Federal Aviation Administration

Office of Aerospace Medicine

OneGuide Published February 25, 2026

PROJECT STATEMENT:

This guide is provided as a 'quick reference' to assist Office of Aviation Medicine (AAM) personnel in evaluating some of the most commonly occurring medical conditions found among individuals requesting airman medical certification under 14 CFR part 67 or Air Traffic Control Specialist (ATCS) medical clearance under FAA Order 3930.3 series. The contents of this guide are not considered all-inclusive or directive AAM policy and are always considered provisional. Because science and the practice of medicine are continually evolving, the contents of this guide undergo planned, continuous periodic reviews and updates to reflect scientific advances, generally accepted standards of care, and to meet statutory requirements (e.g., the 2024 FAA Reauthorization Act). All cases must undergo an individualized and particularized assessment.

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ULOC (unexplained loss of consciousness) or Unexplained disturbance of consciousness or Transient Loss Of Consciousness without satisfactory medical explanation; Transient loss of control of nervous system function

18l. Neurology

ALS - Amyotrophic Lateral Sclerosis aka (Lou Gehrig's disease) & Motor Neuron Diseases

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Aeromedical Concerns

Aeromedical concerns with motor neuron disease include effects of current symptoms on aircraft operation, effects of medications, and inexorable disease progression, including risk for cognitive deterioration such as frontotemporal dementia, which almost inevitably will preclude safe aircraft operations.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. All classes Any history	Submit the following for FAA review: 1. A **current, detailed neurological evaluation** in accordance with the **FAA Specifications for Neurologic Evaluation** generated from a clinic visit **no more than 90 days before the AME exam** from **a certified ALS clinic** or associated clinic. 2. Any other testing deemed clinically necessary or already performed for this condition by the treating physician.	DEFER Submit the information to the FAA for a possible Special Issuance.	If information not yet received: Send *rrINFOINITREQ letter* Add: **mabNEUROEVAL** Add: **From a certified ALS clinic or associated clinic.** Enclosure: **SPEC-NEUROEVAL**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New diagnosis or symptomatic, new medication/change: INCAPACITATE Send an incapacitation memo for: • Evaluation Data Row A	**Diagnosis and Disease Progression:** • This is a brain stem issue. • Diagnosis alone should not result in DQ unless on a DQ medication.

			L.I.E./PA: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC. If the DOC requests a functional assessment, use rrbPTOT.			Consideration of cert/clearance consideration is based on the progression of the disease. **Functional Capacity and Evaluations:** • Concern is more about the functional capacity. If functional capacity evaluation is needed, ask for PTOT FCE which asks for a functional capacity evaluation from PT or OT (not an ortho eval). **Imaging and Medication:** • Imaging. None needed in most cases.

						• Medication treatment is less of a consideration as the condition is the concern. **Certification and Case Management:** • **Mild/focal disease.** An individual with a milder or more focal version of the disease or early ALS cases and those few MND patients with longer-term stability could potentially be considered for SI. These cases are worked in GR workflow. • **Progressive disease** that are expected to cause

						incapacitation during the normal period of certification may be safe when a shorter time period is considered. • If granted SI and you do not want the AME to issue the follow-up, you must clarify this in your notes. • Cases worked in GR with Neuro as needed or short term cert interval. • If the case looks favorable for short-term SI (less than 12 months), or any other concerns, FAS neurology or Neuro workflow should be

						considered.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
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Condition Description

Amyotrophic lateral sclerosis (ALS), sometimes called Lou Gehrig's disease, is a rapidly progressive, invariably fatal neurological disease that attacks the nerve cells (neurons) responsible for controlling voluntary muscles. In ALS, both the upper motor neurons and the lower motor neurons degenerate or die, ceasing to send messages to muscles. Unable to function, the muscles gradually weaken, waste away, and twitch. Eventually the ability of the brain to start and control voluntary movement is lost. Individuals with ALS lose their strength and the ability to move their arms, legs, and body. When muscles in the diaphragm and chest wall fail, individuals lose the ability to breathe without ventilatory support.

The disease generally does not affect a person's ability to see, smell, taste, hear, or recognize touch, and it does not usually impair a person’s thinking or other cognitive abilities.

Other less common motor neuron diseases include Progressive Bulbar Palsy (PBP), Progressive Muscular Atrophy (PMA), and Primary Lateral Sclerosis (PLS).

Additional History or Description of the Condition

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REFERENCES

Go to TOC

Details

Section / Branch
General Review (GR)

ICD-10
G12.21

Pathology Codes (Prefixes)
631 (1,2,3,A,B,C)

Level of Review
3

ICD-9
335.2

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
MABNEUROEVAL, RRBPTOT, RRBDFR

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis or symptomatic: INCAPACITATE and request above information.

Continue INCAP until the above criteria is met and reviewed by the **FS.**

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

4/8/2022 page reviewed.

18l. Neurology

AVM (Arteriovenous Malformation) of the nervous system (brain)

Aeromedical Concerns

Sudden incapacitation such as seizures, vision changes, loss of consciousness, problems speaking, or weakness or difficulty moving any part of the body or due to seizure or blood accumulation with rupture.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Not requiring treatment	Submit the following for FAA review: 1. A **current, detailed neurological evaluation** that meets **FAA Specifications for Neurologic Evaluation**, generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **Imaging studies**. Submit BOTH the report and a copy of all images on compact disc (CD) in DICOM readable format. (There MUST be a 'DICOMDIR' in the root directory	DEFER Submit the information to the FAA for a possible Special Issuance.	Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). **Send to Neuro Panel Reviewer (AMCD)** Neuro L.I.E.:	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	.

	of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain copies of all CDs or images as a safeguard if lost in the mail. • **MRI brain** to **include sequences sensitive to the presence of hemosiderin** performed **no more than 12 months before** the AME exam. • **CTA (preferred) or MRA head** performed **no more than 12 months before** the AME exam. • **Previous Imaging** (such as CT, MRI, CTA, MRA or catheter angiography of the head) performed at any time after the symptoms occurred. 3. Any other testing performed or deemed necessary by the treating physician. Note(s): If associated with a seizure – see that section. A recovery period may apply.		<u>If information not received:</u> *Send rrinfoINITIALREQ letter* Add: **rrbAVMa** (available in DIWS) Add enclosure(s): **SPEC-NEUROEVAL** <u>When all required information received:</u> Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. If associated with a seizure, see that section also			
B. Treated with embolization procedure	Submit the following for FAA review: 1. All items in row A. 2. **Imaging studies.** • Images performed after any procedure to verify the condition has been fully treated. 3. Hospital records for each hospitalization related to this condition. It must include information on surgeries and	DEFER Submit the information to the FAA for a possible Special Issuance.	**Send to Neuro Panel Reviewer (AMCD)** Neuro L.I.E.: <u>If information not received:</u> *Send rrinfoINITIALREQ letter* Add: **rrbAVMb** (available in	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	Row B Embolization: With an embolization procedure, there is a possibility of getting gliosis or a tiny stroke in an already damaged area.

	procedures such as embolization. • Admission History and Physical (H&P). • Emergency Medical; Services (EMS)/ambulance run sheet. (if applicable); • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists); • Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) you can print from your electronic medical record are NOT sufficient for pilot medical certification purposes.); • Lab report(s) including all drug or alcohol testing performed; • Operative/procedure report(s); • Pathology report(s); and • Radiology reports. The interpretive report(s) AND IMAGES of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) performed. *DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or medication administration records.* *If you have a large volume of records, you may wish to*		DIWS) Add enclosure(s): **SPEC-NEUROEVAL** Request images/studies performed by the treating physician to provide clinical evidence the condition has been fully treated. On initial request, leave the imaging type up to the treating physician. Need reports and actual images. When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. If associated with a seizure, see that section also.	B		Request images/studies performed by the treating physician to provide clinical evidence the condition has been fully treated. On initial request, leave the imaging type up to the treating physician. Need reports and actual images.

	bring these records to your AME for review and determine which miscellaneous records are not needed.					

If ruptured or repaired, see Brain Bleed section

*If AVM of another system (such as lung or extremity)--see that page.

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Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Not requiring treatment	Standard follow up would include: 1. Annual **current, detailed Clinical Progress Note** generated from a clinic visit with the pilot's treating neurologist **no more than 90 days before** the AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of all testing performed; diagnosis; assessment and plan (prognosis); and follow-up.		GR when released from Neuro workflow. If stable, meets follow-up criteria - Continue Auth If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: If AME sends in all documents, issues correctly and no changes in medical condition: L.I.E.: create and sign rrCONTINAUTH letter. FMC and send to file.		

	2. It must specifically describe if there has been a change in symptoms, exam findings, or control of risk factors. 3. MRA or CTA of_____ (report with comparison to previous studies) every 12-months or at frequency specified in the Authorization letter. If the treating physician deems it necessary, a catheter angiogram will be accepted in place of a CTA or MRA.		PA: create rrCONTINAUTH letter. FMC and send to DOC. If Cert time limit (t/l) incorrect: L.I.E.: Prepare continue authorization rrCONTINAUTH letter, sign, and send corrected cert. PA: create rrCONTINAUTH letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) L.I.E.: Send: rrinfoINITIALREQ letter for missing items or new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted PA: See above and send to DOC. No longer meets SI (condition worsened): L.I.E./PA: Detail changes, abnormalities or questions in your notes and send to DOC.		

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Condition Description

Arteriovenous malformations (AVMs) are abnormal, snarled tangles of blood vessels that cause multiple irregular connections between the arteries and veins. These malformations most often occur in the spinal cord and in any part of the brain or on its surface, but can develop elsewhere in the body. AVMs can damage the brain and spinal cord by reducing the amount of oxygen reaching neurological tissues, bleeding into surrounding tissue (hemorrhage) that can cause stroke or brain damage, and/or by compressing or displacing parts of the brain or spinal cord. Many people with an AVM experience few, if any, significant symptoms. These include headache, weakness, seizures, pain, and problems with speech, vision, or movement. Most often AVMs are congenital, but they can appear sporadically. In some cases the AVM may be inherited, but it is more likely that other inherited conditions increase the risk of having an AVM. The malformations tend to be discovered only incidentally, usually during treatment for an unrelated disorder or at autopsy.

Additional History or Description of the Condition

Treatment options depend on the type of AVM, its location, noticeable symptoms, and the general health condition of the individual. Medication can often alleviate general symptoms such as headache, back pain, and seizures caused by AVMs and other vascular lesions. The definitive treatment for AVMs is either surgery to either remove the AVM or to create an artificial blood clot to close the lesion or focused irradiation treatment that is designed to damage the blood vessel walls and close the lesion. The decision to treat an AVM requires a careful consideration of possible benefits versus risks.

REFERENCES

https://www.ninds.nih.gov/Disorders/All-Disorders/Arteriovenous-Malformation-Information-Page

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
Q27.39

Pathology Codes (Prefixes)

Level of Review

ICD-9
747.69

602 ((1,2,3,4,5-A,B,C,D,E))	3

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbavma, rrbavmb

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria
New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

9/2723 Update title. This is neu¿rologic AVM only.
¿4/08/22 updated with neuro.

18l. Neurology

Alzheimer's Disease or Mild Cognitive Impairment (MCI) or Dementia

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Aeromedical Concerns

Aeromedical concerns focus on adverse effects of current motor, cognitive or behavioral symptoms, and future disease progression. There is essentially no risk of sudden incapacitation, but subtle/unrecognized impairments can occur unpredictably.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Alzheimer's disease OR Mild Cognitive Impairment (MCI) OR Dementia from: • Creutzfeldt-Jakob	Submit the following for FAA review: 1. The most recent detailed Clinical Progress Note performed by the **treating physician or neurologist**. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. In most cases, this condition is	DEFER Submit the information to the FAA.	Worked in General Review (GR) If no information received to confirm diagnosis: *Send **rrINFOINITIALREQ** letter* Add: **rrbCSLONG** with treating physician or neurologist. **L.I.E./PA**: If appropriate documentation has been	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New presentation/new diagnosis or symptomatic: **INCAPACITATE**. Send an incapacitation memo and request: • Evaluati	**Aeromedical Risk and Certification:** • Alzheimer's disease, all dementias, as well as Mild Cognitive Impairment (MCI) are very high aeromedical risk.

disease; • Frontotemporal dementia; • Lewy body dementia; • Mixed dementia; • Normal Pressure Hydrocephalus; • Vascular dementia; or • Others	incompatible with aviation safety.		received to verify diagnosis, this meets denial criteria in OneGuide: Detail changes, abnormalities or reasons for denial in your problem focused notes. Prepare Appropriate Denial letter and send to DOC for concurrence and signature. <u>If the applicant requests reconsideration</u> *Send rrinfoINITIALREQ letter* Add: **mabNEUROEVAL + mabNEUROPSYCH** Add enclosure(s): **SPEC-NEUROEVAL + SPEC-Neuropsychological Eval (Neurocog Impairment)** When all information received: **L.I.E./ PA:** Add to the problem list, assign	Note: upon receipt and review of the above information, additional documentation may be required.	on Data Row A Note: upon receipt and review of the above information, additional documentation may be required.	• Not all providers are aware that dementia and MCI are incompatible with aviation safety. **Certification and Case Management:** • In most cases, the only path to certification would be for: 1. Preclinical Alzheimer's condition or 2. If the dementia or MCI diagnosis is actually incorrect.

			path/ICD code, summarize findings in note, send to DOC.			• If the documentation received verifies Alzheimer's, most cases will be denied. • If the documentation is favorable, and certification is considered, the case should be reviewed by AMCD Neuro-workflow. **Timing and Expense Considerations:** • The point to avoid unnecessary expense and time is before submitting an FAA certification.

B. Pre-clinical Alzheimer's condition	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam. 2. A Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the **treating neuropsychologist no more than 90 days before** the AME exam 3. **Brain MRI**. Magnetic Resonance Imaging (MRI) of the brain performed no more than 90 days prior to your AME exam. • Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). • Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. **Other testing:** Already performed by the treating **neurologist**. Note: Upon receipt and review of the above information, additional documentation may be required.	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) **Neuro L.I.E**: If information not received: Send *rrinfoINITIALREQ letter* Add: **rrbALZHEIMERS** Add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-Neuropsychological Eval (Neurocog Impairment).** **Neuro L.I.E**: When all required information received, add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician.	Send a Request for Information letter for: • All previous medical records for this condition • Evaluation Data Row B Note: upon receipt and review of the above information, additional documentation may be required.	New presentation/new diagnosis or symptomatic: **INCAPACITATE**. Send an incapacitation memo and request: • Evaluation Data Row B Note: Upon receipt and review of the above information, additional documentation may be required.	Row B **CASES WORKED IN AMCD NEURO WORKFLOW** **Compatibility with Aviation Safety:** • Clinical or symptomatic Alzheimer's is incompatible with aviation safety. **Biomarkers Considerations:** • Pre-Clinical/biomarker diagnosis: Revised AD diagnostic criteria allow a biomarker-based diagnosis of Alzheimer's. The biomarkers may precede clinical expression of Alzheimer's by decades, but the risk

						for development of cognitive problems is accelerated. Biomarkers include a positive Amyloid PET scan or abnormal CSF tau/a-beta ratio. Consider APP, PS1, and PS2 mutations similarly, as the risk of developing clinical symptoms at a young age is drastically increased. • ApoE mutations are less clear – E4/E4 homogeneity carries a 10x risk of AD. Current clinical recommendations are to treat E4/E4 with the same screening as any normal

						individual, as, unlike the mutations mentioned above, many with this variant will live out their lives never having any problem. **Mild Cognitive Impairment (MCI):** • MCI has an individually variable course, with about a 10% annual risk of meeting diagnostic criteria for dementia. **Certification and Monitoring:** • Biomarker evidence of Alzheimer's pathology without clinical evidence of cognitive impairment and not

						requiring memory-enhancing medications may be safely certified under Special Issuance (SI) with annual monitoring as described below.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
B. Pre-clinical Alzheimer's condition	See Authorization letter.	Follow up Issuance will be per Authorization letter.			

Condition Description

Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. The most common form of dementia among older people is Alzheimer's disease, which initially involves the parts of the brain that control thought, memory, and language. Alzheimers Disease is a slow disease, starting with mild memory problems and ending with severe brain damage. The course the disease takes and how fast changes occur vary from person to person.

- Alzheimer's disease is the most common type of dementia.
- It is a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment.
- Alzheimer's disease involves parts of the brain that control thought, memory, and language.
- It can seriously affect a person's ability to carry out daily activities.

Additional History or Description of the Condition

REFERENCES

https://www.cdc.gov/aging/aginginfo/alzheimers.htm

Details

Section / Branch
General Review (GR)

ICD-10
G30.9, F03.90

Pathology Codes (Prefixes)
620 ((1,3,A,C))

Level of Review
4

ICD-9
331.00 Alzheimers, 294.2 Dementia

Pilot Disposition
SI, DENY

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
DENY, SC	8B, 8C (if on medication), 9 (if on SC)	12 months	Indefinite

Blurbs Letters and Specification Sheets

Blurbs
rrbalzheimers

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

7/27/22 updated DOC actions. If favorable reports, send to Neuro Work flow. ¿

3/18/2022 page reviewed.

Neurology

Aneurysm Pointer Page

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Aeromedical Concerns

See individual condition page.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
Cardiac	AAA (Abdominal Aortic Aneurysm) TAA (Thoracic Aortic Aneurysm)		.			
Neurology	Brain Anuerysm Brain Bleed (ruptured anuerysm)					

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
I25.41, I71.00, I71.9, I72.4, I72.9

Pathology Codes (Prefixes)
447 (n/a), 480, 482, 482, 482

Level of Review
0

ICD-9

Pilot Disposition
N/A

Pilot Standard Certification
12 months

CFR(s) Conditions Only
No CFR. See actual condition

CFR(s) Conditions Treated with Meds

ATCS Disposition
N/A

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration

Blurbs Letters and Specification Sheets

Blurbs

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Summary of Changes

1/23/2026 added links.

18l. Neurology

Bell’s Palsy (Facial Nerve Palsy; Cranial Nerve Palsy)

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Aeromedical Concerns

Aeromedical concerns include ocular effects such as corneal abrasion, and speech effects from facial weakness. A further concerns is incorrect diagnosis, as cerebral infarction or multiple sclerosis may be incorrectly assessed as Bell's palsy.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. **Single episode** Completely resolved **5 or more years ago**	If the AME can determine the condition was a SINGLE EPISODE, fully resolved without sequelae with no symptoms or current problems that would interfere with flight duties:	ISSUE Annotate this information in Block 60.	If previously reported and warned: **L.I.E./PA:** Add to DIWS note (ex. history of Bell's Palsy/previously warned), FMC, and send to file. The first time the condition is reported: We **will accept** AME notes: If the AME adequately	Send a Request for Information letter for: • All previous medical records for this condition. If records verify the condition HAS	New diagnosis or symptomatic, new medication/change: INCAPACITATE Send an incapacitation memo for: memo for: • Evaluation Data Row	**Worked in General Review** **Overview and Concerns:** • Bell's Palsy is usually a self-limited condition. • Concerns include: 1. Incorrect

			explains the condition has resolved with no ongoing treatment needed (no functional limitations, no medication or more than one episode): **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. If no AME explanation: *Send rrinfoINITIALREQ letter* Add: **rrbCSLONG** from treating physician or surgeon. When all info received: Process any conditions per OneGuide. **PA:** See above then send to DOC.	resolved, send to FS for determination. If records show condition has NOT resolved or did require surgery, send a Request for Information letter for: • Evaluation Data Row C	C **Verify/review** received information: If any of the following criteria are met, a neurological evaluation will be required. • Resolved in less than 1 week; • lasted longer than 3 months; • continued/ persistent symptoms; • eye symptoms; • or required surgery to correct the condition OR • 2 or more episodes in a lifetime; • Any additional neurological condition, neurological	diagnosis: Aeromedical concern is misdiagnosed stroke/TIA/Horner's syndrome/cranial neuropathy or tumor. Very mild cases lasting less than 1 week are not common and often

					symptoms, or concern.	difficult to distinguish from a stroke/TIA. Bell's can also be a presenting symptom of Multiple Sclerosis (MS). 2. Incomplete recovery: Fully recovered means no persistent symptoms, espe

						cially eye symptoms. No eye droop, no lid lag with blinking. The average case will last between 1 week and 2 months. 80% of patients recover within 2 months. 3. Persistent wea

						knes s of face/ lid: 20% of patie nts will have persi stent wea knes s of varyi ng degr ee of the lid/fa ce. Bell' s pres enta tion inclu des the face AND the fore hea d. If no fore hea d invol vem ent, it is

						probably not Bell's Palsy. If only upper and lower ½ of face involved, concern is stroke/TIA. 4. Sensory changes: Some cases may have slight sensory changes. 5. Eyes: Less than 1% of

						Bell's have eye complications, but Bell's is common so there is a high number of potential cases. The last thing to recover is the ability to close the eye at night. Corneal scarring

						can lead to blindness. Bell's causes a 7th nerve error, so the eye will open, but will have difficulty closing the eye (including at night increasing risk of corneal abrasion). **Diagnosis and**

						Imaging: • MRI findings: If initial MRI imaging shows increased signal in the facial nerve, that confirms the diagnosis of Bell's. • Caution: If MRI negative, could still be TIA. Look at risk factors.
B. Single episode Completely resolved **<u>Less than 5 years ago</u>**	If the AME is able to determine **ALL** of the following are true: 1. The condition/symptoms **lasted between 1 week and 3 months (fully resolved by 3 months).** 2. There is **no other history of a neurologic condition or neurologic symptoms** (numbness, weakness, sensory disturbance, involvement outside the face, or the forehead not involved). 3. There are **no current eye symptoms** (e.g., dry eye, red eye, eye pain, vision disturbance, trouble closing eye, or persistent eyelid weakness). 4. **No surgery** was needed to correct the condition. If the AME is unable to determine above,	ISSUE Annotate Block 60 and submit any evaluation(s) to the FAA for retention in the file. If any underlying cause found, see that section. All others, go to row C	We will accept AME notes. If the AME adequately explains the diagnosis is Bell's Palsy and the condition has resolved with no ongoing treatment needed: **L.I.E.:** Add to the problem list, assign path/ICD code, and WARN. **PA:** See above and send to DOC <u>If no AME explanation:</u> *Send rrINFOINITIALREQ letter* Add: **rrbBELLSb** (avail in DIWS)	See row A	See row A	Row B **Certification and Follow-up:** • If the diagnosis is clear, the condition resolved, and there is a low likelihood of other concerning conditions or high risk of any other neurological event - most can WARN.

	request the treatment records or a current neurological, ENT, or ophthalmology evaluation.		When all info received, process as above. If does not meet above criteria, send to DOC.			
C. **All others** Lasted **less than** one (1) week (probably not Bells, needs further investigation); OR Prolonged course (lasted longer than three (3) months); Continued/persistent symptoms; Eye symptoms or required surgery to correct the condition; OR Two (2) or more episodes in a lifetime; Any additional neurological condition, neurological symptoms, or concern	Submit the following for FAA review: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the specialist (such as **neurology, ENT, or ophthalmology**) no more than 90 days before the AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 2. **It must specifically include** if this was a single episode, if all symptoms have resolved and if any other neurological conditions were identified. 3. **MRI of the brain** (Magnetic Resonance Imaging). The most recent test from time of event or later. Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. **Eye evaluation** by a board certified ophthalmologist **if any continued face or eye symptoms** (e.g., dry eye, red eye, eye pain, vision disturbance, trouble closing eye, persistent eyelid weakness) **OR any surgery** needed to correct the condition. If no eye symptoms or surgery,	DEFER Submit the information to the FAA for a possible Special Issuance.	**These are worked in General Review (GR)** If no AME explanation: *Send rrINFOINITIALREQ letter* Add: rrbBELLS**c** (available in DIWS) If the **specialist Clinical Progress Note** verifies all of the following: 1. Diagnosis is Bell's Palsy; 2. Single episode; 3. All symptoms resolved; 4. NO other neurological conditions found; and 5. Brain MRI is listed as negative/normal (*if **no MRI** see all others below*): L.I.E.: Add to problem list, assign path/ICD code and WARN PA: See above and send to DOC If progress note is from a PCP (not a specialist), and answers number	See row A	See row A	Row C • Persistent symptoms, with favorable neurology evaluation and eye condition adequately addressed with no evidence of vision loss – consider Special Issuance (SI) with annual progress note from treating eye provider. • Persistent weakness, with no concern for current or future eye problems or complications, - consider warn. • Standard

	this must be stated in the clinical progress note or AME notes. 5. Copies of any treatment records such as ER, urgent care, or PCP notes describing events, diagnosis, and treatment. 6. Any other testing performed by the treating physician for this condition.		1-5 above, do not send request for additional evaluation - annotate this information in your note and send to DOCS. **<u>All others</u>**: Still on meds, continued symptoms, any eye, lid, or facial surgeries, continued eye involvement, or two or more lifetime episode: Send to DOCS. If **no MRI -** and neuro note clearly says this is Bells, annotate this information and send to DOCS.			follow-up for SI includes annual eye evaluation. In most cases, neurology follow-up will not be needed. • SI release: When treating eye physician verifies the condition has resolved, consider release with a warning. • Not acceptable for medical certification when diagnosis is unclear or concern for other conditions. Missed diagnoses are uncommon but may include stroke/TIA, tumor, sarcoid, Lyme, MS, and Horner's. Residual weakness

						may be present in up to 20% to varying degrees; aeromedical concern is rare but includes severe complications of corneal dryness, ulceration and scarring with vision loss and glare, potential limitation of visual field due to lid, and forehead droop. **Consultation:** • If questions, consult with AMCD Neuro Workflow physicians.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS	DOC Actions

Stage				(VHT App only if required)	
C.	Standard Follow-up would include: 1. An annual, detailed Clinical Progress Note generated from a clinic visit with the treating **board certified ophthalmologist** no more than 90 day before the AME exam. It must include a detailed interim summary of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing required or performed; diagnosis; assessment and plan (prognosis); and follow-up.	Follow up Issuance will be per the pilot's Authorization letter. ISSUE **Annotate Block 60.** Submit all information for FAA for review. **All others**, the AME should **DEFER** and annotate in Block 60 what aspect or concern caused the deferral.	<u>If no changes in condition, continue the SI and all parameters are met:</u> If the treating eye specialist verifies the condition has resolved, prepare eligibility and warn letter for DOC. If AME sends in all documents, issues correctly, and no changes in medical condition: **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. PA: Create rrCONTINAUTH letter. FMC and send to DOC. <u>If Cert time limit (t/l) incorrect:</u> **L.I.E.**: Prepare continue authorization rrCONTINAUTH letter, sign, and send corrected cert. PA: Create rrCONTINAUTH letter and corrected cert and send to DOC <u>If AME issues Incorrectly</u> (new meds/change in meds/new medical condition) OR <u>Information not received</u> (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) **L.I.E.**: Send: rrinfoINITIALREQ letter for missing items or new condition. Process condition per OneGuide. Determine if need to assign AME “W”	Consider return to work when condition resolves, treating physician verifies no other neurological pathology identified, treatment complete and released from care.	

			error - read AME comments to see if reports have been submitted PA: See above and send to DOC. No longer meets SI, condition worsened: **L.I.E./PA:** Detail changes, abnormalities or questions in your notes and send to DOC.		
				See row A	

Condition Description

Bell's palsy is a form of temporary facial paralysis resulting from damage or trauma to one of the two facial nerves. It is the most common cause of facial paralysis. Generally, Bell's palsy affects only one of the paired facial nerves and one side of the face, however, in rare cases, it can affect both sides. The prognosis for individuals with Bell's Palsy is generally very good. With or without treatment, most people begin to get better within 2 weeks after the initial onset of symptoms and recover completely within 3-6 months.

Additional History or Description of the Condition

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REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10	Pathology Codes (Prefixes)	Level of Review	ICD-9

G51.0, G58.9	642 ((1,3,A,C)), 644	4	351.00

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbbellsb, rrbbellsc

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria
Once the condition is controlled and/or stable with or without an acceptable medication, a Special Consideration may be granted.
Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿3/18/2022 page reviewed

18l. Neurology

Brain Abscess (Brain Infection)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include current residual cognitive or neurologic impairments, effects of treatment, and future seizure risk, which may be elevated for a prolonged period following abscess resolution.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. All classes **Any history** (current or ever in their lifetime)	After appropriate **recovery period*** Submit the following for FAA review: 1. A current, detailed **neurological evaluation,** in accordance with the FAA Specifications for Neurologic evaluation, generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam. 2. A Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations for	DEFER Submit the information to the FAA for a possible Special Issuance.	Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). **Neuro L.I.E.:** If information not received: Send *rrinfoINITIALREQ letter*	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation data row A	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation data row A	These cases are worked in Neuro Workflow. Two-year recovery period required due to risk of seizures. NP testing also required in most cases as this can cause lesions/changes in the brain. Requires full

	Potential Neurocognitive Impairment from a clinic visit with the **treating neuropsychologist no more than 90 days** before the AME exam. 3. The most recent MRI and/or CT imaging of the brain. (If not already performed, a current brain MRI is required.) Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. The most recent electroencephalogram (EEG). • (If not already performed, a current EEG is required.) • The EEG recording should be sleep-deprived: awake, asleep, and with provocation (e.g., hyperventilation, photic/strobe light). • Include any previous EEG(s) available for comparison. • Submit BOTH the final interpretive report(s) and		Add: **rrbBRAINABSCESS (available in DIWS)** Add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-Neuropsychological Eval (Neurocog Impairment)** NEURO L.I.E.: When all required information received, add to the problem list, assign path/ICD code and add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. If the appropriate recovery period after the episode **has not** been met: • 6 months for most cases • two (2) years if surgery was performed to drain the abscess Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter, and send to DOC.	May require review by FAS neurology.	May require review by FAS neurology.	Neurologist (or neurosurgeon or PMR physical medicine and rehabilitation physician) evaluation as these are treated with craniotomy. If SI/SC granted and you do not want the AME to issue the recert, you must specify in your note. Recovery periods after the episode: • 6 months for most cases for a superficial lesion. • two (2) years if surgery was perf

	the actual tracings (ALL pages) for any EEGs on CD. • The CDs of EEG recordings must have proprietary opening software that is compatible with Windows 10. 5. Other testing deemed clinically necessary by the treating physician. ***Note:** Applicants with prior brain abscess should have a minimum of 6 months observation following completion of treatment. If residual cortical lesion(s) are seen on MRI, a longer recovery period may be required. If surgery was performed (penetrating the dura), a minimum two (2)-year recovery period will apply. If associated with a seizure, refer to that section, as a longer recovery period may then apply.					orm ed to drai n the absc ess • If resid ual corti cal lesio n on MRI, reco very peri od may be long er. (12/ 202 2)
For meningitis or encephalitis, see that page.						

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. All classes Any history (current or ever in their lifetime)	Follow up Issuance will be per the Authorization letter.	Follow authorization letter	Verify case has been released from Neuro Workflow (AMCD) If no longer requires Auth L.I.E.: Send rrRELEASEDAUTHELIG letter and WARN. Complete file maintenance (FMC) PA: As above and send to DOC for signature. If stable, meets follow-up criteria - Continue Auth If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: If AME sends in all documents, issues correctly, and no changes in medical condition: L.I.E.: create and sign rrCONTINAUTH letter. FMC and send to file. PA: create rrCONTINAUTH letter, FMC and send to DOC. If Cert time limit (t/l) incorrect L.I.E: Prepare continue authorization rrCONTINAUTH letter, sign, and send corrected cert. PA: Create rrCONTINAUTH letter and corrected cert and send to DOC	Case by Case per Neuro	

			If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received (**if AME states in Block 60 that reports are forthcoming, send to 14-day hold que before sending letter) L.I.E.: Send: rrINFOINITIALREQ letter for missing items or per new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted PA: See above and send to DOC. If No longer meets SI, condition worsened: L.I.E./PA: Detail changes, abnormalities or questions in your notes and send to DOC. If the DOC note states they do not want the AME to issue the recert, add **rrbDFR** to Auth letter.		

Condition Description

A brain abscess is a mass of immune cells, pus, and other material due to a bacterial or fungal infection. Inflammation develops in response. Infected brain cells, white blood cells, and live and dead microorganisms collect in a limited area of the brain. This area becomes enclosed by a membrane that forms around it and creates a mass.

Additional History or Description of the Condition

A brain abscess can lead to elevated intracranial pressure and has significant morbidity and mortality. Management can be divided into medical and surgical approaches.

Medical management can be considered for deep-seated, small abscesses (less than 2 cm), cases of coexisting meningitis, and few other selected cases. Usually, a combination of both medical and surgical approaches is considered.[2]

CT and MRI brain imaging guide management by localizing the abscess and delineating details including dimensions and the number of abscesses. Usually, large abscesses (more than 2 cm) are considered for aspiration or excision based on the surgical skills of the operator. The approach for multiple abscesses includes a long course (4 to 8 weeks) of high-dose antibiotics with or without aspirations, based on weekly CT scanning.

Medically-managed cases should have a minimum 6 months observation following completion of treatment. Most brain abscess cases are treated with surgery (craniotomy) to drain the abscess. If surgery was performed, a minimum two (2) year recovery period is required due to risk of seizures. NP testing is also indicated in most cases, as abscesses can result in cognitive changes.

Condition requires full Neurologist evaluation. We may also accept a neurosurgeon or PMR physical medicine and rehabilitation evaluation physician evaluation.

Study from Chuang et al indicated most seizures occurred within three years of bacterial brain abscesses, but later seizure occurrences were also reported. Study from Bodlisen et al indicated a 16-fold increased epilepsy occurrence in brain abscess cases with median 7.6 year follow up compared to controls.

REFERENCES

Bodlisen J et al. Long-term mortality and epilepsy in patients after brain abscess: a nationwide population-based matched cohort study. Clin Infect Dis 2020; 71(11): 2825-2832.

Chuang M-J et al. Predictors and long-term outcome of seizures after bacterial brain infection. J Neurol Neurosurg Psychiatr 2010; 81:913-917.

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10

Pathology Codes (Prefixes)
629 ((1,3,5,A,C))

Level of Review
4

ICD-9
324

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbbrainabscess, RRBDFR

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

Brain abscess is disqualifying. Requires a 2-year recovery period after treatment complete due to risk of seizures.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Go to TOC

Summary of Changes

12/15/2022 reviewed with neurology.
3/25/22 page reviewed.

18l. Neurology

Brain Aneurysm NOT RUPTURED (Intracranial aneurysm / Cerebral aneurysm)

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Aeromedical Concerns

Sudden incapacitation such as sudden impairment of consciousness, seizures, vision changes, loss of consciousness, problems speaking, or weakness or difficulty moving any part of the body or due to blood accumulation with rupture.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Existing Aneurysm which has not ruptured Note(s): If associated with a seizure – see that section. A recovery	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **CT angiography (CTA is preferred) or MRA head (magnetic resonance angiography)** performed no more than 12 months before the AME exam.* 3. Previous Imaging*. CT, MRI, CTA,	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) If information not received: Send *rrinfoINITIALREQ letter* add: **rrbBRAINANEURYSM** (avail in DIWS) add enclosure(s): **SPEC-NEUROEVAL** **Neuro**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	Initial review by Neuro physicians. Follow indefinitely.

period may apply. If ruptured and/or repaired, refer to Brain Bleed/Intracranial hemorrhage section.	MRA or cerebral catheter angiography/cath angio of the head performed at any time after the symptoms occurred. *Submit BOTH the report and a copy of the images on compact disc (CD) in DICOM readable format. (There MUST be a 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain copies of all CDs or images as a safeguard if lost in the mail.		**L.I.E.:** When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician.			
			Note: if the aneurysm ruptured--see brain/intracranial hemorrhage section			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
.	.				

			These are followed indefinitely. If rupture occurs, see brain/Intracranial hemorrhage section.		

Condition Description

A brain or cerebral aneurysm (also known as an intracranial or intracerebral aneurysm) is a weak or thin spot on a blood vessel in the brain that balloons out and fills with blood. The bulging aneurysm can put pressure on a nerve or surrounding brain tissue. It may also leak or rupture, spilling blood into the surrounding tissue (see Brain Hemorrhage in this section).

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
I67.1

Pathology Codes (Prefixes)
602 (1,2,3,4,5,A,B,C,D,E)

Level of Review
3

ICD-9
437.3

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

Go to TOC

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
SC	8B, 8C (if on medication), 9 (if on SC)	12 months	Indefinite

Blurbs Letters and Specification Sheets

Blurbs
MABNEUROEVAL, rrbbrainaneurysm

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis or finding: INCAP. Will require above Evaluation Data and may require a period of stability before return to SRD.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/12/2022 page reviewed and updated with

neurology.

18l. Neurology

Brain Bleed (cerebral hemorrhage; intracranial hemorrhage; ruptured aneurysm; subarachnoid hemorrhage (SAH); subdural)

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Aeromedical Concerns

Aeromedical concerns include effects of current cognitive or neurologic symptoms, risk of seizures from infarction or other structural brain injury, treatment effects, future re-bleeding risk, and future risk of new aneurysm development.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Any history of a Spontaneous intracranial hemorrhage not due to trauma* [examples may include ruptured	**Required recovery periods :** • If craniotomy performed: **Two (2) years** • Subarachnoid hemorrhage: **One (1) year** **After any required recovery period**, submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA	DEFER Submit the information to the FAA for a possible Special Issuance.	Identify condition that requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). SEND TO NEURO PANEL REVIEWER (AMCD) Neuro L.I.E:	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row	New diagnosis or symptomatic: **INCAPACITATE**. Send an incapacitation memo for: • Evaluation Data Row A	After a ruptured aneurysm or intracranial hemorrhage, blood clogs up arachnoid villi. Many patients will also need a shunt and be followed for **hydrocephalus**.

AVM, Subarachnoid hemorrhage (SAH), Subdural or epidural hemorrhage] (*If due to TRAUMA, See - Traumatic Brain Injury section, subdural hematoma, epidural hematoma, or subarachnoid hemorrhage.)	Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist (vascular neurologist preferred) **no more than 90 days before** the AME exam. 2. **Brain imaging to verify bleed has resolved,** performed **no more than 12 months before** the AME exam. If not already performed, a current test is required. 3. **MRI brain** to include **sequences sensitive to the presence of hemosiderin.** 4. **CT angiography (CTA) or MRA or angiography**. (Head required. Neck if clinically necessary) • Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 5. **Hospital records** for each hospitalization related to this condition. It must include information on surgeries and procedures. • Admission History and Physical (H&P); • Emergency Medical Services (EMS)/ambulance run sheet (if applicable); • Hospital consultant		If information not received: Send *rrINFOBRAINBLEED letter (avail in DIWS)* Add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-Neuropsychological Eval (Neurocog Impairment)** If 2 year recovery period has not been met: Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter, and send to DOC. All others: When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to send to GR Neuro Panel Physician. ***Update MedXPress status check***	A		

report(s) (such as neurology, cardiology, internal medicine, or other specialists);
- Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) that can be printed from an electronic medical record are NOT sufficient for pilot medical certification purposes.);
- Lab report(s) including all drug or alcohol testing performed;
- Operative/procedure report(s);
- Pathology report(s); and
- Radiology reports. The interpretive report(s) AND IMAGES of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) performed.
- DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or medication administration records.

Note: After review of the submitted information, a Neuropsychological (NP) evaluation that meets that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the treating neuropsychologist **may** be required.

If the applicant has a large volume of records, it is recommended that they bring them to the exam so the AME can assist in determining what is miscellaneous and

	not needed by the FAA. If associated with a **seizure** – see that section. An additional recovery period and testing (such as EEG) may apply. If a **shunt** was placed – see the Hydrocephalus section.					
If due to TRAUMA - see Traumatic Brain Injury (TBI) section. Subdural hematoma (SDH), Epidural hematoma, or Subarachnoid hemorrhage (SAH)						

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
	Follow up Issuance will be per the pilot's Authorization letter.		These are followed in Neuro Workflow until released by Neuro Physicians. When released, add to note and change Path code 3658.	.	

Condition Description

Hemorrhages (Intracranial) - Internal bleeding can occur in any part of the brain. Blood may accumulate in the brain tissue or in the space between the brain and the membranes covering it. The bleeding may be isolated to part of one hemisphere (lobar intracerebral hemorrhage) or it may occur in other brain structures, such as the thalamus, basal ganglia, pons, or cerebellum (deep intracerebral hemorrhage). An intracerebral hemorrhage can be caused by a traumatic brain injury or abnormalities of the blood vessels (aneurysm or angioma). When it is not caused by one of these conditions, it is most commonly associated with high blood pressure (hypertensive intracerebral hemorrhage). In some cases, no cause can be found. Blood irritates the brain tissues, causing swelling (cerebral edema). It can collect into a mass called a hematoma. Either swelling or a hematoma will increase pressure on brain tissues and can rapidly destroy them. The most common types are:

Subdural Hematoma - A subdural hematoma is a collection of blood on the surface of the brain and is usually the result of a serious head injury. If it occurs in this way, it is called an "acute" subdural hematoma. The bleeding fills the brain area very rapidly, leaving little room for the brain. This is usually associated with a brain injury. Subdural hematomas can also develop after a very minor head injury, especially in the elderly.
These go unnoticed for many days to many weeks, and are called "chronic" subdural hematomas. Some subdural hematomas occur without cause (spontaneously).

Epidural Hematoma - An epidural hematoma occurs when blood accumulates between the skull and the dura mater, the thick membrane covering the brain. They typically occur when a skull fracture tears an underlying blood vessel.

Subarachnoid Hemorrhage (SAH) - SAH occurs when a blood vessel just outside the brain ruptures. The area of the skull surrounding the brain (the subarachnoid space) rapidly fills with blood. SAH is most often caused by abnormalities of the arteries at the base of the brain. Sudden incapacitation is likely.

Additional History or Description of the Condition

REFERENCES

Go to TOC

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
I61.4, I62.00, I62.1, S06.6X0A

Pathology Codes (Prefixes)
602 (1,2,3,4,5,A,B,C,D,E), 602, 602, 602, 602

Level of Review
4

ICD-9
348.4 brain hemorrhage, 432.1 subdural hemorrhage

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
Appendix A, section 8A and 8C; 9 if on SC

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria
Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/15/2022 page reviewed with neurology

18l. Neurology

Brain Tumor (intracranial tumor) or Brain Cancer

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include subtle cognitive or neurologic impairments, and risk of sudden incapacitation due to seizures or for some tumors: bleeding.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. **Benign** Brain Tumor (meningioma, gliomas, etc) **not surgically treated** Will consider once chemo/radiation complete.	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating **neurologist** no more than 90 days before the AME exam. 2. MRI brain performed no more than 12 months before the AME exam. Submit both the report and a copy of the images on compact disc (CD) in	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) If information not received: Send *rrINFOBRAINTUMOR letter (avail in DIWS)* add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-Neuropsychological Eval (Neurocog Impairment)**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data Row A	(Updated 08/26/2021) Brain tumors (primary brain tumors or lesions metastatic to the brain) should be sent to AMCD Neuro Workflow with most recent neurology evaluation and imaging. Some will need review by FAS Neurology panel or FAS neurology

	DICOM readable format. (There MUST be a file name 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain copies of all CDs or image as a safeguard if lost in the mail. 3. If hospitalized or radiation treatment was performed, submit copies of the following Hospital reports for each hospitalization related to this condition: • Admission History and Physical. • Hospital discharge summary. • Emergency Medical Services (EMS)/ambulance run sheet. • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists). • Lab report(s) including all drug or alcohol testing performed. • Operative/procedure report(s). • Pathology report(s). • Radiology report(s). The interpretive report(s) of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) performed. Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. • DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, and medication		Neuro L.I.E.: When all required information received: Add to the problem list, assign path/ICD code, ADD PATH CODE 3658, summarize findings in notes, and send to Send to GR Neuro Panel Physician.			consultant.

	administration records. 4. After review of the information submitted, a neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluation for Potential Neurocognitive Impairment MAY be required. Note(s): If associated with a seizure also refer to the Seizure section. An additional recovery period may apply. If tumor type is Acoustic neuroma or Pituitary Tumor---see the corresponding section					
B. Benign Brain Tumor (meningioma, gliomas, etc) **surgically treated/resected** Will consider once chemo/radiation complete.	After a **two-year (2) recovery** period, the obtain and submit the following for FAA review: 1. All information in Row A; 2. Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment. (Due to surgical resection, NP testing is required.) Note: if associated with a seizure also refer to the Seizure section. An additional recovery period may apply.	DEFER Submit the information to the FAA for a possible Special Issuance.	If tumor resection/surgery was performed, a 2 year recovery period and NP testing are both required. SEND TO NEURO PANEL REVIEWER (AMCD) Neuro L.I.E.: If information not received: *Send rrINFOBRAIN TUMOR letter* (now avail in DIWS) add enclosure(s): **SPEC - NEUROEVAL + SP**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New presentation/new diagnosis or symptomatic: IN CAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data Row B	

			EC-Neuropsychological Eval (Neurocog Impairment) When all required information received: Add to the problem list, assign path/ICD code, ADD PATH CODE 3658, summarize findings in notes, and send to Send to GR Neuro Panel Physician.			
C. Malignant (cancerous) Brain Tumor Primary Tumor or Secondary metastatic tumor to the brain An individual currently on radiation or chemotherapy should complete treatment before medical certification can be considered.	After a **five-year (5) recovery period** following completion of chemotherapy, radiation or surgery. (Maintenance biologic medication does not add to the above recovery time.) Submit the following for FAA review: 1. All information in Row A; 2. The individual can submit the MOST RECENT detailed neurological evaluation (in lieu of one 90 days before the AME exam) that meets FAA Specifications for Neurologic Evaluation for initial case review.	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) If information not received: Send *rrINFOBRAINTUMOR letter (avail in DIWS)* **edit letter to read**: from " A current "evaluation by a board certified neurologist in accordance with the enclosed FAA Specifications for neurlogic Evaluation. to "The **most recent** ." add: A current neuropsychological evaluation in acordance with the enclosed FAA Specifications for Neurocognitive	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New presentation/new diagnosis or symptomatic: IN CAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data Row C	

			Impairment. add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-Neuropsychological Eval (Neurocog Impairment)** Notes: If tumor resection/surgery was performed, a 5 year recovery period and NP testing are both required. If the neurological evaluation verifies the condition is metastatic to the brain (secondary metastatic malignancy or unknown primary)—work in GR. If the neurological evaluation verifies the condition is a **primary malignant brain tumor**, **with favorable reports:** Note: EMS run sheet may be in the HOSPITAL records. If not, and all the other information s received---send to DOC to determine if EMS run sheet or other information is needed.			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
Any row.	Follow up Issuance will be per the pilot's Authorization letter.		These are worked in Neuro Workflow until path code 3658 has been released. Neuro L.I.E. If stable, meets f/u criteria—Continue Auth If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: If AME sends in all documents, issues correctly and no changes in medical condition: L.I.E.: create and sign *rrCONTINAUTH letter.* FMC and send to file. PA: create *rrCONTINAUTH letter*, FMC and send to DOC. If Cert time limit (t/l) incorrect **L.I.E.**: Prepare continue authorization *rr**CONTINAUTH*** letter, sign, and send corrected cert. **PA:** create *rrCONTINAUTH* letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received. (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter)	Follow up will be per FS	

			L.I.E.: Send: *rrINFOINITIALREQ letter* For missing items or per new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted **PA**: See above and send to DOC. <u>No longer meets SI, condition worsened</u> L.I.E./PA: Detail changes, abnormalities or questions in your notes and send to DOC. **L.I.E./PA:** When all required information received: Send to DOC		
				Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	

Go to TOC

Condition Description

Brain cancer is a disease of the brain where cancer cells (malignant) grow in the brain tissue. Cancer cells grow to form a mass of cancer tissue that interferes with brain tissue functions such as muscle control, sensation, memory, and other normal body functions.

The most frequently diagnosed benign brain tumors are meningioma (20%), acoustic neuroma (9%)--see that section, pituitary adenoma (8%), and hemangioblastoma (2%). Benign brain tumors are usually defined as a group of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a cancer.

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
D36.9, D33.2, D32.9, C71.9, C70.9, C72.9

Pathology Codes (Prefixes)
629 (1,3,5,A,C 1,3,5,8,A,C,H), 614, 629, 614, 629, 630

Level of Review
4

ICD-9
229.90

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Go to TOC

Blurbs Letters and Specification Sheets

Blurbs

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

5/29/24 clarified neurologist does not need to be a vascular neurologist. ¿

4/22/2022 page reviewed w/neuro.

18n. Neurology

CAROTID or VERTEBRAL ARTERY DISEASE(including carotid artery bruit; carotid artery stenosis; vertebral artery stenosis)

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Aeromedical Concerns

Concern with carotid/vertebral artery stenosis is occlusion leading to TIA or Stroke which can be suddenly incapacitating.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. **49% or less** by ultrasound, CTA or angiogram AND No history of TIA or	The AME should review the following: 1. Most recent vascular imaging and verify the testing was not performed for symptoms (TIA/CVA). If documentation verifies • 49% or less blockage (both sides)	ISSUE Summarize findings in Item 60.	If previously reported and warned: L.I.E.:/ PA: Add to DIWS note (ex. history of xx/previously warned), FMC and send to file. The first time the condition is reported: We will accept AME notes:	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	INCAP not needed--- Send information request memo for: • Evaluation Data Row A	A. If no symptoms (no prior TIA or CVA) No indication for anticoagulation (NOAC/DOAC or coumadin) And imaging verifies 49 % or less --AAM can usually warn.

CVA (use row for highest % stenosis from either left or right side)	• no symptoms • no ongoing treatment with DOAC/NOAC or coumadin • no current problems that would interfere with flight duties:		If the AME adequately explains the condition was asymptomatic, stenosis is 49% or less (on the highest side), and no use of NOAC/DOAC/coumadin/Jantoven] : L.I.E. add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. If no AME explanation: Send rrinfoINITIALREQ letter add: rrbCSLONG from treating physician or surgeon. - When all info received, process any conditions per OneGuide. PA: see above then send to DOC.	Imaging within the previous 12 months		
B. **50-79% stenosis**	See the CACI Carotid/Vertebral Stenosis Worksheet.	If the pilot meets all CACI worksheet	If the AME notes the condition is CACI qualified OR the L.I.E./PA determines after reviewing the information the	CACI is not applicable for VHT/ATCS.	CACI is not applicable for VHT/ATCS.	Row B B. Carotid or Vertebral stenosis of 50-79 should be

AND No history of TIA or CVA AND NOAC/DOAC/coumadin or surgery **not** recommended by treating physician at this time	This will require a detailed Clinical Progress Note and vascular imaging (ultrasound, CTA, angiogram) performed within the previous one year. Note: Antiplatelet therapy (including dual Plavix + ASA) can be considered for CACI. Anticoagulation (NOAC/DOAC/coumadin/Jantoven) is not acceptable for CACI. Go to row C.	criteria and is otherwise qualified,  with no time limitation Annotate the correct CACI statement in Block 60 and keep the required supporting information on file. If no AME explanation, the individual may be asked to provide documentation.	pilot is CACI qualified: **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter with rrbCACI, and WARN. If authorization for Special Issuance is required for additional condition(s), add the CACI paragraph rrbCACI to the auth letter. **PA:** See above then send to DOC. **Note:** If the AME made comments on the condition but did not use standard CACI wording (CACI qualified _____condition): Assign an “AME C" error code. If no AME explanation or CACI wording: *Send rrinfoINITIALREQ letter* *Add:* ***mabCAROTID*** When information received, process per OneGuide.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row C	monitored by the treating physician and AME can review documentation. See CACI worksheet. If does not meet CACI criteria—go to row C.

			Determine if you need to assign an AME “C" error code. (These cases still require processing.) **L.I.E./ PA:** Do not need to re-send rrbCACI eligibility letter each time. These cases can be released to file, as they have no time limitation. <u>If AME issued as CACI, but not CACI qualified:</u> Ex: prior stroke, TIA or on coumadin/DOAC/NOAC. Not allowed on CACI: *Send rrinfoINITIALREQ* letter as above. Assign AME “O" error for issuing a CACI in error. Process condition per OneGuide.			

C. All others including: **80% stenosis or higher** OR Taking NOAC/DOAC/coumadin OR Surgery is recommended, Note: if any neurologic symptoms or history of TIA or CVA, see that page.	Submit the following for FAA review: 1. A detailed Clinical Progress Note performed within 90 days of exam from the **treating physician (cardiologist, neurologist, or PCP).** It should include a detailed summary of the history of the condition or diagnosis, treatments and outcomes, current medications, physical exam findings, all pertinent test results obtained, assessment, plan, and follow up. 2. It must specifically include if there has been **any clinically significant increase in stenosis that would prompt a change in treatment or surveillance.** 3. **Carotid Ultrasound** or other vascular imaging report (e.g. CTA, MRA, angiogram) performed **no more than 90 days prior** to AME exam. 4. **Other testing:** Any deemed clinically necessary by the treating physician 5. **Cardiovascular risk assessment** to review risk factors and include testing indicated within the previous one year. [see Protocol for Cardiovascular Evaluation (CVE)]. Note: Stress testing may be required in some cases or when clinically indicated.	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60.	<u>If information not received:</u> *Send rrinfoINITIALREQ letter* Add: mabCAROTID + *Spec (CVE)* <u>When all information received:</u> Denial/DQ. If documentation received meets denial/DQ criteria in OneGuide: **L.I.E./ PA:**: Detail findings, changes, abnormalities, or reasons for denial in your problem focused notes. Prepare appropriate Denial letter and send to DOC for concurrence and signature. <u>All others:</u> **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, and send to DOC.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New presentation/diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row C	Row C Case by case. If asymptomatic, may consider SI with annual cardiac eval (CVE) and imaging. 1. Diagnostic Standards: Angiography is considered the gold standard for diagnosis. We may also accept carotid ultrasound, MRA, or CTA. 2. 80% or Higher Stenosis: • In most cases, an individual with 80% or higher stenosis on any side, must be stable and on anticoagulation for consideration of (SI/SC).

						• Many of these individuals may undergo carotid endarterectomy or receive a stent. 3. Anticoagulation: • Includes NOAC/DOAC, or Coumadin (Jantoven). • Antiplatelet (Plavix, Brilinta, ASA) treatment or dual antiplatelet (Plavix + ASA or Brilinta + ASA) therapy, are NOT anticoagulation. 4. Coronary Artery Disease (CAD): • High stenosis is an indicator for potential CAD.

						• A cardiac assessment is necessary to identify possible CAD. 5. Stress Testing: • An exercise stress test (EST) is not required for initial FAA review if the lesion is 80% or higher unless clinically indicated. • However, a cardiac risk assessment should be performed. CVE (narrative + Lab). • Most individuals will not need an annual stress test.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
B. **50-79% stenosis** AND No history of TIA or CVA AND NOAC/DOAC/coumadin or surgery **not** recommended by treating physician at this time	Standard Follow-up would usually include the following performed **within 90 days of exam**: 1. A detailed Clinical Progress Note* from the **treating physician**. It should include a detailed interim summary, treatments and outcomes, current medications, physical exam findings, all pertinent test results obtained, assessment, plan, and follow up. 2. Vascular imaging (Carotid ultrasound or other imaging). 3. Any other testing deemed necessary by the treating physician or required per the FAA Authorization		If there has been no change and otherwise CACI qualified: **L.I.E./ PA:** Do not need to re-send rrbCACI eligibility letter each time. Complete file maintenance (FMC - update path code, update Class Issue code, remove NTF) and release to file. No further action is required. Was SI/AASI and now qualifies for CACI: (Use this to release from AASI/SI to CACI.) We will accept AME notes “has current OR previous SI/AASI but now CACI qualified," or if the supporting information verifies CACI qualified: *Send rrELIG letter or rrRELEASEDAUTHELIG letter* Add: **rrbNOSICACI** and WARN. Complete file maintenance (FMC). If on Auth for multiple conditions and one becomes CACI qualified: **L.I.E.:** Add **rrbCACI** for the CACI qualified condition to the Auth Letter.		

			PA: See above and send to DOC for signature. If individual reports a new medical condition: **L.I.E./PA:** Process condition per OneGuide.		
C. All others including: **80% stenosis or higher** OR Taking NOAC/DOAC/coumadin OR Surgery is recommended, Note: if any neurologic symptoms or history of TIA or CVA, see that page.	Standard Follow-up will usually include: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the **treating physician** no more than 90 days before the AME exam. It must include a detailed interim summary; current medications, dosage, and side effects (if any); physical exam findings; results of any testing required or performed; diagnosis; assessment and plan; prognosis; and follow up. 2. Vascular imaging (Carotid ultrasound or other imaging). 3. Any other testing performed or deemed necessary by the treating physician or required per the FAA Authorization letter.	Follow up Issuance will be per the Authorization letter.	If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met. **If AME issues correctly** Documents received and no changes in medical condition: **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. **If AME issues Incorrectly** Cert t/l incorrect or not applied: **L.I.E.** *Send rrCONTINAUTH* letter + corrected cert. **PA:** Create r*rCONTINAUTH letter* + corrected cert and send to DOC -		

			Information not received: (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.** Process condition per OneGuide. Determine if need to assign AME “W" error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. Condition worsened or develops new condition or no longer meets AASI. **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC.		
				Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	

Go to TOC

Condition Description

A **carotid brui**t is an abnormal sound heard when using a stethoscope to listen to blood flow in the carotid artery. The carotid artery is the main artery in the neck and it brings blood to the head. A bruit may indicate a fatty buildup (atherosclerosis) in the artery. Carotid bruit is a sign of higher stroke risk. The vertebral artery also supplies blood to portions of the brain.

Highest stroke risk with 80% or greater stenosis.

Asymptomatic means no history of Stroke (CVA or TIA).

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
I65.29, I77.71

Pathology Codes (Prefixes)
488 (1,3,5,A,C,E), 612

Level of Review
4

ICD-9
Carotid Bruit 785.20, Carotid artery disease 433.10

Pilot Disposition
Warn, CACI, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.113(b), 67.213(b), and 67.313(b)

CFR(s) Conditions Treated with Meds
14 CFR 67 113(b)&(c), 67.213(b)&(c), and 67.313(b)&(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs

MABCAROTIDSTATUS, MABCAROTIDDUPLEX, MABCAROTID, MABDUPLEXDATE, MABCAROTIDDATE, rrbheartwarn

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

1/28/2026 page updated. Moved from cardiac to neuro. New CACI.

12/12/2025 page reviewed

12/8/25 reviewed with FAS Neurology. Combine this page and post endarterectomy. Created CACI for low risk. Change from cardiology to neurology.

1/21/2022 Initial page review.

18l. Neurology

Central Sleep Apnea

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Central sleep apnea (CSA) can increase the risk of serious health problems, including heart disease, stroke, and diabetes. CSA can also cause fatigue, daytime drowsiness, subtle cognitive impairments, and irritability.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Central Sleep Apnea **noted on sleep study results only**	If the AME can determine: • The condition is NOT central sleep apnea; • The sleep study apnea/hypopnea indices show: • **Less than 2** Central Apneas and/or Central Hypopnea episodes per hour occur AND	ISSUE Use the OSA protocol. Annotate Block 60 and submit the evaluation to the FAA for retention in the pilot's file.	If information received verifies the condition is OSA (which may have some central apneas noted). and **Less than 2** Central Apneas and/or Central hypopnea episodes per hour occur. AND **Less than 25%** of Total apnea and hypopnea episodes are listed as central.	Go to row B	Go to row B	Some degree of central sleep apnea can be normal. Process like an OSA case if the sleep study shows **Less than 2** Central Apneas and/or Central hypopnea episodes per hour occur or **Less than 25%** of Total apnea and hypopnea episodes are listed as central.

	• **Less than 25%** of total apnea and hypopnea episodes are listed as central; • The individual takes no medication for this condition; and • Individual has **NO** symptoms that would interfere with flight duties:		L.I.E./PA: Follow OSA guidance. all others go to row B			Central sleep apnea occurs when the brain does not send signals to muscles which control breathing. This can be due to a brainstem lesion (post stroke), severe cardiac failure (Cheyne-Stokes respiration), or medication such as narcotics. If not associated with another disease, it is idiopathic central sleep apnea. Per UpToDate, the Apnea/Hypopnea indices portion of criteria needed to make a Primary CSA diagnosis is >= 5 central apneas and/or central hypopneas per hour of sleep. The number of central apneas and/or central hypopneas is > 50% of the total number of apneas and hypopneas.

						Upon FAA DOC review, if these criteria are met and no concerns for diagnosis of CENTRAL sleep apnea, the DOC can consider warn or routine OSA follow up.
B. Central Sleep Apnea **Diagnosis** **If diagnosed with Obstructive SLEEP APNEA - see that page**	Submit the following for FAA review: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the treating neurologist or sleep specialist no more than 90 days before the AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. The evaluator should comment on any cardiovascular or psychological abnormalities and provide the results of any tests deemed necessary. 2. It must specifically include: • If there is excessive daytime sleepiness, • If treatment is successful, and • If the individual is compliant with treatment. 3. Sleep study/ polysomnography (most recent test results). It must be an in-lab Type I laboratory polysomnography. It must be interpreted by a sleep medicine specialist and must include diagnosis and	DEFER Submit the information to the FAA for a possible Special Issuance.	If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbCENTRALOSA (now available in DIWS)** When all information received: If documentation confirms the condition is Obstructive Sleep Apnea with **Less than 2** Central Apneas and/or Central hypopnea episodes per hour occur or **Less than 25%** of Total apnea and hypopnea episodes are listed as central. Follow OSA guidance. If documentation received verifies condition is **Central** Sleep Apnea with excessive daytime sleepiness or unfavorable report:	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	

	recommendation(s) for treatment, if any. 4. Any other testing performed or deemed necessary by the treating physician.		**L.I.E./PA:** Detail findings in your problem focused notes. Add to the problem list, assign path/ICD code, prepare appropriate Denial letter, and send to DOC for concurrence and signature. <u>All others:</u> **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, send to DOC.			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

A neurological disorder, central sleep apnea is a less common type of sleep apnea. It happens when the area of the brain that controls breathing doesn't send the correct signals to the breathing muscles. You make no effort to breathe for brief periods.

It is NOT the same as OSA. Central sleep apnea and OSA can be present in the same person.

Additional History or Description of the Condition

REFERENCES

Central sleep apnea: MedlinePlus Medical Encyclopedia

Details

Section / Branch
General Review (GR)

ICD-10
G47.31

Pathology Codes (Prefixes)
677

Level of Review
3

ICD-9
327.21

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.113(b), 67.213(b), and 67.313(b)

CFR(s) Conditions Treated with Meds
14 CFR 67 113(b)&(c), 67.213(b)&(c), and 67.313(b)&(c)

ATCS Disposition
SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Go to TOC

Blurbs Letters and Specification Sheets

Blurbs
rrbcentralosa

Letters

ATCS Letters/Memos

Specification Sheets

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

5/28/22 reviewed with Policy Committee¿

4/22/2022 page reviewed

18l. Neurology

Cerebral Palsy

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Aeromedical Concerns

Aeromedical concerns include muscle weakness and difficulty with precise movements. While the majority of individuals with CP do not have cognitive impairment, about one third to less than one half condition may have subtle cognitive impairments or attention deficit. Seizures are more common with Cerebral Palsy; see the epilepsy and seizure sections for guidance if these conditions are present.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Any history	Submit the following for FAA review: 1. A **current, detailed neurological evaluation**, in accordance with the FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam. 2. It must include and evaluation of items such as balance, strength, range of motion limitations and pain. It must describe any functional deficits or limitations for	DEFER Submit the information to the FAA for a possible Special Issuance.	If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbCEREBRALPALSY** (available in DIWS) When all information received: L.I.E. /PA:: add to the problem list, assign path/ICD code, summarize	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Physical	N/A will not be a new presentation.	**Cognitive Considerations and Screening:** • Cerebral Palsy is an early injury to the brain. While many pilots with Cerebral Palsy have normal cognition, a

	both large and small muscle groups as well as dexterity to operate an aircraft. 3. **All school/academic records**: Educational accommodations, Individual Education Plan (IEP) such as a "504" plan, educational support services provided, educational assessments and testing associated with IEP or individualized accommodations, neuropsychological assessments and testing, educational transcripts, and, if available, chief pilot reports. **Note**: in some cases additional information such as brain imaging (MRI/CT) or neurocognitive testing may be required after review of the above items. Physical limitations associated with CP may require a medical flight test. If a MFT is required, please state which FSDO the individual would prefer to use.		findings in note, send to DOC. If functional capacity is limited, a medical flight test (MFT) may be required. Send to DOCs for determination. **Note**: Do not ask for and Orthopedic evaluation. If function is of concern, use **rrbPTOT** to ask for PT/OT/PMR evaluation.	limitations associated with Cerebral Palsy may require a PT/OT/PMR evaluation.		high percentage may have cognitive deficiencies or learning difficulties. • There is an increased risk of subtle cognitive defects or learning disabilities that need to be screened. • It can be difficult to determine what is a residual versus well-compensated for or not well-compensated and what is normal. • There is a risk of cognitive impairment for some people with cerebral palsy. Cognitive screening may be appropriate in some cases. • CogScreen

						may over diagnose impairment given the heavy reliance on motor skills in responding to a computer-administered test. If cognitive concerns are present, AAM DOC should consult with FAS NP to identify a test battery that does not rely on or minimizes motor skills. **Certification and Evaluation:** • If the neurological evaluation is favorable, the condition is determined to be non-progressive with the absence of focal deficits, and functional capacity is

						• adequate and without significant limitation, the DOC may consider issuing a certificate. No further follow-up would be required. • If focal deficits are present and/or functional capacity is limited, a medical flight test (MFT) may be required.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
			If the neurological evaluation is favorable, there are no focal deficits, and functional capacity is adequate and without significant limitation, no further follow-up would be required. If focal deficits are present and/or		

			functional capacity is limited, a medical flight test (MFT) may be required. If a medical flight test (MFT) needed, see that page.		

Condition Description

Cerebral Palsy refers to any one of a number of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination but don't worsen over time. Even though cerebral palsy affects muscle movement, it isn't caused by problems in the muscles or nerves. It is caused by abnormalities in parts of the brain that control muscle movements.

Additional History or Description of the Condition

.

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
G80.9

Pathology Codes (Prefixes)
630 (1,2,3,4,5,8,A,B,C,D,E,H)

Level of Review
4

ICD-9
343.9

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and

CFR(s) Conditions Treated with Meds
14 CFR 67 113(b)&(c), 67.213(b)&(c),

67.309(b) and 67.313(b)&(c)

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
Warn, SC	8B, 8C (if on medication), 9 (if on SC)	12 months	per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbcerebralpalsy, RRBPTOT

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/8/2022 page reviewed neurology and NP info

18l. Neurology

Chiari Malformation

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Aeromedical Concerns

Aeromedical concerns include effects of current neurologic symptoms (headache, cranial nerve palsy, etc.) on operational safety, effects of treatments (surgery, etc.), and future risk of neurologic symptom development. A Chiari I malformation with significant crowding has an increased risk of sudden decompensation following otherwise minor head trauma.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Type I (aka low-lying tonsils) Incidental finding on imaging OR	The AME should review: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the **treating physician** no more than 90 days prior to the AME exam. 2. It must specifically include the reason the imaging was performed. If review of documentation verifies the	ISSUE **Annotate** Block 60 **and submit** the evaluation to the FAA for retention in the file.	Worked in GR if asymptomatic. If symptomatic, go to row C. If previously reported and warned: LIE:/ PA: Add to DIWS note (ex. history of incidental Chiari malformation or surgically treated 2+ years ago/previously warned), FMC and send to file. The first time the condition is	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data row A	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data row A	**General Information and Imaging:** • This is a common finding on brain imaging. It may also be called low-lying tonsils. • The individual

Chiari 1 decompression surgery 2+ years ago AND Asymptomatic	Chiari Malformation is: • an incidental finding on imaging, OR • surgically corrected 2 or more years ago and; • asymptomatic, • no additional treatment recommended, and • no symptoms that would interfere with flight or safety related duties: (If an underlying condition is identified, such as a headaches, see that page)		reported: We **will accept** AME notes: If the AME adequately explains the condition was an incidental finding or surgically treated 2 or more years ago with no further symptoms: LIE: add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. If no AME explanation: *Send rrinfoINITIALREQ letter* add: **rrbCHIARIa** from treating physician or surgeon. When all info received, process any conditions per OneGuide. PA: see above then send to DOC. When all information received: Denial/DQ. If documentation received meets denial/DQ criteria in OneGuide: LIE/ PA: Detail findings, changes,		If an underlying condition is identified, such as a headache, see that page. **New, incidental finding,** for ATC, we do not need to follow on SC. May need to follow the underlying condition.	may present for imaging due to headaches. If continued headaches, see headache page. **Chiari Malformation and Treatment:** • If Chiari Type 1 was surgically decompressed 2 or more years ago, can warn if no further treatment is needed and no symptoms.

			abnormalities, or reasons for denial in your problem focused notes. Prepare appropriate Denial letter and send to DOC for concurrence and signature. All others: LIE/ PA: Add to the problem list, assign path/ICD code, summarize findings in note, and send to DOC.			
B. Type 1 surgically corrected/ decompressed Within the past 2 years	There is no mandatory recovery period after decompression surgery. If no complications, can consider once the treating neurosurgeon has determined recovered, no symptoms and stable. Submit the following for FAA review: **1.** Clinical records pertaining to condition (which identifies why surgery was performed); **2. Operative report and** 3. **Post operative clinical notes from neurosurgery** 4. A current, detailed Clinical Progress Note generated from a clinic visit **with the provider managing the Chiari I finding** no more than 90 days prior to the AME exam. It must include: 1. A detailed summary of the history of the condition; 2. Current medications, dosage, and side effects (if any); 3. Physical exam findings;	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60.	Worked in General Review Only send to Neuro workflow if AAM Doc has concerns If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbCHIARIb** When all information received: Denial/DQ. If documentation received meets denial/DQ criteria in OneGuide: **L.I.E./ PA:** Detail findings, changes, abnormalities, or reasons for denial in	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data row B	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data row B	Row B .

	4. results of any testing performed; 5. diagnosis; assessment and plan; prognosis; and follow-up. 5. Is should specifically include: 1. If symptoms have resolved; 2. Any functional impact 3. Any abnormalities in the neurological exam.		your problem focused notes. Prepare appropriate Denial letter and send to DOC for concurrence and signature. <u>All others:</u> **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, and send to DOC.			
C. Currently symptomatic OR ANY Chiari type II, III, IV	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. It must specifically include: • Description of symptoms • Consider Syringomyelia---and supply spinal cord imaging if deemed clinically necessary. • Any f/u or treatment needed 2. Operative/procedure report(s); (if performed); 3. MRI of the brain performed **w/in previous 12 months** the AME exam. Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named	DEFER Submit the information to the FAA for a possible Special Issuance Annotate (elements or findings) in Item 60.	**L.I.E.** /PA: Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). Neuro L.I.E.: <u>If information not received:</u> Send rrinfoINITIALREQ letter Add: rrbCHIARIc + mabNEUROEVAL Add enclosure(s): SPEC-NEUROEVAL	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data row C	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data row C	Row C • If symptomatic, Special Issuance (SI) on a case-by-case basis. • Note: EEG is not indicated in any type of Chiari malformation (unless there is an additional history of seizures). **Air Traffic Control Specialist (ATCS) Considerations:** • New, incidental finding, for ATC, does

	'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. Additional imaging studies (MRI spine, etc.) already performed or clinically indicated. 5. For Chiari Type II----submit copies of most recent spinal cord imaging for syringomyelia.		When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. Note: Applying path code 3658 will automatically send the file into Neuro LIE workflow when info received.			not need follow-up SC. May need to follow the underlying condition (headache). • Chiari decompression surgery does not go into the brain and does NOT require a 2-year recovery period. • Can consider certification once the treating neurosurgeon has released the individual.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
				Send a Request for Information letter for:	

				• All previous medical records for this condition. • Evaluation Data row C	

Condition Description

Chiari malformations are developmental abnormalities in the base of the skull, cerebellum and brainstem. Normally the cerebellum and parts of the brain stem sit above an opening in the skull that allows the spinal cord to pass through it (called the foramen magnum). When part of the cerebellum extends below the foramen magnum and into the upper spinal canal, it is called a Chiari malformation (CM).

Additional History or Description of the Condition

Chiari malformation Is most often caused by structural defects in the brain and spinal cord that occur during fetal development. This is called primary or congenital Chiari malformation. **Chiari malformation** can also be caused later in life if spinal fluid is drained excessively from the lumbar or thoracic areas of the spine either due to traumatic injury, disease, or infection. This is called acquired or secondary Chiari malformation. Primary Chiari malformation is much more common than secondary Chiari malformation.

Chiari malformations are classified by the severity of the disorder and the parts of the brain that protrude into the spinal canal.

- **Chiari malformation Type I – the most common form – happens** when the lower part of the cerebellum (called the cerebellar tonsils) push into the foramen magnum. Normally, only the spinal cord passes through this opening. It is usually first noticed in adolescence or adulthood, often by accident during an examination for another condition. Adolescents and adults who have CM but no symptoms initially may develop signs of the disorder later in life. Chiari I is primarily a radiologic diagnosis of 6mm or greater cerebellar tonsillar descent if under age 15, or 5 mm or greater tonsillar descent age 16 or older. Chiari I can also be associated with syringomyelia and spinal MRI is obtained if there are concerns of spinal involvement. Chiari I can produce obstruction from crowding at the foramen magnum, and may produce symptoms of headache or cranial nerve dysfunction. Asymptomatic cases are generally conservatively managed. Symptomatic cases may be treated with sub occipital craniotomy and decompression.
- **Chiari malformation II (needs spinal cord imaging)—also called classic Chiari malformation – involves** both the cerebellum and brain stem tissue pushing into the foramen magnum. The nerve tissue that connects the two halves of the cerebellum may be missing or only partially formed. Type II is usually accompanied by a **myelomeningocele**—a form of spina bifida that occurs when the spinal canal and backbone do not close before birth (see below). A myelomeningocele usually results in partial or complete paralysis of the area below the spinal opening. Symptoms of Type II usually appear during childhood and are generally more severe than in Type 1. It can cause life-threatening complications during infancy or early childhood, and treating it requires surgery. The term Arnold-Chiari malformation is specific to Type II malformations.
- **Chiari malformation III and IV are both very rare and debilitating from infancy.**

Go to TOC

REFERENCES

https://www.ninds.nih.gov/chiari-malformation-fact-sheet

Steiman GS, Plunkett S. Understanding Chiari Malformations. Practical Neurology June 2022; 51-55.

Steiman GS, Plunkett S. Understanding Chiari malformation comorbidities. Practical Neurology July/August 2022; 58-62.

McVuge JW. Imaging of congenital malformations. Continuum (Minneap Minn) 2016; 22(5):1480-1498.

Kirschen MW, Illes J. Ethical implications of an incidentally-discovered asymptomatic Chiari Malformation in a competitive athlete. Continuum (Minnaep Minn) 2014; 20(6):1683-1687.

Details

Section / Branch
General Review (GR)

ICD-10
G93.5, Q07.00

Pathology Codes (Prefixes)
630 ((1,2,3,4,5,8,A,B,C,D,E,H)), 630

Level of Review
4

ICD-9
348.4741.90, Type 1 compression of the Brain or type II ArnoldChiari, syndrome without spina bifida or hydrocephalus

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Go to TOC

Blurbs

Letters

ATCS Letters/Memos

Specification Sheets

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement

Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

3/27/2024 published to match AME Guide updates
2/29/24 updated blurb names
2/14/24 updated with neuro comments
2/9/24 updated with neurology
10/27/23 reviewed with neurology

18l. Neurology

Cognitive or Mental Impairment or Dysfunction; Cognitive disorder NOS; Mild Cognitive Impairment (MCI)

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Aeromedical Concerns

Aeromedical concerns focus on current subtle cognitive or behavioral symptoms, and future disease progression. There is minimal risk of sudden incapacitation, but subtle/unrecognized impairments can unpredictably affect performance.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Neurological finding Cognitive impairment/ dysfunction	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating **neurologist** no more than 90 days before the AME exam. 2. A Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations	DEFER Submit the information to the FAA for a possible Special Issuance	These cases are worked in General Review If the Clinical Progress Notes do not identify a cause for the neurological impairment or dysfunction: *Send rrinfoINITIALREQ letter* add: **mabNEUROEVAL** **+**	Send a Request for Information letter for: • All previous medical records. • Row A Evaluation Data Note: If a cause	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following:	Possible causes include: Severe head injury Cerebrovascular disease Alcoholic or nutritional cerebral degeneration (Wernicke-Korsakoff Syndrome) Alzheimer's-type dementia

Mental impairment/dysfunction Confusion Delirium Encephalopathy OR When the cause of the neurological finding is unknown	for Potential Neurocognitive Impairment from a clinic visit with the treating **neuropsychologist** no more than 90 days before the AME exam. 3. Any other testing already performed or deemed necessary by the treating physician. Note: If the cognitive impairment is due to another condition (such as Stroke, TBI, substance abuse, MS, Neurodegenerative disease, mood disorder, or a specified medical illness)—See that page for any additional evaluation data requirements.	Summarize findings in Item 60.	**mabNEUROPSYCH** add enclosure(s): **SPEC-NEUROEVAL** **+ SPEC-Neuropsychological Eval** (Neurocog Impairment) L.I.E./PA: When all required information received: add to the problem list, assign path/ICD code, summarize findings in notes If documentation has been received that meets denial criteria in OneGuide: • Detail changes, abnormalities or reasons for denial in your problem focused notes. • Prepare Appropriate Denial letter and send to DOC for concurrence and signature. All others: send to DOC Note: If the cause is identified (e.g. Stroke, TBI, substance abuse, Multiple Sclerosis, Parkinson's Alzheimer's, mood disorder, specified medical illness, specified medication effect), see that section in OneGuide.	has been identified--see that section.	• Row A Evaluation Data Note: If a cause has been identified--see that section. Continue INCAP until the above criteria is met and reviewed by the FS.	Initial Airman Certification/ATCS Clearance: Some cases may be forwarded to a FAA neurologist consultant for review and recommendations. Note: Previous term "ORGANIC BRAIN SYNDROME" updated to Cognitive or Mental Impairment or Dysfunction with UNKNOWN CAUSE (cognitive NOS).

	Note: If the cause is identified (e.g. Stroke, TBI, substance abuse, Multiple Sclerosis, Parkinson's Alzheimer's, mood disorder, specified medical illness, specified medication effect), see that section.					

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

May be used to describe a neurological finding (such as cognitive impairment or dysfunction, mental impairment or dysfunction, confusion, delirium, or encephalopathy) when the cause of the neurological finding is unknown.

If the cause is identified (e.g. Stroke, TBI, substance abuse, Multiple Sclerosis, Parkinson's Alzheimer's, mood disorder, specified medical illness, specified medication effect), see that section.

Additional History or Description of the Condition

The core features of organic brain syndrome are disturbances in cognitive functions (memory, thinking, perception, and attention). The expression of emotions is altered, and alertness and vigilance are disturbed.

REFERENCES

https://pubmed.ncbi.nlm.nih.gov/6962656/

Details

Section / Branch
General Review (GR)

ICD-10
G31.84

Pathology Codes (Prefixes)
620 (1,3,A,C)

Level of Review
4

ICD-9
331.83

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
Appendix A, section 8A and 8C; 9 if on SC

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
MABNEUROEVAL, mabneuropsych

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

Immediate INCAP due to unknown cause of impairment or dysfunction.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿04/29/2022 page reviewed

18l. Neurology

Deep Brain Stimulator (DBS)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns focus on adverse effects from the underlying condition or the DBS. For Parkinson's or Essential Tremor - see the appropriate sections. DBS may cause subtle cognitive impairments. Device failure is rare, but may occur and would result in worsening or re-manifestation of the underlying condition.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Deep Brain Stimulator (DBS)	Submit the following for FAA review: 1. Deep Brain Stimulator (DBS) Status Summary 2. Operative report If applicant has **two** DBS devices, complete a status summary for **each device.**	DEFER Submit the information to the FAA for a possible Special Issuance.	**L.I.E. / PA:** Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). SEND TO NEURO PANEL REVIEWER (AMCD)	Send a Request for Information letter for: • All previous medical records for this condition.; • Evaluation data for the underlying condition;	New presentation/new diagnosis or symptomatic: IN CAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data for underlying	Initial certification after DBS placement. No fixed recovery period. Must be stable and well controlled. Will be case-by-case basis. If you do not want the AME to do the recert, you must specify in your note.

			Neuro L.I.E.: <u>If information not received</u>: *Send rrinfoINITIALREQ letter* Add: **mabDBS** + any required Evaluation Data for the underlying condition Add enclosure(s): **SPEC -Deep Brain Stimulator** When all required information received, add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to send to GR Neuro Panel Physician. If DOC does not want AME to issue the recert, add rrbDFR to auth letter.	and • Row A Evaluation Data Remember to also ask for the info for the UNDERLYING condition.	condition; and • Row A Evaluation Data Remember to also ask for the info for the UNDERLYING condition.	
NOTE: see underlying condition page for additional information requirements						

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
			If on SI for Deep Brain Stimulator and has new surgery or re-position of the device: Send case back to Neuro LIE.		

Condition Description

Deep Brain Stimulators are used for multiple conditions: Parkinson's, Epilepsy, Essential Tremor, Dystonia, and Obsessive compulsive disorder (OCD).

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
Z96.82, T85.190

Pathology Codes (Prefixes)

Level of Review
4

ICD-9
NA see the condition

Pilot Disposition
N/A

Pilot Standard Certification
see underlying condition

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
N/A

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
see underlying condition

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
RRBDFR

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

1/25/2023. DBS status summary published in AME Guide.
8/05/2022 page reviewed¿
8/2/2022 DBS spec sheet created.

18l. Neurology

Dystonia (including torticollis)

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Aeromedical Concerns

Aeromedical concerns include effects of current neurologic symptoms on operational safety, medication/treatment effects, and potential disease progression. .

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Any history of Dystonia at any time This includes cervical dystonia (spasmodic torticollis or torticollis).	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. Any other testing performed or deemed necessary by the treating physician	DEFER Submit the information to the FAA for a possible Special Issuance.	If information not received: Send *rrinfoINITIALREQ letter* Add: **mabNEUROEVAL** Add enclosure(s): **SPEC-NEUROEVAL** L.I.E./PA: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC.	Send a Request for Information letter for: • All previous medical records for this condition. • A current, detailed neurological evaluation that meets FAA	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • A current, detailed neurological evaluation that meets	Dystonia has a massive differential diagnosis and has the potential to progress. If questions or complicated history, discuss with Neuro Workflow physicians. Some cases may need to go to neuro workflow. If notes describe the condition as not

			If functional capacity is limited, a medical flight test (MFT) may be required prior to medical certification and/or Special Issuance. If a medical flight test (MFT) is required, see that page.	Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. • Any other testing performed or deemed necessary by the treating physician	FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist. • Any other testing performed or deemed necessary by the treating physician	stable or not well treated, MFT should not be considered.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

A. Any history of Dystonia at any time This includes cervical dystonia (spasmodic torticollis or torticollis).	Follow up Issuance will be per the Authorization letter. If there has been no change in the condition or treatment and the Authorization instructs the AME to ISSUE: Remember to apply a time limit if required.	See Authorization letter.	If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are me. <u>If AME sends in all documents, issues correctly and no changes in medical condition:</u> **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. <u>Cert t/l incorrect:</u> **L.I.E.**: Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC <u>If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received.</u>: (**if AME states in Block 60 reports are forthcoming, send to 14 day hold queue before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.**: Process condition per OneGuide. Determine if need to assign AME “W” error - read AME comments to see if reports	Continue INCAP until the above criteria is met and reviewed by the **FS.**	

			have been submitted **PA:** See above and send to DOC. <u>Condition worsened. No longer meets SI OR develops new condition:</u> **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		

Condition Description

Dystonia (abnormal tone) can be a manifestation of a number of other medical conditions. Therefore, it requires a full neurological evaluation within the previous 90 days.
It is a disorder characterized by involuntary muscle contractions that cause slow repetitive movements or abnormal postures. The movements may be painful, and some individuals with dystonia may have a tremor or other neurological symptoms. There are several different forms of dystonia that may affect only one muscle, groups of muscles, or muscles throughout the body. Some forms of dystonia are genetic but the cause for most cases is not known.

The dystonias can be divided into three groups: idiopathic, genetic, and acquired.

Acquired dystonia, also called secondary dystonia, results from environmental or other damage to the brain, or from exposure to certain types of medications. Some causes of acquired dystonia include birth injury (including hypoxia, a lack of oxygen to the brain, and neonatal brain hemorrhage), certain infections, reactions to certain drugs, heavy metal or carbon monoxide poisoning, trauma, or stroke. Acquired dystonia often plateaus and does not spread to other parts of the body.

Dystonia that occurs as a result of medications often ceases if the medications are stopped quickly. Dystonia can be a symptom of other diseases, some of which may be hereditary.

Cervical dystonia, also called spasmodic torticollis or torticollis, is the most common of the focal dystonias.

This is a broad condition which can progress over time. Symptom and affect can range from benign (observation only or Botox) to fully disabling. Variable abnormalities may be noted. Cramping/spasm can cycle like a tremor. Different parts of the body may be affected (ex. face/around eye/one side of face/hand when writing [writer's cramp]). Some will affect one side, others will affect all four limbs. If an individual has one dystonia, they are at risk of getting more.

Additional History or Description of the Condition

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REFERENCES

https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Dystonias-Fact-Sheet

Details

Section / Branch
General Review (GR)

ICD-10
G24.9, M43.6

Pathology Codes (Prefixes)
621 ((1,2,3,4,A,B,C,D)), 899

Level of Review
4

ICD-9
333.89

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67 113(b)&(c), 67.213(b)&(c), and 67.313(b)&(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs

Letters	**Specification Sheets**
ATCS Letters/Memos	**ATCS Sheets**

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/1/2022 page reviewed with neurology.

18l. Neurology

Encephalitis

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Aeromedical Concerns

Aeromedical concerns include adverse effects of any medications used for symptom management, residual neurologic or behavioral symptoms or signs, such as brain damage, seizures, paralysis, hearing loss or cognitive impairment, and future seizure risk.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Current or historical diagnosis single episode	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating **neurologist** no more than 90 days before the AME exam. 2. It must specifically include if this was a single episode, if the individual is immunocompromised, and if any seizure activity occurred. 3. MRI and/or CT of the brain (the most recent test). Submit the interpretive report on paper and	DEFER Submit the information to the FAA for a possible Special Issuance.	These are worked in General Review If information not received: *Send rrINFOINITIALREQ letter* Add: **rrbENCEPHALITIS** (available in DIWS) Add enclosure: **SPEC-NEUROEVAL**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data Row A	Row A Single episode, resolved, with no residual lesions, MRI changes or concerns from neurology---consider warn.

	imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. An electroencephalogram (EEG) if already performed, OR if any history of seizures. The EEG recording should be sleep-deprived: awake, asleep, and with provocation (e.g. hyperventilation, photic/strobe light). Include any previous EEG(s) available for comparison. Submit BOTH the final interpretive report(s) and the actual tracings (ALL pages) for any EEGs on CD. The CDs of EEG recordings must have proprietary opening software that is compatible with Windows 10. Note: Neuropsychological (NP) evaluation will be required in some cases (such as any residual lesions found on MRI or any neurocognitive concerns). When required, it must meet FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the treating neuropsychologist.		If the **MRI or CT report shows lesions or scarring** on the brain or the neurologic evaluation determines there is concern for cognitive impairment on clinical exam: Add: **mabNEUROPSYCH** Enclosure: **SPEC-Neuropsychological Eval** (Neurocog Impairment) If uncertain if NP testing is necessary, when other information received, send to DOC. L.I.E./PA: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC.	Note: Most cases will go to a FAS neurology consultant for review.	Note: Most cases will go to a FAS neurology consultant for review.	

	Seizure - if associated with a seizure, refer to that section. A recovery period may apply.					
B. Current or historical diagnosis with 2 or more lifetime episodes, immunocompromised, or seizure activity	All information required in Row A PLUS • EEG is required if a history of seizures. • Additional information may be required after review of above information.	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) who will send the initial info request letter (if needed). Note: Cases sent to NEURO PANEL REVIEWER (AMCD) will be reviewed by AMCD Neuro Workflow physicians and may not require Neurology Panel. Neuro L.I.E.: If information not received: *Send rrinfoINITIALREQ letter* Add: **mabNEUROEVAL + mabNEUROPSYCH** Add enclosure(s): **SPEC-NEUROEVAL + SPEC-Neuropsychological Eval** (Neurocog Impairment) When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data Row B	Row B If residual brain lesions or neurology note identifies any neurocognitive concerns, NP evaluation needed. Multiple episodes or immunocompromised: Send to AMCD Neuro Workflow.

			workflow, summarize findings in notes, and send to GR Neuro Panel Physician.			

Note: For Brain Abscess or Meningitis--see that page.

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Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Current or historical diagnosis	Follow up Issuance will be per the pilot's Authorization letter.	Follow up Issuance will be per the Authorization letter.	If No longer requires Auth: L.I.E.: Create and send *rrRELEASEDAUTHELIG letter* and WARN. Complete file maintenance (FMC). PA: as above. Send to DOC for signature. If stable, meets follow-up criteria: Continue Auth if the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: If AME sends in all documents, issues correctly, and no changes in medical condition: L.I.E.: create and sign	See SC letter for follow up requirements.	

			rrCONTINAUTH letter. FMC and send to file. PA: create rrCONTINAUTH letter, FMC and send to DOC. <u>If Cert time limit (t/l) incorrect:</u> L.I.E.: Prepare continue authorization rrCONTINAUTH letter, sign, and send corrected cert. PA: create rrCONTINAUTH letter and corrected cert and send to DOC <u>If AME issues Incorrectly</u> (new meds/change in meds/new medical condition) OR Information not received. (**if AME states in Block 60 reports are forthcoming, send to 14-day hold que before sending letter) L.I.E.: Send: rrINFOINITIALREQ letter for missing items or per new condition. Process condition per OneGuide. Determine if need to assign AME "W" error - *read AME Block 60 comments to see if reports have been submitted. PA: See above and send to DOC. <u>No longer meets SI, condition worsened</u> L.I.E./PA: Detail changes, abnormalities, or questions in your notes and send to		

			DOC.		

Condition Description

The term "encephalitis" literally means "inflammation of the brain." It usually refers to brain inflammation resulting from a viral infection. Encephalitis occurs in two forms, primary and secondary. Primary encephalitis involves direct viral infection of the brain and spinal cord. In secondary encephalitis, a viral infection first occurs elsewhere in in the body and then travels to the brain. Severe viral encephalitis can cause respiratory arrest, coma, and death. It may also leave marked mental impairment, which can include loss of memory, the inability to speak coherently, lack of muscle coordination, paralysis, or hearing or vision defects.

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
G04.90, G93.40

Pathology Codes (Prefixes)
603 ((1,A)), 620

Level of Review
4

ICD-9
323.90

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
Warn, SC	8B, 8C (if on medication), 9 (if on SC)	12 months	per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbencephalitis, mabneuropsych

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

Current or active encephalitis is disqualifying. INCAPACITATE.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿¿3/25/22 page reviewed

18l. Neurology

Epilepsy (seizure disorder)

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Aeromedical Concerns

Aeromedical concerns include any residual neurologic symptoms or signs, adverse effects of any medications used for symptom management, and risk of sudden or subtle incapacitation.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Epilepsy by history **Seizure-free for** **Ten (10) years** AND **off medication for the last 3 years**	After a **ten (10)-year seizure-free recovery period**, obtain the following and submit for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating **neurologist (Epileptologist preferred),** no more than 90 days before the AME exam. 2. It must specifically include the date of last seizure activity and dates medication discontinued. 3. **MRI brain** performed at any time after the seizure activity started. If not already performed, a current brain MRI is required. Submit	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) **Neuro L.I.E.:** If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbSEIZURE** Change recovery period to: **After a ten (10)-year seizure-free recovery period** obtain the following: Add enclosures: SPEC-	Send a Request for Information letter for: The FAA requires a ten (10) year seizure-free recovery period with the last three (3) years off medication. • All previous medical records	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following after a ten (10) year seizure-free recovery period with the last three (3) years off medication:	Before consideration can be given to an applicant with the diagnosis of epilepsy, they must be seizure-free for 10 years and off medication for at least the last 3 years This refers to all types of epileptic seizures (petit mal, focal, etc.) and not just grand mal seizures.

	BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. **Electroencephalogram (EEG)** performed no more than 12 months before the AME exam. It must be a sleep-deprived EEG: awake, asleep, and with provocation (hyperventilation, photic/strobe light). A 24-hour EEG study is preferred. • If not already performed, a current EEG is required. • Submit any previous EEG(s) available for comparison. • Submit BOTH the interpretive report(s) on paper and a copy of the EEG recording(s) on CD with proprietary opening software that is compatible with Windows 10. You may wish to retain a copy of all films as a safeguard if lost in the mail. 5. FAA Airman Seizure Questionnaire completed by the applicant..		NEUROEVAL + FAA Airman Seizure Questionnaire <u>If recovery period has not been met:</u> Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter, and send to DOC. This is a Specifically Disqualifying condition. This is a **FINAL DENIABLE** condition. If the FAA physician instructs to Deny, the appropriate FINAL DENIAL letter and exact condition name/wording must be used. Epilepsy See Denials and Disqualifications Pointer Page <u>When recovery period met and all required information received:</u> Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician.	for this condition. • Evaluation Data	• Evaluation Data .	

			Note: While epileptologist (a neurologist who specializes in treating seizures and epilepsy) is preferred, we may accept neurologist evaluation.			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

Epilepsy is a brain disorder in which clusters of nerve cells, or neurons, in the brain sometimes signal abnormally. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness. Epilepsy is a disorder with many possible causes. Anything that disturbs the normal pattern of neuron activity - from illness to brain damage to abnormal brain development - can lead to seizures. Epilepsy may develop because of an abnormality in brain wiring, an imbalance of nerve signaling chemicals called neurotransmitters, or some combination of these factors. Having a seizure does not necessarily mean that a person has epilepsy.
§ 67.109 Neurologic.

Neurologic standards for a first-class airman medical certificate are:
(a) No established medical history or clinical diagnosis of any of the following:
(1) Epilepsy;

Additional History or Description of the Condition

Imaging. We can accept images performed at any time after the seizures/epilepsy started. Will need both the reports and images on CD. Approximately 40% of epilepsy cases have brain pathology on imaging.

EEGs are not helpful unless abnormal and can make the diagnosis difficult. If performed, we need a copy.
If 10 years seizure free: Request a current EEG performed within the previous year. It does not need to be a 24-hour study. Compare to old studies and verify no discharges. If it

is abnormal, they still have epilepsy.

REFERENCES

https://www.cdc.gov/epilepsy/about/faq.htm#What%20is%20epilepsy?%20What%20is%20a%20seizure?

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
G40.109, G40.209, G40.909

Pathology Codes (Prefixes)
605 ((1,3,A,C)), 605 ((1,A)), 605

Level of Review
4

ICD-9
Epilepsy 345.90, Jacksonian 345.50

Pilot Disposition
Warn, SI, DQ

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(a)(1), 67.209(a)(1), and 67.309(a)(1)--Sp DQ condition Epilepsy

CFR(s) Conditions Treated with Meds
14 CFR 67.109(a)(1) and 67.113(c) ;
67.209(a)(1) and 67.213(c);
67.309(a)(1) and 67.313(c)

ATCS Disposition
Warn, DQ, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Blurbs Letters and Specification Sheets

Blurbs
rrbseizure

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

If new condition or symptoms: INCAP

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

8/3/2023 updated to show specifically DQ condition and CFRs.¿
5/31/23 clarified EEG is on CD with opening software.
4/29/22 clarified prefer Epileptologist preferred (vs general neurologist).
¿4/12/2022 reviewed with neurology

18l. Neurology

Guillain-Barre Syndrome

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include adverse effects of any residual neurologic symptoms or signs, medication/treatment effects, future recurrence risk, and possible development of chronic inflammatory demyelinating polyradiculoneuropathy (CIDP). Residual reduced pulmonary function can also be aeromedically-significant due to potential for altitude-related decompensation.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Single episode, no complications, fully resolved and recovered, with a minimum of six months of stability	If the AME can determine this was a single episode, fully resolved for six (6) months or longer with no complications or sequelae: **Note:** If the episode occurred within the **previous 12 months**, the AME must review documentation from the treating physician. If 6 months of stability has not been met, go to row B.	ISSUE Summarize findings in Item 60 and submit the evaluation to the FAA for retention in the pilot's file.	We **will accept** AME notes: If the AME adequately explains the condition has resolved with no ongoing treatment needed, add to the problem list, assign path/ICD code, and WARN. If no AME explanation: Send rrinfoINITIALREQ letter Add: rrbCSLONG	Send a Request for Information letter for: • All previous medical records for this condition.	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	Row A Single episode, resolved - consider warning.

		If any underlying cause found, see that page.	Request the most current, detailed Clinical Progress Note and any testing performed regarding the history of Guillain-Barre Syndrome. If information received verifies single episode, no complications, fully recovered and 6 months of stability: L.I.E.: Add to the problem list, assign path/ICD code, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. PA: See above then send to DOC.			
B. Less than six (6) months of stability after episode, OR Continued symptoms	Submit the following for FAA review: 1. A current, detailed neurological evaluation, in accordance with the FAA Specifications for Neurologic evaluation, generated from a clinic visit with the treating **neurologist** no more than 90 days before the AME exam. 2. It must specifically include if there is any persisting deficit and period	DEFER Submit the information to the FAA for a possible Special Issuance.	<u>If information not received:</u> *Send rrinfoINITIALREQ letter* Add: **mabNEUROEVAL** Add enclosure(s): **SPEC-NEUROEVAL** <u>When all information received:</u>	Send a Request for Information letter for: • All previous medical records for this condition.	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row	Row B If recurrent episodes, needs Neurology evaluation.

OR complications OR Two or more episodes in a lifetime	of stability without symptoms. 3. Other testing already performed or deemed necessary by the pilot's physician. Note: If associated with a seizure, refer to the Seizure section. An additional recovery period may apply.		**L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, send to DOC.	• Evaluation Data Row B	B	ATCS when completely resolved, treating physician has released, and no sequelae that would interfere with ATCS duties, can consider warning one year after symptoms resolve.

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Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
B. Two or more episodes in a lifetime, Continued symptoms, OR complications	Follow up Issuance will be per the Authorization letter.	.	If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all of those parameters are met: **L.I.E.**: Prepare and sign continue authorization. **PA**: Prepare continue authorization letter and send to DOC.	See SC.	

			All others (including parameters not met) **L.I.E./PA:** When all required information received, send to DOC If the DOC does not want the AME to issue the recert, use rrbDFR.		

Condition Description

Guillain-Barré syndrome is a rare, autoimmune disorder in which a person's own immune system damages the nerves, causing muscle weakness and sometimes paralysis. GBS can cause symptoms that last for a few weeks to several years. Most people recover fully, but some have permanent nerve damage. Some people have died of GBS.

Symptoms can progress over hours, days, or weeks, and weakness typically peaks within the first two weeks after symptoms appear. Recovery may take as little as a few weeks or as long as a few years.

About two-thirds of people with GBS had diarrhea or a respiratory illness several weeks before developing symptoms. Infection with Campylobacter jejuni, which causes diarrhea, is one of the most common risk factors for GBS. People also can develop GBS after some other infections, such as flu, cytomegalovirus, Epstein Barr virus, and Zika virus. Very rarely, people have developed GBS in the days or weeks after receiving certain vaccines. About 1 in every 1,000 reported Campylobacter illnesses leads to GBS. As many as 40% of GBS cases in the United States are thought to be triggered by Campylobacter infection.

CIDP would require Special Issuance certification with indefinite follow-up.
Common treatments include plasma exchange (a procedure that removes and replaces the liquid part of the blood) and high-dose immunoglobulin therapy (an infusion of antibodies).

Additional History or Description of the Condition

.

REFERENCES

Guillain-Barré Syndrome | Campylobacter | CDC

Sheikh KA. Guillain-Barre Syndrome. Continuum (Minneap Minn) 2020; 26(5):1184-1204.
Gwathmey K. Chronic inflammatory demyelinating polyradiculopathy and its variants. Continuum (Minneap Minn) 2020; 26(5):1205-1223.

Details

Section / Branch
General Review (GR)

ICD-10
G61.0

Pathology Codes (Prefixes)
643 (1,3,A,C)

Level of Review
4

ICD-9
357.0

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Go to TOC

Blurbs
RRBDFR

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis or symptomatic: INCAPACITATE and request a follow-up evaluation by the treating physician.
Continue INCAP until reviewed and cleared by the FS.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/08/2022 page reviewed

3/28/2022 reviewed with Neurology

18l. Neurology

HEAD INJURY or BRAIN INJURYConcussion, Closed Head Injury (CHI), Open Head Injury, Traumatic Brain Injury (TBI)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include effects of current cognitive and neurologic symptoms, medication effects, and future risk of seizures, with resulting sudden incapacitation. The severity of injury is the governing factor in aeromedical disposition, but every case is unique and must be considered in this context.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
If Head injury only or REMOTE Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page **********	If Head injury only or **REMOTE Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page** ********** After a **6-month recovery period** obtain the following evaluation(s) and submit for FAA review:	DEFER Submit the information to the FAA for a possible Special Issuance.	If Head injury only or REMOTE **Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page** ********** If information not received: *Send rrinfoINITIALREQ letter* add: **rrbCONCUSSION (avail in DIWS)**	If Head injury only or REMOTE **Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page** ********** Historical info	If Head injury only or REMOTE **Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page** ********** New diagnosis or symptomatic:	If Head injury only or REMOTE **Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page** ********** NOTE: B1 is remote brain injury

B2. Brain injury Within the past 5 years This includes: • Concussion • MILD brain Injury • Loss of Consciousness (LOC) • Alteration of Consciousness (AOC) • Post-Traumatic Amnesia (PTA) ALL less than 1 HOUR AND	1. A **current, detailed Clinical Progress Note** generated from a clinic visit with the treating physician **or neurologist no more than 90 days before** the AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 2. **It must specifically include**: • Any evidence of seizure; • Any post-traumatic amnesia or mental fogginess (incomplete memory of the incident, does not recall the impact/crash, etc.) • Any post-concussive symptoms such as headaches, dizziness, irritability; • Any changes in vision; • Any focal deficit; • Any imaging performed and if (CT/MRI) was negative; • Any clinical indication for further brain imaging; initial CT head/face negative. 3. Records from any hospitalization(s) for this condition to include: • Admission History and Physical; • Hospital discharge summary. (Typically, the patient portal notes or After Visit Summary [AVS] printed from the electronic medical		<u>When all information received</u>: Denial/DQ. If documentation received meets denial/DQ criteria in OneGuide (including if recovery period has not been met): **L.I.E./PA:** Detail findings, changes, abnormalities, or reasons for denial in your problem focused notes. Add to the problem list, assign path/ICD code, prepare appropriate Denial letter, and send to DOC for concurrence and signature. <u>All others</u>: **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, send to DOC.	based on severity. Remote is 5 years or more per neuro docs. Send a Request for Information letter for: • All previous medical records for this condition. After review of the above, some cases will need: • Evaluation Data Row A	INCAPACITATE. Send an incapacitation memo and request: Records from any hospitalization(s) for this condition to include: Admission History and Physical. • Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) you can print from your electronic medical record are NOT sufficient for pilot medical certification purposes.). • Lab report(s) including all drug or alcohol testing performed.	B2 is brain injury w/in past 5 years Small parafalcine SDH. No symptoms. No mid-line shift. No craniotomy. MRI done within 3-6 months shows complete resolution. Neuro and neuropsych are OK. We do not require a 5-year wait. These can be considered for certification in 6 months. Diffuse axonal injury. Even though there is hemosiderin at the gray-white junction, these may be considered in 2-3 years with full recovery.

• No seizure Exception: An immediate impact seizure (within 24 hours of injury) can be reviewed using Row B criteria. Note: High impact/penetrating injuries (e.g., gunshot or severe trauma) may present with few or no concussive symptoms. For high impact injuries, see Row D Do NOT use this row if the individual had any items listed in Row C or D (e.g., brain injury, seizure, skull fracture)	record are NOT sufficient for pilot medical certification purposes.); • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists); • Operative/procedure report(s); • Pathology report(s); • Radiology reports*. The interpretive report(s) of all diagnostic imaging performed (CT scan, MRI, X-ray, ultrasound, or others); • Lab report(s) including all drug or alcohol testing performed; and • Emergency Medical Services EMS)/ambulance run sheet. • *DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or medication administration records.* • Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail. Note: If any abnormalities noted, go to Row C.				• Emergency Medical Services (EMS)/ambulance run sheet. Radiology reports. The interpretive report(s) of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) already performed. After a 6-month recovery period obtain the following evaluation(s) and submit for FAA review: A current, detailed Clinical Progress Note generated from a clinic visit with your treating physician or neurologist no more than 90 days prior to your AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side	

					effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment; plan (prognosis); and follow-up. It must specifically include: • Any evidence of seizure; • Any posttraumatic amnesia or mental fogginess (incomplete memory of the incident, does not recall the aircraft impact/crash) • Any post-concussive symptoms, such as headaches, dizziness, irritability; • Any changes in vision; • Any focal	

					deficit; • Any imaging performed (CT/MRI) was negative; • Any clinical indication for further brain imaging, initial CT head/face negative.	
C. Moderate BRAIN Injury This includes: • LOC,AOC, or PTA of 1 to 24 hours • Non-depressed skull fracture • Small/trace parafalcine or tentorial subdural hematoma (resolved by MRI) • Small/trace subarachnoid hemorrhage (resolved by	After a **12-month recovery period** obtain the following evaluation(s) and submit for FAA review: 1. A **current, detailed neurological evaluation,** in accordance with the FAA Specifications for Neurologic Evaluation, that is generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam. 2. **It must specifically include** if there is (or is NOT) any concern or history of seizure(s). 3. EEG only if a seizure occurred and an EEG was obtained, submit results. EEG* Sleep-deprived and sleep awake state with activating	DEFER Submit the information to the FAA for a possible Special Issuance.	CHANGED 10/2024--send to NEURO LIE **L.I.E. /PA:** Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). SEND TO NEURO PANEL REVIEWER (AMCD) If information not received: Send rrinfoTBI letter (avail in DIWS) add enclosure(s): SPEC-NEUROEVAL + SPEC-Neuropsychological	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New diagnosis or symptomatic: INCAPACITATE and request: 1. Records from any hospitalization(s) for this condition to include: 2. Admission History and Physical. • Hospital discharge summary. (Typically, the patient portal notes or after visit	Row C (of 4 rows) Moderate TBI. (updated 10/2024) Worked in neuro workflow to obtain and review review. AMCD/RFS can still work the case to disposition. If any quesitons, contact FAS neuro or neuro team.

MRI) • Any hemorrhage must be resolved on MRI. If the MRI shows signs of hemosiderin deposition, go to Row D.	procedures (with provocation) performed at the time of event or later. 4. A **Neuropsychological evaluation** that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the **treating neuropsychologist no more than 90 days before** the AME exam. 5. **MRI brain** with hemosiderin-sensitive sequences (with contrast as clinically appropriate) performed any time after the event. • Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail. 6. Records from any hospitalization(s) for this condition to include: • Admission History and Physical. • Hospital discharge summary. (Typically, the patient portal notes or after visit summary [AVS] printed from the electronic medical		Eval (Neurocog Impairment) When all information received: **Neuro L.I.E./PA:** add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC If required recovery period has not been met: Add to the problem list, assign path/ICD code, add path code 3658, summarize findings in notes, create appropriate denial letter and send to DOC. These are reviewed by AMCD/RFS. Some may go to neuro workflow.		summary (AVS) you can print from your electronic medical record are NOT sufficient for pilot medical certification purposes.). • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists). • Operative/ procedure report(s). • Pathology report(s). • Radiology reports. The interpretive report(s) of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) pe	

	record are NOT sufficient for pilot medical certification purposes.). • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists). • Operative/procedure report(s). • Pathology report(s). • Radiology reports. The interpretive report(s) of all diagnostic imaging (CT scan, MRI, X-ray, ultrasound, or others) performed. For all imaging, submit the interpretive report(s) AND the actual images on CD in DICOM readable format. • Lab report(s) including all drug or alcohol testing performed. • Emergency Medical Services (EMS)/ambulance run sheet. • *DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or medication administration records.* 7. Progress notes from ALL clinic follow-up visits related to this condition. 8. Other tests already performed or clinically indicated. Note: Small parafalcine or tentorial Subdural Hematoma: If asymptomatic and MRI 3-6 months after the injury shows complete resolution, FAA may consider after a 6-month recovery period. Submit the Evaluation Data in this row after the recovery period.				rformed. • Lab report(s) including all drug or alcohol testing performed. • Emergency Medical Services (EMS)/ambulance run sheet. • DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or medication administration records. After a **twelve (12)-month recovery period**, request: 1. A current, detailed neurological evaluation, in	

					accordance with the FAA Specifications for Neurologic Evaluation, that is generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. It must specifically include if there is (or is NOT) any concern or history of seizure(s). 3. EEG* Sleep deprived and sleep awake state with activating procedures (with provocation) performed at the time	

					of event or later only if seizure occurred. 4. A Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the treating neuropsychologist no more than 90 days before the AME exam. 5. MRI brain* (prefer with contrast if clinically appropriate) performed any time after	

					the event. 6. Progress notes from ALL clinic follow up visits related to this condition. 7. Other tests already performed or clinically indicated.	
D. Severe BRAIN Injury This includes: • Blood in the Brain: • Brain contusion • Intracranial bleed • Hematoma • Epidural hematoma • Subdural hematoma • Diffuse axonal injury • LOC,	After a **five (5)-year recovery period** submit for FAA review: • All items in **Row C**	DEFER Submit the information to the FAA for a possible Special Issuance.	**L.I.E. /PA:** Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). SEND TO NEURO PANEL REVIEWER (AMCD) If required recovery period has NOT been met: Detail abnormalities or reasons for denial in your problem focused notes. Prepare	After a **five (5)-year recovery period** obtain the following evaluation(s) and submit for FAA review: Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New diagnosis or symptomatic: INCAPACITATE. Requires a **five (5)-year recovery period** Send an incapacitation memo for: • Evaluation Data Row B	Row D (of 4 rows) Penetrating injury is considered one notch above severe TBI. These are typically seen in military action and not civilian population.

AOC, PTA: 24 hours or more • Depressed skull fracture • Penetrating head injury			Appropriate Denial letter and send to DOC for concurrence and signature. If information not received: *Send rrinfoTBI letter* (avail in DIWS) add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-Neuropsychological Eval (Neurocog Impairment)** (delete info already received) Neuro L.I.E.: When all required information received: add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. These are reviewed by FAS Neurology Panel			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
				After a **five (5)-year recovery**	

				period obtain the following evaluation(s) and submit for FAA review: Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	

Condition Description

Head injuries are classified based on levels of severity.

Traumatic Brain Injury (TBI) - occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue.

If Head injury only or REMOTE **Brain injury 5 or more years ago (B1) --go to HEAD INJURY or REMOTE BRAIN INJURY page**

LOC: Loss of Consciousness

AOC: Alteration of Consciousness

PTA: Post-Traumatic Amnesia

Additional History or Description of the Condition

REFERENCES

Selected Post-Traumatic Seizure References:

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Najafi MR et al. Early and late posttraumatic seizures following traumatic brain injury: A five-year follow-up survival study. Adv Biomed Res 2015 May 11;4:82. doi: 10.4103/2277-9175.156640. PMID: 26015908; PMCID: PMC4434449.

Englander J, Cifu DX, Diaz-Arrastia R. Information/education page. Seizures and traumatic brain injury. Arch Phys Med Rehabil 2014 Jun;95(6):1223-4. doi: 10.1016/j.apmr.2013.06.002. PMID: 24862307; PMCID: PMC4516165.

Perron AD, Brady WJ, Huff JS. Concussive convulsions: emergency department assessment and management of a frequently misunderstood entity. Acad Emerg Med 2001 Mar; 8(3):296-8. doi: 10.1111/j.1553-2712.2001.tb01312.x. PMID: 11229957.

McCrory, P.R., Berkovic, S.F. Concussive Convulsions. Sports Med 1998; 25:131–136. https://doi.org/10.2165/00007256-199825020-00005

McCrory PR, Bladin PF, Berkovic SF. Retrospective study of concussive convulsions in elite Australian rules and rugby league footballers: phenomenology, aetiology, and outcome. BMJ 1997 Jan 18;314(7075):171-4. doi: 10.1136/bmj.314.7075.171. PMID: 9022428; PMCID: PMC2125700.

Incidental SAH References:

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Tentorial/Subfalcine SDH References:

Juhasz KA et al. Risk factors, management, and outcomes in isolated parafalcine or tentorial subdural hematomas. Am J Emerg Med. 2023 Apr;66:135-140. doi: 10.1016/j.ajem.2023.01.014. Epub 2023 Jan 13. PMID: 36753929.

Howard BM et al. Management and Outcomes of Isolated Tentorial and Parafalcine "Smear" Subdural Hematomas at a Level-1 Trauma Center: Necessity of High Acuity Care. J Neurotrauma. 2017 Jan 1;34(1):128-136. doi: 10.1089/neu.2015.4270. Epub 2016 May 26. PMID: 27025978.

Pruitt P et al. Seizure frequency in patients with isolated subdural hematoma and preserved consciousness. Brain Inj. 2019;33(8):1059-1063. doi: 10.1080/02699052.2019.1606446. Epub 2019 Apr 21. PMID: 31007086.

Infratentorial Hemosiderin References:

Haapaniemi E et al. The CAVE score for predicting late seizures after intracerebral hemorrhage. Stroke 2014; 45:1971-1976. doi: 10.1161/STROKEAHA.114.004686.

Asconapé JJ, Penry JK. Poststroke seizures in the elderly. Clin Geriatr Med 1991; 7(3):483-92. PMID: 1868406.

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
S06.0X0, S06.9X0

Pathology Codes (Prefixes)
604 ((1,3,4,A,C,D)-concussion(1,4,5,A,D,E)), 866, 604

Level of Review
4

ICD-9
850.9 concussion, 959.01 head injury closed or not

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbconcussion

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

11/6/2025 simplified row D, severe. Removed MRA/CTA as required. Same Eval Data as row C. Wait time currently 5 years. Row C clarified small/trace.
9/24/2025 row D, severe. Removed EEG as required evaluation data item.
7/2/25 corrected typo. Row D requires all of row C eval data after recovery period.
10/25/24 reviewed with neurology. Send all moderate TBI to neuro LIE to generate information request and review. AMCD/RFS can still work case when documents received.
8/28/24 Updated and re-lettered rows to harmonize with AME Guide. B1 is now REMOTE brain injury. B2 is w/in 5 years.
6/26/24 Updated title and row names to BRAIN injury. For HEAD injury only, see that page.
2/28/24 Edits to ATCS on-board section to clarify when records should be requested
9/23 additional reference added¿
5/06/2022 page reviewed

18l. Neurology

Head Injury or Remote Brain Injury

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include any residual neurologic symptoms or signs, adverse effects of any medications used for symptom management and complications such as brain damage, seizures, cognitive impairment, and behavioral disorders.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Head injury ONLY This means: • NO brain injury • NO concussion • NO neurological symptoms	If the AME can determine the condition was • Head injury only (no brain injury) such as superficial scalp injury or globe (eyeball/eye injury) and/or musculoskeletal injuries (facial/maxilla/ mandible fractures) that do not persist and do not rise to the level of even a mild concussion; • No neurological symptoms; and • No “mild concussion symptoms" such as headache, dizziness, nausea, or non-focal neurological symptoms such as	ISSUE Summarize findings in Item 60 including mechanism and date of injury.	If previously reported and warned: **L.I.E./ PA:** Add to DIWS note (ex. history of head injury/previously warned), FMC and send to file. The first time the condition is reported: We **will accept** AME notes: If the AME adequately explains the condition has	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New presentation/diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	Use this page for recent or remote HEAD injury.

DO NOT use this row if the individual had any items listed in Row B, C, or D (e.g., brain injury, seizure, skull fracture.)	photo/phonophobia, tinnitus, irritability, mental fogginess, etc., as a result of the injury. • If imaging (CT/MRI) was performed, no evidence of brain trauma. • Has completely resolved and the individual has been released to full activity by the treating physician: Note: The AME should NOT use this row if any symptoms, concerns for concussion/brain injury, or any complications. If any concerns in history, the AME should review the most recent, detailed Clinical Progress Note describing the incident, recovery, and follow-up (if applicable).		resolved or fully recovered and no concussion symptoms: **L.I.E.:** Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. If no AME explanation: Send *rrinfoINITIALREQ letter* Add: **rrbCSLONG for DCPN from treating physician (this could be PCP)** NOTE: CT/MRI of brain may have been performed in ER. If negative, and no symptoms, can use row A. **PA:** See above then send to DOC			
B1. Brain injury 5 or more years ago This includes: • Concussion	The AME should gather information regarding the diagnosis, severity, treatment, symptoms, and address ALL the questions on the Brain Injury Decision Tool for the AME.	ISSUE Summarize this history, diagnosis, and annotate Block 60: “Discussed	If previously reported and warned: L.I.E.:/ PA: Add to DIWS note (ex. history of brain injury/previously warned), FMC and send to file.	Ask for personal statement that includes date and details of injury, and any residual problems from the injury. If any	N/A If not previously reported, ask for personal statement which includes date and details of injury, and any	Row B without AME comments or decision tool • We are unsure of severity of

(a type of mild brain injury) • MILD brain Injury As long as NO seizure* *Exception: An immediate impact seizure (within 24 hours of injury) can be reviewed using Row B criteria.) Note: High impact/ penetrating injuries (e.g., gunshot or severe trauma) may present with few or no concussive symptoms. For high impact injuries, see Row D.	If all items on the decision tool are in the clear, “NO column, the AME may: Note: For a remote injury with no concerns, the most recent progress note is acceptable. IF NO COMMENTS IN ITEM 60, THE INDIVIDUAL MAY BE ASKED TO PROVIDE INFORMATION.	the history of BRAIN INJURY, no positives to screening questions, and no concerns." If any “YES" answers, any AME concerns, or unable to verify history ISSUE Summarize findings and reason for deferral in Block 60.	<u>The first time the condition is reported:</u> We will accept AME notes if they comment they used the Brain Injury Decision Tool and no positive answers OR DCPN verifies remote, no blood in brain, no continued symptoms. L.I.E.: add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. <u>If no AME explanation:</u> Send *rrinfoINITIALREQ* letter add: **rrbCONCUSSION** PA: see above then send to DOC.	positives, Send a Request for Information letter for: • All previous medical records for this condition. • Brain Injury Decision Tool for the AME or Current DCPN which verifies date of injury, if there was any blood in brain, and any continued symptoms.	residual problems from the injury. If associated with a NEW injury see BRAIN INJURYConcussion; Closed Head Injury (CHI); Open Head Injury; Traumatic Brain Injury (TBI)	the condition. Request neurology eval and old records. Upon receipt and review, additional information may be required based on severity. • We ask for this information because even a remote hea d injury can result in persistent cognitive deficits. • Seizure risk decreases after 4-5 years if they remain seizure free.

Recent Brain injury

or moderate/severe injury

B2

C

D

go to BRAIN INJURYConcussion; Closed Head Injury (CHI); Open Head Injury; Traumatic Brain Injury (TBI)

go to BRAIN INJURYConcussion; Closed Head Injury (CHI); Open Head Injury; Traumatic Brain Injury (TBI)

go to BRAIN INJURYConcussion; Closed Head Injury (CHI); Open Head Injury; Traumatic Brain Injury (TBI)

go to BRAIN INJURYConcussion; Closed Head Injury (CHI); Open Head Injury; Traumatic Brain Injury (TBI)

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
				go to BRAIN INJURYConcussion; Closed Head Injury (CHI); Open Head Injury; Traumatic Brain Injury (TBI)	

Condition Description

Additional History or Description of the Condition

Go to TOC

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
S06.9X0A

Pathology Codes (Prefixes)
604

Level of Review
4

ICD-9

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Summary of Changes

Go to TOC

2/28/2025 updated row B with LIE/PA; VHT/ATCS info
8/28/2024 Added B1 Remote Brain injury; Decison tool. LInk back to TBI page if needed.
¿6/26/2024 published in OneGuide and AME Guide. New page created for Head injury. (for recent Brain injury, see that page)
6/21/2024 page reviewed with Neurology

18a. Neurology

Headache or Migraine (Cluster; Tension; Ocular migraine; Acephalic migraine; Ophthalmic migraine; Retinal migraine; Vestibular migraine)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include any residual neurologic symptoms or signs, adverse effects of any medications used for symptom management, complications such as problems with memory or concentration, and unpredictable recurrence risk.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Stress Headache Tension Headache Controlled with OTC meds	If the AME can determine the condition is mild and under control, • Average of less than two headache days per month; • Medications are acceptable (seldom requiring more than OTC analgesics); • Is not incapacitating (The individual has no symptoms that would interfere with flight duties.); and • Not associated with any	ISSUE Summarize findings in Item 60.	If previously reported and warned: **L.I.E./PA:** Add to DIWS note (ex. history of migraine or headache/previously warned), FMC, and send to file.	If history of headache, Send a Request for Information letter for: • Headache Questionnaire Verify/review received information to determine	If New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Headache	**Medical Certificate Eligibility:** • No class of medical certificate should be considered for an airman with significant complications such as

	neurological findings:		<u>The first time the condition is reported:</u> We **will accept** AME notes. If the AME adequately explains the condition is mild, treated with OTC meds only and not incapacitating: **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. <u>If no AME explanation:</u> *Send rrinfoINITIALREQ letter* Add: **rrbHEADACHE** <u>When all info received</u>: L.I.E.: When all info received, see above. **PA:** See above then send to DOC.	Disease/Condition Stage: • If the Headache Questionnaire verifies the Headache is stress tension, controlled with OTC meds: • send to FS for determination and action (possible WARN).	<u>Questionnaire</u> Verify/review received information to determine Disease/Condition Stage: If the Headache Questionnaire verifies the Headache is stress tension, controlled with OTC meds and less than 2 headaches per month: send to FS for determination and action (possible WARN). Note: If taking prescribed medication or headaches more than 2 per month Incapacitate. • Send Headaches Questionnaire • A detailed Clinical Progress Note (actual clinical record) performed from your physi	severe and/or frequent headaches (one or more per month), visual, motor, sensory, or language disturbances, vertigo, syncope, or acute confusional states. • Persons with a non-visual prodromal aura (which provides a warning of impending onset of headache) will have more favorable consideration than those with a history of sudden onset without warning. • If the medical reports support the fact that the headache is not likely to

					cian or neurologist. It should include a detailed summary of your history of migraine, current medications, applicable test results, assessment, treatment plan, follow-up, and any other testing deemed necessary by the treating physician. Verify/review received information Disease/Condition Stage:	cause sudden incapacitation, there are no reported associated neurologic or visual deficits, and any medication use is acceptable for aeromedical purposes, a medical certificate may be considered. **Medications:** • Medication: See list for continuous daily prophylactic use on CACI. FAA Migraine Medication Guide.
B. Migraine with aura	See the CACI-Migraine and Chronic Headache Worksheet. CACI updated 8/28/24 This will require a current, detailed Clinical Progress Note from the treating physician	If the pilot meets **all** CACI worksheet criteria and is otherwise	Note: **remember to review medications used as some may be DQ.** If the AME notes the condition is	Send a Request for Information letter for: • All	If New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an	**Row B** **CACI Considerations:**

(Classic migraine/ Common Migraine) OR Chronic tension OR Chronic daily OR Cluster OR (Older terms include acephalgic migraine, ocular migraine, ophthalmic migraine Classic migraine is now called migraine headache with aura.)	or neurologist. Detailed list of migraine medication can be found in the Pharmaceuticals Section, Migraine Medications. Pharmaceuticals - Migraine Medications (faa.gov) *Note: Migraine with any visual symptoms. Identify if peripheral and non-disabling. (If central loss or disabling, see row C).	qualified, ISSUE with no time limitation Annotate the **correct CACI statement** in Block 60 **and keep the required supporting information** on file.	**CACI** qualified OR the L.I.E./PA determines after reviewing the information the pilot is CACI qualified-: **L.I.E.**: add to the problem list, assign pathology code, send eligibility letter with RRBCACI and WARN. If authorization for **Special Issuance** is required for **additional condition(s)** add the CACI paragraph rrbCACI to the auth letter. **PA**: see above then send to DOC. If **no AME comment:** Send *rrinfoINITIALREQ letter* add: **rrbHEADACHE** Once information received, process as described above and determine if you need to assign an error code. If not CACI qualified, **L.I.E.**. **may process and sign the initial AASI** certification on 1st, 2nd, or 3rd class medical certificates to otherwise qualified pilots **if information received verifies:** - Frequency: **no greater than one**	previous medical records for this condition. • Headache Questionnaire • A **detailed Clinical Progress Note** (actual clinical record) performed from your physician or neurologist. It should include a detailed summary of your history of migraine, **current** medications, applicable test results, assessment, treatment plan, follow-up, and any other testing deemed necessary by the treating physician.	incapacitation memo and request the following: • Headache Questionnaire • A detailed Clinical Progress Note (actual clinical record) performed from your physician or neurologist. It should include a detailed summary of your history of migraine, current medications, applicable test results, assessment, treatment plan, follow-up, and any other testing deemed necessary by the treating physician.	• NOTE: CACI updated 8/28/2024 to allow more meds/treatment and simplify info we need from treating physician. • CACI: Most will qualify. Verify medications acceptable for CACI. **AASI Considerations** • AASI: If not CACI qualified, usually due to symptom frequency or medication use, yet still aeromedically acceptable. There may also be cases where the significance of mild non-disabling tension headaches more than once a

			migraine headache on average per month. [2 or more per month would be 24 migraine/year which is aeromedically concerning] - Severity: progress notes or AME notes verify headaches are not severe enough to be incapacitating, there is no mention of migraine-associated speech difficulty, motor weakness, or cognitive dysfunction. --Symptoms. Any vision disturbance. Diplopia (double vision), or a large area of visual field loss (i.e. any significant neurologic signs). --Onset. Headaches are preceded by a non-visual prodrome or other warning of headache. --Trigger: Known and generally avoidable trigger (e.g. food, environmental exposure,	Verify/review received information: • If the progress note indicates a diagnosis of migraine treated with prescribed medication:		month may be overcalled. These may be OK for an AASI, but for reasons other than the medication not listed on the CACI, initials should go to the DOC. This should cover the "90%" of not quite CACI qualified cases.

			physiological stress, etc.). Add to the problem list, assign path/ICD code, and summarize findings in notes. Change Class Issued to 19, 29, or 39 Prepare AASI auth Send: rr1CLAASIAUTH, rr2CLAASIAUTH, or rr3CLAASIAUTH letter add enclosure(s): AASI quick coversheet + AASI Migraine Spec **L.I.E.**.: sign AASI **If outside the above AASI parameters:** send to DOC **PA**: When information received, send to DOC.			
C. Any history of a migraine which results in disabling visual symptoms such as loss of central vision or large visual field cut (excluding migraine aura) OR Chronic daily,	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. MRI* of the brain performed no more than one (1) year before the AME exam. • *If an MRI is contraindicated or cannot be performed, the treating	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) Neuro L.I.E.: If information not received: Send *rrinfoINITIALREQ letter* add: **rrbNEUROHEADACHE (avail in DIWS)** add enclosure(s): **SPEC-NEUROEVAL**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	If New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • A detailed neurologic	**Row C** **Specific Conditions to consider SI (not AASI):** • 1 or more migraines/month. • Ocular migraine if "not functionally incapacitati

Complicated migraine, OR Post-traumatic headaches, OR Retinal migraine (This type spreads across the retina and the concern is Amaurosis). Previously called ocular migraine--row C if disabling visual distrubance such as central vision loss. OR Vestibular migraine	neurologist should discuss why. If CT is used, with or without contrast is per the treating neurologist. • • Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 3. Number of headache days per month per the applicant. 4. Other testing completed or deemed necessary by the treating physician. Note: If associated with a seizure – see seizure section. Chronic recurring headaches or pain syndromes often require medication for relief or prophylaxis, and, in some instances, the use of such medications is disqualifying because they may interfere with the individual's alertness and functioning. Notes: Pain, in some conditions, may be acutely incapacitating. Chronic recurring headaches or pain syndromes often require medication for relief or prophylaxis, and, in most instances, the use of such medications is disqualifying because they may interfere with a pilot's		When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. **PA**: Send initial letter as above then release case to NEURO PANEL REVIEWER workflow.	Verify/review received information: • If the progress note indicates a diagnosis of complicated migraine and/or post traumatic headaches: send to FS for clearance determination. Note: If associated with a seizure, refer to the Seizure section. Pain, in some conditions, may be acutely incapacitating. Chronic recurring headaches or pain syndromes	al evaluation in accordance with the FAA Specifications for Neurologic Evaluation performed within 90 days of exam . • MRI brain, most recent testing already performed. • Other testing: Any deemed clinically necessary by the ATCS's treating physician. Verify/review received information: • If the progress note indicates a diagnosis	ng,". Aeromedical risk, chance of recurrence is less than 1% per year. The statistics 30 years ago were that 40% of people would have at least one acephalgic migraine in a lifetime. That number has gone up with PDE5 Inhibitors, where this is a very common side effect. However the headache may occur some time after using sildenafil (e.g. a week) so not temporally associated. If the PDE5I is stopped, the ocular migraines usually resolve.

	alertness and functioning.			often require medication for relief or prophylaxis, and, in some instances, the use of such medications are disqualifying because they may interfere with the ATCS's alertness and functioning.	of complicated migraine and/or post traumatic headaches: send to FS for clearance determination. Note: If associated with a seizure, refer to the Seizure section. Pain, in some conditions, may be acutely incapacitating. Chronic recurring headaches or pain syndromes often require medication for relief or prophylaxis, and, in some instances, the use of such medications are disqualifying because they may interfere with and ATCS's alertness and functioning. Note: Annual clearance recertification requirements will be based on the classification of headache	• Uncomplicated ocular migraines are very benign from an aeromedical perspective. These airmen can continue to fly the airplane with minimal distraction; the visual disturbances are minimal and of brief duration unless they progress to other migraine manifestations. **VHT/ATCS Considerations:** • New history of migraine: Most will be INCAP until evaluated and resolved. • Two or more migraines is the current upper limit. Some may be continual on separate

					listed above or as specified by the FS if SC is granted.	days. Migraines treated with meds, some may persist or resolve and come back.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
B. Migraine with aura (Classic migraine/ Common Migraine) OR Chronic tension OR Chronic daily OR Cluster OR (Older terms include acephalgic migraine, ocular migraine, ophthalmic migraine Classic migraine is	Standard follow-up would include: 1. A **detailed Clinical Progress Note*** performed **within 90 days of exam** from the treating neurologist. It should include a detailed interim summary, treatments and outcomes, **current** medications, physical exam findings, all pertinent test results obtained, assessment, plan, and follow up. 2. Any other testing deemed necessary by the treating physician or required per the FAA Authorization letter. **<u>If placed on an AASI, the AME must defer the AASI recertification when</u>**: • The **frequency** of headaches and/or other **symptoms increase** since the last follow-up report; or • The applicant is placed on Unacceptable medication(s), such	ISSUE With the time limitation specified on the pilot's AASI Authorization for Special Issuance. Summarize findings in Item 60. Submit all information for FAA review.	CACI note. If the pilot was previously on AASI/SI and now qualifies for CACI (we will accept AME notes "has current OR previous SI/AASI but now CACI qualified", or if the supporting information verifies CACI qualified. To release from SI/AASI to CACI send eligibility letter with RRB**NOSI**CACI. If current progress note verifies the condition is stable and 1. No reported change in frequency or severity of headaches. 2. No reported change in medications or treatment. **L.I.E.**: Prepare and sign continue authorization letter.	Annual clearance recertification requirements will be based on the classification of headache/migraine listed in Initial Clearance Requirements above. **Verify/review** received information: • If the progress note indicates a diagnosis of hea	

now called migraine headache with aura.)	as isometheptene mucate--Midrin, [DSC], narcotic analgesic, tramadol, tricyclic-antidepressant medication, etc.		**PA**: Prepare continue authorization letter and send to DOC. ***Remember to remove the 3658 path code if case if now*** general review so case will no longer route to Neuro workflow. **All others** (ex: not stable, outside parameters, new condition): Send to DOC. Continue AASI: If AME sends in all documents, issues correctly, and • there is no worsening of the condition (no increase in frequency or severity) • No chagne in medications or treatment **L.I.E.:** FMC and send to file. **PA:** Create continue rrCONTINAUTH.v2 letter and send to DOC. Condition worsened If documentation does not meet AASI criteria: L.I.E/**PA**:.: When all required information received: Add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC.	dache/ migraine with or without medication: Send to **FS** for continued Special Consideration. Send Special Consideration memo per condition stage: • See the above Initial Clearance Requirements.	

c. Any history of a migraine which results in disabling visual symptoms such as loss of central vision or large visual field cut (excluding migraine aura) OR Chronic daily, OR Complicated migraine, OR Post-traumatic headaches, OR Retinal migraine. (This type spreads across the retina and the concern is Amaurosis). Previously called ocular migraine. OR Vestibular migraine	Standard follow-up would include: 1. A **detailed Clinical Progress Note*** performed **within 90 days of exam** from the treating neurologist. It should include a detailed interim summary, treatments and outcomes, **current** medications, physical exam findings, all pertinent test results obtained, assessment, plan, and follow up. 2. Any other testing deemed necessary by the treating physician or required per the FAA Authorization letter.		<u>If stable, meets f/u criteria—Continue Auth</u> If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: <u>If AME sends in all documents, issues correctly and no changes in medical condition:</u> **L.I.E.**: create and sign *rrCONTINAUTH letter.* FMC and send to file. **PA**: create *rrCONTINAUTH letter.* FMC and send to DOC. <u>If Cert time limit (t/l) incorrect</u> **L.I.E.**: Prepare continue authorization *rrCONTINAUTH* letter, sign, and send corrected cert. **PA:** create *rrCONTINAUTH* letter and corrected cert and send to DOC <u>If AME issues Incorrectly</u> (new meds/change in meds/new medical condition) OR <u>Information not received</u> (**if AME		

			states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) **L.I.E.**: Send: *rrinfoINITIALREQ letter* for missing items or new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted **PA**: See above and send to DOC. <u>No longer meets SI (condition worsened)</u> **L.I.E./PA**: Detail changes, abnormalities or questions in your notes and send to DOC.		
				Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	

				Verify/review received information: • If the progress note indicates a diagnosis of complicated migraine and/or post traumatic headaches: send to FS for clearance determination. Note: If associated with a seizure, refer to the Seizure section. Pain, in some conditions, may be acutely incapacitating. Chronic recurring headaches or pain syndromes often require medication for relief or prophylaxis, and, in some instances, the use of such medications are disqualifying because they may interfere with the ATCS's alertness and functioning.	

Condition Description

There are many types of headaches.

Stress headaches, or tension headaches, are the most common type of headache. These headaches are sometimes called muscle contraction headaches, daily headaches, or chronic non-progressive headaches. Another common type is a sinus headache. Most people with headaches have them no more than once or twice a month, but the headaches can occur more frequently.

M**igraine headache** is often disabling. In some cases, these painful headaches are preceded or accompanied by a sensory warning sign (aura), such as flashes of light, blind spots or tingling in your arm or leg. A migraine headache is also often accompanied by other signs and symptoms, such as nausea, vomiting, and extreme sensitivity to light and sound. Additionally, an individual may have associated cognitive defects. Migraine pain can be excruciating and may incapacitate a person for hours or even days.

Childhood Onset Migraine: Same as adult onset migraine only occurring during childhood. May be associated with underlying conditions such as epilepsy, neurological deficits, or brain tumor.
Cluster headaches are severe, one-sided headaches that recur in groups, or "clusters," over a period of weeks to months. While common headaches can be painful, cluster headaches can be debilitating.

Ocular Migraines - This is a neurological condition (not an eye condition). It can have adverse affects on vision. The symptoms of ocular migraines vary from person to person, and may include seeing zigzagging lines or patterns, especially at the outer edges of your vision, seeing shimmering or colored lights, loss of vision in one spot or off to one side.

Additional History or Description of the Condition

Ocular migraine is an outdated term. Current headache system terminology is :

> migraine with visual aura or aura with headache or migraine visual aura without headache.
>
> These types of headaches have more in common with migraine than with anything ocular/eye related. There is NO ocular pathology. Typical characteristics of ocular migraine: 1) 20-30 min duration, 2) usually involve vision one eye, 3) not associated with pain or headache, 4) no confirmed therapy to prevent or control any type of migraine attack including ocular migraine, 5) recurrence of ocular migraine is unpredictable.

True retinal migraine is rare, occurs in one (1) eye only. Spreads across the retina.

REFERENCES

Go to TOC

Details

Section / Branch
General Review (GR)

ICD-10
G43.009, G43.B0, G44.001, G44.209, R51

Pathology Codes (Prefixes)
628 (628 (1,3,A,C)), 628 (Migraine), 628 (ClusterHeadache 628 (1,3,A,C)), 675, 675

Level of Review
4

ICD-9
Migraine 346.10, Cluster 339.00

Pilot Disposition
Warn, CACI, SI, AASI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbheadache, rrbneuroheadache

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria
Uncontrolled Headache with or without medications is disqualifying: FS will determine DQ or incapacitation status based on medical information received

Go to TOC

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

9/24/2025 updated migraine terminology column 1 row B and C
2/27/2025 page maintenance.
8/28/2024 updated CACI, allowed more meds/treatement. New Migraine pharmacy page. Updated review to 4 (neuro docs)
6/26/2024 updated title to include vestibular migraine
2/1/23 moved Chronic daily and Any history of a migraine which results in changes in vision (excluding migraine aura) to row C. These are not CACI. Not on the worksheet. Classic migraine is now called migraine headache with our without aura)d/w neurology.
reviewed with VHT/ATCS

11/12/2022 AASI not used for more than 1 migraine a month.
3/11/2022 page reviewed
1/19/2022 Updated Evaluation Data and DOC case dispositions. Removed hospital records, added neurology eval per specs for complicated migraine. Changed BBlockers and Ca++ to allowed with CACI.

18l. Neurology

Huntington's Disease

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include adverse effects of current motor, cognitive or behavioral symptoms, and inexorable disease progression. There is essentially no risk of sudden incapacitation, but subtle/unrecognized impairments can occur unpredictably. Aeromedically-significant cognitive/behavioral symptoms may precede development of chorea.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Huntington's Disease	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. A Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the treating neuropsychologist no	DEFER Submit the information to the FAA for a possible Special Issuance.	**These cases are worked in General Review** If information not received: Send *rrinfoINITIALREQ letter* add: mabNEUROEVAL + mabNEUROPSYCH add enclosure(s): **SPEC-NEUROEVAL** + **SPEC-**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data	**Denial and Symptomatic Cases:** • In most cases, when symptomatic, will be a denial. **Pre-Clinical Conditions and Evaluation:** • If records

	more than 90 days before the AME exam. 3. Any other testing deemed clinically necessary or already performed for this condition by the treating physician. Note: If the diagnosis is confirmed as symptomatic Huntington's, the individual may want to submit that information to AAM before obtaining the NP evaluation.		**Neuropsychological Eval (Neurocog Impairment)** **Note: Do NOT ask for genetic testing.** When all information received: 1. Symptomatic If we receive **only the neurology evaluation**, and it verifies the diagnosis is **symptomatic** Huntington's do not ask again for NP testing--send info to DOC.. **L.I.E./PA:** Detail findings, changes, abnormalities, or reasons for denial in your problem focused notes. Add to the problem list, assign path/ICD code, prepare appropriate Denial letter, and send to DOC for concurrence and signature. 2. Asymptomatic If the neurology evaluation verifies: • Huntington's and no symptoms, AND • if the other reports are favorable **L.I.E./PA:** Detail findings in your problem focused notes and Release to NEURO PANEL REVIEWER (AMCD) who will request any additional information such as NP evaluation for possible SI.			reviewed determine the condition is pre-clinical with favorable reports, send to AMCD Neuro Workflow. Subtle cognitive and behavioral manifestations may precede the motor onset and present a grave aeromedical concern even in seemingly asymptomatic individuals, often identified after a family member was diagnosed. **Neurocognitive Testing and Screening:** • Need NP testing for potential neurocognitive

			Neuro L.I.E.: When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. **Note: Do not ask for genetic testing.** In rare cases, genetic testing may be positive but no symptoms. In this case, do not create a Denial letter. Send to DOC to determine if needs to be sent to Neuro Workflow			impairment before considering medical certification. Most will need continued screening at renewal. **Special Issuance (SI) and Recertification:** • If an SI is granted and the DOC does not want the AME to issue a recert, that must be specified in your note.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Huntington's Disease	Follow up Issuance will be per the pilot's Authorization letter.		SEND TO (AMCD) NEURO PANEL REVIEWER All recerts for this condition must be reviewed by a DOC.		

			L.I.E./PA: When all required information received: Update problem list, update path/ICD code, summarize findings in notes, and Send to DOC.		

Condition Description

Huntington's disease is an inherited disease. Huntington's disease is a progressive, degenerative disease that causes certain nerve cells in the brain to waste away. As a result, individuals may experience uncontrolled movements, emotional disturbances, and mental deterioration. The disease usually develops slowly; the severity of signs and symptoms is related to the degree of nerve cell loss. Death occurs about 10-30 years after signs and symptoms first appear.

Additional History or Description of the Condition

Huntington's Disease is the most common cause of adult-onset hereditary chorea, affecting approximately 5 per 100,000 to 12 per 100,000 people. It is caused by an autosomal dominant trinucleotide repeat expansion (CAG) in the huntingtin gene (*HTT*) on chromosome 4p16.3. Repeat lengths of 40 and above have full penetrance, with a phenotype consisting of progressive motor, cognitive, and behavioral changes. A CAG repeat length of 26 or lower is considered normal. Individuals who have 36 to 39 CAG repeats are considered to have reduced penetrance but can still develop the disease. In those with 27 to 35 CAG repeats, the phenomenon of "anticipation" via paternal inheritance can pose risk for expansion into the HD range in the next generation. The average age of onset is in the third or fourth decade of life, and the average lifespan is approximately 15 to 20 years after symptom onset. Prodromal HD can occur approximately 10 years before a clinical diagnosis. During this period, subtle motor and nonmotor symptoms maybe be present but are not significant enough to warrant a clinical diagnosis. A clinical diagnosis of HD has historically been based on motor symptoms. However, cognitive and behavioral symptoms can be deleterious and may precede significant motor symptoms. Treatment is symptomatic management only, and is not curative.

Cognitive risk is higher as number of CAG repeats in the HTT gene increase. Subtle cognitive and behavioral changes have also been reported in asymptomatic individuals with intermediate CAG repeats, i.e, repeat length increased but below threshold for diagnosis of fully penetrant HD genotype. This is in the 27-39 CAG repeat range.

REFERENCES

Stimming EF, Bega D. Chorea. Continuum (Minneap Minn) 2022; 28(5):1379-1408.

Details

Section / Branch
General Review (GR)

ICD-10
G10

Pathology Codes (Prefixes)
620 (1,3,A,C)

Level of Review
4

ICD-9
333.4

Pilot Disposition
SI, DENY

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
DENY, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Blurbs Letters and Specification Sheets

Blurbs
mabneuropsych, RRBDFR

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Go to TOC

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/1/2022 page updated Neurology.

18l. Neurology

Hydrocephalus (with or without shunt)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include headaches, confusion, blurred or double vision, memory issues and balance problems, risk of hardware infection, and risk of sudden deterioration with shunt failure.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. **With Shunt** Placement	After a **two (2) year symptom-free** recovery period, submit the following for FAA review: 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. It **must specifically include** the reason a shut was placed and is the shunt functional or non-functional.	DEFER Submit the information to the FAA for a possible Special Issuance.	Worked in General Review (GR) If 2-year recovery period has not been met: **L.I.E/PA**: Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter and send to DOC. If information not received: Send *rrinfoINITIALREQ letter*	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	**Craniotomy and Ventriculostomy:** • A craniotomy is performed to place a shunt. FAS neurology consultants have advised a minimum wait of **2**

	3. **Shunt series CT or MRI brain** performed no more than **12 months before** the AME exam. • Include both the report and a copy of the images on compact disc (CD) in DICOM readable format. (There MUST be a 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain copies of all CDs or image as a safeguard if lost in the mail. Notes: • Neuropsychological (NP) evaluation in accordance with the **FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment** may be required after review of the above information due to the condition which caused the need for the shunt. • If associated with a seizure, brain tumor, or brain bleed – see the corresponding section. An additional recovery period may apply.		add: **rrbSHUNT**--available in DIWS add enclosure: **SPEC-NEUROEVAL** **L.I.E**/**PA**: When all required information received: Add to the problem list, assign path/ICD code, summarize findings in notes, and Send to DOC. These cases are worked in General Review. Some may go to Neuro Panel Reviewer after DOC review.			**years following any craniotomy**, including a burr hole. Ventriculostomy for a VP shunt is no different. The only way to reach the ventricle requires penetrating the cortex. • Most common underlying conditions include congenital or birth trauma, adult trauma, after bleed (SAH), or ruptured aneurysm. **With Shunt Placement:** **Non-Functioning Shunt:** • I

						f t h e s h u n t i s n o l o n g e r f u n c t i o n i n g , a n d t h e c a u s a t i v

						eorunderlyingconditionhasresolvedoriisstable,m

						ostcan berelease dwithawarning. **Functioning Shunt:** • Functional

						shunt: If all reports are favorable, CT/MRI shunt ser

						iesshowsnoacutefindings,andrecoveryperiodisun

						eventful, considerSI with annual neurology evaluat

						ion and imaging every 24 months for patency. Some will

						need more frequent imaging based on the cause or if cli

						• nically indicated. • Cases with concerns should be rev

						iewedinthenneurowworkflow.Typicalproblemsarreobs

						truction, disconnections and breaks, migration, CS

						Fpseudocysts, andinfection(withinn2monthspost-o

						p). Follow on Slide fine tune functioning.

B. **Without (w/o)** Shunt placement (such as Normal Pressure Hydrocephalus)	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **MRI and/or CT of the brain** performed no more than 90 days before the AME exam. • Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail.	DEFER Submit the information to the FAA for a possible Special Issuance.	SEND TO NEURO PANEL REVIEWER (AMCD) Neuro L.I.E.: If information not received: Send rrinfoINITIALREQ letter add: **mabNEUROEVAL** + **rrbNEUROMRI** **change sentence #1 of MRI to add and/or CT** **A current Magnetic Resonance Imaging (MRI)** **and/or CT of the brain...** add enclosure(s): **SPEC-NEUROEVAL** When all required information received: Add to the problem list, assign path/ICD code, Apply path code 3658, summarize findings in notes, and send to Send to GR Neuro Panel Physician.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B Hydrocephalus without shunt will need FAS neurology consultant review.	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B Hydrocephalus without shunt will need FAS neurology consultant review.	Row B **Hydrocephalus Without a Shunt:** • For conditions like Normal Pressure Hydrocephalus (NPH), in some cases, this is just large ventricles and may be a result of an obstruction as a child or a big head, but otherwise normal. • A major concern is whether this is the correct diagnosis. • Any 'asymptomatic' congenital hydrocephalus that is incidentally discovered should be discussed with a Neuro Workflow Physician.

						• If the correct diagnosis is not definitively treated, it is likely aeromedically unacceptable. Once the ventricles begin to expand, the pressure required for further expansion decreases exponentially, resulting in a high risk of progression when left untreated. • Cases proposed as NPH with no shunt placed may indicate inadequate treatment or inaccurate diagnosis. Send to Neuro Workflow.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. With Shunt Placement	Standard follow-up would include: 1. A detailed **neurological evaluation** that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. **Shunt series CT** or **MRI brain performed** no more than 90 days before the AME exam.	See Authorization letter.	Follow on SI--indefinitely. If stable, meets f/u criteria—Continue Auth If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: If AME sends in all documents, issues correctly and no changes in medical condition: **L.I.E**.: create and sign *rrCONTINAUTH letter.* FMC and send to file. **PA**: create *rrCONTINAUTH letter.* FMC and send to DOC. If Cert time limit (t/l) incorrect **L.I.E.**: Prepare continue authorization *rrCONTINAUTH* letter, sign, and send corrected cert. **PA:** create *rrCONTINAUTH* letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) **L.I.E**.: Send: *rrinfoINITIALREQ*	Follow up Issuance will be per FS	

			letter for missing items or new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted **PA**: See above and send to DOC. No longer meets SI (condition worsened) **L.I.E./PA**: Detail changes, abnormalities or questions in your notes and send to DOC.		
B. Without Shunt placement (such as Normal Pressure Hydrocephalus)	Standard follow-up would include: 1. A **detailed neurological evaluation** that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. **MRI and/or CT of the brain** performed no more than 90 days before the AME exam.	See Authorization letter.	Follow on SI--indefinitely.--verify in notes if released to GR or still in NEURO workflow If stable, meets f/u criteria—Continue Auth If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met: If AME sends in all documents, issues correctly and no changes in medical condition: **L.I.E**: create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** create rrCONTINAUTH letter. FMC and send to DOC. If Cert time limit (t/l) incorrect		

			L.I.E.: Prepare continue authorization rrCONTINAUTH letter, sign, and send corrected cert. **PA**: create rrCONTINAUTH letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) **L.I.E**.: Send: rrinfoINITIALREQ letter for missing items or new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted **PA**: See above and send to DOC. No longer meets SI (condition worsened) **L.I.E**./**PA**: Detail changes, abnormalities or questions in your notes and send to DOC.		

Condition Description

Hydrocephalus is the buildup of too much cerebrospinal fluid in the brain. Normally, this fluid cushions your brain. When you have too much, though, it puts harmful pressure on your brain. There are two kinds of hydrocephalus. Congenital hydrocephalus is present at birth. Causes include genetic problems and problems with how the fetus develops.
An unusually large head is the main sign of congenital hydrocephalus. Acquired hydrocephalus can occur at any age. Causes can include head injuries, strokes, infections, tumors and

bleeding in the brain. Treatment usually involves the insertion of a shunt which diverts fluid from the brain into the abdominal cavity where it is safely absorbed into the blood stream.

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
G91.9, Z98.2

Pathology Codes (Prefixes)
608 ((5,C)), 608

Level of Review
4

ICD-9
331.4

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbshunt, rrbneuromri

Letters	**Specification Sheets**
ATCS Letters/Memos	**ATCS Sheets**

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis or finding: INCAP

If surgery performed, requires 2 year recovery period.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/12/2022 page reviewed w/neurology.

18l. Neurology

Meningitis

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Aeromedical Concerns

Aeromedical concerns include any residual neurologic symptoms or signs, adverse effects of any medications used for symptom management and complications such as brain damage, seizures, paralysis or stroke, hearing loss, and cognitive impairment.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Single episode no complications, fully resolved and recovered AND No hospitalization OR hospitalized 5 or more years ago	If the AME can determine the condition has resolved with no complications and the the individual has no symptoms that would interfere with flight duties/SRD: If **within the past one year**, provide the AME with the **most recent detailed, Clinical Progress Note** from the treating physician describing the clinical course and resolution without complications. **Note:** If associated with a seizure or more than one episode, go to Row C.	Summarize findings in Item 60 including approximate date.	We will **accept AME** notes. If the AME adequately explains the condition has resolved with no ongoing treatment needed: L.I.E.: Add to the problem list, assign path/ICD code, summarize in notes, and WARN. PA: As above and send to DOC. If no AME explanation: L.I.E.: Create and send *rrlinfoINITIALREQ letter*	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New diagnosis or symptomatic, new medication/change: INCAPACITATE Send an incapacitation memo for: • Evaluation Data Row B	Single episode, fully recovered is not of aeromedical concern. Many will be treated by primary care provider, ER, or urgent care. Recent history should be reviewed by the AME. If hospitalized, verify discharge summary shows no

			Add: **rrbMENINGITIS (availabe in DIWS)** PA: As above and send to DOC for signature At this row do **NOT ask for NEW imaging** unless requested by DOC. Request imaging (CT/MRI) already performed. If reports received identify complications, questionable for full recovery, continued symptoms, or other concerns, send to DOC. rrbMENINGITIS requests Row B eval data			evidence of compications such as encephalities, meningoencephalitis (meningitis with superficial stroke), or cortical involvement.
B. Single episode requiring hospitalization **<u>less than 5 years ago</u>**	Submit the following for AME and FAA review: 1. The most recent **detailed, Clinical Progress Note** performed from the treating physician or neurologist. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment; plan (prognosis); and follow-up. 2. It **must specifically include** if the condition has resolved and if any residual side effects remain. 3. **Hospital Discharge Summary**. This is NOT the same as patient portal notes or After Visit Summary (AVS). 4. **MRI** and/or **CT** brain imaging	If the AME can determine the condition has resolved with no residual symptoms, MRI and EEG (if performed) are negative, and the pilot has no symptoms that would interfere with flight duties. ISSUE Summarize	We **will accept** AME notes. If the AME adequately explains the condition • has resolved with no ongoing treatment needed, • no complications noted, • no concern of neurocognitive impairment, • MRI or EEG (if already performed) are read as normal **L.I.E.:** Add to the problem list, assign path/ICD code, summarize in notes, and WARN.	See above	See above	Row B Hospitalization w/in past 5 years, AME should review records.

	report (if already performed). 5. **EEG -** electroencephalogram report (if already performed). Note: If the MRI or CT report verifies lesions or scarring on the brain; or the neurologic evaluation determines there is concern for cognitive impairment on clinical exam; or any history of seizure (a recovery period may apply), go to Row C.	findings in Item 60 and submit the evaluation to the FAA for retention in the pilot's file.	**PA:** See above and send to DOC. <u>If no AME notes:</u> send *rrinfoINITIALREQ letter* add: **rrbMENINGITIS** (available in DIWS) Request imaging (CT/MRI) already performed. Do not ask for new imaging unless requested by DOC. <u>Abnormal reports</u>. If reports show any evidence or suspicion of residual neurological deficits, impaired cognitive function, or abnormal MRI or EEG findings: send to DOC to deterimine if additional information is necessary. **L.I.E./PA:** When all required information received: Add to the problem list, assign path/ICD code, summarize findings in notes, and Send to DOC. **If associated with a seizure or complications, go to Row C.**			

C. More than one episode (ever), Complications such as meningoencephalitis, cortical involvement (stroke), seizure; abnormal MRI or EEG findings; or not fully resolved or recovered	Submit the following for FAA review 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **Remember to also submit** all items listed under "Prior Testing, Treatment, Or Other Records". 3. MRI and or CT of the brain performed **no more than 90 days before** the AME exam. • Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. Hospital records (admission H&P, Discharge Summary, All consultant reports, copies of imaging reports). 5. An electroencephalogram (EEG) if already performed OR if any history of seizures. • The EEG recording should be sleep-deprived: awake, asleep, and with provocation (e.g., hyperventilation, photic/strobe light). • Include any previous EEG(s) available for comparison. • Submit BOTH the final interpretive report(s) and	DEFER Submit the information to the FAA for a possible Special Issuance.	If information not received: send rrinfo*INITIALREQ letter* add: **rrbMENINGITIS** enclosures: **SPEC-NEUROEVAL +** **SPEC-Neuropsychological Eval (Neurocog Impairment).** L.I.E./PA: When all required information received: Add to the problem list, assign path/ICD code, summarize findings in notes, and Send to DOC. For these complex cases, once the initial information is received, send to the DOC to determine what additional information is required. **If associated with a seizure, send to Neuro Panel Reviewer.**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New diagnosis or symptomatic, new medication/change: INCAPACITATE Send an incapacitation memo for: • Evaluation Data Row C	Row C Complicated or recurrent are reviewed on case by case basis.Any residual brain scarring can be a seizure risk.

	the actual tracings (ALL pages) for any EEGs on CD. • The CDs of EEG recordings must have proprietary opening software compatible with Windows 10. Additional testing If the CT/MRI report identifies lesions or scarring on the brain or the clinical neurologic evaluation has concern for cognitive impairment, a Neuropsychological (NP) evaluation will be required. When required, it must meet FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the treating neuropsychologist. Seizure: If associated with a seizure, refer to the Seizure section. A recovery period may apply.					

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

.	.				
				Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	

Condition Description

Meningitis is an inflammation of the membranes (meninges) and cerebrospinal fluid surrounding your brain and spinal cord, usually due to the spread of an infection.

Complications include permanent neurological damage such as hearing loss, blindness, loss of speech, learning disabilities, behavior problems and brain damage, and even paralysis. Non-neurological complications may include kidney failure and adrenal gland failure.

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
General Review (GR)

ICD-10
G03.9

Pathology Codes (Prefixes)
603 (1,A)

Level of Review
4

ICD-9
322.9

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbmeningitis, mabneuropsych, RRBDICOM, RRBMEDHOSP

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic: INCAPACITATE

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿3/25/22 page reviewed

18l. Neurology

Multiple Sclerosis (MS); Neuromyelitis Optica Spectrum Disorder (NMOSD); Myelin Oligodendrocyte Glycoprotein Antibody Disorder (MOGAD); Clinically Isolated Syndrome (CIS)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include effects of current cognitive and neurologic symptoms, medication effects, and unpredictable future risk of new symptom development. There is very low risk of sudden incapacitation, but relapses may have a subacute onset and course. Subtle incapacitation may occur and be unrecognized.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Multiple Sclerosis	After a minimum of 6 (six) months of clinical and radiological stability, submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic	DEFER Submit the information to the FAA for a possible	These are worked in GR If information not received: Send *rrinfoMS letter (avail in DIWS)* add enclosures: **SPEC-**	**Send a Request for Information letter for:** • All previous medical records	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation	6 months of clinical and radiologic stability is MINIMUM time to consider. Most will require longer as unsure how this condition will progress. If

	visit with the treating neurologist no more than 90 days before the AME exam. 2. MRI brain with and without gadolinium performed no more than 90 days before the AME exam. 3. MRI cervical and thoracic spine with and without gadolinium (most recent, if already performed). • For each MRI submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. Eye evaluation. A current detailed Clinical Progress Note generated from a clinic visit with your treating ophthalmologist no more than 90 days prior to your AME exam. It must include a detailed summary of the history of any eye condition(s); current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. • It must specifically include an interpretation of the visual field testing. • Visual field testing (24-2 SITA standard) performed within the previous 90 days.	Special Issuance.	**NEUROEVAL +** **SPEC-Neuropsychological Eval (Neurocog Impairment)** L.I.E./PA: When all required information received: Add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC. Note: 6 months of clinical and radiological stability is a change. If functional capacity is limited, a medical flight test (MFT) may be required prior to medical certification and/or Special Issuance. If a medical flight test (MFT) is required, see that page.	for this condition. • Evaluation Data row A	memo and request the following: • Evaluation Data row A	there is no clinical or radiological relapse, certification can be considered. In general, two years of clinical and radiologic stability are recommended before certification consideration when the diagnosis is not confirmed. MULTIPLE SCLEROSIS RECERT: Repeat MRI imaging at discretion of the treating neurologist (w/o contrast) should be stated in the auth letter. If currently stable, may only need annual or longer. If MRI shows progressive lesions, the LIE/PA will prepare a denial letter. Eye exam every 12 months. If visual disturbances identified in the initial evaluation, additional testing or more frequent follow up should be considered. Cognitive testing. Initial full battery. If no significant abnormalities, consider CogScreen every 24 months. Some

	• Optical Coherence Tomography (OCT) if performed. Supply the color draft and printouts. 5. A Neuropsychological (NP) evaluation that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment. 6. Lab. The following testing if already performed or clinically indicated: • Rheumatological antibody screening (ANA, RF, Lyme titer); • Cerebrospinal Fluid (CSF) testing; • All evoked potential testing; • NMO antibody panel (such as anti AQP4, anti MOG) in cases with spinal involvement, optic neuritis, or concerns for NMO-SD (submit most recent test result). 7. Any other testing already performed or deemed clinically necessary by the treating physician.					cases will need more frequent testing or follow up. If poor neurocognitive function without any other significant clinical manifestations, may need to consult FAS NP (may not need neuro workflow) If functional capacity is limited, a medical flight test (MFT) may be required prior to medical certification and/or Special Issuance. **RELAPSE--send to Neuro Workflow or consult with FAS Neuro.** Active disease with evidence of new MRI activity with increasing disability; secondary progressive; or primary progressive (not responding to biologics or other medications) and characterized by worsening neurological function---consult with AMCD neuro workflow docs. If relapsing episodes---despite treatment---

						consider neuro workflow. After initiating or change in therapy, most will need 6 months to verify stable on the new treatment. Updated DPCN and MRI Brain to establish a new baseline (additional scans such as spinal cord and any other imaging performed by the treating physician). If new MRI lesions, may need additional cognitive testing. **Recert: Brain MRI WITHOUT contrast is acceptable unless contrast is clinically indicated or there is a worsening/concern for progression of the condition. (9/27/2023).**
B. Neuromyelitis Optica Spectrum Disorder (NMOSD)	After a minimum of 6 (six) months of clinical and radiological stability, submit the following for FAA review:	DEFER	Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note.	Send a Request for Information letter for:	New presentation/new diagnosis or symptomatic: INCAPACITATE.	

OR Myelin Oligodendrocyte Glycoprotein Antibody Disorder (MOGAD)	• All information listed above for MS Row A • On #6 Lab. NMO and anti-MOG antibody panel are required. (submit most recent test result).	Submit the information to the FAA for a possible Special Issuance.	**Release to NEURO PANEL REVIEWER (AMCD),** who will send the initial info request letter (if needed). Note: Cases sent to NEURO PANEL REVIEWER (AMCD) will be reviewed by AMCD Neuro Workflow physicians and may not require Neurology Panel. Neuro Workflow **Neuro L.I.E.:** If information not received: Send *rrinfoMS letter (avail in DIWS)* ***add as #8:*** *"NMO and anti-MOG antibody panel are required. (submit most recent test result)."* add enclosures: **SPEC-NEUROEVAL +** **SPEC-Neuropsychological Eval (Neurocog Impairment)** When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow,	• All previous medical records for this condition. • Evaluation Data row B	• Send an incapacitation memo and request the following: • Evaluation Data row B	

			summarize findings in notes, and send to GR Neuro Panel Physician. **Note:** Applying path code 3658 will automatically send the file into Neuro L.I.E. workflow when info received. If MRI shows progressive lesions, the LIE/PA should prepare a denial letter and send to DOC for review.			

Row B

NMOSD or MOGAD (added 1/29/25)

6 months of clinical and radiologic stability is MINIMUM time to consider. Some will require longer as unsure how this condition will progress. If there is no clinical or radiological relapse, certification can be considered.

In general, two years of clinical and radiologic stability are recommended before certification consideration when the diagnosis is not confirmed.

RECERT:

- Copies of all interim clinical notes.
- Test results from all interim laboratory testing.
- Interpretive reports and images from all interim brain and spinal imaging studies.
- Repeat MRI imaging at discretion of the treating neurologist (w/o contrast) should be stated in the auth letter. If currently stable, may only need annual or longer.

If MRI shows progressive lesions, the LIE/PA should prepare a denial letter.

- Eye exam with 24-2 visual field testing every 12 months if visual disturbances identified on the initial evaluation. Additional testing or more frequent follow up as indicated.
- Cognitive testing as specified in the previous SI certification letter. If poor neurocognitive function without any other significant clinical manifestations, may need to consult FAS NP.
- Any additional required information as specified in the previous SI certification letter.
- If functional capacity is limited, a medical flight test (MFT) may be required prior to medical certification and/or Special Issuance.

RELAPSE--send to Neuro Workflow or consult with FAS Neuro.

Active disease with evidence of new MRI activity with increasing disability; secondary progressive; or primary progressive (not responding to biologics or other medications) and characterized by worsening neurological function---consult with AMCD neuro workflow docs.

If relapsing episodes---despite treatment---consider neuro workflow.

C. Clinically Isolated Syndrome (CIS)

- any history of
- no matter how long ago
- include Transverse Myelitis

If optic neuritis see that page

After a minimum of **6 (six) months** of clinical and radiological stability, submit the following for FAA review:

- All information listed above for MS Row A
- On #3 MRI cervical and thoracic spine--submit only if clinically indicated or already performed.

DEFER

Submit the information to the FAA for a possible Special Issuance.

These are worked in GR

If information not received:

Send rrinfoMS letter (avail in DIWS)

on #3 MRI add-submit only if clinically indicated or already performed.

add enclosures: **SPEC-NEUROEVAL +**

SPEC-Neuropsychological Eval (Neurocog Impairment)

L.I.E./PA: When all required information received: Add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC.

Send a Request for Information

letter for:

- All previous medical records for this condition.
- Evaluation Data row C

New presentation/new diagnosis or symptomatic: INCAPACITATE.

- Send an incapacitation memo and request the following:
- Evaluation Data row C

Row C

Clinically Isolated Syndrome

- Current information required no matter how long ago the CIS episode was to verify there has been no silent or subtle relapse.
- **Eye eval** required for most, even if no eye symptoms to verify current or past evidence of optic nerve involvement which may indicate a different condition.
- **Brain lesion**--consider NP testing.
- **MRI abnormalities** or treating **neurologist concerns**—send to neuro workflow.
- Thoracic presentation/problem can cause residual leg weakness or spasticity-- consider MFT.

If CIS was previously warned, no matter how long ago, and now a second episode affecting any ---clinically indicates MS. Follow that section.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Multiple Sclerosis All classes	Standard follow-up would include: 1. Every 6 months Neurology Evaluation: (sent to the FAA every 12 months) 2. A detailed neurological evaluation in accordance with the FAA Specifications for Neurologic Evaluation performed no more than 90 days prior to your AME exam. 3. Annual Eye Evaluation if any concerns for visual involvement (any visual symptoms or visual field involvement). A current detailed Clinical Progress Note generated from a clinic visit with your treating ophthalmologist no more than 90 days prior to your AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment; plan (prognosis); and follow-up. 4. MRI brain performed no more than 90 days before the AME exam. The treating neurologist should determine the type of MRI necessary to show stability of the condition based on clinical findings. Frequency will be identified in the Authorization letter. 5. MRI cervical and thoracic spine, if already performed.	See Authorization letter.	Note: Routine follow up brain MRI does not require contrast 9/2023. If using the rrinfoMS letter, repace bullet with Eval Data #4. <u>If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met:</u> If AME sends in all documents, issues correctly and no changes in medical condition: L.I.E.: create and sign rrCONTINAUTH letter. FMC and send to file. PA: create rrCONTINAUTH letter. FMC and send to DOC. If Cert time limit (t/l) incorrect L.I.E.: Prepare continue authorization rrCONTINAUTH letter, sign, and send corrected cert. PA: create rrCONTINAUTH letter and corrected cert and send to DOC	Note: Routine follow up brain MRI does not require contrast 9/2023. If using the rrinfoMS letter, repace bullet with Eval Data #4. When all required information received: summarize findings in notes.	

	• For each MRI submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 6. Every 24 months CogScreen AE. • If results of this study are abnormal or the evaluating provider has concerns, a full Neuropsychological (NP) evaluation in accordance with the FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment will be required. Note: these are general follow up items. The actual interval and requirements will be specified in the Authorization for Special Issuance letter. Note: Routine follow up brain MRI does not require contrast 9/2023.		<u>If AME issues Incorrectly (new meds/change in meds/new medical condition</u>) OR Information not received (**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter) L.I.E.: Send: rrinfoINITIALREQ letter for missing items or new condition. Process condition per OneGuide. Determine if need to assign AME "W" error—read AME comments to see if reports have been submitted PA: See above and send to DOC. No longer meets SI (condition worsened) OR develops new condition: L.I.E.:./PA: Detail changes, abnormalities or questions in your notes and send to DOC. <u>If new MRI lesions and worsening symptoms on DCPN</u>: L.I.E.:./PA: Detail this information in your note, prepare appropriate denial letter and send to DOC for concurrence and signature.		

	.				
				Send a Request for I nformation letter for: • All previous medical records for this condition. • Evaluation Data row C	

Condition Description

Multiple sclerosis is a disease that impacts the brain, spinal cord and optic nerves, which make up the central nervous system and controls everything we do. The exact cause of MS is unknown, but we do know that something triggers the immune system to attack the CNS. The resulting damage to myelin, the protective layer insulating wire-like nerve fibers, disrupts signals to and from the brain. This interruption of communication signals causes unpredictable symptoms such as numbness, tingling, mood changes, memory problems, pain, fatigue, blindness and/or paralysis. Everyone's experience with MS is different and these losses may be temporary or long lasting.

Clinically isolated syndrome (CIS) refers to a single clinical attack of central nervous system (CNS) inflammatory demyelinating symptoms that are suggestive of multiple sclerosis (MS). CIS presentations can be monofocal or multifocal and typically involve the optic nerve, brainstem, cerebellum, spinal cord, or cerebral hemispheres. Although CIS may represent the first manifestation of definite multiple sclerosis (DMS), some patients may not develop a second clinical relapse.

May present as:

transverse myelitis (partial or complete)
optic neuritis
brainstem damage symptoms (N/V, double vision, dizziness, hearing loss, trouble walking)

Additional History or Description of the Condition

Multiple sclerosis is an inflammatory condition of yet undetermined etiology that affects central nervous system myelinated regions. It can manifest with widely varied symptoms and signs,

and formal diagnosis is often not made for several years. Diagnosis is made by established (Revised McDonald) criteria. Management includes disease modifying agents such as the interferons, glatiramer acetate, monoclonal agents and other immunomodulating agents, with regular surveillance activities. Symptomatic management is also often done. Clinical symptoms can be exacerbated with high temperature, other medical conditions such as infections, and exertion.

9/27/2023 reduced annual brain MRI with and w/o contrast to brain MRI w/o contrast only in routine cases which are clinically stable.

The contrast is usually Gadolinium (GAD) which may be toxic over time to some individuals. Neuroradiology literature now supports a technique called “double inversion recovery sequences" in some situations including clinically stable MS in lieu of repeat gadolinium.

Contrast can assess for current active disease and may identify disease activity early. Contrast enhancement usually only persists for a few weeks around a new activation, and often there will be clinical symptoms or residual T2 lesion to mark the exacerbation or progression. The clinical history and serial changes in T2/FLAIR burden on MRI are the most useful to follow clinically

The choice of contrast, double inversion or other sequences should be determined by the treating neurologist, based on a careful clinical history and neurological examination. At a minimum, still need T2/FLAIR for serial comparison.

Progression or exacerbation should trigger a contrast enhanced study. If this occurs, most would be denied until at least 6 months of stability have occurred. Contrast may be a reasonable requirement at the reconsideration stage.
See reference articles and image slides. Table 11-7 (slide 12) addresses question and supporting references are cited and noted in the reference list. This is based on the 2016 recommendations of the Consortium of MS Centers Task Force for diagnosis and follow up of MS.

Clinically isolated syndrome (CIS). To be termed as CIS, the episode should last for at least 24 h and should occur in the absence of fever or infection and with no clinical features of encephalopathy. CIS can present as transverse myelitis, optic neuritis, or can look like a single MS attack. It may represent a pre-MS diagnosis. 50% remain symptom free over 5 years, but 50% may convert to MS.

REFERENCES

Thompson AJ, Banwell BL, Barkhof F et al. Diagnosis of multiple sclerosis: 2017 revisions of the McDonald criteria. Lancet Neurol 2018; 17(2):162-173.

Cross A, Riley C. Treatment of multiple sclerosis. Continuum (Minneap Minn) 2022; 28(4):1025-1051.

Costello F. Neuromyelitis optica spectrum disorders. Continuum (Minneap Minn) 2022; 28(4):1131-1170.

Longbrake E. Myelin oligodendrocyte glycoprotein-associated disorders. Continuum (Minneap Minn) 2022; 28(4):1171-1193.

https://www.nationalmssociety.org/What-is-MS

Multiple Sclerosis Guidelines: Guidelines Summary (medscape.com)

Revised Recommendations of the Consortium of MS Centers Task Force for a Standardized MRI Protocol and Clinical Guidelines for the Diagnosis and Follow-Up of Multiple Sclerosis - PMC (nih.gov)

Imaging of Central Nervous System Demyelinating Disorders By Jan-Mendelt Tillema, MD

Continuum MS imagings slides

Cognitive Outcomes in Myelin Oligodendrocyte Glycoprotein-IgG Associated Disease Compared to Multiple Sclerosis - Galvani - 2025 - Brain and Behavior - Wiley Online Library

Clinically Isolated Syndromes: Clinical Characteristics, Differential Diagnosis, and Management - PMC

www.nationalmssociety.org/understanding-ms/what-is-ms/clinically-isolated-syndrome-cis

Details

Section / Branch
General Review (GR)

ICD-10
G35

Pathology Codes (Prefixes)
618 (1,3,5,A,C,E)

Level of Review
4

ICD-9
340

Pilot Disposition
SI

Pilot Standard Certification
6-12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
6-12 months

Follow on Special Consideration
Indefinite

Go to TOC

Blurbs Letters and Specification Sheets

Blurbs

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

08/27/2025 updates to NMOSD and MOGAD published
5/16/2025 added guidance for Clinically Isolated Syndrome (CIS); updated recert MS to clarify interim spinal imaging studies already perormed.
3/31/2025 updated references

01/29/2025 added row B for NMOSD and MOGAD¿
9/27/2023 reduced follow up brain MRI from w/ and w/o contrast to brain MRI w/o contrast in most cases.
12/5/22 reviewed with neurology panel
¿4/22/2022 page reviewed.

18x. Neurology

Muscular Dystrophy

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Aeromedical Concerns

Aeromedical concerns include effects of motor weakness and speech difficulty on aircraft operations, impairment of aircraft ingress and egress, effects of involvement of other organ systems such as cardiac or pulmonary, and inexorable disease progression.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Muscular Dystrophy	Submit the following for FAA review: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the **treating physician, musculoskeletal specialist, neurologist or PMR** no more than 90 days before the AME exam. It must include a detailed summary of the condition; • current medications, dosage, and side effects (if any); • physical exam findings; • results of any testing required or	DEFER Submit the information to the FAA If not addressed in the progress note, the AME should describe any functional	If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbCSLONG** When all information received Denial/DQ. If documentation received meets denial/DQ criteria in OneGuide: **L.I.E./ PA:** Detail findings, changes, abnormalities, or reasons for denial in your problem focused notes. Prepare appropriate Denial letter and send to DOC for	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New presentation/diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	Some may have involvment of other other systems such as cardiac or pulmonary. Additional informaton may be required for those systems. Concern is accurate diagnosis.

	performed; • diagnosis; • assessment and plan; • prognosis; and follow up. 2. It must specifically include • Functional status (degree of impairment as measured by strength, range of motion, pain); NOTE: If the AME has concerns with the applicant's ability to operate the aircraft during routine or emergency procedures, explain in Block 60.	limitations that could affect ability to operation aircraft controls during routine or emergency operations.	concurrence and signature. All others: **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, and send to DOC. Some may go to Neurology workflow after General Review Docs			Some cases may need MFT due to muscular involvement. Pilot and ATCS If any concerns, send to or consult with FAS Neurology

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

Muscular dystrophy is a group of diseases that cause progressive weakness and loss of muscle mass. In muscular dystrophy, abnormal genes (mutations) interfere with the production of proteins needed to form healthy muscle.
There are many kinds of muscular dystrophy. Symptoms of the most common variety begin in childhood, mostly in boys. Other types don't surface until adulthood.
There's no cure for muscular dystrophy. But medications and therapy can help manage symptoms and slow the course of the disease.2

Additional History or Description of the Condition

REFERENCES

1 https://www.nichd.nih.gov/health/topics/musculardys/conditioninfo/causes#:~:text=Most%20cases%20of%20MD%20are,by%20an%20affected%20person's%20offspring.

2 https://www.mayoclinic.org/diseases-conditions/muscular-dystrophy/symptoms-causes/syc-20375388

Details

Section / Branch
General Review (GR)

ICD-10
G71.0

Pathology Codes (Prefixes)
898 (1,3,A,C)

Level of Review
3

ICD-9

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.113(b), 67.213(b), and 67.313(b)

CFR(s) Conditions Treated with Meds
14 CFR 67 113(b)&(c), 67.213(b)&(c), and 67.313(b)&(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Go to TOC

Summary of Changes

2/23/2024 page reviewed

18l. Neurology

Myasthenia Gravis (Generalized or Ocular)

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Aeromedical Concerns

Aeromedical concerns include effects of current motor symptoms, medication effects, and potential for sudden deterioration from unpredictable relapses.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. **Generalized** Myasthenia Gravis	Requires **one (1)-year** recovery period after diagnosis. After 1-year recovery, submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating **neurologist no more than 90 days before** the AME exam. 2. **It must specifically include**: Medications prescribed for this condition including start and stop	DEFER Submit the information to the FAA for a possible Special Issuance.	Worked in General Review (GR) If information not received: *Send rrinfoMYASTHENIA letter* Add enclosure(s): **SPEC-NEUROEVAL** L.I.E./PA: When all required information received: add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC If one (1) year recovery period has not been met:	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: After a **1-year recovery period**, submit the following for FAA review:	Requires stability period after first diagnosed and treatment initiated. It take months to get a handle on the condition. Medication titration can take a minimum of 3 months to get the condition under control. Some cases do well with maintenance therapy. Medicatio

	dates, dosages, and side effects (if any).
	
	• How long has the condition been stable;
	• Any periods of weakness, motor fluctuations, or fatigability;
	• Any history of myasthenic crisis; and
	• Any evidence of **ocular myasthenia**. If yes, also address:
	  • Presence or absence of eye exam findings:
	  • Any current finding of eye motility abnormality, symptoms of double vision; or
	  • Any clinically significant ptosis.
	
	3. Lab studies already performed.
	
	4. CT Chest (performed at any time as a screening for Thymoma). Submit the report.
	5. **Previous Imaging** (e.g., CT, MRI, CTA, MRA, or catheter angiography of the head) performed at any time after the symptoms occurred.*
	6. Other testing already performed such as an Electromyogram (EMG) or nerve conduction studies.
	
	*For all imaging, submit BOTH the report and a copy of the images on compact disc (CD) in DICOM readable format. (There MUST be a 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain copies of all CDs or images as a
			Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter, and send to DOC.
			
			Note: The Evaluation Data requirements is a change.
					• Evaluation Data Row A	ns such as pyidostigmine, prednisone (20 mg or less), or Imuran are acceptable.
						
						To consider medical certification, there must be no functional limitation and no side effects from the medication like muscle fasciculations or hypersialorrhea (excessive salivation) which is marker of overtreatment and can lead rapidly to severe weakness.
						
						Relapses in the previous year are unfavorable for medical certification. Episodes of weakness or motor fluctuations are indicative of poor control and should not be certified until an additional recovery period has passed to verify the condition is stable.

	safeguard if lost in the mail.					
B. **Ocular** Myasthenia Gravis	Submit the following for FAA review: 1. All items listed in Row A above 2. If ocular status is not addressed, an evaluation from an ophthalmologist may be required.	DEFER Submit the information to the FAA for a possible Special Issuance.	Worked in General Review (GR) Verify medications are acceptable. work as described in Row A. Ocular Myasthenia Gravis is a form of Myasthenia Gravis. If the diagnosis is Ocular Myasthenia and is not addressed by the neurologist, a current, detailed Clinical Progress Note from a board certified ophthalmologist may be required. Visual field testing is NOT required in most cases.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data row B	New presentation/new diagnosis or symptomatic: IN CAPACITATE. Send an incapacitation memo and request the following: After 1-year recovery, submit the following for FAA review: • Evaluation Data row B	Row B Ocular Myasthenia. Can cause eye droop and creates trouble passing visual fields. Some may need an eye evaluation.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

A. Generalized OR Ocular Myasthenia Gravis	Standard follow-up includes: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. It must include a detailed interim summary; current medications, dosage, and side effects (if any); physical exam findings; results of any testing required or performed; diagnosis; assessment; plan (prognosis); and follow-up. 2. Any other testing deemed necessary by the treating physician or required per the pilot's FAA Authorization for Special Issuance letter.	See Authorization letter.	Use this row for an SI recert If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are me. If AME sends in all documents, issues correctly and no changes in medical condition: **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. Cert t/l incorrect: **L.I.E.**: Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received.: *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.**: Process condition per OneGuide. Determine if need to assign AME "W" error - read AME comments to see if reports have been submitted **PA:** See above and send to	See SC letter.	

			DOC. Condition worsened. No longer meets SI OR develops new condition: **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		

Condition Description

Myasthenia Gravis is a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal (voluntary) muscles of the body. It is caused by a defect in the transmission of nerve impulses to muscles. The name, which is Latin and Greek in origin, literally means "grave muscle weakness."

Additional History or Description of the Condition

MG affects the neuro-muscular junction resulting in classical symptoms of variable muscle weakness and fatigability. It is called the great masquerader owing to its varied clinical presentations. Very often, a patient of MG may present to the ophthalmologist given that a large proportion of patients with systemic myasthenia have ocular involvement either at presentation or during the later course of the disease. The treatment of ocular MG involves both the neurologist and ophthalmologist.

It is a is a potentially serious, but treatable autoimmune disease affecting the neuro-muscular junction (NMJ) of the skeletal muscle. Ocular myasthenia gravis (OMG) can mimic isolated cranial nerve palsies, gaze palsies, internuclear ophthalmoplegia, blepharospasm, and even a stroke.

MG is characterized by a variable weakness of skeletal muscles, which improves on resting. Weakness is exacerbated by repetitive contraction.[5] Generalized myasthenia involves the bulbar, limb, and respiratory muscles. OMG is a subtype of MG where the weakness is clinically isolated to the EOMs, levator, and orbicularis oculi.[5] Expectedly, due to variable involvement of different EOMs, motility patterns are not characteristic of lesions of one or more nerves.[6] Ptosis and diplopia are the initial signs of the disease in over 50% of MG patients;[8] 50-80% of these patients go on to develop generalized disease.[7] In the majority of cases (90%), progression of OMG to its generalized form will occur within the first 2 years after ocular symptoms begin.[9]

With OMG, the muscles that move the eyes and control the eyelids are easily fatigued and weakened. Common symptoms include trouble with sight due to double vision and/or drooping eyelids. Eyes do not move together in balanced alignment, causing the individual to see “double” images. One or both eyelids may droop to cover all or part of the pupil of the eye, blocking vision.

These symptoms may be mild to severe. Eye weakness often changes from day-to- day and over the course of a day. Eye problems often worsen at the end of the day or after a prolonged period of use. Individuals with OMG may find that eye problems temporarily improve after several minutes of rest.

About half of all people with ocular issues related to MG in the first year will develop generalized MG. People that have had only ocular MG symptoms for five years or more will most likely not develop generalized MG.

REFERENCES

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4278125/

https://myasthenia.org/MG-Education/Learn-More-About-MG-Treatments/MG-Brochures/ocular-mg#:~:text=Ocular%20myasthenia%20gravis%20is%20a,vision%20and%2For%20drooping%20eyelids.

Details

Section / Branch
General Review (GR)

ICD-10
G70.00

Pathology Codes (Prefixes)
619 (1,3,5,A,C)

Level of Review
3

ICD-9
358.00

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Blurbs Letters and Specification Sheets

Blurbs

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/8/2022 page reviewed with neurology and ophthalmology

18l. Neurology

Narcolepsy or Idiopathic Hypersomnia

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include cognitive effects of excessive somnolence, unpredictable sleep occurrence at inappropriate times, sudden loss of muscle tone with cataplectic episodes, and medication effects.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Current or historical diagnosis Treated or Untreated Note: This condition is incompatible with aviation safety.	Submit the following for FAA review: 1. The most recent detailed Clinical Progress Note, generated from a clinic visit with the physician who treats or diagnosed this condition (narcolepsy or idiopathic hypersomnia). It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis);	DEFER Submit the information to the FAA.	If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbNARCOLEPSYa (available in DIWS)** Do not ask for new testing unless requested by DOC If information received confirms the diagnosis: **L.I.E./ PA:** Add to the problem list,	See row B	See row B	Narcolepsy is **incompatible** with aviation safety. If the diagnosis is confirmed, a denial should be issued. If the additional testing or evaluation verifies the diagnosis was incorrect, medical certification can be considered. Untreated OSA may be diagnosed as Narcolepsy. In

	and follow-up. • **The evaluator should comment on any cardiovascular or psychological abnormalities and provide the results of any tests deemed necessary.** 2. Copies of the most recent • Sleep study (sleep lab polysomnography); • Multiple Sleep Latency Test [MSLT]); and • Any other testing already performed for this condition.		assign path/ICD code, summarize findings in note **detail where the diagnosis is confirmed** in your problem focused note and send to DOC. Prepare Appropriate Denial letter - Narcolepsy is incompatible with aviation safety and certification should not be considered for any class. Add: **rrbNARCOLEPSY b** for recon info Send to DOC for concurrence and signature.			these specific cases, an MSLT can help to differentiate the diagnosis. New tests to diagnose Narcolepsy are being developed. While we do not require this testing for aeromedical purposes at this time, if the pilot/ATCS submits the results of additional testing, they may be considered in the certification/clearance decision. Hypocretin/orexin: Several studies on cerebrospinal fluid hypocretin-1 levels in narcolepsy and in various other sleep disorders have shown that hypocretin deficiency is both highly sensitive and specific for narcolepsy/cataplexy. Importantly, 15% of narcoleptic patients show low hypocretin levels, despite a negative multiple sleep latency test. Hypocretin measurements may now be applied as a new diagnostic

						tool, providing the results are interpreted within the clinical context.
B. Current or historical diagnosis on medical records WITH new information which rescinds this diagnosis. Ex: Previously diagnosed with Narcolepsy but additional evaluation determines cause is another condition. We will need the information for that condition and the following:	If additional testing, evaluation(s), or documentation verifies the diagnosis of Narcolepsy was rescinded, no longer requires treatment, or has resolved, submit the following for FAA review: 1. A **current, detailed neurological evaluation** in accordance with the FAA Specifications for Neurologic Evaluation, generated from a clinic visit with a **Board-Certified neurologist or sleep specialist no more than 90 days before** the AME exam. 2. It must specifically include the current diagnosis, how the diagnosis of Narcolepsy was rescinded, and any occurrence(s) and frequency of cataplexy. 3. A Type 1 or Type 2 Sleep Study (polysomnogram) performed within the previous 12 months 4. A **MSLT** (multiple sleep latency test) **performed within the previous 12 months**. To assure the usefulness of the testing, it is recommended that the MSLT is performed in conjunction with the sleep study, and interpreted by the same physician. 5. Results of any additional testing already performed for this condition (e.g. Maintenance of Wakefulness Test [MWT]).	DEFER Submit the information to the FAA for a possible Special Issuance.	If we have not received ALL info for recon and the application has not yet been denied. **L.I.E./ PA:.** add to the problem list, assign pathology code, detail where the diagnosis is confirmed in your problem focused note, ***prepare Appropriate Denial letter*** add: **rrbNARCOLEPSYb (available in DIWS)** add enclosure: SPEC-NEUROEVAL send to DOC for concurrence and signature. If application has been denied and all information not received: *Send rrinfoINITIALREQ letter* Add: **rrbNARCOLEPSYb**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data row B Note: Cannot work solo. Case-by- case evaluation by FS.	New presentation/new diagnosis or symptomatic: IN CAPACITATE. Send an incapacitation memo and request the following: • All previous medical records for this condition. • Evaluation Data row B Note: Cannot work solo. Case by case evaluation by FS.	

			Add enclosure: **SPEC-NEUROEVAL** If information received confirms the diagnosis is still accurate: Process as described in Row A. If information received verifies the diagnosis is some other condition (OSA, etc.): Request any information for that condition as well. Make sure and clarify there is a question of Narcolepsy in your problem focused note. **All of these cases must go to DOC for review.**			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
	Standard follow up would include: 1. A current, detailed clinical progress note with a Board-Certified neurologist or sleep specialist no more than 90 days before the AME exam.		When all information received, send to DOC for recert (unless note states LIE can do recert and what criteria). Note: Recert is on case by case basis.		

	2. Testing deemed necessary by the treating physician.				

Condition Description

Narcolepsy is a chronic neurological disorder caused by the brain's inability to regulate sleep-wake cycles normally. At various times throughout the day, people with narcolepsy experience fleeting urges to sleep. Narcoleptic sleep episodes can occur at any time, and thus frequently prove profoundly disabling.

People with narcolepsy may feel rested after waking, but then feel very sleepy throughout much of the day. Many individuals with narcolepsy also experience uneven and interrupted sleep that can involve waking up frequently during the night.

Narcolepsy can greatly affect daily activities. People may unwillingly fall asleep even if they are in the middle of an activity like driving, eating, or talking. Other symptoms may include sudden muscle weakness while awake that makes a person go limp or unable to move (cataplexy), vivid dream-like images or hallucinations, and total paralysis just before falling asleep or just after waking up (sleep paralysis).

Similar to narcolepsy, idiopathic hypersomnia (IH) is a sleep disorder in which a person is excessively sleepy (hypersomnia) during the day and has great difficulty being awakened from sleep. Idiopathic means there is not a clear cause.

Additional History or Description of the Condition

.

REFERENCES

Recommended protocols for the Multiple Sleep Latency Test and Maintenance of Wakefulness Test in adults: guidance from the American Academy of Sleep Medicine | Journal of Clinical Sleep Medicine (aasm.org)

https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Narcolepsy-Fact-Sheet

Hypocretin/orexin and sleep: https://pubmed.ncbi.nlm.nih.gov/12447114/

Go to TOC

Details

Section / Branch
General Review (GR)

ICD-10
G47.419, G47.10

Pathology Codes (Prefixes)
607 ((1,2,3,A,B,C) = Narcolepsy), 675 ((1,3,A,C) = Hypersomnolence or hypersomnia)

Level of Review
3

ICD-9
347.00Narcolepsy, 780.54Hypersomnolence or Hypersomnia

Pilot Disposition
SI, DENY

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
DQ, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Blurbs Letters and Specification Sheets

Blurbs
rrbnarcolepsya

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis: immediately INCAP

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

3/24/2025 updated row A eval data and clarify not compatible with aviation safety. Updated recert row A to DCPN and testing deemed necessary.¿
4/29/2022 page reviewed

18l. Neurology

Neuralgia (trigeminal neuralgia; post herpetic neuralgia)

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Aeromedical Concerns

Aeromedical concerns include operational degradation from severe pain, medication effects, and other treatment-related effects. Glossopharyngeal neuralgia also has potential for sudden incapacitation from syncope due to pain and cardiac effects.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A1. **Post Herpetic Neuralgia,** **Occipital Neuralgia** Fully resolved AND off medications	If the AME can determine that the **Post herpetic or occipital neuralgia** • Has fully resolved; • Medications have been discontinued; and • Individual has no symptoms that would interfere with flight or safety related duties: ----------	Summarize findings in Item 60. If no AME explanation, the individual may be asked to provide documentation.	We **will accept** AME notes: If the AME adequately explains the condition resolved or for Trigeminal Neuralgia: 5 or more years ago: **L.I.E.:** Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special	Send a Request for Information letter for: • All previous medical records for this condition. Once records received, determine if additional	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • DCPN from treating	Evaluate on a case by case basis.

---------- A2. **Trigeminal Neuralgia** symptom free and treatment completed **5 or more years ago** **AND** did NOT require surgery, gamma knife, or other procedure	If the AME can determine that the **Trigeminal Neuralgia** • Fully resolved 5 or more years ago; • Does not require any medication; • Was never treated with surgery; and • Individual has no symptoms that would interfere with flight or safety related duties: If the AME is unable to determine the above, request a current, detailed Clinical Progress Note from the treating physician. If medications are currently used, the AME should check with the Do Not Issue - Do Not Fly list.		Issuance is required for additional condition(s), add WARN in the auth letter. **PA**: See above then send to DOC. If no AME explanation: *Send rrinfoINITIALREQ letter* Add: **rrbCSLONG** [**Trigeminal Neuralgia or Neuralgia**] When all info received, process per OneGuide.	information is required.	provider to include a detailed summary of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing required or performed; diagnosis; assessment and plan (prognosis); and follow-up.	
B. **Trigeminal Neuralgia** symptomatic, unresolved OR	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **It must specifically include** medications prescribed for this	DEFER Submit the information to the FAA for a possible Special Issuance.	If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbTRIGEMINAL** (delete brain imaging after the procedure and hospital records) Add enclosure(s): **SPEC-**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	

requiring treatment **within the past 5 years**	condition. Include start and stop dates; dosages, and side effects (if any). 3. Imaging performed at any time after symptoms started: • MRI brain • MRA head • Any other imaging (such as CT, MRI, CTA, MRA, or cerebral catheter angiography/cath angio of the head) already performed. • Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. **Note:** If due to Multiple Sclerosis or other condition - see that section.		**NEUROEVAL** **L.I.E/PA:** When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC	Data Row B		

C. **Trigeminal Neuralgia** treated with surgery or gamma knife (ever)	Submit the following for FAA review: 1. Row B Evaluation Data 2. Brain Imaging performed AFTER the procedure. 3. Hospital records. Include these specific hospital records for any hospitalization, surgery, or procedures related to this condition. • Admission History and Physical (H&P); • Emergency Medical Services (EMS)/ambulance run sheet; • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists); • Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) you can print from your electronic medical record are NOT sufficient for pilot medical certification purposes.); • Lab report(s) including all drug or alcohol testing performed; • Operative/procedure report(s); • Pathology report(s); and • Radiology reports. The interpretive report(s) of all diagnostic imaging (CT, MRI, X-ray, ultrasound, or others) performed. • DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60.	<u>If information not received:</u> *Send rrinfoINITIALREQ letter* Add: rrbTRIGEMINAL (available in DIWS) Add enclosure(s): **SPEC-NEUROEVAL** **L.I.E/PA**: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row C	

	medication administration records. For all imaging, submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. If you have a large volume of records, you may wish to bring these records to your AME for review and determine which miscellaneous records are not needed. Note: If due to Multiple Sclerosis or other condition - see that section.					

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
				Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	

Condition Description

Neuralgia is nerve pain.
It is a sharp, shocking pain that follows the path of a specific nerve. The most common type is trigeminal neuralgia (involves the face).
Other causes are post herpetic neuralgia (after a shingles episode). The causes include chemical irritation, inflammation, trauma (including surgery), compression of nerves by nearby structures (e.g. tumors), and infections may all lead to neuralgia. In many cases, however, the cause is unknown. Neuralgia is most common in elderly persons, but it may occur at any age.

Neuropathy is nerve INJURY.
Damage or dysfunction to the nerve causes numbness, tingling, muscle weakness or pain. Causes may include trauma, illness, or medications.
Alcohol, vascular disease, kidney disease, vitamin deficiencies, and other medical condition can cause neuropathy. The most common cause is diabetes. Some medications such as chemotherapy can also cause neuropathy.

Additional History or Description of the Condition

These may be referred to as suicide headaches due to the intense pain in the face and temples. The pain originates from the trigeminal nerve.

Most of the medication to treat is DQ.

One time MRI and MRA head required (any time in their life) to look for a vascular loop. The loop can be seen in approximately 30% of cases and can be surgically corrected.

REFERENCES

Neuralgia: MedlinePlus Medical Encyclopedia

Details

Section / Branch
General Review (GR)

ICD-10
G50.0, G52.9, G57.00, G58.8

Pathology Codes (Prefixes)
642 ((1,3,A,C)), 642

Level of Review
4

ICD-9
Trigeminal Neuralgia 350.10, Sciatic Neuralgia 355.00, Peripheral Nerve 355.90, Cranial Nerve 352.90

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbtrigeminal

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the

Flight Surgeon.

Summary of Changes

¿4/12/2022 page updated w/neurology.

18l. Neurology

Neuro Workflow Conditions; Neurology Panel Conditions; Neurological Conditions Requiring Initial Neuro Workflow Review; neuro workflow

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Aeromedical Concerns

See individual condition page.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
			The initial review of these neurological conditions must be performed by the Neuro Reviewer (forward to Neuro Section as outlined in the below image release path): *Note: If you come across one of these cases, assign the pathology code 3658 and release to Neuro section. The file will stay within the neuro workflow in DIWS and not route the file back to the GR			

			reviewers. Once a file has been seen and cleared by the neuro panel and/or physician, the 3658 path code will be removed by the neuro LIE, and all follow ups will be processed by GR LIEs.			
			NOTE: some conditions may be worked by GR and a higher level of severity worked by Neuro Reviewer. (ex: Stroke--see row requirements on each condition page).			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

The initial review of these neurological conditions must be performed by the Neuro Reviewer (AMCD) for pilots. GREEN ITEMS--indicate a CHANGE

1. All specifically disqualifying neurologic conditions described under 67.109, 67.209 and 67.309. This includes a medical history or clinical diagnosis of any of the following:

    a) Epilepsy;

    b) A disturbance of consciousness without satisfactory medical explanation of the cause;

    c) A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause.

2. Transient Global Amnesia (TGA)

3. Severe Traumatic Brain Injury (TBI) as defined in Head Injury section of OneGuide

4. All STROKE/CVA or TIA (cerebrovascular accident or transient ischemic attack)—all classes. All types. Ever in their life.

5. Neurologic condition requiring treatment with deep brain stimulation

6. Initial review of all neuraxial (brain and spinal cord) tumors to include primary and metastatic brain tumors. (Excludes pituitary adenomas and acoustic neuroma)

7. Initial review of aneurysms, AVMs , vascular malformations and neurovascular disease treated with stenting or bypass surgery.

8. Migraines: Any history of migraine which results in changes in vision (excluding migraine aura); chronic daily migraine, complicated migraine;

post-traumatic headaches; vestibular migraine; retinal migraine (previously called ocular migraine) *. *This type spreads across the retina and the concern is amaurosis.

9. BRAIN BLEED (intracranial hemorrhage; cerebral hemorrhage; ruptured aneurysm; subarachnoid hemorrhage (SAH); subdural)

10. Encephalitis (Current or historical diagnosis with 2 or more lifetime episodes; immunocompromised; or seizure activity)

11. HYDROCEPHALUS with or without shunt placement

12. Pre-clinical Alzheimer's or other degenerative dementias

13. Seizure -- Single seizure event UNprovoked (no known or questionable etiology) OR Complex febrile seizure

14. Tremor -- that does not CACI-qualify.

15. Meningitis/meningoencephalitis with seizure or recurret episodes.

16. Brain abscess

17. Chiari malformation (Currently symptomatic OR ANY Chiari type II, III, IV) [row C]

18. Neuromyelitis Optica Spectrum Disorder (NMOSD) OR Myelin Oligodendrocyte Glycoprotein Antibody Disorder (MOGAD)

OR

If the individual has not completed the minimum recovery periods as follows:

a) Cerebrovascular accident (Stroke/CVA)	2 years for most cases 1 year if etiology is known and corrected 1 year for subcortical, brainstem and cerebellar	**Neuro Workflow for all CVA/Strokes**

	strokes 2 years for ALL cortical infarcts even if the etiology is known. (due to risk of post-stroke seizure)	
b. Seizure, single UNprovoked	4 years AND off all anticonvulsants for 2 years	**Neuro workflow for all**
c) Seizure, single provoked	1 year	**General Regiew (GR)**
d) Transient ischemic attacks (TIA)	2 years	**Neuro workflow for all TIAs**
e) Traumatic brain injury (TBI)	1. Mild (no residual effects) - 6 months 2. Moderate - 1 year 3. Moderate with early seizure(s) - 2 years 4. Severe (subdural, etc.) - 5 years	**Mild/Moderate which have met recovery period---GR** **All others Neuro workflow**
f) Transient Global Amnesia (TGA)	6 months-single episode 2 years for recurrent TGA	**Neuro workflow**
g) Unexplained loss of consciousness (ULOC) or loss of neurologic function(s)	2 years	**Neuro workflow**
h) History of craniotomy (includes placement of VP shunt)	2 years	**Neuro workflow**
i) History of radiation treatment (brain) [excludes Gamma Knife or stereotactic radiation for small tumors]	3 years	**Neuro workflow**
j) Metastatic brain tumors	5 years	Neuro workflow
k) Neuromyelitis Optica Spectrum Disorder (NMOSD) OR Myelin Oligodendrocyte Glycoprotein Antibody Disorder (MOGAD)	6 months	Neuro workflow

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
Neurology Workflow (AMCD)

Go to TOC

ICD-10	Pathology Codes (Prefixes)	Level of Review	ICD-9
NEU.658	3658 (1,3)	0	

Pilot Disposition	Pilot Standard Certification
N/A	

CFR(s) Conditions Only	CFR(s) Conditions Treated with Meds

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
N/A	8B, 8C (if on medication), 9 (if on SC)		n/a

Blurbs Letters and Specification Sheets

Blurbs

Letters	Specification Sheets

ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Summary of Changes

2/27/2025 added Neuromyelitis Optica Spectrum Disorder (NMOSD) OR Myelin Oligodendrocyte Glycoprotein Antibody Disorder (MOGAD)
¿2/28/24 added Chiari row C
9/27/2023 updated list¿
3/16/2023 updated neuro conditions

18l. Neurology

Neurofibromatosis (Type 1/NF-1 von Recklinghausen Disease and Type 2/NF-2 Wishart Disease)

Aeromedical Concerns

Aeromedical concerns include adverse operational effects from nerve damage-related impairment, effects of neuropathic pain, medication effects, and increased impairment with disease progression.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Neurofibromatosis type 1 (NF1) von Recklinghausen's disease	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. Brain MRI with and without contrast performed no more than 90 days before the AME exam (reports and CD)*. 3. Any other neuroimaging such as	DEFER Submit the information to the FAA for a possible Special Issuance.	Worked in General Review (GR) If information not received: Send rrinfoNF1 letter (now avail in DIWS) Add enclosures: SPEC-NEUROEVAL + SPEC-Neur	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	**Neurofibromatosis type 1 (NF1)** has an extremely broad range of clinical presentations. It may be diagnosed by clinical criteria, with or without family history or genetic testing. The condition is autosomal dominant. Although many serious complications are

	MRI spine, plexus, optic nerves, or other areas, most recent, if already performed (reports and CD)*. For all images (CT/MRI), submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail. 4. Eye evaluation from a board-certified ophthalmologist (NOT optometrist). Submit a current, detailed Clinical Progress Note, generated from a clinic visit with the treating ophthalmologist no more than 90 days before the AME exam. It must include a detailed summary of the any eye conditions; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 5. Threshold Visual field testing with good reliability (30-2 or 24-2) performed within the previous 90 days with an interpretation of the visual field testing by the treating ophthalmologist. 6. Neuropsychological (NP) evaluation is required in most cases. The type of evaluation may vary. The applicant may want to wait until FAA review of other items above before obtaining NP testing. • If a history of cognitive impairment, brain lesion, or brain surgery: FAA		opsychological Eval (Neurocog Impairment) if brain lesion or surgery or + SPEC-ADHD/ADD if not certain which NP protocol, send to DOC for review before asking for NP testing. **L.I.E./PA:** When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC. If AASI approved by DOC			reported in childhood, milder cases may not be diagnosed until later in life. Mild cases may present with no more than cutaneous or subcutaneous lesions (café au lait spots), axillary freckling, and Lish nodules (growth on the iris) may only be visible on slit lamp examination. Cases that are mild on presentation as an adult are expected to have a benign course. [AASI is appropriate for following most cases.] **Complicated cases may manifest with** enlarging Plexiform Neurofibromas, nerve or spinal cord compression syndromes, optic nerve or optic tract glioma, neurofibroma, bone dysplasia, pheochomocytoma, or learning disability. Malignant transformation of peripheral tumors

	Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment is required; • If there is a history or suspicion of learning disability or ADHD: FAA Specifications for Neuropsychological Evaluation for ADHD is required needed; • If no history: FAA may accept an abbreviated evaluation after review of the other neurologic evaluation items. 7. Any other testing deemed clinically necessary by the treating physician		Add: **AASI Neurofibromatosis Spec** to auth letter			occur in about 5% (1-10%) of individuals in a lifetime. Gliomas in the brain have a predilection for the optic tracts and present more commonly in children. Malignant glioblastoma is reported to be a very rare occurrence. We are particularly concerned about neurological and ophthalmological complications, thus our requirement for neurology and ophthalmology follow up. Cutaneous manifestations may best be detected by a dermatologist, so dermatology may also be involved. Cases with malignant peripheral nerve sheath tumor (MPNST) portends a poor prognosis. [not appropriate for AASI] Cases using selumetinib (Koselugo) for peripheral nerve tumors, and cases with brain tumors of

						any type, should be referred to or consult with Neuro Workflow Physicians. Specific **learning problems** have been observed in 30–60% of children with NF-1. 1. If there is any history of a learning disability, ADHD, cognitive impairment or brain lesion, full NP testing to FAA Specifications for Pote

						ntial Neurocognitive Impairment. 2. First-time applicants with none of the above, the DOC may consider Cog Screen only. If abnormal, full NP testing. 3. First-time adult applicants

						where the condition is unlikely to progress, with documentation of normal educational and occupational achievement, and a normal brain MRI - the DOC may consider waiving NP

						evaluation on a case-by-case basis.
B. Neurofibromatosis type 2 (NF2) Wishart Disease	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. Audiologic evaluation including pure tone and speech discrimination and speech audiometry with interpretation performed no more than 90 days before the AME exam. 3. Brain MRI with and without contrast with fine cuts through the posterior fossa performed no more than 90 days before the AME exam (reports and CD)*. 4. Any other neuroimaging such as MRI spine, plexus, optic nerves, or other areas, most recent, if already performed (reports and CD)*. * For all images (CT/MRI). Submit BOTH the interpretive report and the actual images on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail.	DEFER Submit the information to the FAA for a possible Special Issuance.	Worked in General Review (GR) If information not received: Send *rrinfoNF2 letter (avail in DIWS)* Add enclosures: **SPEC-NEUROEVAL** **+ SPEC-Neuropsychological Eval (Neurocog Impairment) if brain lesion or surgery** **or** **+ SPEC-ADHD/ADD** **if not certain which protocol, send to DOC for review before asking for NP testing.**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	Row B **Neurofibromatosis Type 2 (NF2) Disposition** Despite the term "neurofibromatosis," NF2 is most commonly associated with the development of bilateral vestibular Schwannomas. Patients also have a predisposition to develop other tumors including meningiomas; ependymomas; and peripheral, spinal, and cranial nerve Schwannomas. Skin lesions may resemble NF-1, but consist of plaque-like Schwannomas. The diagnosis is often based on clinical features. Some genetic tests have recently been identified. Although

	5. Eye evaluation from a board-certified ophthalmologist (NOT optometrist). A current, detailed Clinical Progress Note generated from a clinic visit with the treating ophthalmologist no more than 90 days before the AME exam. It must include a detailed summary of the history of any eye conditions; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment; plan (prognosis); and follow-up. 6. Threshold Visual field testing with good reliability (30-2 or 24-2) performed within the previous 90 days with an interpretation of the visual field testing by the treating ophthalmologist. 7. Neuropsychological (NP) evaluation is required in most cases. The type of evaluation may vary. The applicant may want to wait until FAA review of other items above before obtaining NP testing. • If a history of cognitive impairment, brain lesion, or history or brain surgery: FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment is required; • If there is a history or suspicion of learning disability or ADHD: FAA Specifications for Neuropsychological Evaluation for ADHD is required;		**L.I.E./PA**: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC. **Note:** NF-2. The MRI must be a specific type AND also requries an audiology evaluation.			NF2 is autosomal dominant, family history is not always helpful as it has a highly variable clinical course. Some patients exhibit a severe phenotype and development of multiple tumors at an early age, while others may be nearly asymptomatic throughout their lifetime. Many cases result from new mutations. Posterior lenticular opacities (early cataracts) are common. Malignant transformation is rare, though complications of the disease can be serious due to more rapid growth rate and local invasion than lesions found in NF-1. Because the presentation is highly variable, AASI is **not** appropriate for NF-2. SI follow up and surveillance should include at a minimum

	• If no history - FAA may accept an abbreviated evaluation after review of the other neurologic evaluation items. 8. Any other testing deemed clinically necessary by the treating physician. Note: Brain surgery including resection of benign tumors that requires dural penetration (except resection of vestibular Schwannomas) requires a 2-year recovery period.					• Annual detailed clinical neurology reports; • Ophthalmology evaluations and audiometry; • Follow-up imaging such as brain MRI with and without contrast with fine cuts through posterior fossa, spine, or plexus imaging; and • Brainstem Auditory Evoked Potentials and need for ENT consultation must be determined on a case-by- case basis considering the presenting manifestations and clinical evidence for progression

						over time.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Neurofibromatosis type 1 (NF1) von Recklinghausen's disease	Standard follow up would include: 1. A current, **detailed neurological evaluation** that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than **90 days before** the AME exam. 2. Any other imaging such or testing deemed necessary by the treating physician(s).	See Authorization letter.	If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met. If AME sends in all documents, issues correctly and no changes in medical condition: **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. Cert t/l incorrect: **L.I.E.**: Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical	Review evaluation data for changes or concerns. Detail changes, abnormalities, or questions in your notes.	

			condition) OR Information not received.: (**if AME states in Block 60 reports are forthcoming, send to 14 day hold queue before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.**: Process condition per OneGuide. Determine if need to assign AME "W" error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. Condition worsened. No longer meets SI OR develops new condition: **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		
A. Neurofibromatosis Type 2 (NF2) Wishart Disease	Standard follow would include: 1. A current, **detailed neurological evaluation** that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than **90 days befor**e the AME exam. 2. Audiologic evaluation including pure tone and speech audiometry performed no more than **90 days before** the AME exam.	See Authorization letter..	NF-2 is not applicable for AASI. If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met. If AME sends in all documents, issues correctly and no changes in medical condition:		

	3. Eye evaluation from a **board certified ophthalmologist** (not optometrist). A current, detailed **Clinical Progress Note,** generated from a clinic visit with the treating ophthalmologist no more than **90 days before** the AME exam. It must include a detailed interim summary for any eye condition(s); current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment; plan (prognosis); and follow-up. • It must specifically include an interpretation of the visual field testing. • Visual field testing (HVF 24-2 SITA standard) performed within the previous 90 days. 4. Any other testing deemed clinically necessary by the treating physician. * All images (MRI/CT): Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail.		**L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. Cert t/l incorrect: **L.I.E.**: Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received.: (**if AME states in Block 60 reports are forthcoming, send to 14 day hold queue before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.**: Process condition per OneGuide. Determine if need to assign AME “W” error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. Condition worsened. No longer meets		

			SI OR develops new condition: **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		
.					

Condition Description

Neurofibromatosis type 1 (NF1) is a genetic condition that affects the skin, the skeleton, part of the nervous system outside the brain, and spinal cord peripheral nervous system.

NF-2 is less common and more likely to develop tumors.

Additional History or Description of the Condition

Neurofibromatosis type 1 (NF1) is a genetic condition that affects the skin, the skeleton, part of the nervous system outside the brain, and spinal cord peripheral nervous system. The main signs and symptoms of NF1 include dark colored spots on the skin (café-au-lait spots), benign growths along the nerves (neurofibromas), and freckles in the underarm and groin. Other symptoms may include colored spots in the eye (Lisch nodules), curvature of the spine, learning disabilities, and an increased risk for cancer. The number of neurofibromas typically increases over time. Some can get large or turn cancerous and need to be removed. The severity and symptoms can vary greatly from person to person. This condition is caused by genetic changes (DNA variants) in the *NF1* gene and is inherited in an autosomal dominant pattern. NF1 is diagnosed based on a clinical examination, the specific signs and symptoms, and genetic testing. Treatment is based on the signs and symptoms present in each person.[1][2][3][4]

Neurofibromatosis type 2 (NF2) is a disorder characterized by the growth of noncancerous tumors of the nervous system. Childhood symptoms include skin growths and eye findings. Almost all people with NF2 develop vestibular schwannomas affecting both ears by age 30. Other tumors of the central nervous system (the brain and spinal cord), skin, and eye are also common. The signs and symptoms vary from person to person. The severity depends on the size, location, and number of tumors. NF2 is caused by changes (mutations) in the NF2 gene and is inherited in an autosomal dominant manner. It is diagnosed based on a clinical examination and the symptoms. Genetic testing may be helpful. The treatment is based on managing the signs and symptoms and may include surgery and medications.[1][2][3]

REFERENCES

Neurofibromatosis type 1 | Genetic and Rare Diseases Information Center (GARD) – an NCATS Program (nih.gov)

Neurofibromatosis type 2 | Genetic and Rare Diseases Information Center (GARD) – an NCATS Program (nih.gov)

Details

Section / Branch
General Review (GR)

ICD-10
Q85.00, Q85.01, Q85.02

Pathology Codes (Prefixes)
919 ((1,3)), 919, 919

Level of Review
4

ICD-9
237.7 NF unspecified237.71, NF1237.72, NF2

Pilot Disposition
Warn, SI, AASI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

Go to TOC

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

01/28/2026 Updated NF-1 AASI. Removed requirement for annual eye eval unless clinically indicated.
09/24/2025 clarified visual fields can be 30-2 or 24-2 and we need interpretation.
¿04/29/2022 reviewed w/neurology.

18l. Neurology

Neuropathy (peripheral neuropathy)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

The primary aeromedical concern with neuropathy is impaired sensation and motor function in the extremities, with resulting degradation in aircraft control operation. A secondary concern is medication-related effects.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Neuropathy Without functional limitations	If the AME can determine the condition is: • Under control; • Medications are acceptable; and • The individual has no symptoms that would interfere with flight duties:	Summarize findings in Item 60. If no AME explanation, the pilot may be asked to provide documentation.	We **will accept** AME notes: If the AME adequately explains the condition has no functional limitations: **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter and WARN. If authorization for Special Issuance is required for	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B If due to an underlying condition - see	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	Symptoms or functional limitations, evaluate on case by case basis.

			additional condition(s), add WARN in the auth letter. **PA:** See above then send to DOC. If no AME explanation: Send *rrinfoINITIALREQ letter* Add: **rrbNEUROPATHY** (now avail in DIWS) When all information received, process as above.	that section.	If due to an underlying condition - see that section.	
B. Neuropathy with weakness/numbness or functional limitations	Submit the following for FAA review: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the treating physician no more than 90 days before the AME exam. It must include a detailed summary of the neuropathy (including etiology if known); current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 2. It must specifically include a description of any weakness, numbness or functional limitations. 3. Lab already performed for this condition. 4. Any other testing or imaging deemed clinically necessary by the treating	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60. If not addressed in the progress note, the AME should describe any functional limitations that could affect the pilot's ability to	If information not received: Send *rrINFORECON letter* Add: **rrbNEUROPATHY** When all information received: **L.I.E./PA:** Add to the problem list, assign path/ICD code, summarize findings in note, and send to DOC. Note: if neuropathy is due to an underlying condition (diabetes, etc) also see that page.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B If due to an underlying condition - see that section.	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B If due to an underlying condition - see that section.	

	physician. Note: If the neuropathy is due to an underlying condition such as diabetes - see that section.	operation aircraft controls.				

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

Neuropathy is nerve INJURY. Damage or dysfunction to the nerve causes numbness, tingling, muscle weakness, or pain. Causes may include trauma, illness, or medications. Alcohol, vascular disease, kidney disease, vitamin deficiencies, and other medical condition can cause neuropathy. The most common cause is diabetes. Some medications such as chemotherapy can also cause neuropathy.

Peripheral neuropathy, a result of damage to the nerves located outside of the brain and spinal cord (peripheral nerves), often causes weakness, numbness and pain, usually in the hands and feet. It can also affect other areas and body functions including digestion, urination, and circulation.

Additional History or Description of the Condition

REFERENCES

Peripheral neuropathy - Symptoms and causes - Mayo Clinic

Details

Section / Branch
General Review (GR)

ICD-10
G51.9, G62.9

Pathology Codes (Prefixes)
642 ((1,2,3,4,5,8,A,B,C,H)), 649

Level of Review
4

ICD-9
357.9

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
Appendix A, section 8A and 8C; 9 if on SC

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbneuropathy

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Go to TOC

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/12/2022 reviewed w/neurology

18l. Neurology

Paraplegia

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns with paraplegia include effects of limited mobility and lack of leg extremity function on aircraft operation, including ingress and egress. A secondary concern is increased susceptibility to deep vein thrombosis (DVT) due to prolonged immobility and dehydration during flight.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Paraplegia	Submit the following for FAA review: 1. A current, detailed neurological evaluation in accordance with the FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam. 2. It must specifically address:	DEFER Submit the information to the FAA for a possible Special Issuance or Medical Flight Test and SODA.	If information not received: *Send rrinfoINITIALREQ letter* add: **rrbPARAPLEGIA (now available in DIWS)** add enclosure: **SPEC-NEUROEVAL** When all information received:	**Use this for VHT instead of generic Evaluation Data** **Send a Request for Information letter for:** 1. All previous medical records for this	**Use this for ATCS instead of generic Evaluation Data** New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an	In most cases, a Medical Flight Test (MFT) is required prior to medical certification and/or Special Issuance for all classes.

	• Cause of paraplegia; • Medication use and side effects, if any; • Autonomic functions such as bowel, bladder, and blood pressure control; • Orthostatic episodes; • Hypotensive episodes on the ground. (This could be exacerbated with G-forces in flight.); and • Description of movement, strength, and tone (ability to get into and out of an airplane). **Note:** Most anticholinergic medications are not acceptable. If the neurology evaluation does not adequately describe movement, strength, and functional ability, the AME should describe any functional limitations that could affect the ability to operate aircraft controls. If not addressed, a PT/OT/PMR Functional Capacity Evaluation (FCE) may be required. In most cases, a Medical Flight Test (MFT) is required prior to medical certification and/or Special Issuance for all classes.		L.I.E./PA: Add to the problem list, assign path/ICD code, summarize findings in note, send to DOC for possible MFT. Note: A Medical Flight Test (MFT) is required prior to medical certification and/or Special Issuance for all classes. If the neuro eval does not describe/detail a good exam, we may need a PT/OT/PMR eval (use rrbPTOT) - send to DOC first. Evaluation data: We do not need a urology or orthopedic eval. Use rrbPTOT instead. This will give a funtional evaluation.	condition. 2. A current, detailed neurological evaluation, in accordance with the FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 3. It must specifically address: • The cause of paraplegia; • Medication use and side effects; • Autonomic functions such as bowel, bladder, and blood pressure control; • Orthostatic episodes; • Hypotensive episodes;	incapacitation memo and request the following: 1. A current, detailed neurological evaluation, in accordance with the FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. It must specifically address: • The cause of paraplegia; • Medication use and side effects; • Autonomi	VHT/ATCS • The PT/OT/PMR evaluation should address the ability to navigate stairs with or without assistance. Towers have stairs not elevators. May need a facility restriction.

				• Description of movement, strength, and tone; and • PT/OT/PMR evaluation should address the ability to navigate stairs with or without assistance. Note(s): Most anticholinergic medications are not acceptable. If the neurology evaluation does not adequately describe movement, strength, and functional ability, the AME should describe any functional limitations. If not addressed, a PT/OT/PMR Functional Capacity Evaluation (FCE) may be required.	c functions such as bowel, bladder, and blood pressure control; • Orthostatic episodes; • Hypotensive episodes; • Description of movement, strength, and tone; and • PT/OT/PMR evaluation should address the ability to navigate stairs with or without assistance. Note(s): Most anticholinergic medications are not acceptable. If the neurology evaluation does not adequately	

				PT should address the ability to navigate stairs with or without assistance. Towers have stairs not elevators. May need a facility restriction.	describe movement, strength, and functional ability, the AME should describe any functional limitations. If not addressed, a PT/OT/PMR Functional Capacity Evaluation (FCE) may be required. PT should address the ability to navigate stairs with or without assistance. Towers have stairs not elevators. May need a facility restriction.	

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS	DOC Actions

Stage				(VHT App only if required)	

Condition Description

Paraplegia is an impairment in motor and/or sensory function of the lower extremities. It is usually the result of a spinal cord injury or a congenital condition. The area of the spinal canal affected in paraplegia is either the thoracic, lumbar, or sacral regions.

Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of the body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia.

Most paralysis is due to stroke or injuries such as spinal cord injury or broken neck.
Other causes of paralysis include:

- Nerve diseases such as amyotrophic lateral sclerosis
- Autoimmune diseases such as Guillain-Barre syndrome
- Bell's palsy, which affects muscles in the face

Additional History or Description of the Condition

REFERENCES

https://medlineplus.gov/paralysis.html

Details

Section / Branch
General Review (GR)

Go to TOC

ICD-10
G81.90, G82.20, G82.50

Pathology Codes (Prefixes)
639 ((1,2,A,B))

Level of Review
4

ICD-9
344.10

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbparaplegia

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/8/2022 page reviewed. Note specific items for VHT and ATCS.

18l. Neurology

Parkinson’s Disease or Parkinsonism (secondary)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include functional impairment from tremor, slow muscular movements and speech difficulty, cognitive impairment, medication/treatment effects, and inexorable disease progression, which eventually will preclude safe aircraft operation.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Current or historical diagnosis	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the treating neurologist no more than **90 days before** the AME exam. 2. **It must specifically include:** • Unified Parkinson's UPDRS-III motor rating scale; • Medication. Comment on medications, side effects; and effectiveness of medication or	DEFER Submit the information to the FAA for a possible Special Issuance.	**These are worked in General Review (GR)** If information not received: *Send rrINFOINITREQ letter* Add: **rrbPARKINSONS (now avail in DIWS)** Add enclosure(s): **SPEC-NEUROEVAL + SPEC-Neuropsychological Eval** (Neurocog Impairment)	Send a Request for Information letter for: • All previous medical records for this condition. • Row A Evaluation Data	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Row A Evaluation Data.	Even though the rate can vary person to person, sudden decline to an incapacitating level in less than 6 months, without any prior evidence of persisting decline, would **not** be typical of Parkinson's disease. **If such a rapid**

	treatment; • Describe findings if/when an individual misses a dose of medication; • Must discuss stability of the condition: fluctuations of motor and cognitive function; dyskinesia, in response to the medication and what is the pattern of fluctuations throughout the day; and • Autonomic dysfunction such as blood pressure fluctuation or orthostasis; and **Acceptable Medication(s)**: The **only** medication currently acceptable for aeromedical purposes is **carbidopa + levodopa** (in either long or short acting preparations). 3. **MRI brain** (Magnetic Resonance Imaging) performed **within the 12 months before the AME** exam. Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. A current **Neuropsychological (NP) evaluation** that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment, generated from a clinic visit with the **treating neuropsychologist** no more than **90 days before** the AME exam.		**L.I.E./PA:** When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC **Note:** If treated with Deep Brain Stimulator - go to Row B.			**decline were to occur, it would suggest the need to look for an alternative diagnosis** (strokes "vascular parkinsonism," med ication, toxicity, CJD, other neurodegenerative diagnosis like MSA or CBD). A decline from mild to significant disability certainly could occur, in 6 months or less, but not likely as a "surprise." The clinical evidence should suggest a gradual onset of symptoms, with no more that mild changes in the 6-12 months leading up to the initial application. The medical officer may consider the need to obtain further evaluation after a wait period that assures lack of progression, to the degree that eligibility may be assured for the duration of certification (possibl y also through a shorter term

						certification). For example, cases where progression was not assuredly slow enough for 12 months cert. The UPDRS-III does not deal with fluctuations of symptoms during the day, so info is specifically required. <u>Most cases 12 month SI/SC:</u> • Neuro per spec eval every 6 months for ALL classes, aggregated and submitted every 12 months. • NP testing every 12 months for all classes can be CogScreen. If any concerns, request NP testing. • Repeat brain imaging is not necessary

						unless clinically indicated. • While Parkinson's can have fluctuations, progression rates tend to be a bit more predictable. •
B. Parkinson's Treated with Deep Brain Stimulator (DBS)	Submit the following for FAA review: 1. All Row A evaluation data 2. Operative report 3. DBS Status Summary Note: DBS and lesioning therapy may carry a risk of cognitive impairment and are reviewed on a case-by-case basis.	DEFER Submit the information to the FAA for a possible Special Issuance.	**L.I.E./ PA:** Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). NEURO PANEL REVIEWER (AMCD) Neuro L.I.E.: If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbPARKINSONS (now avail in DIWS)** Add **"Operative report and Deep Brain Stimulator (DBS) Status Summary."** Add enclosure(s): **SPEC-NEUROEVAL +** **SPEC-**	Send a Request for Information letter for: • All previous medical records for this condition. • Row B Evaluation data	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Row B Evaluation Data.	Row B Initial certification after Deep Brain Stimulator placement: No fixed recovery period. Must be stable and well controlled. Will be case-by-case basis. If you do not want the AME to do the recert - you must specify in your note.

			Neuropsychological Eval (Neurocog Impairment) + **SPEC-DBS (pending in DIWS)** When all required information received, add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. If DOC does not want AME to issue the recert, add **rrbDFR** to auth letter.			

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Current or historical diagnosis All classes	Standard follow up for ALL CLASSES/ATCS includes: 1. **Every 6 months**, a detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation, generated from a clinic visit with the **treating neurologist** no more than **90 days** before the AME exam. AGGREGATED and bring to AME	See Authorization letter.	If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are me. If AME sends in all documents, issues correctly and no changes in medical	Detail changes, abnormalities, or questions in your notes.	

	evaluation annually. **2. Every 12 months**, CogScreen AE. If any concerns, a **Neuropsychological (NP) evaluation** that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment, generated from a clinic visit with the **treating neuropsychologist** no more than **90 days before** the AME exam may be required. 3. Repeat brain imaging is **not necessary unless clinically indicated.**		condition: **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. Cert t/l incorrect: **L.I.E.**: Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received.: (**if AME states in Block 60 reports are forthcoming, send to 14 day hold queue before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.**: Process condition per		

			OneGuide. Determine if need to assign AME “W” error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. <u>Condition worsened. No longer meets SI OR develops new condition:</u> **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		
B. Parkinson's Treated with Deep Brain Stimulator All classes		See Authorization letter.	See Row A. If on SI for Deep Brain Stimulator and has new surgery or re-position of the device - send case back to Neuro LIE.		

Condition Description

Parkinson's disease is a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination. Parkinson's disease occurs when the nerve cells in the part of the brain that controls muscle movement are gradually destroyed. The damage gets worse with time. The exact reason that the cells of the brain waste away is unknown. The disorder may affect one or both sides of the body, with varying degrees of loss of function. It is one of the most common neurological disorders of the elderly.

Secondary parkinsonism is similar to Parkinson's disease, but is caused by certain medicines, a different nervous system disorder, or another illness.

Deep Brain Stimulators are used for multiple conditions including Parkinson's, Epilepsy, Essential Tremor, Dystonia, and Obsessive compulsive disorder (OCD). **Verify the condition.**

Go to TOC

Additional History or Description of the Condition

Parkinson Disease is a progressive condition. Aeromedical certification is safely possible only in early stages, and if medical certification is given, it must be short-term, with the expectation that Denial will eventually be necessary.

REFERENCES

Certification Issues for Airmen Diagnosed with Parkinson's Disease
Literature Review, Analysis, Population Comparisons, and Recommendations

Thaler A, Alcalay AN. Diagnosis and management of Parkinson Disease. Continuum (Minneap Minn) 2022; 28(5):1281-1300.

Rawls AE. Surgical therapies for Parkinson Disease. Continuum (Minneap Minn) 2022; 28(5):1301-1313.

Weintraub D, Irwin D. Diagnosis and treatment of cognitive and neuropsychiatric symptoms in Parkinson Disease and Dementia with Lewy Bodies. Continuum (Minneap Minn) 2022; 28(5):1314-1332.

Details

Section / Branch
General Review (GR)

ICD-10
G20

Pathology Codes (Prefixes)
621 (1,2,3,4,A,B,C,D)

Level of Review
4

ICD-9

Pilot Disposition
SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
SC	8B, 8C (if on medication), 9 (if on SC)	12 months	Indefinite

Blurbs Letters and Specification Sheets

Blurbs
rrbparkinsons, RRBDFR

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿8/2/2022 DBS spec sheet created 4/19/22 reviewed w/ neurology

18l. Neurology

Polio (poliomyelitis)

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Aeromedical Concerns

Aeromedical concerns include effects of residual muscle weakness on aircraft operations, with potential for worsening during stresses of flight, especially from fatigue and G-forces.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Polio Any history including post-polio syndrome with NO functional limitation	If the AME can determine • The condition is under control, • No medications are needed, AND • The individual has no functional limitations that could affect their ability to operation aircraft controls or perform safety related duties:	ISSUE Summarize findings in Item 60..	<u>If previously reported and warned:</u> **L.I.E./PA:** Add to DIWS note (ex. history of polio/previously warned), FMC, and send to file. <u>The first time the condition is reported:</u> We **will accept** AME notes: If the AME adequately explains	Go to row B	May see as post polio syndrome. Go to row B	(Updated 7/27/2022) Similar to cerebral palsy, but no cognitive impairment. Should see a physical deformity. Does not need a neurological evaluation or orthopedic eval in most cases.

			• The condition is under control, • No medications needed, and • The individual has no functional limitations that could affect their ability to operation aircraft controls or perform safety related duties: **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. <u>If no AME explanation:</u> *Send rrinfoINITIALREQ letter* Add: **rrbCSLONG** from treating physician <u>When all info received</u>: **L.I.E.** Process any conditions per OneGuide. **PA:** See above then send to DOC. Do NOT ask for Neuro per specs or Ortho. If function is of concern, use rrbPTOT to ask for PT/OT/PMR evaluation.			

B. Polio Any history including post-polio syndrome with a functional limitation that could interfere with flight or safety related duties	Submit the following for FAA review: 1. A current, detailed Clinical Progress Note generated from a clinic visit with a **physical medicine and rehabilitation physician, physical therapist, or occupational therapist no more than 90 days before** the AME exam. It should include a detailed history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 2. **It must include** the components of a Functional Capacity Evaluation (FCE). • It should evaluate items such as balance, strength, range of motion limitations, and pain. • It must describe any functional deficits or limitations for both large- and small-muscle groups as well as dexterity to operate an aircraft. If not addressed in the Clinical Progress Note, the AME should describe any	DEFER Submit the information to the FAA for a possible Special Issuance or SODA.	<u>If information not received:</u> *Send rrinfoINITIALREQ letter* Add: **rrbPTOT** Add: **90 days to fill in** <u>If the evaluation adequately explains the condition has no functional limitations:</u> L.I.E.: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. PA: See above then send to DOC. All others L.I.E. /PA: Add to the problem list, assign path/ICD code, summarize findings in note. If functional capacity is limited, a Medical Flight Test (MFT) may be required. Send to DOCs for determination.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B • the DCPN can be allowed if no more than 12 months before the AME exam. • If not addressed in the progress note, the AME should describe any functional limitations. • • Note:	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B • remove ◦ If not addressed in the progress note, the AME should describe	Row B If any report of concerns or functions limitations that could interfere with flight duties, LIE/PA will ask for an evaluation from PMR/PT/OT. It must include components of the Functional Capacity Evaluation and evaluation (FCE). It should evaluate items such as balance, strength, range of motion limitations, and pain. It must describe any functional deficits or limitations for both large and small muscle groups as well as dexterity to operate an aircraft. If not addressed in the progress note, the AME should describe any functional limitations that could affect the pilot's ability to operation aircraft

	functional limitations that could affect the individual's ability to operate aircraft controls. **Note**: If functional capacity is limited, a Medical Flight Test (MFT) may be required. See that page. Specify on the exam the FSDO location the pilot wants to use for the MFT.		Do NOT ask for Neuro eval, Neuro per specs or Orthopedic eval. If function is of concern, use rrbPTOT to ask for PT/OT/PMR evaluation. PT/OT/PMR are trained to perform a Functional Capacity Evaluation which will better describe the individual's functional status.		any functional limitations that could affect the pilot's ability to operation aircraft controls.	controls. Previous information request was for a neurology eval and orthopedic eval. (For other conditions which need an FCE, the LIE/PA can use rrbPTOT blurb to ask for PMR/PT/OT evaluation.) MFT may be needed in some cases. Most can be WARN. Post polio syndrome: See late, progressive weakness and pain. If new post polio syndrome with age, when stable can consider. Most will be WARN.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Polio Any history including post-polio syndrome	Follow up Issuance will be per the Authorization letter.		Very few of these will be followed on SI. Most will be a warning after a one time PT/OT/PMR evaluation.		

Condition Description

Polio is a contagious viral illness (poliovirus). Most people who get infected with poliovirus (about 72 out of 100) will not have any visible symptoms. A smaller proportion of people (much less than one out of 100, or 1-5 out of 1000) with poliovirus infection will develop other, more serious symptoms that affect the brain and spinal cord:

- Paresthesia - feeling of pins and needles in the legs.
- Meningitis - infection of the covering of the spinal cord and/or brain) occurs in about 1 out of 25 people with poliovirus infection.
- Paralysis - can't move parts of the body) or weakness in the arms, legs, or both, occurs in about 1 out of 200 people with poliovirus infection.

Paralysis, the most severe symptom associated with polio, can lead to permanent disability and death. Between 2 and 10 out of 100 people who have paralysis from poliovirus infection die, because the virus affects the muscles that help them breathe.

Even children who seem to fully recover can develop new muscle pain, weakness, or paralysis as adults 15 to 40 years later. This is called post-polio syndrome.

Note that "poliomyelitis" (or "polio" for short) is defined as the paralytic disease. Only people with the paralytic infection are considered to have the disease.

FCE-Functional Capacity Evaluation is a detailed exam usually performed by PT or OT (sometimes a Physical Medicine and Rehabilitation physician [PMR]). It is used to evaluate and measure balance, strength, cardiac function, range of motion limitations, and pain.

Additional History or Description of the Condition

REFERENCES

https://www.cdc.gov/polio/what-is-polio/index.htm#:~:text=Polio%2C%20or%20poliomyelitis%2C%20is%20a,move%20parts%20of%20the%20body).

Details

Section / Branch
General Review (GR)

ICD-10
A80.30, A80.9

Pathology Codes (Prefixes)
632 ((1,A)), 632

Level of Review
3

ICD-9
45.10

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67 113(b)&(c), 67.213(b)&(c), and 67.313(b)&(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
RRBPTOT

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

¿4/1/2022 page updated

18l. Neurology

Pseudotumor Cerebri (idiopathic intracranial hypertension)

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Aeromedical Concerns

Aeromedical concerns include risk of progressive vision loss, distraction or incapacitation from headache, risk of diplopia from abducens palsy, and side effects of medications used for management. There is low risk for sudden incapacitation, but subtle incapacitation is possible with ongoing or progressive symptoms.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
Pseudotumor Cerebri (idiopathic intracranial hypertension) previous name: benign intracranial	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist no more than 90 days before the AME exam. 2. MRI of the brain performed no more than 90 days before the AME exam. o Submit the interpretive report on paper	DEFER Submit the information to the FAA for a possible Special Issuance	If information not received: *Send rrinfoINITIALREQ letter* Add: **rrbPSEUDOTUMOR** (new blurb) When all information received: **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in note, send to	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row A	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row A	The disorder may cause progressive, permanent visual loss in some patients. In some cases, pseudotumor cerebri recurs.

hypertension	and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 3. A current, detailed Clinical Progress Note generated from a clinic visit with the treating **ophthalmologist or neuro-ophthalmologist** no more than 90 days prior to the AME exam. It must include: · A detailed summary of the history of the condition; · Current medications, dosage, and side effects (if any); · Physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 4. Visual Field graphs (24-2 or 30-2) with narrative interpretation by the treating eye specialist. 5. If surgery was performed, it should indicate follow-up results and note any complications. • If a shunt was placed as part of treatment, a minimum recovery period of two (2) years is required. 6. Records from any hospitalization to include: • Admission History and Physical; • Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) you can print from your electronic medical record are NOT sufficient	Summarize findings in Item 60.	DOC.			

	for pilot medical certification purposes.); • Emergency Medical Services (EMS)/ambulance run sheet; • Hospital consultant report(s) (such as neurology, cardiology, internal medicine, or other specialists); • Lab report(s) including all drug or alcohol testing performed; • Operative/procedure report(s); to include lumbar puncture(s) • Pathology report(s); and 7. Radiology report(s). The interpretive report(s) of all diagnostic imaging (CT scan, MRI, MRA, MRV, X-ray, ultrasound, or others) performed.					

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

Pseudotumor cerebri literally means "false brain tumor." It is likely due to high pressure within the skull caused by the buildup or poor absorption of cerebrospinal fluid (CSF). The disorder is most common in women between the ages of 20 and 50. Symptoms of pseudotumor cerebri, which include headache, nausea, vomiting, and pulsating sounds within the head, closely mimic symptoms of large brain tumors.

Treatment. Obesity, other treatable diseases, and some medications can cause raised intracranial pressure and symptoms of pseudotumor cerebri. A thorough medical history and physical examination is needed to evaluate these factors. If a diagnosis of pseudotumor cerebri is confirmed, close, repeated ophthalmologic exams are required to monitor any changes in vision.

Drugs may be used to reduce fluid buildup and to relieve pressure. Weight loss through dieting or weight loss surgery and cessation of certain drugs (including oral contraceptives, tetracycline, and a variety of steroids) may lead to improvement. Surgery may be needed to remove pressure on the optic nerve. Therapeutic shunting, which involves surgically inserting a tube to drain CSF from the lower spine into the abdominal cavity, may be needed to remove excess CSF and relieve CSF pressure.

Go to TOC

Additional History or Description of the Condition

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REFERENCES

Pseudotumor Cerebri | National Institute of Neurological Disorders and Stroke (nih.gov)

Idiopathic intracranial hypertension: MedlinePlus Medical Encyclopedi

Thurtell MJ. Idiopathic intracranial hypertension. Continuum (Minneap Minn) 2019; 25(5):1289-1309.

Details

Section / Branch
General Review (GR)

ICD-10
G93.2

Pathology Codes (Prefixes)
620

Level of Review
3

ICD-9
348.2

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbpseudotumor

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement

Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

12/22/22 updated with neurology

18l. Neurology

Seizure

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include future recurrence risk with resulting sudden incapacitation, and medication effects.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Simple Febrile Seizure occurring at **Age 5 or younger** (fever seizure/febrile seizure)	If the AME can determine all of the following apply: • A single seizure only; • Condition fully resolved age 5 or younger; • NO recurrence; • NO anticonvulsant medication given; AND • Condition has resolved without sequelae with NO symptoms or current problems that would interfere with flight duties: If the AME is unable to determine all of the above information, a detailed neurological	ISSUE Summarize findings in Item 60.	We **will accept** AME notes: If the AME adequately explains the condition was a single episode, age 5 or younger, and with no further episodes: L.I.E.: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s),	Send a Request for Information letter for: • All previous medical records for this condition.	N/A. Do not use this row. Go to row B.	Febrile seizures are often described as simple and complex. While a single episode may include more than one seizure **within the same day,** if this occurs, the concern is the underlying neuropathology and a neuro eval is necessary.

	evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist will be required. If the neurology evaluation verifies the condition was a simple febrile seizure:		add WARN in the auth letter. PA: See above then send to DOC. If no AME explanation: *Send rrinfoINITIALREQ letter* add: **rrbCSLONG [febrile seizure]** When all info received, process as above. **L.I.E./ PA:** If any concerns or unsure if single or multiple seizure episode(s), assign path/ICD code, summarize findings in note, and send to DOC. If recurrent seizures or treated with medication go to row B.			
B. **Single seizure** event **Provoked** by a known cause which has been corrected May be due to: Electrolyte or severe metabolic imbalance; Medication use; or	After a **One (1)-year recovery** period, submit the following for FAA review: 1. A **detailed neurological evaluation** that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the **treating neurologist no more than 90 days** before the AME exam. 2. It **must specifically include** the date of last seizure activity and dates medication discontinued.	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item	If clearly due to drug or alcohol withdrawal send to D&A LIE If one (1) year recovery period has not been met, work in GENERAL REVIEW: **L.I.E./ PA:** Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter and send to DOC. If information not received: Send *rrinfoINITIALREQ lett*	If recovery period has been met, send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New diagnosis or symptomatic: INCAPACITATE. After a One (1) year recovery period, Send an incapacitation memo for: • Evaluation Data Row B	Row B A **simple febrile seizure** is isolated, brief and generalized. Simple febrile seizures do not require use of anti-epileptic meds, and depending on the literature, their development of epilepsy later in life is low, probably in the 2 to 2.5% range.

Convulsive syncope; If due to TBI or post concussive seizure--see that section; Drug or Alcohol withdrawal--see D&A section	3. ***MRI brain** performed at any time after the seizure activity started. • If not already performed, a current brain MRI is required. *Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail. 4. **Electroencephalogram (EEG)** performed **no more than 12 months before the AME exam**. It must be sleep-deprived EEG: Awake, asleep, and with provocation (hyperventilation, photic/strobe light). • If not already performed, a current EEG is required. • Submit any previous EEG(s) available for comparison. • Submit BOTH the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before	60.	*er* add: **rrbSEIZURE** add enclosure(s): **SPEC-NEUROEVAL** **+ FAA Airman Seizure Questionnaire** L.I.E./PA: When all required information received: add to the problem list, assign path/ICD code, summarize findings in notes, and send to DOC If denied, recovery period not met and requests reconsideration: SEND TO NEURO PANEL REVIEWER (AMCD)			Although most cases of medication use turn out to be overly-cautious, the use of medications for febrile seizures raises potential concerns for underlying neuropathology that might warrant additional scrutiny. Simple febrile seizure are handled in General Review.

	sending. Retain a copy of all films as a safeguard if lost in the mail. 5. FAA Airman Seizure Questionnaire completed by the applicant. **Note:** In some cases, a longer recovery period will be required based on the underlying cause.					
C. **Single seizure** event **UNprovoked** (no known cause) OR **Complex febrile seizure**; or atypical/complex febrile seizures or febrile seizures treated with medication as a child (usually age 5 or younger). Note: If **2 or more seizures in a lifetime**, from any cause, go to the	After a **four (4) year recovery period** and the **last two (2) years** must be **without anticonvulsant medication**, submit the following for FAA review: • All information in row B. Upon review, additional information may be required.	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60. .	SEND TO NEURO PANEL REVIEWER (AMCD) If information not received: Send *rrinfoINITIALREQ letter* add: **rrbSEIZURE** Change recovery period to: **After a four (4) year recovery period and the last two (2) years must be without anticonvulsant medication** obtain the following: add	After a four (4) year recovery period and the last two (2) years must be without anticonvulsant medication • See row B	After a four (4) year recovery period and the last two (2) years must be without anticonvulsant medication • See row B	Row C A **complex febrile seizure** is one that may have a focal onset, occurs more than once during a febrile illness, or lasts more than 10-15 minutes. Usually medications are given if there are recurrent or atypical/complex febrile seizures. Complex febrile seizures have a higher risk of developing into epilepsy. Depending on the literature, it can be from 8 to 12%, Febrile status epilepticus is an

EPILEPSY page			enclosure(s): **SPEC-NEUROEVAL** **+ FAA Airman Seizure Questionnaire** **Neuro L.I.E.:** When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. If four (4) year recovery period has not been met: Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter and send to DOC. This is a change from previous process.			extreme type of complex febrile seizure that may last for more than 30 minutes. Febrile status epilepticus has even an even higher risk of developing into epilepsy. Complex febrile seizures, recurrent febrile seizures (on different days), atypical/complex febrile seizures, and any that were treated with medication and should be processed in neuro workflow. ATCS--if questions if recurrent seizure or epilepsy, discuss with Neuro Workflow physicians. Seizure vs Epilepsy The International

						League Against Epilepsy (ILAE) accepted recommendations of a task force altering the practical definition for special circumstances that do not meet the two unprovoked seizures criteria. The task force proposed that epilepsy be considered to be a disease of the brain defined by any of the following conditions: (1) At least two unprovoked (or reflex)

						seizures occurring >24 h apart; (2) one unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60%) after two unprovoked seizures,occurring over the next 10 years; (3) diagnosis of an epilepsy syndrome. Epilepsy is considered to be resolved for individuals

						who either had an age dependent epilepsy syndrome but are now past the applicable age or **who have remained seizure-free for the last 10 years and off anti-seizure medicines for at least the last 5 years.** "Resolved" is not necessarily identical to the conventional view of "remission or "cure." Different practical

						definitions may be formed and used for various specific purposes. This revised definition of epilepsy brings the term in concordance with common use. Specific circumstances—Drug or Alcohol Withdrawal Provoked seizure(s) due to alcohol or drug withdrawal must be considered on a case by case basis. • If provoked by alcohol withdrawal, then use CFR for substance dependence. • There is no

						specific neurology wait time or need for neurology review in the majority of these cases. • These all need to go through D&A and to be considered for certification, will need sufficient recovery (HIMS or similar). • D&A will send cases to neuro case by case if there is concern for other potential seizure disorders in addition to the alcohol withdrawal.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
				.	
				After a four (4) year recovery period and the last two (2) years must be without anticonvulsant medication • See row B	

Condition Description

A seizure is a sudden change in behavior due to an excessive electrical activity in the brain. A seizure can be triggered by many things, some of which include high fever (primarily in children), head injury, brain tumor, and drug use (especially cocaine or stimulants).

When a person has had two or more seizures he or she is considered to have epilepsy--see that section.

Febrile seizures. Multiple seizures on the same day (back to back) may be considered a single episode.
Head trauma may have a seizure immediately after the trauma. This should not need a seizure evaluation. Follow guidance for the head trauma (TBI).

Additional History or Description of the Condition

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REFERENCES

https://www.ilae.org/guidelines/definition-and-classification/definition-of-epilepsy-2014

Details

Section / Branch
General Review (GR)

ICD-10
G40.309, G40.409, R56.00, R56.1, R56.9

Pathology Codes (Prefixes)
605 ((1,3,A,C)), 605, 609, 609, 605

Level of Review
4

ICD-9
Convulsive Reaction 780.39Grand Mal seizure 345.10Jacksonian Epilepsy 345.50Petit Mal Seizure 345.10Psychomotor Epilepsy, Seizures 345.00Abnormal EEG wo epilepsy 794.02Electroencephalogram, Abnormal 794.02 Febrile SeizuresConvulsions 780.31, PostTraumatic seizuresconvulsions 780.33

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Go to TOC

Blurbs Letters and Specification Sheets

Blurbs
rrbseizure

Letters

ATCS Letters/Memos

Specification Sheets

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

8/27/25 seizure due to D&A issue, send to D&A workflow
7/7/2025 clarified D&A withdrawal info
4/8/2022 reviewed with neurology

18l. Neurology

Stroke or CVA (cerebrovascular accident) or TIA (transient ischemic attack)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include potential impairment from residual neurologic or cognitive deficits, future recurrence risk, future seizure risk (with supratentorial cortical strokes), and medication-related effects.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. All Classes All types Ever in their life OR TIA (transient ischemic	**Required recovery period:** · Cortical stroke or TIA: **2-year recovery** · Sub-cortical stroke: 1-year recovery **Note:** If the cause of stroke/CVA or TIA is known and corrected (e.g., high-grade carotid stenosis, fully treated, or PFO and fully corrected), the recovery period may be waived on a case-by-case basis. Sub-	DEFER Submit the information to the FAA for a possible Special Issuance	These are worked in Neuro Workflow (as of 12/2022) If granted AASI--followed indefinitely: Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note.	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data row A	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data row	**AMCD/RFS** All stroke(s)/TIA(s) go to neuro workflow. (7/20/2022) Recovery periods (in general) • 2-years following cortical stro

attack) Note: Strokes have different causes and pathology and therefore require different evaluations. Once the initial information is reviewed by the neurology physicians, additional items may be required.	cortical or TIA with known cause may also be considered sooner than one year. Once the **required recovery period has been met** submit the following for FAA review: 1. A detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam. 2. ***Brain MRI performed within the previous 12 months**. New imaging may be required after FAA physician review. Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. Retain a copy of all films as a safeguard if lost in the mail. 3. Hospital records from the event: · Admission History and Physical; · Hospital discharge summary. (Typically, the patient portal notes or after visit summary (AVS) printed from an electronic medical record are NOT sufficient for pilot medical certification purposes.); · Emergency Medical Services (EMS)/ambulance run sheet, if applicable; · Hospital consultant report(s) (e.g.,	Summarize findings in Item 60.	Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). **Neuro L.I.E.:** If information not received: Send *rrinfoSTROKE letter* add enclosure(s): **SPEC-NEUROEVAL** **+ SPEC-Neuropsychological Eval (Neurocog Impairment)** **Neuro L.I.E.:** When all required information received: add to the problem list, assign path/ICD code, add 3658, summarize findings in notes, and send to GR Neuro Panel Physician. If AASI approved by DOC Add: **AASI CVA/STROKE/TIA Spec** to auth letter Note: The following are no longer requested: • A carotid ultrasound. MRA or CTA head and neck yields better imaging. If the applicant submits a		A	ke or TIA • 1-year for subcortical stroke. Shorter observation time may be appropriate in some cases with defined causes (e.g. traumatic arterial dissection, paradoxical embolism with PFO closure) on a case-by-case basis. AASI Initial criteria Neuro workflow physicians will consider AASI for TIA or small stroke with complete work-up, no findings on imaging, and good risk factor control. Follow up imaging will be in DIWS notes for authorization letter. Once initial AASI or SI is assigned, the case may be released back to general review (GR). • GR L.I.E.s can do

	neurology, cardiology, internal medicine, or other specialists); · Lab report(s); · Operative/procedure report(s), if applicable; · *Radiology report(s). The interpretive report(s) of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) performed. · DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, and medication administration records. 4. Cardiac Monitor o TIA - Results of a current 30-day cardiac event monitor such as a Zio patch or implanted loop recorder (ILR). o If an implanted cardiac monitor was placed, OR if a cryptogenic stroke, submit a minimum of **six (6) months** of device reports. o If ILR is currently implanted, submit data from implantation to the most recent interrogation. 5. Any other testing below, if already performed. New testing should not be obtained for aeromedical purposes until requested by FAA physicians. (See note on next page regarding additional testing.) · *Imaging. Copies of all previous imaging such as CT, MRI, MRA, or other radiological tests; · Carotid ultrasound. A carotid ultrasound is NOT acceptable in place of		carotid ultrasound instead of MRA/CTA of neck, send to DOC before asking for a new test. • A personal statement. ATTENTION: as of 1/2023 AASI are now followed indefintely			recertification if no changes, no new stroke/TIA, and/or no change on imaging. • **Any changes or new conditions - send to GR DOCS.** • If new stroke, afib - L.I.E. sends back to Neuro Workflow As of 1/2023 AASI are followed indefinitely <u>SI Initial criteria</u> Consider SI (not AASI) when: • CT is allowed in place of MRI (The reason pilot cannot have MRI must be provided and acceptable.) • MRI needed every 12 months to verify no changes

	an MRA or CTA; · Transthoracic echocardiogram (TTE); · Cardiovascular Evaluation (CVE). (This may be found in hospital records as many are completed during the hospital stay.); · Stress test; and · Holter monitors performed since the event.					• L.I.E.s can do recertification if neuro note verifies stability, no changes on MRI/imaging, and/or no changes in condition. • If change on imaging or other concern - send to GR DOCS. **<u>TIA vs Stroke</u>** About half of TIAs are actually strokes when Diffusion Weighted Imaging (MRI) is performed. TIA carries a similar risk of recurrence as a completed stoke so equally high aeromedically risk to stroke. • **if the first test was abnormal (atherosclerotic disease, carotid stenosis**

						(any severity); dissection, aneurysm), submit an updated MRA or CTA of head and neck performed no more than 12 months before the AME exam. • **if the first test was normal (no pathology identified) submit the most recent MRA or CTA of head and neck.** • If not performed in the initial manageme nt or monitoring of the condition, a current MRA or CTA of the head and neck is required. Occipital infarct or

						vision disturbance symptoms may need ophthalmology eval and visual field testing (24-2 or equivalent SITA standard) with interpretation. SITA standard is better at detecting a visual field **neglect** vs a field cut.
Additional information that may be required on a case by case basis in addition to items in row A.	ADDITIONAL TESTING: Due to the complex etiology of strokes, once the initial information (Row A) is reviewed by the FAA, the items below may be required on a case-by-case basis. Additional testing should not be obtained until requested by FAA physicians. 1. Neuropsychological evaluation that meets FAA Specifications for Neuropsychological Evaluations for Potential Neurocognitive Impairment from a clinic visit with the treating neuropsychologist. In some cases, such as very small stroke in non-eloquent area, this may be reduced or waived after FAA review. 2. A comprehensive hypercoagulopathy panel to include the following test results: · Factor V Leiden mutation · PT and INR	.	.			

	· PTT · Antithrombin III · Protein S free antigen · Activated protein C level · Prothrombin (Factor II) G20210A gene mutation · Homocysteine level · Antiphospholipid antibodies: · Lupus anticoagulant · Anticardiolipin antibodies · Beta-2 glycoprotein antibodies					
	.					

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
AASI	If AASI, the AME should review the following: 1. A current, detailed Clinical Progress Note generated from a clinic visit with the treating physician [or add specialist type here] **no more than 90 days before** the AME exam. It must include a detailed interim summary of the condition; current medications, dosage, and side	If all requirements of the Authorization are met, the AME can ISSUE with the time limitation specified on the Authorization. Submit all information	As of 1/2023 AASI are followed indefinitely. (if previously released with a warning, we do not return to workflow unless a new event). If DOC does not want the AME to issue a recert, use rrbDFR (add note for the DOCS in purple section). Continue AASI:	Review evaluation data for changes or concerns. Detail changes, abnormalities, or questions in your notes.	

effects (if any); physical exam findings; results of any testing required or performed; diagnosis; assessment and plan (prognosis); and follow-up.
    - It must **specifically describe** if there has been **any change** in symptoms, exam findings, or control of risk factors.
2. **Brain MRI** (report with comparison to prior studies) **every 24-months**.

AME must defer and describe in Block 60 what item(s) caused the deferral if the neurologist evaluation or AME exam identifies any of the following:

- An interval change or worsening of the condition;
- New neurologic symptom(s), diagnosis, or episode - focal or non-focal including a new CVA/Stroke/TIA based on symptoms or imaging;
- Atrial fibrillation or atrial flutter - new onset or not previously reported;
- Bleeding which required medical intervention;
- New or not previously reported neurologic diagnosis or disqualifying medical condition or therapy;
- Physical exam changes identified by either the neurologist or AME; and/or
- Inadequate risk factor control - new risk factor identified OR inadequate control of known risk factors such as hypertension, hyperlipidemia, diabetes, smoking, hypercoagulable conditions, and/or obstructive sleep apnea.

for FAA review.

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If there has been any recurrence, disease progression, or new treatment is started, the AME must DEFER and annotate in Block 60 what aspect or concern caused the deferral.

If AME sends in all documents, issues correctly, and there is no change in medical condition:

L.I.E. FMC and send to file.

PA: Create continue rrCONTINAUTH letter and send to DOC.

Cert t/l incorrect:

L.I.E. Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert.

PA: Create continue rrCONTINAUTH letter and corrected cert and send to DOC

If AME issues Incorrectly (new meds/change in meds/new medical condition) or Information not received:

(**if AME states in block 60 reports are forthcoming, send to 14 day hold que before sending letter)

Send: rrinfoINITIALREQ letter for missing items or per new condition.

			L.I.E. Process condition per OneGuide. Determine if need to assign AME “W” error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. <u>Condition worsened. No longer meets AASI. Outside AASI/SI recert parameters OR develops new condition:</u> **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC.		

Condition Description

Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die. There are two main types of stroke. The more common kind, called ischemic stroke, is caused by a blood clot that blocks or plugs a blood vessel in the brain. The other kind, called hemorrhagic stroke, is caused by a blood vessel that breaks and bleeds into the brain. Sudden incapacitation is likely for either kind of stroke. A cryptogenic stroke is one of unknown cause or etiology.

Transient Ischemic Attack (TIA) - A transient ischemic attack (TIA) is a "mini-stroke" that comes and goes quickly. It happens when a blood clot blocks a blood vessel in your brain. This causes the blood supply to the brain to stop briefly. Symptoms of a TIA are like other stroke symptoms, but do not last as long.

Additional History or Description of the Condition

Go to TOC

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REFERENCES

TOAST Classification Of Stroke | STROKE MANUAL (stroke-manual.com)
Risk Levels and Adverse Clinical Outcomes Among Patients With NonvalvularAtrial Fibrillation Receiving Oral Anticoagulants -- AAM authors

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
G45.9, I63.40, I63.9, I66.9

Pathology Codes (Prefixes)
610 ((1,2,3,4,5,A,B,C,D,E)), 610, 602, 602

Level of Review
4

ICD-9
434.91 stroke, 435.9 TIA

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
Indefinite

Blurbs Letters and Specification Sheets

Go to TOC

Blurbs

Letters

ATCS Letters/Memos

Specification Sheets

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

11/29/23 reviewed with neurology. Clarified AASI are followed indefinitely (if previously warned, do not bring back unless new symptoms)
1/25/2023 AASI published in AME guide
1/17/2023 new AASI approved by AAM-1
12/9/2022 confirmed with FAS neurology; Move ALL stroke and TIA to Neuro Workflow for initial eval. F/U-if meet new AASI, will release back to GR. Others will stay in Neuro Workflow
12/5/2022 neuro panel¿
4/22/22 reviewed with neurology

18l. Neurology

Tourette Syndrome or Tic Disorder

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include potential for involuntary movements (tics) to interfere with critical flight controls, particularly during critical phases of flight, medication effects, and additional aeromedical concerns from associated conditions such as anxiety, attention deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD).

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Tic disorder (Chronic motor or vocal tic) **present 5 or more years** not worsening	If the AME can determine: • The condition is under control, • No medications or treatment required, and • The individual has NO symptoms that would interfere with flight duties or communication: Note: Adult-onset tic disorder, go to Row B	ISSUE Summarize findings in Item 60..	<u>If previously reported and warned:</u> **L.I.E./PA:** Add to DIWS note (ex. history of Tic disorder/previously warned), FMC, and send to file. <u>The first time the condition is reported:</u>	Go to row B	Go to row B	Most cases will be worked in GR. If concerns discuss with Neuro Workflow physician. In some cases information from a flight instructor may be requested. (If DOC requests information from a flight instructor, LIE/PA will use rrbINSTRUCTOR noted below.)

			We **will accept** AME notes: If the AME adequately explains the condition has no functional limitations, then AAM needs nothing. **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. If no AME explanation: *Send rrinfoINITIALREQ letter* Add: **rrbCSLONG** for tic disorder from treating physician When all info received: **L.I.E./ PA:** process as above. If unfavorable report:			• An assessment and statement from an instructor pilot. This assessment should address operational flight experience (ability to implement emergency procedures, ability to communicate with air traffic control, ability to manipulate aircraft controls, etc.), academic performance in ground school, cockpit resource management, aeronautical decision making skills, and an opinion on whether applicant can safely operate an

			L.I.E./ PA: Send to DOC to determine if additional info needed.			aircraft.
B. Tic disorder (Chronic motor or vocal Tic) Present **less than 5 years** Unknown cause OR Worsening OR Adult-onset tic	Submit the following for FAA review: 1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. Due to the strong association with tic disorder and ADHD, a current neuropsychological and cognitive evaluation (Specifications for Neuropsychological Evaluations for ADHD/ADD) **MAY** be required after review of the initial neurological evaluation.	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60.	If information not received: *Send rrinfoINITIALREQ letter* Add: **mabNEUROEVAL** L.I.E./PA: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and Send to DOC. DOC will determine if current neuropsychological and cognitive evaluation or letter from instructor is needed. If DOC requests additional information: Send *rrINFORECON letter* Add as required per DOC notes **mabNEUROPSYCH** and/or **rrbINSTRUCTOR** ~~Enclosure: SPEC-ADHD/ADD (AMN Info/Neuropsych Info/Test Req)~~ When received, send back to	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B (remove 90 day clause)	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row B	

			DOC.			

Row B
Conditon due to an abnormal basal ganglia function. Can start as a child and resolve. Does not usually worsen with age.

New onset as an adult is a concern. This requires a neurological evaluation for possible basal ganglia lesion (tumor/stoke/autoimmune disease).

C. Tourette Syndrome

Submit the following for FAA review:

1. A current, detailed neurological evaluation that meets **FAA Specifications for Neurologic Evaluation** generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam.
2. A **Neuropsychological (NP) evaluation that meets FAA Specifications for Potential Neurocognitive Impairment**

Note: Tourette's syndrome and tics are commonly associated with Attention Deficit Hyperactivity Disorder (ADHD). Neuropsychological evaluation and testing is required.

DEFER

Submit the information to the FAA for a possible Special Issuance.

Summarize findings in Item 60.

Worked in General Review (GR)

L.I.E./PA: When all required information received, add to the problem list, assign path/ICD code, summarize findings in notes, and Send to DOC (General Review).

If information not received:

Send rrinfoINITIALREQ letter

Add: **rrbTOURETTE (now avail in DIWS) **delete reference to ADHD spec sheet (pending update)**

(in this row, the NP eval is REQUIRED)
Add Enclosures **SPEC-NEUROEVAL**

Note: Most cases will be worked in GR.
Some will go to Neuro Workflow after DOC review.
The blurb contains reminder that a drug screen is required.

Send a Request for Information letter for:

- All previous medical records for this condition.
- Evaluation Data Row C (remove the 90 day clause)

New diagnosis or symptomatic: INCAPACITATE.

Send an incapacitation memo for:

- Evaluation Data Row C

Row C

Tourette's is disabling in their day-to- day life. High overlap with ADHD and cognitive issues. May need to request Neuropsychological testing.

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
A. Tic disorder (Chronic motor or vocal tic) present 5 or more years not worsening	Follow up Issuance will be per the Authorization letter.		If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are me. <u>If AME sends in all documents, issues correctly and no changes in medical condition:</u> **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. <u>Cert t/l incorrect:</u> **L.I.E.**: Prepare continue authorization letter rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC <u>If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received.</u>: (**if AME states in Block 60 reports are forthcoming, send to 14 day hold queue before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition.	Review evaluation data for changes or concerns. Detail changes, abnormalities, or questions in your notes.	

			L.I.E.: Process condition per OneGuide. Determine if need to assign AME “W” error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. <u>Condition worsened. No longer meets SI OR develops new condition:</u> **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		
C. Tourette Syndrome	Follow up Issuance will be per the pilot's Authorization letter.		as above		
				Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C (remove the 90 day clause)	

Condition Description

Tourette syndrome is a neurological disorder characterized by repetitive, stereotyped, involuntary movements and vocalizations called tics. There are two types of tics - motor and vocal.

Many with Tourette Syndrome experience additional neurobehavioral problems including inattention, hyperactivity and impulsivity, and obsessive-compulsive symptoms such as intrusive thoughts/worries and repetitive behaviors. Attention deficit hyperactivity disorder (ADHD) is the most prevalent of the comorbid psychiatric disorders that complicate tic disorders.

The types of tics and how often a person has tics changes a lot over time. Even though the symptoms might appear, disappear, and reappear, these conditions are considered chronic. In most cases, tics decrease during adolescence and early adulthood, sometimes disappear entirely. However, many people with Tourette Syndrome experience tics into adulthood and, in some cases, tics can become worse during adulthood.1

Although the media often portray people with Tourette Syndrome as involuntarily shouting out swear words (called coprolalia) or constantly repeating the words of other people (called echolalia), these symptoms are rare, and are not required for a diagnosis of Tourette Syndrome.

Additional History or Description of the Condition

.

REFERENCES

https://www.cdc.gov/ncbddd/tourette/facts.html#:~:text=Tourette%20Syndrome%20(TS)%20is%20a,keep%20blinking%20over%20and%20over.
Diagnosing Tic Disorders | CDC

https://pubmed.ncbi.nlm.nih.gov/29944175/

Details

Section / Branch
General Review (GR)

ICD-10
F95.2, F95.9

Pathology Codes (Prefixes)
675 ((1,3,A,C)), 675

Level of Review
4

ICD-9
307.23

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbtourette, rrbinstructor

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New presentation/new diagnosis or symptomatic

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

2/27/25 page maintaince (add blurb names, move DOC info)

1/9/2024 crossed out reference to ADHD spec sheet (not routinely required)

¿4/1/2022 reviewed with neurology

18l. Neurology

Transient Global Amnesia (TGA)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

The greatest aeromedical concern is accurate diagnosis, as some cases labeled as TGA can turn out to have diagnoses with different aeromedical implication, such as TIA, complicated migraine, and seizure. Recurrent TGA is uncommon, and if there is history of 2 or more TGA episodes, the diagnosis should then be questioned.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Single episode 5 or more years ago	Submit the following for FAA review: 1. A **current, detailed neurological evaluation,** in accordance with the FAA Specifications for Neurologic Evaluation, that is generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **It must specifically include** if there is or is NOT any concern for seizure. 3. **MRI brain*** (Prefer with contrast, if clinically appropriate.) Magnetic Resonance Imaging (MRI) of the brain performed no more than 90 days before the AME	DEFER Summarize findings in Item 60. Submit the information to the FAA for a possible Special Issuance. .	Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). **AMCD NEURO PANEL REVIEWER** If information not received: Send *rrinfoTGA letter* (now available in DIWS) Add enclosure(s): **SPEC-NEUROEVAL**	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row B	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • Evaluation Data Row B	(Updated 8/26/2021) A medical certificate/clearance should not be considered for any class or for Agency ATCS duties until cleared by FAA review.

	exam. Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 4. **MR angiogram (MRA) or CT angiogram (CTA)** of both the **head and neck*.** ◦ Carotid Doppler may be acceptable on a case-by-case basis. Generally, this is not preferred because it does not evaluate intracranial circulation. (The pilot may still need a MRA). 5. **EEG*** Sleep deprived and sleep awake state with activating procedures (with provocation). 6. **Echocardiogram** (Echo), if already performed. 7. Prolonged ECG such as a **Holter or loop** recorder (or telemetry reading from hospital), if already performed. 8. **Records** from any hospitalization(s) for this condition to include: ◦ Admission History and Physical; ◦ Hospital Discharge Summary (Typically, the patient portal notes or after visit summary [AVS] that can be printed from the electronic medical record are NOT sufficient for pilot medical certification purposes.) ◦ Hospital consultant		Neuro L.I.E.: When all required information received, add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician. Note: **Hospital records**. If episode was **5 or more years ago** and we receive everything except hospital records, send the case to the DOC. Do not need to ask out again for this specific item.			

	report(s) (such as neurology, cardiology, internal medicine, or other specialists); ◦ Operative/procedure report(s); ◦ Pathology report(s); ◦ Radiology reports. The interpretive report(s) of all diagnostic imaging (CT Scan, MRI, X-ray, ultrasound, or others) performed; ◦ Lab report(s) including all drug or alcohol testing performed; ◦ Emergency Medical Services (EMS)/ambulance run sheet; ◦ DO NOT submit miscellaneous hospital records such as flowsheets, nursing notes, physician orders, or medication administration records; 9. Progress notes from all clinic follow-up visits related to this condition; 10. Other tests already performed or as clinically indicated. **Note:** If imaging **(MRI DWI brain)** was performed in the acute period after the episode, it should be submitted (both reports and images). *Submit the reports and the actual images in DICOM format on CD.					

B. Single episode **less than 5 years ago** OR 2 or more lifetime episodes	After a 6-month recovery period obtain the following evaluation(s) and submit for FAA review: • All Evaluation Data items in Row A Note: *For all imaging, submit the interpretive report(s) AND the actual images on CD in DICOM readable format. MRI, MRA/CTA, or electroencephalogram (EEG) studies are required. If not performed during the initial management or monitoring of the condition, new testing must be obtained. If an MRI DWI brain was performed during the acute period after the episode, it should be submitted (both reports and images). If the MRI DWI shows classic TGA findings, the 6-month recovery period may be reduced. This waives the recovery period only. The evaluation items are still required.	DEFER Summarize findings in Item 60. Submit the information to the FAA for a possible Special Issuance. .	SEND TO AMCD NEURO PANEL REVIEWER If information not received: Send *rrinfoTGA letter* (now available in DIWS) add enclosure(s): **SPEC-NEUROEVAL** If 6-month recovery period has not been met: • If MRI DWI brain was submitted: the 6 month recovery period can be waived by the DOC. • If no MRI DWI brain submitted and recovery period not met: create appropriate denial letter and see below. Neuro L.I.E.: When all required information received: Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and Send to GR Neuro Panel Physician.	see row A	see row A	Row B Exception to the 6-month recovery time: If imaging (MRI DWI brain) was performed in the acute period after the episode and shows classic TGA findings, earlier consider may be considered per Neuro Workflow physician. (Note: Currently only large/select centers perform an MRI DWI brain in the acute phase). This exception only waives the recovery period, not the required evaluation items. FAA Physician Review. These cases are worked at AMCD by the Neuro Workflow Physicians. Neuro workflow physicians will determine if a case can be adjudicated or requires review by FAS neurology panel or a FAS neurology consultant. Cases with and

						unclear diagnosis will be reviewed by FAS neurology or Neuro panel. Continued Airman Certification/ATCS Clearance: In some cases, the pilot may be cleared with a warning by the Neurology Workflow Physician. For all others, the case will be reviewed by FAS neurology or FAS neurology panel. The disposition and follow up depends on the underlying condition. Only the original brain imaging (CT, MRI) and EEG studies are required, with no need to repeat studies unless deemed unacceptable quality by either the FAA physicians or the FAS Neurology Consultant. The concern with TGA is making the correct diagnosis. As of April 2021, one-third of TGA diagnosis seen at

						FAS Neurology Panel were other aeromedically concerning conditions incorrectly diagnosed as a TGA. The most common conditions misdiagnosed as TGA were TIA, stroke, or seizure. Other inaccurate diagnoses included complex migraine or transient loss of function due to an unknown cause. To ensure consistency in medical certification decisions, these cases are to be routed through the neurology physician workflow. A single lifetime episode of TGA may be considered for certification/clearance following a 6-month post-event observation period, when there has been no recurrence and the pilot's history meets the following diagnostic criteria: • Witnessed attack by a second

						party corroborating manifestation of acute symptoms; • Clear-cut anterograde amnesia (unable to register new memories); • Preservation of personal identity throughout the episode; • Transient memory loss of 1-24 hours (average 4-6 hours), and complete resolution within 24 hours from the initial witnessed manifestations; and/or • NO evidence of: • General cognitive impairment (other than

						amnesia) or confusion; • Loss or altered level of consciousness; • Focal neurological deficits; • Epileptiform features; or • History of seizures or recent head trauma

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

Transient global amnesia is a sudden, temporary episode of memory loss that can't be attributed to a more common neurological condition such as epilepsy, transient ischemic attack, stroke, or head injury. During an episode of transient global amnesia, recall of recent events simply vanishes, so an individual cannot remember where they are or how they got there.

Additional History or Description of the Condition

.

REFERENCES

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
G45.4

Pathology Codes (Prefixes)
611 (1,3,5,A,C)

Level of Review
4

ICD-9
437.7

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c); 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition	ATCS Order	ATCS Standard Clearance	Follow on Special Consideration
Warn, SC	8B, 8C (if on medication), 9 (if on SC)	12 months	per FS

Blurbs Letters and Specification Sheets

Blurbs

Letters	Specification Sheets
ATCS Letters/Memos	ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis: Immediate INCAP.

If the diagnosis is confirmed, requires **6-month recovery period** before consideration.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

04/29/2022 page reviewed with neurology

18l. Neurology

Tremor (benign essential tremor; physiologic tremor)

DISCLAIMER - The OneGuide is a quick reference for AAM personnel involved in the medical certification and clearance processes. AAM personnel should not solely rely on this guide in making determinations, which must include an individualized assessment based on generally accepted up-to-date medical practices. The contents of the OneGuide do not constitute medical advice and should not be used for purposes of diagnosis or treatment.

Aeromedical Concerns

Aeromedical concerns include adverse effects of tremor on operating aircraft controls and also medication-related side effects.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. Physiologic tremor • Not requiring medication • Not progressing • No functional limitations	If the AME can determine the individual has no symptoms that would interfere with flight duties: This is not a disease. It can be a normal physiological finding for the situation.	ISSUE Summarize findings in Item 60.	If previously reported and warned: **L.I.E./PA:** Add to DIWS note (ex. history of physiologic tremor previously warned), FMC, and send to file. The first time the condition is reported: We **will accept** AME notes: If the AME adequately explains the condition has no functional	Send a Request for Information letter for: • All previous medical records for this condition. • A current, detailed Clinical Progress Note, generated	New presentation/new diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following: • A current, detailed Clinical	Tremor is very common with a 10% penetrance throughout a lifetime. The vast majority of cases are not disabling. It can be detected through clinical observation (eating with spoon or drawing a spiral). Gross motor tasks are generally not affected.

			limitations and medications are allowed: **L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter, and WARN. If authorization for Special Issuance is required for additional condition(s), add WARN in the auth letter. <u>If no AME explanation:</u> *Send rrinfoINITIALREQ letter* Add: **rrbCSLONG** from treating physician. <u>When all info received</u>: **L.I.E.**: When all info received, see above. **PA:** See above then send to DOC.	from a clinic visit with the treating physician. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up.	Progress Note, generated from a clinic visit with the treating physician no more than 90 days before the AME exam. It must include a detailed summary of the history of the condition; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up.	

B. **Essential Tremor** treated with an acceptable medication. (previous term benign essential tremor) **Note:** If the tremor is due to a specific condition (e.g., Parkinson's disease, multiple sclerosis, stroke, traumatic brain injury, etc.) - see that section.	Follow the CACI –Essential Tremor Worksheet This requires a current, detailed Clinical Progress Note from the treating physician. Acceptable medication for CACI is **NONE or a beta-blocker.** (All others go to Row C). If the pilot meets all CACI worksheet criteria and is otherwise qualified:	If the pilot meets all CACI worksheet criteria and is otherwise qualified, ISSUE with no time limitation Annotate the correct CACI statement in Block 60 and keep the required supporting information on file. If no AME explanation, the pilot may be asked to provide documentation.	If the AME notes the condition is CACI qualified OR the L.I.E./PA determines after reviewing the information the pilot is **CACI qualified**: **L.I.E.**: add to the problem list, assign path/ICD code, summarize findings in note, send eligibility letter with **rrbCACI** and WARN. If authorization for Special Issuance is required for additional condition(s), add the CACI paragraph rrbCACI to the auth letter. **PA**: see above then send to DOC. Note: if the AME made comment on the condition but did not use standard CACI wording (CACI qualified essential tremor): assign an "AME C" error code. If **no AME explanation or CACI wording** Send *rrinfoINITIALREQ* letter Add: **rrbTREMOR (available in DIWS)** Once information received, process as described above and determine if you need to assign AME "C" error code. (These cases still require processing.)	Send a Request for Information letter for: • All previous medical records for this condition. • Evaluation Data Row C	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row C Once the condition is controlled and/or stable with or without an acceptable medication, FS will determine if Special Consideration needed. **Notes:** SC or warn depends on clinical situation. Needs evaluation to document the diagnosis. If clearly documented as essential tremor and unlikely to change, the FS will determine if regular clearance with warning may be considered (even when	Row B

			L.I.E./PA: Do not need to re-send **rrbCACI** eligibility letter each time. These cases can be released to file, as they have no time limitation. If AME issued as CACI, but not CACI qualified: Send *rrinfoINITIALREQ letter* Add: **rrbTREMOR (avail in DIWS)** (delete info already received). Assign AME "O" error for issuing a CACI in error. Process condition per OneGuide.		taking beta blocker) or if SC is needed.	
C**. All others** The diagnosis is suspect or uncertain; The individual is dependent on medication to be functional or requires a medication change; Assistive devices (such as weighted gloves, utensils) are used;	Submit the following to the FAA for review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the treating neurologist **no more than 90 days before** the AME exam. 2. **MRI and/or CT of the brain** (the most recent test). Submit the interpretive report on paper and imaging on CD in DICOM readable format (there must be a file named 'DICOMDIR' in the root directory of the CD-ROM). Please verify the CD will	DEFER Submit the information to the FAA for a possible Special Issuance Summarize findings in Item 60.	**L.I.E./PA:** Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). SEND TO NEURO PANEL REVIEWER Neuro LIE: If information not received: Send ***rrinfoINITIALREQ*** letter	Send a Request for Information letter for: All previous medical records for this condition. Evaluation Data Row C	New diagnosis or symptomatic: INCAPACITATE. Send an incapacitation memo for: • Evaluation Data Row C Once the condition is contr	Row C

Condition is clinically uncontrolled or disabling (limits any day-to-day function such as holding cup, handwriting, flipping switches, etc.); and/or dependent on medication. **Note:** Most medication to treat tremor is not acceptable (e.g., gabapentin, mysoline [primadone]). If a deep brain stimulator (DBS) is in place - see that section.	display the images before sending. You may wish to retain a copy of all films as a safeguard if lost in the mail. 3. **Electroencephalogram (EEG)** performed no more than **12 months before** the AME exam. It must be sleep-deprived EEG: awake, asleep, and with provocation (hyperventilation, photic/strobe light). • Include any previous EEG(s) available for comparison. • Submit BOTH the final interpretive report(s) and the actual tracings (ALL pages) for any EEGs on CD. • The CDs of EEG recordings must have proprietary opening software that is compatible with Windows 10. **4. Other testing** already performed by the treating physician for this condition.		Add: **mabNEUROEVAL** enclosure **SPEC-NEUROEVAL** <u>When all required information received:</u> Add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel Physician.		olled and/or stable with or without an acceptable medication, FS will determine if Special Consideration needed. **Notes:** SC or warn depends on clinical situation. Needs evaluation to document the diagnosis. If clearly documented as essential tremor and unlikely to change, the FS will determine if regular clearance with warning may be considered (even when taking beta blocker) or if SC is needed.	

Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions
B. **Essential Tremor** treated with an acceptable medication. (previous term benign essential tremor)	Standard follow up may include: 1. A **current, detailed Clinical Progress Note,** generated from a clinic visit with the treating physician no more than **90 days before** the AME exam. It must include a detailed interim history; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment; plan (prognosis); and follow-up. 2. It must specifically include any changes since the previous clinical evaluation and describe if the tremor is disabling, limits day-to-day function, is medication dependent, or requires treatment such as a deep brain stimulator. 3. Any other testing performed the treating physician(s).	ISSUE Summarize findings in Item 60. Submit all information for FAA for review. ********** All others, the AME should DEFER and summarize in Block 60 what aspect or concern caused the deferral.	DIWS notes will say if followed in Neuro workflow or released to GR <u>If there has been no change and otherwise CACI qualified:</u> **L.I.E./ PA:** Do not need to re-send rrbCACI eligibility letter each time. Complete file maintenance (FMC - update path code, update Class Issue code, remove NTF) and release to file. No further action is required. <u>Was SI/AASI and now qualifies for CACI</u>: (Use this to release from AASI/SI to CACI.) We will accept AME notes “has current OR previous SI/AASI but now CACI qualified,” or if the supporting information verifies CACI qualified: *Send rrELIG letter or rrRELEASEDAUTHELIG letter* Add: **rrbNOSICACI** and WARN. Complete file maintenance (FMC). <u>If on Auth for multiple conditions and</u>	Review evaluation data for changes or concerns. Detail changes, abnormalities, or questions in your notes.	

			one becomes CACI qualified: **L.I.E.:** Add **rrbCACI** for the CACI qualified condition to the Auth Letter. **PA:** See above and send to DOC for signature. If individual reports a new medical condition: **L.I.E./PA:** Process condition per OneGuide.		
C. **All other causes or severity of tremor** The diagnosis is suspect or uncertain; The individual is dependent on medication to be functional or requires a medication change; Assistive devices (such as weighted gloves, utensils) are used. Condition is clinically	Standard follow up may include: 1. A **current, detailed Clinical Progress Note,** generated from a clinic visit with the treating physician no more than **90 days before** the AME exam. It must include a detailed interim history; current medications, dosage, and side effects (if any); physical exam findings; results of any testing performed; diagnosis; assessment and plan (prognosis); and follow-up. 2. It must specifically include any changes since the previous clinical evaluation and describe if the tremor is disabling, limits day-to-day function, is medication dependent, or requires treatment such as a deep brain stimulator. 3. Any other testing performed the treating physician(s).	See Authorization letter.	These conditions are followed in Neuro Workflow until Path code 3658 is removed by Neuro L.I.E. If the DOC note specifies parameters for an L.I.E (or PA) to continue the SI and all parameters are met. If AME sends in all documents, issues correctly and no changes in medical condition: **L.I.E.**: Create and sign rrCONTINAUTH letter. FMC and send to file. **PA:** Create rrCONTINAUTH letter. FMC and send to DOC. Cert t/l incorrect: **L.I.E.**: Prepare continue authorization letter		

uncontrolled or disabling (limits any day-to-day function such as holding cup, handwriting, flipping switches, etc.) or dependent on medication; Note: Most medication to treat tremor is not acceptable (e.g. gabapentin, mysoline [primadone]). If **Deep Brain Stimulator (DBS)** placed - see that section.			rrCONTINAUTH and sign send corrected cert. **PA:** Create continue rrCONTINAUTH letter and corrected cert and send to DOC <u>If AME issues Incorrectly (new meds/change in meds/new medical condition) OR Information not received.</u>: (**if AME states in Block 60 reports are forthcoming, send to 14 day hold queue before sending letter) *Send: rrinfoINITIALREQ letter* for missing items or per new condition. **L.I.E.**: Process condition per OneGuide. Determine if need to assign AME "W" error - read AME comments to see if reports have been submitted **PA:** See above and send to DOC. <u>Condition worsened. No longer meets SI OR develops new condition:</u> **L.I.E./ PA:** Detail changes, abnormalities, or questions in your notes and send to DOC		
				Send a Request for Information letter for:	

				All previous medical records for this condition. Evaluation Data Row C	

Condition Description

Tremor is an involuntary, rhythmic muscle contraction leading to shaking movements in one or more parts of the body. It is a common movement disorder that most often affects the hands but can also occur in the arms, head, vocal cords, torso, and legs. Tremor may be intermittent (occurring at separate times, with breaks) or constant. It can occur sporadically (on its own) or happen as a result of another disorder.

Tremor is most common among middle-aged and older adults, although it can occur at any age. The disorder generally affects men and women equally. It is not life threatening. It can be embarrassing and even disabling, making it difficult or even impossible to perform work and daily life tasks.

Essential tremor (previously also called benign essential tremor or familial tremor) is one of the most common movement disorders. The exact cause of essential tremor is unknown. For some people this tremor is mild and remains stable for many years. The tremor usually appears on both sides of the body, but is often noticed more in the dominant hand because it is an action tremor. Other medical conditions can cause tremor (e.g. Parkinson's disease).

Additional History or Description of the Condition

REFERENCES

https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Tremor-Fact-Sheet

Details

Section / Branch
General Review (GR)

ICD-10
G25.2, R25.0, R25.1

Pathology Codes (Prefixes)
845 (3,6,C,F for all), 863, 630

Level of Review
4

ICD-9
arm,, hand,, or head58, 781.0, unspecified58, 333.10

Pilot Disposition
Warn, CACI, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(b), 67.209(b), and 67.309(b)

CFR(s) Conditions Treated with Meds
14 CFR 67.109(b) and 67.113(c) ; 67.209(b) and 67.213(c); 67.309(b) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
RRBTREMOR, mabneuropsych, RRBDFR

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

Go to TOC

1/25/2023 New CACI published
1/17/2023 New CACI approved by FAS
7/25/22 Dispo table and CACI reviewed at Policy Committee.
4/1/22 New CACI. Dispo table created. Clarified levels of risk and evaluation required.

18l. Neurology

ULOC (unexplained loss of consciousness) or Unexplained disturbance of consciousness or Transient Loss Of Consciousness without satisfactory medical explanation; Transient loss of control of nervous system function

Aeromedical Concerns

Aeromedical concern is related to the unknown etiology, which precludes an adequate risk determination assessment, and therefore undetermined future risk of recurrence.

Initial Certification (Pilot)/Initial Clearance (ATCS)

			Initial Certification (Pilot)	Initial Clearance VHT App	Initial Clearance Onboard/ATCS	Initial Certification/Clearance
Disease/Condition Stage	**Evaluation Data**	**AME Actions**	**AAM (LIE/PA) Actions**	**VHT PA Actions**	**ATCS PA Onboarding ATC Actions**	**DOC Actions**
A. ULOC unexplained loss of consciousness current or historical	After a **2-year, symptom-free recovery period**, obtain and submit the following for FAA review: 1. A current, detailed neurological evaluation that meets FAA Specifications for Neurologic Evaluation generated from a clinic visit with the **treating neurologist no more than 90 days before** the AME exam.	DEFER Summarize findings in Item 60. Submit the information to	**L.I.E./PA:** Identify condition, which requires Neuro Panel Reviewer (AMCD) in your problem focused note. Release to NEURO PANEL REVIEWER (AMCD), who will send the initial info request letter (if needed). SEND TO NEURO PANEL REVIEWER (AMCD)	Send a Request for Information letter for: • All historical medical records • Evaluation Data.row A	New presentation, new diagnosis, or symptomatic: INCAPACITATE. Send an incapacitation memo and request the following:	Review Evaluation Data. If it is determined that the event was a single vasovagal syncope, a medical certificate may be considered. No recovery or observation period is required.

	2. The neurologic evaluation must specifically include: · A description of the event(s) and a summary of all testing or evaluation(s) performed to identify the cause; · If there has been any recurrence and the length of time without symptoms; and · If no cause was identified, that should be stated. 3. Copies of any testing already performed such as lab, imaging, EEG, or other testing. 4. Hospital or clinic records from this episode and follow-up. This may include History and Physical (H&P), operative notes, and hospital discharge summary (if applicable). **If no neurological explanation is found**, additional evaluations may be required on a case-by-case basis such as: · Cardiovascular evaluation from a cardiologist; · Exercise stress test; · Holter monitor; and/or · TTE Transthoracic echocardiogram (TTE) If the above items have already been performed, they should be submitted to the FAA. If not yet performed, the applicant may want to wait until FAA review of their case before undergoing	the FAA for a possible Special Issuance. .	<u>If 2 year recovery period has not been met:</u> **Neuro L.I.E.**: Add to the problem list, assign path/ICD code, summarize findings in notes, create appropriate denial letter, and send to GR Neuro Panel Physician. <u>If information not received:</u> Send *rrinfoINITIALREQ letter* Add: **rrbULOC (now available in DIWS)** Add enclosure(s): **SPEC-NEUROEVAL** **Note**: Cardiology evaluation. We will tell the applicant and cardiology evaluation **may** be required. If they submit all items except the cardiac evaluation, send to GR Neuro Panel physician for reveiw and determination if additional testing or evaluations are required. **Neuro L.I.E.**: When all required information received, add to the problem list, assign path/ICD code, add path code 3658 for neuro workflow, summarize findings in notes, and send to GR Neuro Panel physician.	Verify the 2-year recovery period has been met. **Note**: Upon review of the above items, additional information or testing may be required. If a cause is identified - see that section.	After a 2-year symptom-free recovery period, submit the following for FAA review: • Evaluation Data row A Note: Upon review of the above items, additional information or testing may be required. If a cause is identified - see that section.	

	additional testing. Note: Upon review of the above items, additional information or testing may be required. If a cause is identified - see that section.		The evaluation data are used to identify the cause of the LOC. Most ULOC is actualy LOC. Once a cause is identified, see that section.			
B. Disturbance of consciousness without satisfactory medical explanation of the cause OR Transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause	This is a specifically disqualifying condition.	DEFER Summarize findings in Item 60. Submit the information to the FAA for a possible Special Issuance. .	SEND TO NEURO PANEL (AMCD) REVIEWER This is a Specifically Disqualifying condition. This is a **FINAL DENIABLE** condition. If the FAA physician instructs to Deny, the appropriate FINAL DENIAL letter. **Use these exact words for the final denial letter:** A disturbance of consciousness without satisfactory medical explanation of the cause CFR: 14 CFR 67.109(a)(2), 67.209(a)(2), and 67.309(a)(2) OR A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause.	See row A.	See row A.	Row B No class of medical certificate should be considered unless acceptable medical explanation has been documented of the cause. A history of recurrent vasodepressor syncopal episodes is usually disqualifying. If there is no adequate medical explanation of the cause, at least a 2-year recovery period is generally required. Some cases may be forwarded to a FAA consultant for review and recommendations.

			CFR: 14 CFR 67.109(a)(3), 67.209(a)(3), and 67.309(a)(3) See Denials and Disqualifications Pointer Page			After an acceptable recovery period, if no other adverse changes occur, medical certification can be considered. If it is determined that the applicant is eligible for medical certification, in some cases a warning only for adverse changes is necessary and follow-up is not usually required.

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Condition Notes

Recertification (Pilot)/Continued Clearance(ATCS)

Disease/Condition Stage	Evaluation Data	AME Actions	AAM (LIE/PA) Actions	Onboard/ATCS (VHT App only if required)	DOC Actions

Condition Description

ULOC is a loss of consciousness that has been evaluated by medical providers and the etiology remains undetermined.

A transient loss of control of nervous system function(s) without satisfactory medical explanation could be due to many causes (e.g. neurological, cardiac, ENT, or other).

Transient Loss of Nervous System Function (Unexplained) - This is a loss of nervous system function that has been evaluated by medical providers and an etiology has yet to be determined.

§ 67.109, 67.209, 67.309 Neurologic.

Neurologic standards for an airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) Epilepsy;

(2) A disturbance of consciousness without satisfactory medical explanation of the cause; or

(3) A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause.

Additional History or Description of the Condition

REFERENCES

Details

Section / Branch
Neurology Workflow (AMCD)

ICD-10
G90.9, R41.82

Pathology Codes (Prefixes)
611 ((1,3,5,A,C)), 611

Level of Review
4

ICD-9
780.2 syncope and collapse, or 780.4 dizziness and giddiness

Pilot Disposition
Warn, SI

Pilot Standard Certification
12 months

CFR(s) Conditions Only
14 CFR 67.109(a), 67.209(a), and 67.309(a)--see LIE/PA section for actual wording *****

CFR(s) Conditions Treated with Meds
14 CFR 67.109(a) and 67.113(c) ; 67.209(a) and 67.213(c); 67.309(a) and 67.313(c)

ATCS Disposition
Warn, SC

ATCS Order
8B, 8C (if on medication), 9 (if on SC)

ATCS Standard Clearance
12 months

Follow on Special Consideration
per FS

Blurbs Letters and Specification Sheets

Blurbs
rrbuloc

Letters

Specification Sheets

ATCS Letters/Memos

ATCS Sheets

DQ/ Incapacitation Criteria and Warning Statement

DQ/ Incapacitation Criteria

New diagnosis: immediately INCAPACITATE. A two-year symptom free recovery period is requried.

Warning Statement
Please adhere to FAA Order 3930.3C, Air Traffic Control Specialist Health Program, and report any health problems or the use of restricted medication(s) to facility management and/or the Flight Surgeon.

Summary of Changes

8/3/2023 updated to show row B goes to Neuro Panel Reviewer.
10/18/2022 added disturbance of consciousness w/o satisfactory medical explanation to title¿
04/29/2022 reviewed w/neurology