as per the table for the age and sex(Tables 6 &7).
Step 2

Table 4

Impairment in CAD	
Impairment%	Criteria
10	CAD – Chronic Stable Angina, Uncomplicated Acute Myocardial Infarction, Single Vessel Disease, Post successful Intervention/surgery
15	CAD- Multi Vessel Disease (not successfully corrected)
20	CAD-recurrent MI/ angina
	CAD- Left Main involvement not fully corrected
	CAD-Post intervention/surgery with recurrent angina/MI/Heart failure/LV dysfunction

(e) **Primary Hypertension**

(i) Uncomplicated Hypertension Impairment- 05%

(ii) Hypertension with Target Organ Damage (Hypertensive Heart Disease with moderate to severe LVH, Heart Failure, Great Vessel Disease-Aneurysm/ Dissection, Cerebro Vascular Disease, more than grade 2 retinopathy, Chronic Kidney Disease, etc) or multiple drugs with significant side effects, Refractory/resistant hypertension- Impairment :20%

They will be also assessed for impairment due to specific target organ damage separately for depending on the target organ affected.

For example, in case of Hypertensive target organ damage to heart (Hypertensive Heart Disease)

Step 1
Assessment due to Hypertensive target organ damage- 15%
Step 2
Assess the exercise capacity as per METS table (Table 5). Calculate the impairment as per the table for the age and sex (Tables 6&7).

Step 3
If the assessment of exercise capacity can't be done due to limitation of activity or there are features of cardiac functional impairment as per imaging assessment, the individual can be assessed based on the table on cardiac failure (Table 1).

Step 4
Total impairment due to Hypertension can be calculated by adding step1 to either step 2 or step 3 (whichever is higher).

Table 5

ACTIVITY LEVELS IN METS		
LEVEL	TYPE OF ACTIVITY	EXAMPLES

1-2 METS	Energy expended at rest/minimal activity	Sitting, Standing, Strolling, Clerical work
2-3 METS	Energy expended in household activities	Light household activities, Dressing, Washing, Walking at 3.5 km/h, Playing golf using a cart
3-4 METS	Energy expended in walking at average pace	Walking 5 km/h, table tennis, cycling 10 km/h, light stretching, yoga, volley ball
4-5 METS	Moderate exertion with strenuous activities excluding manual labor and vigorous exertion	Gentle Swimming, Golf (carrying club), Gardening
5-6 METS	Heavy exercise, manual labor/vigorous exertion	Brisk walking (6.5 km/h), Slowly Climbing upstairs, Swimming laps, Carpentry
6-7 METS	Heavy exertion	Playing badminton (competitive), Weight lifting (vigorous), Digging trenches
7-8 METS	Very heavy exertion	Jogging 8 km/h, Carry heavy objects on level ground (30 kg)
8-9 METS	Very heavy exertion	Running 9 km/h, Squash (non-competitive), Skipping rope, Basketball, Calisthenics (heavy)
+ 10 METS	Extreme exertion	BPET, PPT, Running quickly(10 km/h), Cycling 25km/h, Carrying load 10 kguphill, Football, Tennis

Table 6

Age	Symptomatic Activity Level Males (METs*)									Age	Symptomatic Activity Level Males (METs*)								
less Than	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+		1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+
25	90	80	70	60	50	40	30	20	10	55	80	70	55	40	25	15	10		
25	90	80	70	60	50	40	30	20	10	56	80	70	54	39	24	15	9		
26	90	80	70	60	50	40	30	20	10	57	80	69	53	38	23	14	8		
27	89	80	70	59	48	38	28	19	10	58	80	69	52	37	22	14	7		
28	89	80	70	59	47	37	27	19	10	59	80	68	51	36	21	13	6		
29	88	80	70	58	46	36	26	18	10	60	80	68	50	35	20	12	5		
30	88	80	70	58	45	35	25	18	10	61	80	67	49	34	19	12	4		
31	87	80	70	57	44	34	24	17	10	62	80	67	48	33	18	11	3		
32	87	80	70	57	43	33	23	17	10	63	80	66	47	32	17	11	2		
33	86	80	70	56	42	32	22	16	10	64	80	66	46	31	16	10			
34	86	80	70	56	41	31	21	16	10	65	80	65	45	30	15	9			

35	85	80	70	55	40	30	20	15	10	66	80	64	44	29	14	8			
36	85	80	70	55	39	29	20	15	9	67	79	63	43	28	14	7			
37	85	69	69	54	38	28	19	14	8	68	79	62	42	27	13	6			
38	85	69	69	54	37	27	19	14	7	69	78	61	41	26	13	5			
39	85	68	68	53	36	26	18	13	6	70	78	60	40	25	12	4			
40	85	68	68	53	35	25	18	13	5	71	77	59	39	24	12	3			
41	85	67	67	52	34	24	17	12	4	72	77	58	38	23	11	2			
42	85	67	67	52	33	23	17	12	3	73	76	57	37	22	11	1			
43	85	66	66	51	32	22	16	11	2	74	76	56	36	21	10				
44	85	66	66	51	31	21	16	11		75	75	55	35	20	9				
45	85	65	65	50	30	20	15	0		76	75	55	35	19	8				
46	85	64	64	49	30	20	15	9		77	75	54	34	18	7				
47	84	62	63	48	29	19	14	8		78	75	54	34	17	6				
48	84	62	62	47	29	19	14	7		79	75	53	33	16	5				
49	83	61	61	46	28	18	13	6		80	75	53	33	15	4				
50	83	60	60	45	28	18	13	5		81	75	52	32	14	3				
51	82	59	59	44	27	17	12	4		82	75	52	32	13	2				
52	82	58	58	43	27	17	12	3		83	75	51	31	12	1				
53	81	57	57	42	26	16	11	2		84	75	51	31	11					
54	81	56	56	41	26	16	11			85	75	50	30	10					
									above	85	75	50	30	10					

Table 7

	Symptomatic Activity Level Females (METs*)									Age	Symptomatic Activity Level Females (METs*)								
less Than	---	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+	---	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+

25	90	80	70	55	40	30	20	15	10	55	80	65	50	30	20	15	10		
25	90	80	70	55	40	30	20	15	10	56	80	65	49	29	20	15	09		
26	90	80	69	54	40	30	20	15	10	57	80	64	48	28	19	14	08		
27	89	79	68	53	39	29	20	15	10	58	80	64	47	27	19	14	07		
28	89	79	67	52	39	29	20	15	10	59	80	63	46	26	18	13	06		
29	88	78	66	51	38	28	20	15	10	60	80	63	45	25	18	13	05		
30	88	78	65	50	38	28	20	15	10	61	80	62	44	24	17	12	04		
31	84	77	64	49	37	27	20	15	10	62	80	62	43	23	17	12	03		
32	87	77	63	48	37	27	20	15	10	63	80	61	42	22	16	11	02		
33	86	76	62	47	36	26	20	15	10	64	80	61	41	21	16	11			
34	86	76	61	46	36	26	20	15	10	65	80	60	40	20	15	10			
35	85	75	60	45	35	25	20	15	10	66	80	59	39	20	15	9			
36	85	75	60	45	34	25	20	15	9	67	79	58	38	19	14	8			
37	85	75	60	44	33	24	19	14	8	68	79	57	37	19	14	7			
38	85	75	60	44	32	24	19	14	7	69	78	56	36	18	13	6			
less Than		2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+		1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+
39	85	75	60	43	31	23	18	13	6	70	78	55	35	18	13	5			
40	85	75	60	42	30	23	18	13	5	71	77	54	34	17	12	4			
41	85	75	60	42	29	22	17	12	4	72	77	53	33	17	12	3			
42	85	75	60	41	28	22	17	12	3	73	76	52	32	16	11	2			
43	85	75	60	41	27	21	16	11	2	74	76	51	31	16	11	1			
44	85	75	60	40	26	21	16	11		75	75	50	30	15	10				
45	85	75	60	39	25	20	15	10		76	75	49	29	15	9				
46	85	74	59	38	25	20	15	9		77	75	48	28	14	8				

47	84	73	58	37	24	19	14	8		78	75	47	27	14	7					
48	84	72	57	36	24	19	14	7		79	75	46	26	13	6					
49	83	71	56	35	23	18	13	6		80	75	45	25	13	5					
50	83	70	55	34	23	18	13	5		81	75	44	24	12	4					
51	82	69	54	33	22	17	12	4		82	75	43	23	12	3					
52	82	68	53	32	22	17	12	3		83	75	42	22	11	2					
53	81	67	52	31	21	16	11	2		84	75	41	21	11	1					
54	81	66	51	31	21	16	11			85	75	40	20	10						
									above	85	75	40	20	10						

22. **Diseases of the Digestive System**.

(a) **Peptic Ulcer**

Peptic ulcers are defects in the gastric or duodenal mucosa that extends through the muscular is mucosa. Natural history of peptic ulcer range from healing without intervention to the development of complications with the potential for significant morbidity and mortality

The assessment of peptic ulcer is as under:

5 %- Peptic ulcer: with intermittent symptoms necessitating ongoing maintenance treatment.

10% -Peptic ulcer: proven endoscopically: active disease with complications and troublesome daily symptoms or bleeding or outlet obstruction or progressing to carcinoma stomach.

(b) **Inflammatory Bowel Disease**

Montreal classification of extent of ulcerative colitis (UC)

Extent	Anatomy
E1	Ulcerative proctitis Involvement limited to the rectum (that is, proximal extent of inflammation is distal to the rectosigmoid junction)
E2	Left sided UC (distal UC) Involvement limited to a proportion of the colorectum distal to the splenic flexure
E3	Extensive UC (pancolitis) Involvement extends proximal to the splenic flexure

Montreal classification of severity of ulcerative colitis (UC)

Severity	Definition
S0	Clinical remission / Asymptomatic
S1	Mild UC Passage of four or fewer stools/day (with or without blood), absence of any systemic illness, and normal inflammatory markers (ESR/CRP).
S2	Moderate UCPassage of more than four stools per day but with minimal signs of systemic toxicity.
S3	Severe UC Passage of at least six bloody stools daily, pulse rate of at least 90 beats per minute, temperature of at least 37.5°C, haemoglobin of less than 10.5 g/100 ml, and ESR of at least 30 mm/h

Vienna and Montreal Classification for Crohn's disease

	Vienna	Montreal
Age at diagnosis	A1 below 40 y	A1 below 16 y
	A2 above 40 y	A2 between 17 and 40 y
	A3 above 40 y	
Location		
	L1 ileal	L1 ileal
	L2 colonic	L2 colonic
	L3 ileocolonic	L3 ileocolonic
	L4 upper	L4 isolated upper disease*
Behaviour		
	B1 non-structuring, non-penetrating	B1 non-structuring, non-penetrating
	B2 structuring	B2 structuring
	B3 penetrating	B3 penetrating
	p perianal disease modifier†	

Assessment is based on clinical, and endoscopic profile of patient

IBD only with mild –moderate disease- 10%

IBD with mild to moderate disease with greater than 04 episodes/year or 02 hospital admissions per year for treatment-20 %

IBD with severe disease and or extra intestinal complication

Or Post operative status, fistulising, stricturing disease- 30-40 %

(c) **Hernia (operated)**- Nil

Incisional Hernia (Not amenable to repair) - 20%

Hemorrhoids – Nil

Inoperable Fissure – 05%

Persistent Fistula – 10%

(d) **Assessment of miscellaneous conditions of gut**

Colonic diverticulitis 10%
Tropical Sprue
Enteropathy

(e) **Pancreas**

Impairment %	Criteria
10%	Acute pancreatitis (local complication or organ failure).
15%	Severe pancreatitis (persistent organ failure of one or more organ) or Chronic pancreatitis with ongoing intermittent attacks of abdominal pain and/or steatorrhea.
20 %	Chronic pancreatitis with persistent abdominal pain and steatorrhea, requiring two or more admissions to hospital within the past year.

(f) **Assessment liver diseases** (other than alcohol and life style related NASH)

Impairment	
05%	HCV Treated
05%	HBV Carrier state
10 %	Chronic persistent hepatitis (Infective, autoimmune, drug induced).Signs of chronic liver disease, but no evidence of portal hypertension.
20 %	Cirrhosis with evidence of portal hypertension/ HCC.
30 %	Decompensated Cirrhosis/ Acute liver failure

23. **Assessment of AIDS**.

Assessment of Longevity:

(a) Asymptomatic HIV Infection: Since transition to AIDS may not occur even up to 10 – 15 years, such cases on release can be recommended for full commutation of pension.

(b) AIDS. With the advances in highly active retroviral therapy and treatment of opportunistic infections, these cases are known to survive for long periods. The assessment should be based on the clinical profile of the case and consensus of medical opinion. Loading of age for 01 – 02 years at RMB is considered appropriate in such cases.

Assessment of Degree of Impairment on Invalidment and Release:

(a) Asymptomatic HIV infection - As per Medical Boards recommendation
(b) Manifest AIDS defining illness - 100%
(c) On release (RMB) - Actual percentage

24. **Assessment of Pulmonary Diseases**.

Respiratory impairment refers to an alteration in lung structure and/or lung function that results in decreased or limited functional ability and is usually manifested by dyspnoea on exertion. Many respiratory diseases may cause impairment, from airway disease such as asthma and chronic obstructive pulmonary disease (COPD) to interstitial lung diseases. The degree of impairment can be objectively assessed at most centres by:

(a) Spirometry

(b) Single breath diffusing capacity

1. **Obstructive diseases (Only by spirometry)**

Percentage of FEV1 (to predicted) Assessment

>80% of predicted value	05%
70-79%	10%
50-69%	20%
31-49%	30%
<30 %	50%
Cor pulmonale requiring continuous O2	80%

2. **Restrictive Diseases (Spirometry, DLCO or oxygenation– Whichever is low)**

Percentage of FVC (to predicted)	Assessment
≥80% of predicted value	05%

60-79%	10%
50-59%	20%
36-49 %	30%
≤35%	50%
Supplemental domiciliary oxygen, Cor Pulmonale	80%

3. **Percentage of DLCO-SB (to predicted) Assessment**

≥75% of predicted value.	05%
60-74%	10%
41-59%	20%
≤40 %	30%
Supplemental domiciliary oxygen, Cor Pulmonale	100%

25. **Assessment – Pulmonary Tuberculosis**.

Pulmonary Tuberculosis will be assessed as per following:

(a) Restrictive sequalae after treatment – Assessment a per restrictive lung disease

(b) Obstructive sequelae after treatment- Assessment as per obstructive lung disease.

(c) Degree of disablement will be regarded as 100% for 2 years if the patient is regarded as incapable of improvement and is invalidated out of service.

(d) Active Pulmonary Tuberculosis on regular discharge from service while on treatment and is capable of improvement will be assessed at 60% for two years.

(e) Active Pulmonary Tuberculosis on regular discharge and is doubtful of improvement (drug resistant cases) will be assessed at 100 percent for 2 years. If on the other hand, the Reassessment Medical Board finds that there has been an improvement subsequently they will classify the impairment as capable of improvement, and the degree of disablement will be assessed as in (d) above.

26. **Assessment of COPD**.

Assessed as per Chapter VII, Para 54.

27. **Assessment of Asthma**.

Stable asthma- As per obstructive lung diseases chapter VII, Para 24

28. **Assessment of Bronchiectasis**.

Assessed as per restrictive lung diseases as per chapter VII, Para 24

29. **Assessment of Mental Behavioural (Psychiatric) Disorders**.

Functional impairment assessment component is adapted from IDEAS Scale of RPwD Act of 2016.

Assessment of Total Score is based on following domains -

1) Self Care
2) Interpersonal Activities (Social Relationships)
3) Communication and Understanding
4) Work

Scores for each of domains will be calculated as per severity

0 - No impairment (none, absent, negligent)
1- mild impairment (slight, low)
2- moderate impairment (medium, fair)
3- severe impairment (high, extreme)
4- profound impairment(totally cannot do)

Add scores of 4 items to obtain – Total Score

0 No Impairment = 0%
1-6 Mild Impairment = < 40 %
7-13 Moderate Impairment = 40 - 70 %
14-19 Severe Impairment = 71-99%
20 Profound Impairment = l00%

Adapted IDEA Score	Impairment % (Rounded off to multiples of 05 & 10)
0	0
1& 2	5
3&4	10
5	20
6	30
7-9	40 -50
10 - 13	55 -75
14-19	76-99
20	100

30. **Assessment of Skin Diseases**.

(a) **Leprosy**. Assessment of locomotor impairment:

Assessment of functional impairment to be based upon assessment guidelines RPwD Act of 2016 for Locomotor impairment.

Extra points in cases of:

i. Amputation on account of leprosy shall be assessed vide RPwD guidelines

Amputation through Proximal phalanx or Disarticulation through MP joint of	% assessment
Index finger	15
Middle finger	5
Ring finger	3
Little finger	2
Amputation through Middle phalanx or Disarticulation through PIP joint of	
Index finger	10
Middle finger	4
Ring finger	2
Little finger	1
Amputation through Distal phalanx or disarticulation through DIP joint of	
Index finger	5
Middle finger	2
Ring finger	1
Little finger	1

ii. Trophic ulceration:

Recurrent trophic ulceration of hands and / feet	Assessment will be as per the functional impairment of locomotor component as RPwD Act of 2016 as para 35 (viii)

iii. Face involvement

Face involvement with deformity of nose/ ear	Assessment as per Para 41 for superficial burns.

(b) **Corns, Callosities, and Warts** based on the functional impairment of locomotor component as per RPwD Act of 2016.

(c) **Eczema/ Dermatitis/ Psoriasis**. The assessment to be done during remission of the disease after treatment.

(i) Assessment based on superficial skin surface involvementas per RPwD Act of 2016 for burns as per Para 41.

(ii) Extra-cutaneous involvement- based on the functional impairment of the organ system involved. For involvement of palms, soles and joints, functional impairment of locomotor component as per RPwD Act of 2016.

31. **Assessment of Bone and Specific Injuries**.

Impairment of the functional status as per RPWD Act of 2016 for locomotor disablement.

Any improvement due to skilled orthopaedic treatment or Joint replacement surgeries will call for corresponding reduction in assessment.

In cases where joint replacement has been undertaken:

Initial impairment of 100% up to one year after Arthroplasty.

32. **Assessment of Spinal Deformity**.

Vertebral Fractures (per vertebra)

Compression fracture with loss of height < 25 % 05 %

Compression fracture with loss of height 25 – 50 % 10 %

Compression fracture with loss of height > 50 % 20 %

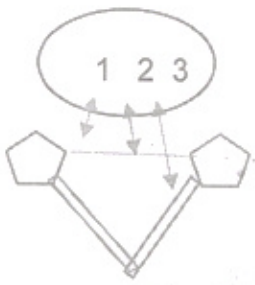
Followed by 50% for two years and 10% per joint for life.

Burst fractures/unstable fractures 30 %

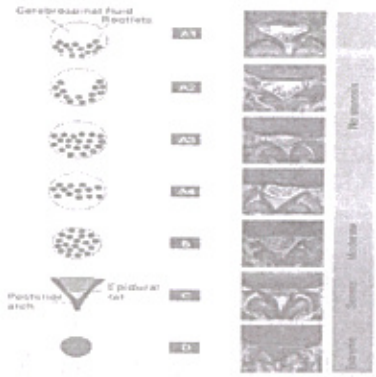
33. **Assessment of Neck Pain & Backache**

(a) Back Ache/Neck Pain without any neurological deficit 05%

(b) Disc prolapse per level



Interlaminar line



Cervical	**Lumbar**
Size 1	01 %
Size 2	05 %
Size 3	20 %

(c) Canal Stenosis per level

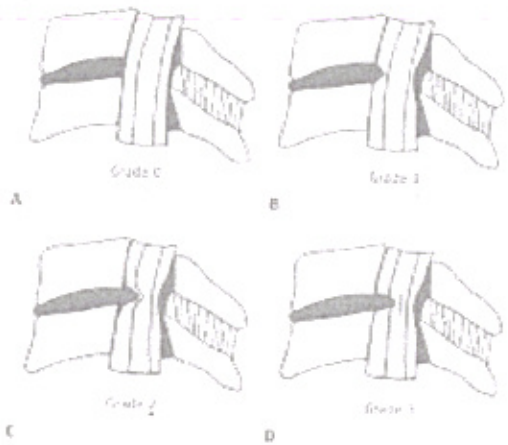
< 25 %	(Grade I / B)	01 %
25 – 75 %	(Grade II / C)	05 %
> 75 %	(Grade III / D)	20 %

- For multiple levels (b & c) of either (i) or (ii) above, the values are added numerically.
- If (i) & (ii) are both present, the condition with higher value is considered alone.

(d) With neurological deficit

(i) For each nerve root involvement

(aa)	Sensory only	05 %
(ab)	Motor Gd 4/5	05 %
(ac)	Motor Gd 1-3/5	20 %
(ad)	Motor Gd 0/5	30 %



(ii) Foot drop/wrist drop 30 %

(iii) Cauda Equina Syndrome (with bladder/bowel involvement) 50 %

(Only the most impaired parameter of (d) to be used for assessment of percentage of impairment.)

34. **Assessment for Knee injuries**.

Impairment as per the functional status as per RPwD Act of 2016 for locomotor disablement.

35. **Assessment of neurological disorders**.

(a) Assessment in neurological conditions is not the assessment of disease but the assessment of its effects, i.e. clinical manifestations.

(b) Total percentage of physical impairment in any neurological condition shall not exceed 100%.

(c) In mixed cases the highest score will be taken into consideration. The lower score will be added to it by the help of combining formula: a+b(90-a)/90.

(d) Additional 10% will be given for involvement of dominant upper extremity.

(e) Additional weightage up to 10% can be given for loss of sensation in each extremity but the total physical impairment should not exceed 100%.

(i) **Stroke**

Stroke leads to multiple levels of neural axis being involved and contributing to impairment- ranging from speech/language, cranial nerve, motor, sensory, cerebellar dysfunction. The total functional impairment is assessed as per RPwD Act of 2016.

The **modified Rankin Scale (mRS)** is a commonly used scale for measuring the degree of impairment or dependence in the daily activities of people who have suffered a stroke or other causes of neurological impairment. The scale runs from 0-6, running from perfect health without symptoms to death. The scale has been adapted from it.

Score	Degree of impairment (Adapted from mRS scale)	% PPI
0	No symptoms.	Nil
1	No significant impairment. Able to carry out all usual activities, despite some symptoms.	5-10%
2	Mild impairment. Able to look after own affairs without assistance, but unable to carry out all previous activities.	10-20%
3	Moderate impairment Requires some help, but able to walk unassisted.	21-40%
4	Moderately severe impairment. Unable to attend to own bodily needs without assistance, and unable to walk unassisted.	41-70%
5	Severe impairment. Requires constant nursing care and attention, bedridden, incontinent.	71-100%

Apart from the adapted mRS which chiefly reflects the impairment due to motor functions, addl impairment caused due to certain disabling deficits like visual or sectoral losses, aphasia or dysarthria etc may be calculated from the relevant sections given below or in GMO and a composite impairment be arrived at (not exceeding 100%).

(ii) **Other Neurological Impairment**

The impairment caused due to chronic neurological conditions such as multiple sclerosis, parkinsonism, spinocerebellar ataxias, dementias is multi-dimensional involving manifestation in muscular skeleton system and also psycho-social behaviour. The impairment. in Musculo-skeletal system on account of these conditions shall be assessed in terms of guidelines relating to assessment of locomotor impairment due to chronic neurological conditions. Comprehensive impairment on account of these conditions shall then be calculated by using the formula:

a + b (90-a)/90.

Cognitive dysfunction- Dementia of various etiologies are assessed for cognitive dysfunction. These will be utilized for only the cognitive assessment. Any other associated speech, language motor or sensory dysfunction will be calculated as the appropriate section on these and the composite impairment decided by the formula :
a +b(90-a)/90

Grade	Criteria	% Impairment
Nil	Negligible impairment: reasoning is comparable with that of peers. Memory similar to that of peers: written notes, etc., used in the manner of busy people of all ages.	Nil
Mild	Mild impairment: appropriate use is made of accumulated knowledge and reasonable judgement is shown in routine daily activities most of the time. Difficulties are apparent in new circumstances. Mild but demonstrable impairment of memory: misplaces objects, and has increased difficulty in remembering names and appointments. Can learn, although at a slower rate than previously. Impairment has little impact on everyday activity because of compensation through reliance on written notes, schedules, checklists and spouse.	10
Moderate	Moderate impairment of memory: has frequent difficulty in recalling details of recent experiences; frequently misplaces objects; fails to follow through with intentions or obligations; tends to get lost more easily in unfamiliar areas. Compensation through use of aids, eg lists and diaries, is adequate. Moderate impairment of problem solving ability, relies on accumulated knowledge. Suffers significant disadvantage in circumstances requiring complex decision-making or non-routine activities, i.e. when past decision-making is not directly relevant. Has reduced initiative, spontaneity, and capacity for abstract thinking.	30
Severe	Symptoms as above, but more frequent and severe. Is partially able to compensate, but unable to function with complete independence, and needs some supervision.	60
Very Severe – incapacitating	Severe impairment: has difficulty in carrying out basic activities such as sequencing the steps needed for dressing and for preparing meals. Planning/organisational ability is reduced. Is unable to	70

	function independently in new or complex situations. Shows markedly reduced initiative and spontaneity, and perseverative thinking. Severe memory deficiency: is unable to retain any information about recent experiences. New learning is not possible after attention has been directed elsewhere. Is unable to work or live independently, needing supervision to avoid harm, eg from fire caused by forgetting to put out cigarettes or to turn off appliances. Has extreme difficulty in keeping track of finances, scheduled activities, social relationships, etc.	

(iii) **Speech, Language, Articulation**.

(aa) **Speech and articulation**. These are of various types and may impairment is to be calculated as per the assessment of the spoken speech regarding its clarity and comprehension by the medical officer. Speech impairment can be assessed as follows

No	Criterion	% Impairment
1.	Normal or nearly normal	0
2.	Speech is of sufficient intensity and vocal quality for most everyday needs, eg: - normal speech, but unable to shout; or - needs to repeat self at times; or - is unable to produce some phonetic units; or - speech is sustained over a 10-minute period, but with difficulty that includes hesitation and word-retrieval problems; or - is permanently hoarse.	10
3.	Speech is of sufficient intensity and vocal quality for many of the needs of everyday speech, eg: - is adequate with low background noise, but is heard with some difficulty in vehicles or public places; or - has many inaccuracies, but is easily understood by strangers; or - is slow or discontinuous, conveying the distinct impression of difficulty. Converses in simple sentences on familiar topics, although word-finding problems are frequent, and has difficulty in explaining long or complex ideas.	20

4.	Speech is of sufficient intensity and vocal quality for some of the needs of everyday speech, eg: - is adequate under quiet conditions, but is heard with great difficulty against any background noise; voice fades rapidly; or - is understood by family and friends, but is difficult for strangers; or - needs frequent repetition; or - speech is sustained for short period only: fatigues rapidly.	30
5.	Speech is of sufficient intensity and vocal quality for only a few of the needs of everyday speech, eg: - is reduced to a whisper at best: inaudible over the telephone; or - can produce only a few phonetic units approximating some words, but these are not intelligible if the context is unknown; or - can produce only short phrases or single words: speech flow is not maintained, or is too slow to be useful. Is unable to initiate conversation, but, with considerable effort, is able to respond in short simple sentences or phrases.	50
6.	Has no speech production, but is able to use non-verbal means of expression. Is limited to single words or familiar social or stereotyped phrases requiring considerable listener inference.	70

(ab) **Language Test**

Western Aphasia Battery (WAB) in Indian languages is to be administered post six month of the onset of the stroke and Aphasia Quotient (AQ) is to be calculated as per standard procedure.

(ac) **Percentage of Language Impairment**.

Percentage of language impairment can be computed directly from the ready reckoner given below by intersection of value for Number in Tens place in WAB score and Number in Unit place

in WAB score. For example, if the AQ is 56, intersection of 5 (in column) and 6 (in row) is 40. The Percentage of Language impairment is 40%.

Number in Tens Place in WAB Score	Number in Unit Place in WAB Score									
	0	1	2	3	4	5	6	7	8	9
0	100	98.9	97.8	96.8	95.7	94.6	93.6	92.5	91.4	90.4
1	89.3	88.2	87.2	86.1	85.0	84.0	82.9	81.8	80.8	79.7
2	78.6	77.6	76.5	75.4	74.4	73.3	72.2	71.2	70.1	69.0
3	68.0	66.9	65.8	64.8	63.7	62.6	61.6	60.5	59.4	58.4
4	57.3	56.2	55.2	54.1	53.0	52.0	50.9	49.8	48.8	47.7
5	46.6	45.6	44.5	43.4	42.4	41.3	40.0	39.2	38.1	37.1
6	36.0	34.9	33.9	32.8	31.7	30.7	29.6	28.5	27.5	26.4
7	25.3	24.3	23.2	22.1	21.1	20	18.9	17.9	16.8	15.7
8	14.7	13.6	12.5	11.5	10.4	09.3	8.3	07.2	06.1	05.1
9	4.0	2.9	1.9	0.8	00.0	00.0	00.0	00.0	00.0	00.0

(iv) **Cranial Nerves**

No	Cranial Nerve	Function	% PPI Unilateral	% PPI Bilateral
1	I	Smell	Nil	20%
2	II	Vision	As per para 19	
3	III, IV & VI	Eye Movements	As per diplopia assessment given below	
4	V	Facial sensation	10%	20%
5	VII	Taste, Facial expression, Chewing and Speech	10% for partial, 20 % for full	20% for partial, 40 % for full
6	VIII	Hearing, balance	As per para 20	
7	IX, X and XII	Speech and swallowing	As per para above	
8	XI	Shoulder elevation	10%	20%

(v) **Diplopia and Ocular Field Defects**. Diplopia due to neurological diseases are secondary to involvement of the cranial nerves III, IV and VI at various sites due to various etiologies. Diseases/conditions affecting the optic visual pathway can lead to varying degrees of field defects. The following will be adopted in determining degree of disablement due to these conditions.

No	Criterion or quantification of diplopia	% Impairment
1	Heterotropia with diplopia one quadrant of upward gaze	20

2	Heterotropia without diplopia near vision only	20
3	Heterotropia with diplopia one quadrant of downward gaze	20
4	diplopia all directions of downward gaze	40
5	Heterotropia with diplopia one direction of sideways gaze	20
6	Heterotropia with diplopia all directions of upward gaze	40
7	Heterotropia with diplopia both directions of sideways gaze 15	40
8	Heterotropia with diplopia all range of near vision	40
9	Heterotropia with diplopia all directions of gaze	60
10	Gaze defects vertical due to Supranuclear gaze palsy	40
11	Gaze defects horizontal due to Supranuclear gaze palsy	40
12	Gaze defects vertical and horizontal due to Supranuclear gaze palsy	60

(vi) **Dysphagia**. Dysphagia can arise from mechanical or neurological causes. Functional assessment of impairment can be graded as under:

Grade	Criterion	% Impairment
1	Some difficulty in chewing or swallowing, but only minor or occasional restriction of diet and there is no weight loss.	NIL
2	Significant difficulty in chewing or swallowing, but diet is not grossly restricted and there is no weight loss.	Up to 20
3	Difficulty in chewing or swallowing that limits diet to soft orsemi-solid foods.	30
4	Diet limited to liquid or to pureed food because of difficulty in chewing.or swallowing.	50
5	Unable to swallow or chew and on RT or PEG feeding	60

(vii) **Spasticity**.

Spasticity is an important component of neurological impairment leading to contribution to functional impairment. It should be calculated after drug/anti-spasticity measures have been optimised. It can be quantified based on the modified Ashworth scale as below:

Grade		% PPI
0	No increase in tone	Nil
1	slight increase in tone giving a catch when slight increase in muscle tone, manifested by the limb was moved in flexion or extension.	10
1+	slight increase in muscle tone, manifested by a catch followed by minimal resistance throughout (ROM)	20
2	more marked increase in tone but more marked increased in muscle tone through most limb easily flexed	30
3	considerable increase in tone, passive movement difficult	40
4	limb rigid in flexion or extension	50

(viii) **Locomotor Impairment**

Definition:-"Locomotor impairment" means a person's inability to execute distinctive activities associated with movement of self and objects resulting from affliction of musculoskeletal or nervous system or both.

(A) **Guidelines for Evaluation of Permanent Physical Impairment (PPI) of Extremities Upper Extremities**

(B) **Guidelines for Evaluation of Permanent Physical Impairment (PPI) of Lower Extremities**

(a) The estimation and measurement shall be made when the clinical condition has reached the stage of maximum improvement from the medical treatment.

(b) The upper extremity is divided into two component parts; the arm component and the hand component.

(c) Measurement of the loss of function of arm component consists of measuring the loss of range of motion, muscle strength and co-ordinated activities

(d) Measurement of loss of function of hand component consists of determining the prehension, sensation and strength. For estimation of prehension opposition, lateral pinch, cylindrical grasp, spherical grasp and hook grasp have to be assessed.

(e) The impairment of the entire extremity depends on the combination of the impairments of both components.

(f) Total impairment % will not exceed 100%.

(g) Impairments to be certified as whole number and not as a fraction.

(h) Impairment is to be certified in relation to that upper extremity.

ARM (UPPER EXTREMITY) COMPONENT

Total value of the arm component is 90%

A. **Principles of evaluation of range of motion (ROM) of joints:**

(a) The value of maximum ROM in the arm component is 90%

(b) Appropriate weightage is given to involvement of different joints as mentioned below;

Shoulder = up to 20%,

Elbow = up to 20%,

Wrist = up to 10%, &

Hands = up to 40%, dependent upon extent of involvement (mild – less than 1/3, moderate – up to 2/3, or severe – almost total).

If more than one joint of the upper extremity is involved, the loss of percentage in each joint is calculated separately as above and then added together.

B. **Principles of evaluation of strength of muscles:**

(a) Strength of muscles can be tested by manual method and graded from 0-5 as advocated by Medical Research Council (MRC), London, UK depending upon the strength of the muscles as below:

Numerical Score of Muscle Power	Qualitative Score	Loss of strength in %
0	Zero	100
1	Trace activity	80
2	Poor	60
3	Fair	40
4	Good	10-20%
5	Normal	0

(i) The mean percentage of loss of muscle strength around a joint is multiplied by 0.30.

(ii) If loss of muscle strength involves more than one joint the mean loss of percentage in each joint is calculated separately and then added together as has been described for loss of motion.

C. **Principles of evaluation of coordinated activities:**

(a) The total value for coordinated activities is 90%
(b) Ten different coordinated activities should be tested as given in the **Form A. (Appendix I – assessment proforma for upper extremity).**
(c) Each activity has a value of 9%
(d) Average normal range of different joints for reference is at **Appendix III.**

D. **Combining values for the Arm Component:**

The total value of loss of function of arm component is obtained by combining the value of loss of ROM, muscle strength and coordinated activities, using the combining formula.

a + b (90-a)/90
where a = higher value and b = lower value

HAND COMPONENT:

(a) Total value of hand component is 90%
(b) The functional impairment of hand is expressed as loss of prehension, loss of sensation and loss of strength.

E. **Principles of evaluation of prehension:**

Total value of prehension is 30% It includes:

(a) Opposition - 8%

Tested against

- Index finger - 2%
- Middle finger - 2%
- Ring finger - 2%
- Little finger - 2%

(b) Lateral pinch - 5% - Tested by asking the patient to hold a key between the thumb and lateral side of index finger.

(c) Cylindrical grasp - 6% Tested for

(i) Large object of approx. 4 inches size - 3%

(ii) Small object of 1-2 inch size - 3%

(d) Spherical grasp - 6% Tested for

(i) Large object of approx. 4 inches size - 3%

(ii) Small object of 1-2 inch size - 3%

(e) Hook grasp - 5% -Tested by asking the patient to lift a bag

F. **Principles of evaluation of sensation:**

1. (a) Total value of sensation in hand is 30%.
2. (b) It shall be assessed according to the distribution given below:
   (i) Complete loss of sensation
   - Thumb ray 9%
   - Index finger 6%
   - Middle finger 5%
   - Ring finger 5%
   - Little finger 5%

   (ii) Partial loss of sensation: Assessment should be made according to percentage of loss of sensation in thumb/finger(s).

G. **Principles of evaluation of strength:**

(a) Total value of strength is 30%.

(b) It includes:

(i) Grip strength 20%

(ii) Pinch strength 10%

Strength of hand should be tested with hand dynamo-meter or by clinical method (grip method). 10% weightage to be given to persons with involvement of dominant upper extremity (mostly right upper extremity) due to acquired conditions (diseases/ injuries etc.).

For shortening of upper extremity, addition weightage is as follows:

First 1" - No additional weightage

For each 1" beyond first 1" - 2% additional weightage.

Additional weightage - A total of upto 10% additional weightage can be given to following accompanying factors if they are continuous and persistent despite treatment.

(i) Deformity

In functional position 3%

In non-functional position 6%

(ii) Pain

Severe (grossly interfering with function) 9%

Moderate (interfering with function) 6%

Mild (slightly interfering with function) 3%

(iii) Loss of sensation

Complete Loss 9%

Partial Loss 6%

(iv) Complications

Superficial complications 3%

Deep complications 6%

Total % of PPI will not exceed 100% in any case.

Impairment % is to be certified in relation to that extremity.

Impairment % is to be mentioned as whole number, and not as a fraction.

H. **Combining values of hand component:**

The final value of loss of function of hand component is obtained by summing up values of loss of prehension, sensation and strength.

J. **Combining values for the extremity:**

Values of impairment of arm component and impairment of hand component should be added by using combining formula:

$a + b (90-a)/90$

where a = higher value and b = lower value.

Guidelines for Evaluation of Permanent Physical Impairment in Lower Extremity

The measurement of loss of function in lower extremity is divided into two components, namely, mobility and stability components.

A. **MOBILITY COMPONENT**

Total value of mobility component is 90% which includes range of movement (ROM) and muscle strength.

B. **Principles of Evaluation of Range of Movement:**

(a) The value of maximum range of movement in mobility component is 90%

(b) The appropriate weightage is given to involvement of proximal and middle joints, as follows:

Hip= up to 35%, Knee= up to 35%, Ankle= up to 20%, dependent upon extent of involvement (mild – less than 1/3, moderate – up to 2/3, or severe – almost total).

If more than one joint of the limb is involved the mean loss of ROM in percentage should be calculated in relation to individual joint separately and then added together to calculate the loss of mobility component in relation to that particular limb.

C. **Principle of Evaluation of Muscle Strength:**

The value for maximum muscle strength in the extremity is 90%.

(a) Strength of muscles can be tested by manual method and graded from 0-5 as advocated by Medical Research Council (MRC), London, UK depending upon the strength of the muscles as below:

Numerical Score of Muscle Power	Qualitative Score	Loss of strength in %
0	Zero	100
1	Trace activity	80
2	Poor	60
3	Fair	40
4	Good	10-20%
5	Normal	0

(b) Mean percentage of muscle strength loss around a joint is multiplied by 0.30 to calculate loss in relation to the limb.

(c) If there has been a loss muscle strength involving more than one joint the values are added as has been described for loss of ROM.

D. **Combining values for mobility component:**

The values of loss of ROM and loss of muscle strength should be combined with the help of combining formula: a+b(90-a)/ 90 where a = higher value, b = lower value.

E. **Stability Component:**

(a) Total value of the stability component is 90%

(b) It shall be tested by clinical method as given in **Form B** (Assessment Proforma for lower extremity) in **Appendix II**. There are nine activities, which need to be tested, and each activity has a value of ten per cent (10%). The percentage valued in relation to each activity depends upon the percentage of loss stability in relation to each activity.

F. **Extra Points:**

Extra points (% of impairment) are given for deformities, pain, contractures, loss of sensations and shortening etc. For Shortening (true shortening and not apparent shortening)

First 1/2" Nil

Every 1/2" beyond first 1/2" 4%

Maximum extra points for associated problems such as deformity, pain, contractures etc. to be added are 10% (excluding shortening).

(i) Deformity

In functional position 3%

In non-functional position 6%

(ii) Pain

Severe (grossly interfering with function) 9%

Moderate (interfering with function) 6%

Mild (slightly interfering with function) 3%

(iii) Loss of sensation Complete Loss 9%

Partial Loss 6%

(iv) Complications Superficial complications 3%

Deep complications 6%

Total % of PPI will not exceed 100% in any case.

impairment % is to be certified in relation to that extremity.

Sensory impairment

Extent of Sensory Deficit	% Permanent Physical Impairment(PPI)
Anaesthesia	Up to 10% for each limb
Hypoesthesia	Up to 5 % for each limb
Paraesthesia	Up to 5 % for each limb
Hands/feet sensory loss	Up to 20% for each limb

Bladder impairment due to neurogenic Involvement Bladder Involvement

Extent of Sensory Deficit	% PPI
Mild (Hesitancy/Frequency)	20 %
Moderate (precipitancy)	40%
Severe (occasional but recurrent Incontinence)	60 %
Very Severe (Retention/Total Incontinence	80 %

Ataxia (Sensory or Cerebellar) Severity of Ataxia

Severity of Ataxia	Description of impairment	% of PPI
Mild	Detected on examination, patient not symptomatic	Less than 20
Moderate	Able to walk unsupported with minimal to slight difficulty	21-40
Severe	Able to walk with support of walker, requires aid of another person	41- 60
Very severe	Unable to walk	100

(i) **Paraplegia/Tetraplegia:**

Non-surgical causes of spinal cord disease like transverse myelitis, cord infections, demyelination, tractopathies can result in paraplegia or tetraplegia. The individuals with SC involvement shall be categorized into one of the four main diagnostic categories for the purpose of impairment evaluation and certification:

No	Diagnostic category	% PPI
1	Tetraplegia (or more specifically, bilateral severe extremity function plus the presence of paraplegia	81- 100
2	Paraplegia with sensory, bladder, bowel or erectile dysfunction	61- 80
3	Tractopathies or selective sensory or motor tract involvement or Cauda equine-like syndrome with bowel or bladder impairment such as lumbosacral plexopathies	40- 60
4	Tractopathies or selective sensory or motor tract involvement or Cauda equine-like syndrome Cauda equine syndrome without bladder or bowel or erectile dysfunction	20

(aa) Tetraplegia replaced the term quadriplegia in 1992.

(ab) Terms such as tetraparesis, quadriparesis, paraparesis are to be avoided.

(ac) Additional weightage of upto 20% is given for presence of significant neuropathic pain, spinal deformity, spasticity, contracture, heterotopic ossification, pressure ulcer etc. depending on severity, and added to the permanent physical impairment % computed as above.

(ad) Total impairment % will not exceed 100%.

(ae) Impairment is to be certified as whole number.

(ii) **Movement Disorders**

Parkinsonism- For assessment of Parkinson's disease(PD) the degree of impairment may be calculated from modified Hoehn and Yar scale which grades the degree of functional impairment in case of PD.

Stage	Modified Hoehn and Yahr Scale	% PPI
1	Unilateral involvement only	10
1.5	Unilateral and axial involvement	20
2	Bilateral involvement without impairment of balance	30
2.5	Mild bilateral disease with recovery on pull test	40
3	Mild to moderate bilateral disease; some postural instability; physically independent	50
4	Severe impairment; still able to walk or stand unassisted	75
5	Wheelchair bound or bedridden unless aided	100

(iii) **Dystonia/Abnormal Movements :** The dystonia's form a large group of heterogenous disorders ranging from Generalised to focal dystonia's, may be intermittent or persistent and they may be graded based on the resultant functional limitations caused thereof.

No	Criterion	% Impairment
Nil	Abnormal Movements localised to only a face-hemifacial Spasm, tics , tremors which are not causing any significant functional impairment	10
Mild	Involving only one non-dominant body part leading to mild functional impairment	20
Moderate	Abnormal movement involving multiple body parts/ dominant limb/writer's cramp/oromandibular dystonia/severe tremors etc leading to significant impairment of function like difficulty in speaking/ writing/ holding objects/ buttoning/unbuttoning shirt/tying laces etc	40
Severe	Multiple body parts involved like in Segmental/Generalised dystonia leading to significantimpairment leading to dependence for activities of daily living, significant impairment of walking/standing etc	60

(iv) **Seizures/Epilepsy**

Seizures and epilepsy may cause limitation of employability and reduced quality of life. In case of seizures/epilepsy calculation for impairment is to be done based on seizure frequency as suggested below. The patient should be on optimal therapy and drug compliance should be assured. In case of seizures are secondary to traumatic or underlying structural brain disease the impairment may be incorporated in the disease/condition leading to seizures.

Severity	**Seizure frequency (On AEDs)**	**% Impairment**
Mild	One seizure only	05
Moderate	1-5/month	20
Severe	6-10/month	50
Very severe	>10 /month	90

(v) **Peripheral Nerves**–(not recovered.)

For sensory loss in a dermatome/peripheral nerve the following table may be utilised and the % impairment obtained. Ratings from one Functional Loss table may be combined with ratings from any other table for a different loss of function (like motor functional loss due to nerve/radicular disease). Ratings from Functional Loss tables are not to be combined with ratings from Other Impairment tables for the same condition.

Dermatome or Peripheral Nerve	**Partial/Unilateral / non-dominant limb Loss**	**Total Unilateral / Partial Bilateral/ Dominant limb Loss**	**Total Bilateral Loss**
C2&3 (together)	0	5	10
C6&7 (together)	5	10	20
C8	0	5	10
L5&S1 (together)	0	5	10
S2&3&4 (together)	0	5	10
Hemianaesthesia (central)	15	30	
Greater auricular	0	5	10
Median	5	10	15
Ulnar	0	5	10
Radial	0	0	0
Posterior femoral cutaneous	0	5	10

Sciatic	0	5	10
Common Peroneal	0	5	10
Tibial (medial popliteal)	0	5	10
Pudendal	0	5	10

The functional scoring attached as Appendix IV may be utilised for assessment of functional impairment due to loss of motor function. This grades upper limb into 5 grades and lower limb into 7 grades. Varying from nil to incapacitating grades of severity. The overall scale (out of maximum 12) may be converted to functional impairment in % as given below:

Grade	% Impairment
0	Nil
1-2	10-20%
3-4	21-30%
5-6	31-40%
7-8	41-60%
9-10	61-80%
11-12	81-100%

Appendix I to Para 35

ASSESSMENT PROFORMA FOR UPPER EXTREMITY

Arm component (Total Value 90%)

Arm component	Component	Normal Value (Degrees)	Rt Side	Lt Side	Loss of % Rt side	Loss of % Lt side	Sum of % Loss Rt Lt	Combining value Rt. LT.	% Summary value for component
Range of movement (Active) value 90% Shoulder									
Range of movement (Active) value 90% Elbow									
Range of Movement (Active) Value 90% Wrist									
Muscle Strength Value 90% Shoulder	1. Flexion 2. Extension 3. Rotation - Ext 4. Rotation - Int. 5. Abduction 6. Adduction								
Muscle Strength Value 90% Elbow	1. Flexion 2. Extension 3. Pronation 4. Supination								
Muscle Strength Value 90% Wrist	1. Dorsal Flexion 2. Palmar Flexion 3. Radial Deviation 4. Ulnar deviation								
Coordinated Activities Value 90%	1. Lifting overhead objects remove and placing at the same place 9% 2. Touching nose with end of extremity 9% 3. Eating Indian Style 9% 4. Combing and Plaiting 9% 5. Putting on a shirt/kurta 9% 6. Ablution glass of water 9% 7. Drinking Glass of water 9% 8. Buttoning 9% 9 Tie Nara /Dhoti 9% 10. Writing 9%								

HAND COMPONENT (TOTAL VALUE 90%)

Arm component	Component	Normal Value (Degrees)	Rt Side	Lt Side	Loss of % Rt side	Loss of % Lt side	Sum of % Loss Rt Lt	Combining value Rt. LT.	% Summary value for component
30% prehension 1. Hand Component A. Opposition (8%) B. Lateral Pinch (5%) C. Cylindrical Grasp D. Spherical Grasp E. Hook Grasp									
2. Sensation 30%									
Strength 30%									

Summary value for upper extremity is calculated from component and hand component values.

Add 10% for dominant extremity.

10% Additional weightage to be given to infection, deformity, malalignment, contracture, cosmetic appearance and abnormal mobility.

Appendix II to Para 35

ASSESSMENT PROFORMA FOR LOWER EXTREMITY

MOBILITY COMPONENT (Total Value (90%)

Joint	Component	Normal Value	Rt Side	Lt Side	Loss of % Rt side	Loss of % Lt side	Mean % Rt Lt	Mean Rt Lt	Combining value Rt. LT.	% Summary value of mobility
Range of Movement (Active) HIP										
Range of Movement (Active) Knee										
Range of Movement (Active) Ankle & Foot										
Muscles Strength HIP	1. Flexion 2. Extension 3. Rotation - Ext 4. Rotation - Int. 5. Abduction 6. Adduction									
Muscles Strength KNEE	1. Flexion 2. Extension 3. Pronation 4. Supination									
Muscles Strength ANKLE & FOOT	1. Dorsal Flexion 2. Palmar Flexion 3. Radial Deviation 4. Ulnar deviation									
STABILITY COMPONENT (Total Value 90%) Based on CLINICAL METHOD of Evaluation	1. Standing on both legs 10 2. Standing on affected leg 10 3. Walking on plain surface 10 4. Walking on slope 10 5. Climbing Stairs 10 6. Taking turns 10 7. Squatting on floor 10 8. Kneeling 10 9. Sitting Cross leg 10									

10% is given for complications like (i) Infection (ii) Deformity (iii) Loss of sensation

Appendix III to Para 35

Average Normal Range (degrees) at different Joints:

Joint	Movement	Average Normal Range (degrees)
Shoulder	Flexion	0-180
	Extension (hyper)	0-50
	Abduction	0-180
	Adduction	0-50
	Medial (Internal) rotation	0-80
	Lateral (External) rotation	0-90
Elbow	Flexion	0-150
	Extension	0
Forearm	Pronation	0-80
	Supination	0-85
Wrist	Flexion	0-80
	Extension	0-70
	Radial deviation	0-20
	Ulnar deviation	0-50
Thumb CMC	Abduction	0-70
	Flexion	0-15
	Extension	0-20
	Opposition	Tip of thumb to base or tip of fifth digit
Thumb MCP	Flexion	0-50
Thumb IP	Flexion	0-80
Digits 2-5 MCP	Flexion	0-90
	Extension	0-30
PIP	Flexion	0-90
DIP	Flexion	0-90
	Hyperextension	0-10
Hip	Flexion	0-125
	Extension (hyper)	0-15
	Abduction	0-45
	Adduction	0-30
	Lateral (External) rotation	0-45
	Medial (Internal) rotation	0-40
Knee	Flexion	0-135
	Extension (hyper)	0-10
Ankle	Dorsiflexion	0-20
	Plantarflexion	0-50
Ankle/ foot	Inversion	0-35
	Eversion	0-25
	Adduction	0-20
	Abduction	0-10
MTP joints	Flexion	0-30
	Extension	0
	Flexion	0-50
IP joints	Extension	0

36. **Assessment of Renal Function**.

(a) Assessment of renal function is done by corroborating clinical profile with biochemical parameters like Renal Function tests and albuminuria.

(i) Structural abnormality with eGFR > 60 ml/min with albuminuria < 30 mg/g: 15%

(ii) eGFR 45 – 59 ml/min or albuminuria 30 – 300 mg/g: 40%

(iii) eGFR 30 – 44 ml/min or albuminuria > 300 mg/g: 60%

(iv) eGFR 45 – 59 ml/min with albuminuria 30 – 300 mg/g: 60%

(v) eGFR 45 – 59 ml/min with albuminuria > 300 mg/g: 80%

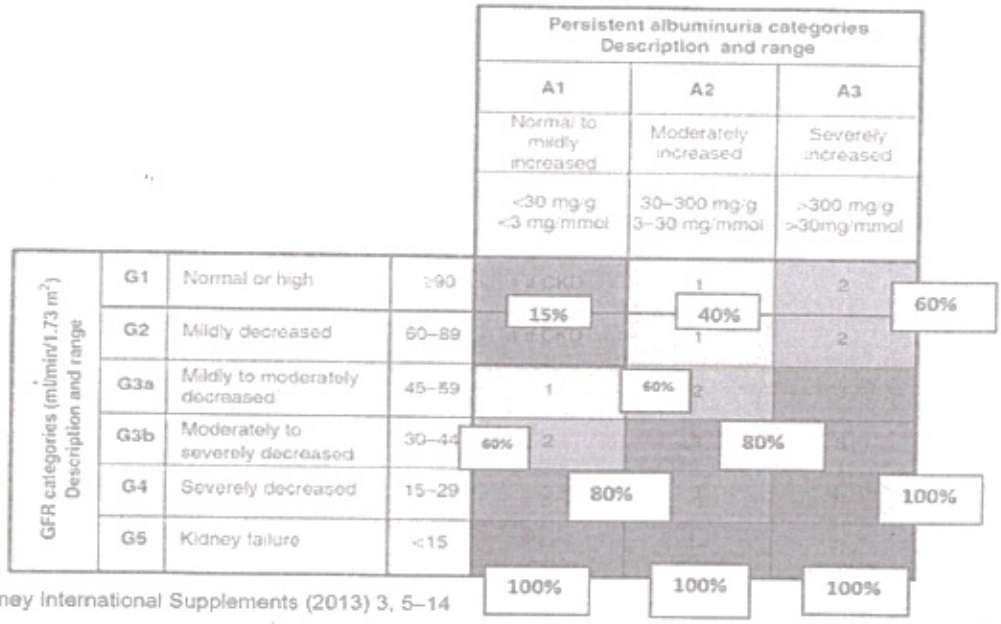
(vi) eGFR 30 – 44 ml/min with albuminuria 30 - 300 mg/g: 80%

(vii) eGFR 15 – 29 ml/min - 80%

(viii) eGFR 15 – 29 ml/min with albuminuria > 300 mg/g: 100%

(ix) eGFR < 15 ml/min: 100%

(x) On Renal Replacement Therapy: 100% with CAA



Ref: Kidney International Supplements (2013) 3, 5–14

For calculation of eGFR values: Estimation of S. creatinine levels should be IDMS standardized and EPI equation should be used to calculate the eGFR.

(b) **Urolithiasis**

Assessment as per para 36 (a)

37. **Endocrine Disorders**

Many endocrine conditions will affect various other body systems. Hence, loss of endocrine function is established by assessing the effect of the condition on those other body systems. In many cases, an endocrine condition will be under therapeutic control as a result of the use of continuous replacement therapy or the like. In these cases, the effect on other body systems may be minimal and the members principal inconvenience is that of undergoing the continuous therapy.

Step 1: Establish which body systems are affected by the endocrine disorder

Step 2: Determine an impairment % for functional impairment of the affected body systems.

For Addisons disease and Hypopituitarism % of activity score for age to be added as per Para 21 Table 5, 6 &7.

Use the appropriate Para to determine the impairment %.

Step 3: Determine an impairment % for the accepted condition.

There are two Impairment tables for loss of endocrine function. Table 1 is to be applied if assessing diabetes mellitus, while Table 2 is to be applied if assessing any other endocrine condition. Both tables provide an impairment % based on the type of treatment required by the member.

Step 4: Add the total functional impairment % of the affected body systems with the % obtained in Step 3.

Table 1

DIABETES MELLITUS	
Impairment %	Criteria
Nil	Hyperglycaemia controlled by weight loss.
02	Gestational diabetes mellitus.
05	Diabetes mellitus necessitating dietary control, Diabetes mellitus controlled(HbA1c ≤ 7%) by use of OHA
10	Diabetes mellitus controlled (HbA1c ≤ 7%) with insulin
20	Diabetes mellitus uncontrolled (HbA1c.> 7%) *

*The member must be treatment compliant and any failure to comply with the treatment cannot be taken as treatment failure or HbA1c>7% and for every hospitalisation per year for worsening 2% to be added.

Table 2

Endocrine Disorders (excluding Diabetes Mellitus)	
Impairment %	Criteria
Nil	An endocrine disorder controlled by regular oral medication taken less often than daily or by injections less often than once a month.
02	An endocrine disorder requiring daily oral medication. An endocrine disorder requiring regular injections not more often than once a month.
05	An endocrine disorder requiring injections not more often than once a fortnight.
10	An endocrine disorder requiring daily injections or lifelong steroids*

For every hospitalisation per year for worsening 2% to be added for Addisons disease/ Hypopituitarism.

38. **Assessment of Spondylarthritis**. Assessment of spondylarthritis will be based on mobility of spine and involvement of peripheral joints. Mobility of spine will

be assessed based on BASMI table and chest expansion. For the purposes of impairment assessment the following parameters are to be followed.

Cervical spine :

Degree of Lateral Rotation	Impairment%
>40	Nil
26-40	05
11-25	10
0-10	20

Dorsal Spine

Chest expansion (cm)	Impairment%
>4	Nil
3-4	05
2-3	10
1-2	15
< 1	20

Lumbar spine

Modified Schober's (cm)	Impairment%
>4	Nil
3-4	05
2-3	10
1-2	15
< 1	20

Dorsal kyphosis

Tragus to wall (cm)	Impairment%
<15	Nil
15-20	5
>20	20

The percentage of impairment to be taken for the most affected parameter examined.

The mobility of spine should be corroborated with presence of structural radiological changes in the form of squaring of vertebra, non-bridging and bridging syndesmophytes (leading on to bamboo spine).

Assessment of peripheral arthritis: Will be based on assessment for bone/joint injuries

39. **Post Transplant Assessment**.

The assessment will be done as per the relevant para on functional impairment of the organ transplanted and an addition of 20% impairment due to the daily activity limitations because of the procedure & immunosuppressive therapy.

40. **Assessment of Haematological Disorders**.

The Hematopoietic System - Assessment based on treatment requirements:

Impairment (%)	Criteria
NIL	Symptoms in remission and no active therapy is required
20%	Transfusion requirements: 2-3 units every 12-16 weeks
50%	Intermittent combination cytotoxic therapy – one course every 3-4 weeks or Phlebotomy once every 4 weeks or Transfusion requirements: 2-3 units every 6 weeks
75%	Phlebotomy more than one once every 4 weeks Transfusion requirements: 2-3 units per 4 weeks
100%	Transfusion requirements: 2-3 units per 2 weeks

Patients with anemia due to thalassemia minor or sickle cell disease should be assessed at their baseline haemoglobin levels-that is without blood transfusions. If they have breathlessness of fatigue as assessed by NYHA criteria, they are scored for disability as per the Blood disorders disability guidelines of RPwD 2016. They should also be evaluated for cardiac disease and iron overload.

41. **Assessment of Burns**.

The Assessment of burns will be based upon the guidelines for assessment of RPwD Act of 2016.

(a) Impairments resulting from burns are not restricted to the skin. Often, more than one system is involved, such as musculoskeletal, respiratory, vision etc. Scarring represents a special type of disfigurement. Scars affect sweat glands, hair growth, and nail growth, and cause pigment changes or contractures and may affect loss of performance and cause impairment. Impairment in burns is to be estimated by taking into consideration extent of damage in terms of area and depth.

(b) Restriction of normal movement by contracture is not limited to the extremities. Scars around the trunk also can become tight and stiff. When a scar occurs over the trunk or anterior chest, severe and chronic postural changes can result which may cause secondary spinal deformity or altered respiratory function. A badly scarred perineum or buttocks may make sitting in one position for prolonged period painful and difficult.

(c) The guideline for assessment shall be as follows:

Part of body affected	Deficit	% of permanent impairment
Scalp and vault including forehead	Disfigurement alone Deformity or full thickness loss	5 10
Eye brows (Right & Left)	Loss of part of one or both Total loss of one or both	3% each 5% each
Eye lids- Upper Lower	Skin disfigurement alone Deformity or full thickness loss Skin disfigurement alone Deformity or full thickness loss	3% each 5% each 2% each 3% each
Ear (Pinna)	Skin disfigurement alone Deformity due to full thickness involvement of skin and cartilage without obliteration of meatus Deformity due to full thickness involvement of skin and cartilage with obliteration of meatus	2% each 3% each 5% each
Nose	Skin cover disfigurement alone Deformity due to full thickness involvement with both nares (nostrils) patent Full thickness deformity with one nares obliterated Full thickness deformity with both nares obliterated	3% 5% 10% 20%
Lips	Skin cover disfigurement one lip alone Deformity or full thickness loss of one lip alone Deformity due to involvement of both lips leading to contracture	3% 5% 10%
Cheek and lateral area of face	Skin disfigurement Deformity or full thickness loss	5% each side 10% each side
Neck	Skin cover disfigurement Deformity due to involvement of skin, muscle or deeper tissue	5% 15%
Breast (Female)	Only skin cover disfigurement Deformity resulting in loss of function due to involvement of i) skin, areola & nipple ii) Skin, areola, nipple & parenchyma	5% each 10% each 15% each
Front of trunk & abdomen excluding breast	Only skin cover disfigurement Deformity or full thickness loss	5% 10%
Total back	Only skin cover disfigurement Deformity or full thickness	5% 10%

	loss	
Groins	Only skin cover disfigurement Deformity or full thickness loss	2% each 5% each
Buttocks	Only skin cover disfigurement Deformity or full thickness loss	3% each 5% each
Genitalia	Skin loss resulting in mild deformity Severe contracture of orifices or sloughing of urethra or severe deformity of penis	7% 20%
Thigh	Only skin cover disfigurement Deformity or full thickness loss	3% each 5% each
Lower leg	Only skin cover disfigurement Deformity or full thickness loss	3% each 5% each
Foot	Only skin cover disfigurement Deformity or full thickness loss	3% each 5% each
Upper arm	Only skin cover disfigurement Deformity or full thickness loss	3% each 5% each
Forearm	Only skin cover disfigurement Deformity or full thickness loss	3% each 5% each
Hand	Only skin cover disfigurement Deformity or full thickness loss	5% each 10% each

Mouth: Sometimes, the lips may be partly or totally destroyed, exposing the teeth. Eating and speaking can become difficult. Up to 20%

Esophagus: Inhalation of smoke creating upper digestive tract problems. Up to 20%.

Respiratory involvement: Smoke creating upper respiratory problems. Up to 20%. In addition, significant respiratory function impairment is to be assessed based on the guidelines as given in respective section. The total percentage of permanent impairment will not exceed 100%.

Restriction of limb/hand movements due to contractures: The assessment due to locomotor impairment will be added along with the assessment for dominant hand/arm involvement.

FIG-1

ASSESSMENT OF SUPERFICIAL BURNS

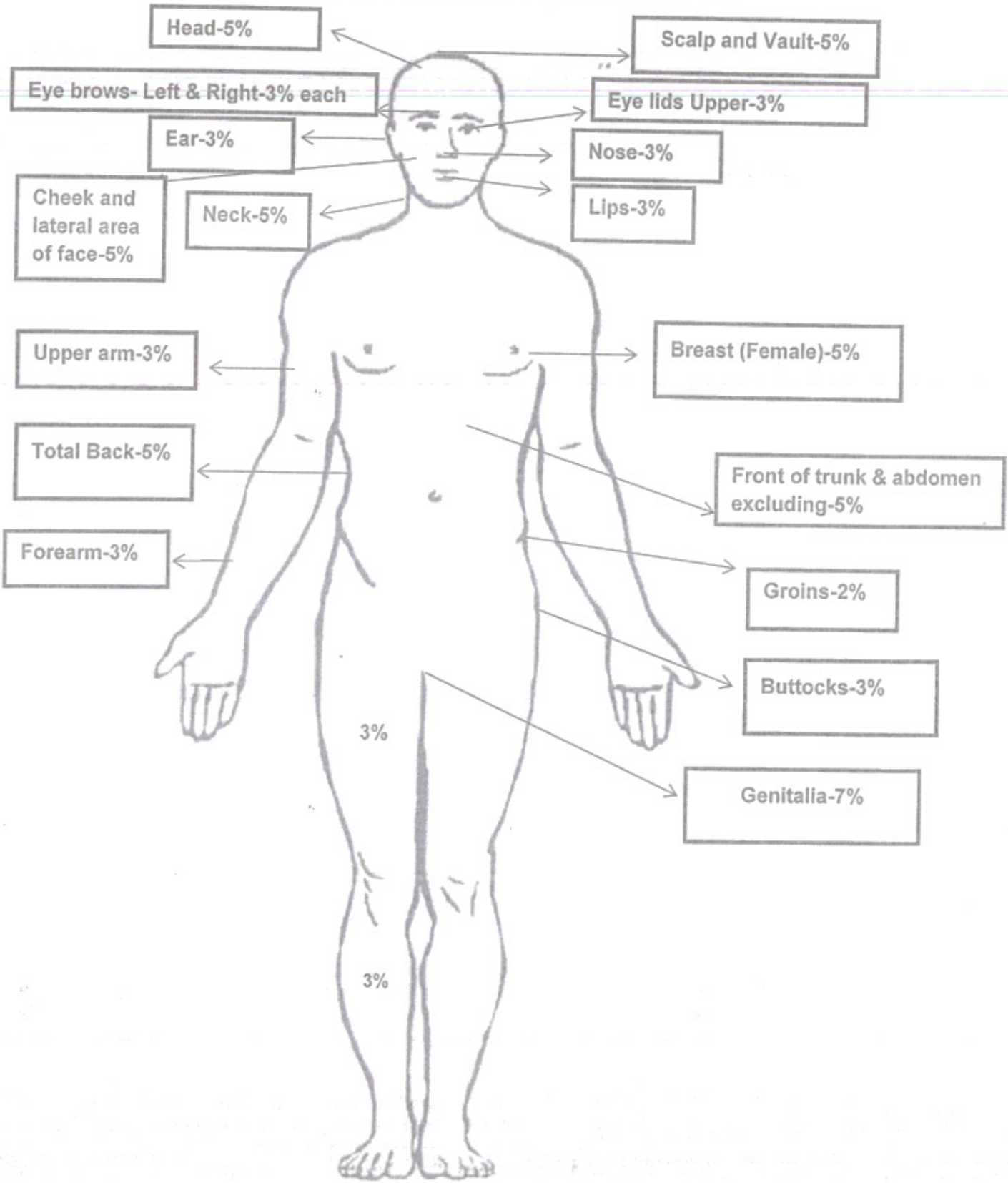


FIG-2

ASSESSMENT OF DEFORMITY OR FULL THICKNESS BURNS

