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14 CFR Parts 61 and 67

Revision of Airman Medical Standards and Certification Procedures and Duration of Medical Certificates; Final Rule

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 61 and 67

[Docket No. 27940; Amendment Nos. 61–99 and 67–17]

RIN 2120–AA70

Revision of Airman Medical Standards and Certification Procedures and Duration of Medical Certificates

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This rule revises airman medical standards and medical certification procedures. The amendments implement a number of recommendations resulting from a comprehensive review of the medical standards announced in previous notices. This revision of the standards for airman medical certification and associated administrative procedures is necessary for aviation safety and reflects current medical knowledge, practice, and terminology. Also, this rule revises procedures for the special issuance of medical certificates ("waivers") for those airmen who are otherwise not entitled to a medical certificate.

This rule also changes the duration of third-class airman medical certificates, based on the age of the airman, for operations requiring a private, recreational, or student pilot certificate.

Also, in this document, the FAA is announcing disposition of a number of petitions for rulemaking related to medical standards and duration of medical certificates.

EFFECTIVE DATE: September 16, 1996.

FOR FURTHER INFORMATION CONTACT: Dennis McEachen, Manager, Aeromedical Standards and Substance Abuse Branch, 800 Independence Avenue, SW., Washington, DC 20591; telephone (202) 493–4075.

SUPPLEMENTARY INFORMATION:

Background

Current Requirements—Airman Medical Certification

Section 61.3(c) of Title 14 of the Code of Federal Regulations (14 CFR part 61) provides, with some exceptions, that no person may serve as pilot in command or in any other capacity as a required pilot flight crewmember unless that person has in his or her personal possession an appropriate current airman medical certificate issued under 14 CFR part 67. Part 67 provides for the issuance of three classes of medical certificates. A first-class medical certificate is required to exercise the privileges of an airline transport pilot certificate. Second- and third-class medical certificates are needed to exercise the privileges of commercial and private pilot certificates, respectively.

A person who is found to meet the appropriate medical standards, based on a medical examination and an evaluation of the applicant's history and condition, is entitled to a medical certificate without restrictions or limitations other than the prescribed limitation as to its duration. These medical standards are currently set forth in §§ 67.13, 67.15, and 67.17.

Special Issuance of Airman Medical Certificates

An applicant for a medical certificate who is unable to meet the standards in §§ 67.13, 67.15, or 67.17, and be entitled to a medical certificate, may nevertheless, be issued a medical certificate on a discretionary basis. Procedures for granting special issuances or exemptions have always been available, and, thus, failure to meet the standards has never been absolutely disqualifying. Historically, approximately 99 percent of all applicants ultimately receive a medical certificate.

Under § 67.19, Special issue of medical certificates, at the discretion of the Federal Air Surgeon, acting on behalf of the Administrator under § 67.25, a special flight test, practical test, or medical evaluation may be conducted to determine that, notwithstanding the person's inability to meet the applicable medical standard, airman duties can be performed, with appropriate limitations or conditions, without endangering public safety. If this determination can be made, a medical certificate may be issued with appropriate safety limitations.

Duration of Airman Medical Certificates

Section 61.23 identifies the duration of validity and privileges of each class of medical certificate. Currently, a first-class medical certificate is valid for 6 months for operations requiring an airline transport pilot certificate, 12 months for operations requiring a commercial pilot certificate or an air traffic control tower operator certificate (for non-FAA controllers), and 24 months for operations requiring only a private, recreational, or student pilot certificate. A second-class medical certificate is valid for 12 months for operations requiring a commercial pilot certificate or an air traffic control tower operator certificate (for non-FAA controllers) and for 24 months for operations requiring only a private, recreational, or student pilot certificate. A third-class medical certificate currently is valid for 24 months for operations requiring a private, recreational, or student pilot certificate.

History

On October 21, 1994, the FAA published a notice of proposed rulemaking (NPRM) (Notice No. 94–31, 59 FR 53226) proposing to amend parts 61 and 67. The proposed revisions to part 67 were based on an agency review of part 67 which was announced in the preamble to Amendment 67–11 (47 FR 16298; April 15, 1982) and on recommendations from a report prepared for the FAA by the American Medical Association (AMA). In the preamble to Amendment 67–11, the FAA announced that it intended to conduct an overall review of the medical standards in part 67. A complete review of the regulations was needed to bring the standards and procedures for airman medical certification up to date with advances in medical knowledge, practice, and terminology. Amendment 67–11 was considered interim clarification until a comprehensive review of the medical standards contained in part 67 could be concluded.

The FAA began the review of the medical standards for airmen and of its certification practices and procedures by requesting public comment (47 FR 30795; July 15, 1982). In addition, the FAA initiated a contract with the AMA to provide professional and technical information. The AMA presented its report, "Review of Part 67 of the Federal Air Regulations and the Medical Certification of Civilian Airmen" (AMA Report), on March 26, 1986. The public was again invited to comment on part 67 in "Announcement of the Availability of a Report" (51 FR 19040; May 23, 1986). The AMA Report detailed the results of a comprehensive review of the standards for airman medical certification and of their application. The AMA Report considered pertinent advances in the field of medicine since 1959, recommended changes in the FAA medical standards, and explained the rationale for such changes. The FAA considered public comments received on the AMA Report in developing Notice No. 94–31.

In a separate but related issue, on May 11, 1979, the Aircraft Owners and Pilots Association (AOPA) petitioned to amend § 61.23 to require medical examinations for private pilots at 36-month intervals rather than at 24-month

intervals. In response to the 1979 AOPA petition to amend § 61.23, the FAA issued on October 29, 1982, NPRM No. 82–15 (47 FR 54414, December 2, 1982) proposing to amend part 61 to revise the duration of validity of third-class privileges of airman medical certificates for operations requiring a private or student pilot certificate. As proposed by Notice No. 82–15, the requirement for a third-class medical examination would have been changed to every 5 years for the youngest pilots then increasing in frequency to the existing 2-year interval for older pilots.

On September 27, 1985, prior to the issuance of the AMA Report on its review of the airman medical standards and certification procedures in part 67, the notice proposing to amend part 61 to revise the duration of third-class airman medical certificates was withdrawn (50 FR 39619). The proposal was withdrawn, in part, because of issues raised by the medical community. Given the then pending issuance of the AMA Report and the possibility that the report would provide better data on which to base an evaluation of the safety concerns raised by the medical community, the FAA decided that any future consideration of examination frequency would be within the context of the outcome of the comprehensive review of part 67.

Petitions for Rulemaking

The FAA has received a number of other petitions for rulemaking that relate to airman medical certification and duration. These petitions are disposed of in this rulemaking. For each of these petitions a public docket was established, a notice of the petition was published in the **Federal Register**, and comments, if any, received on the petition were placed in the docket for public inspection.

On July 30, 1981, the Civil Pilots for Regulatory Reform petitioned the FAA to revise the rules so that pilots who have incurred a myocardial infarction will not be automatically disqualified for life for airman medical certification. (Docket No. 22054) This petition was discussed in the preamble to the NPRM (59 FR 53243). Also, see the discussion in this preamble under "Cardiovascular §§ 67.111, 67.211, and 67.311" and the corresponding rule language. Comments received on the petition totaled 311; all of which generally supported the petition. After careful consideration of all the comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has determined that a diagnosis or medical history of myocardial infarction will continue to be disqualifying under part 67.

On February 26, 1986, AOPA again petitioned the FAA to revise the duration of a third-class airman medical certificate to 36 calendar months for noncommercial operations requiring a private, recreational, or student pilot certificate. (Docket No. 24932) See preamble discussion under "Discussion of Comments and Amendments to Part 61" (§ 61.23) and the corresponding rule language. Comments received on this petition totaled two; both supported the petition. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to deny this AOPA petition and adopt the proposal (Docket No. 27940) with the modifications discussed under "Discussion of Comments and Amendments to Part 61."

On January 20, 1989, a petition was submitted to the FAA by Thomas J. Rush to provide a longer timeframe (60 or 90 days) for airmen to schedule medical examinations when they renew their special issuances of medical certificates. (Docket No. 25787) See the discussion in the preamble under "Special Issuance § 67.401;" "Discussion of Comments and Amendments to Part 61;" and the corresponding rule language. The **Federal Register** notice of this petition received no comment. After careful consideration of the issues of this petition and of comments to the current rulemaking action (Docket No. 27940), the FAA has determined that the rule as it relates to this issue should remain unchanged.

On February 12, 1990, AOPA petitioned the FAA to revise certain eye and cardiovascular standards to facilitate medical certificate issuance and better relate those standards to current medical knowledge and technology. Changes sought included the following: (1) Change the color vision standard for first-class medical certificates to the standard used for second-class medical certificates; and delete the color vision standard for third-class medical certificates; (2) Delete the uncorrected visual acuity standards; (3) Change the pathology of the eye standard for second-class medical certificates to the standard used for first-class medical certificates; and (4) For second- and third-class medical certificates, relate cardiovascular conditions to their impact on the applicant's ability to operate safely. (Docket No. 26156) See the discussion in the preamble under the major heading "Vision §§ 67.103, 67.203, and 67.303" ("Color Vision §§ 67.103(c), 67.203(c), and 67.303(c)"; "Distant Visual Acuity"; "Near Visual Acuity Standard"; and "Intermediate Visual Acuity Standard"); and "Cardiovascular §§ 67.111, 67.211, and 67.311". Also see the corresponding rule language for these sections. Comments received on the petition totaled 80; 79 generally support the petition and 1 from the Air Line Pilots Association (now known as the Air Line Pilots Association International) (ALPA) opposed the petition. ALPA opposed the petition because they considered it premature in light of FAA's active rulemaking project to revise all of part 67. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to adopt the vision and cardiovascular proposals of the current rulemaking action (Docket No. 27940) with the modifications discussed under "Discussion of Comments and Final Rule for Part 67."

On June 25, 1990, AOPA petitioned the FAA to amend frequently waived medical standards as follows: (1) Add a provision for continued limited pilot privileges pending FAA action on an application for renewal of a medical certificate; (2) Permit applicants for all classes of medical certificates to meet revised hearing standards in either or both ears with or without a corrective device; (3) Change the 2-year period of abstinence from alcohol to a period "reasonable to ensure abstinence"; and (4) Permit issuance of second- and third-class medical certificates to diabetics using hypoglycemic drugs other than insulin (with Federal Air Surgeon concurrence). (Docket No. 26281) See the discussion in the preamble under "Discussion of Comments and Amendments to Part 61" (§ 61.23); "Hearing §§ 67.105(a), 67.205(a), and 67.305(a)"; under the major heading "Mental Standards §§ 67.107, 67.207, and 67.307" ("Substance Dependence and Definitions" and "Substance Abuse"); and "Diabetes §§ 67.113(a), 67.213(a), and 67.313(a)". Also see the corresponding rule language for these sections. Comments received on the petition totaled 29; 28 generally supported the petition, and one from ALPA opposed the petition. ALPA opposed the AOPA petition for the same reason it opposed the February 1990 AOPA petition; ALPA considered it premature in light of FAA's active rulemaking project to revise all of part 67. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to adopt the duration, hearing, mental, and

general medical proposals with the modifications discussed under "Discussion of Comments and Amendments to Part 61" and "Discussion of Comments and Final Rule for Part 67."

On August 27, 1990, a petition was submitted to the FAA by Frank Goeddeke, Jr., to allow individuals with alcoholism problems to obtain a medical certificate after abstaining from alcohol for 90 days, rather than the 2-year time period stipulated in the rules. (Docket No. 26330) See the discussion in the preamble under the major heading "Mental Standards §§ 67.107, 67.207, and 67.307" ("Substance Dependence and Definitions" and "Substance Abuse"). Also see the corresponding rule language for these sections. Comments received on the petition totaled three; all three supported the petition. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to retain the 2-year abstinence requirement related to alcoholism.

In February 1991, the American Diabetes Association petitioned the FAA to amend the special issuance provisions of part 67 or, alternatively, amend the FAA special issuance policy to permit grants of special issuance of medical certificates to persons with insulin-treated diabetes mellitus (ITDM) and permit grants of special issuance of medical certificates on a case-by-case basis. The ADA also requested the creation of an FAA-appointed medical task force to develop a medical protocol to permit meaningful case-by-case review. (Docket No. 26493) The FAA referred to this petition in a request for comments on a proposed policy change concerning individuals with diabetes mellitus who require insulin that was published in the **Federal Register** on December 29, 1994. (See 59 FR 67246) See also the discussion in this preamble under "Diabetes §§ 67.113(a), 67.213(a), and 67.313(a)" and the corresponding rule language. Comments received on the petition totaled 160; there was general support for the rulemaking part of the petition. Most commenters, however, strongly support special issuance of medical certificates for persons with ITDM. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA is denying that part of the ADA petition that requested rulemaking; i.e., an amendment to § 67.19. The FAA will respond to the ADA request for a policy change and to the comments received to both dockets when it publishes in a separate notice its disposition of the December 29, 1994, notice on that subject (Docket No. 26493).

On September 24, 1993, AOPA once again petitioned the FAA to revise the duration of a third-class airman medical certificate to 48 calendar months for a specific trial period for noncommercial operations requiring a private or student pilot certificate. Docket No. 27473) See the preamble discussion under "Discussion of Comments and Amendments to Part 61" (§ 61.23) and the corresponding rule language. Comments received on the petition totaled 140; 137 generally supported the petition and 3 opposed it. After careful consideration of all comments, both from this petition and the current rulemaking action (Docket No. 27940), the FAA has decided to deny this AOPA petition and adopt the current rulemaking action's duration proposal (Docket No. 27940) with the modifications discussed under "Discussion of Comments and Amendments to Part 61."

The FAA considered each of these petitions for rulemaking and the public comments on the petitions in preparing the NPRM and this final rule. The FAA believes that the actions requested in the petitions are addressed and resolved in this rulemaking action. Therefore, action in each of the referenced petitions is considered completed by publication of this final rule.

The FAA is also addressing two other petitions for rulemaking relating to part 67. On August 14, 1991, a petition was submitted to the FAA by Charles Webber and on June 20, 1992, a petition was submitted to the FAA by Robert H. Monson. Both of these petitioners request that the FAA eliminate § 67.3 in its entirety. The petitioners state that this rule allows the FAA to obtain a copy of an applicant's automobile driving record before an airman medical certificate can be issued and that this violates individual privacy rights (under the Privacy Act, 5 United States Code (U.S.C.) 552a). (Docket No. 26782 and Docket No. 26913) Section 67.3 was added to part 67 in 1990 after the National Driver Register (NDR) Act of 1982 was amended to specifically authorize the FAA to receive information from the NDR regarding motor vehicle actions that pertain to any individual who has applied for an airman medical certificate. In the NPRM and in this final rule § 67.3 has been recodified as § 67.7. The substance of this section was not discussed in the NPRM for this rulemaking because the background, issues, and public comments had been thoroughly covered in the final rule for § 67.3 (August 1, 1990; 55 FR 31300). Since § 67.3 went into effect, the FAA has found access to the NDR useful in making medical certification determinations. Comments received to the Webber petition totaled 24; all generally supported the petition. The Monson petition received no comment. After careful consideration of both petitions and all the comments, both from the petitions and the current rulemaking action (Docket No. 27940), the FAA has determined it will take no further action on the referenced petitions after publication of this final rule.

In accordance with the above discussion and after consideration of comments received on the NPRM, the FAA is revising part 67 and §§ 61.23 and 61.39 of part 61.

Summary of Amendments to Part 67

The following is a summary of the substantive revisions made by this rulemaking. Because this rulemaking completely recodifies part 67, this summary states both the current and new section/paragraph numbers.

1. Distant visual acuity requirements for first- and second-class medical certification are changed to delete the uncorrected acuity standards. However, each eye must be corrected to 20/20 or better, as in the current standard. [Current §§ 67.13(b) and 67.15(b); Final §§ 67.103(a) and 67.203(a)]

2. For third-class medical certification, the current 20/50, uncorrected, or 20/30, corrected, distant visual acuity standard is changed to 20/40 or better, in each eye, with or without correction. [Current § 67.17(b); Final § 67.303(a)]

3. For first- and second-class medical certification, minimum near visual acuity requirements are specified in terms of Snellen equivalent (20/40), corrected or uncorrected, each eye, at 16 inches. This replaces the current standard of v=1.00 at 18 inches for first-class only. An intermediate visual acuity standard (near vision at 32 inches) of 20/40 or better at 32 inches Snellen equivalent, corrected or uncorrected, is added to the first- and second-class visual requirements for persons over age 50. [Current §§ 67.13(b) and 67.15(b); Final §§ 67.103(b), 67.203(b), and 67.303(b)]

4. A near visual acuity standard of 20/40 or better, Snellen equivalent (20/40), corrected or uncorrected, each eye, at 16 inches is added to the third-class visual requirements. [Current (None); Final § 67.303(b)]

5. Color vision requirements are amended to read: "ability to perceive those colors necessary for safe performance of airman duties," and are the same for all classes. Current

standards require "normal color vision" for first-class and the ability to distinguish aviation signal colors for second- and third-class applicants. [Current §§ 67.13(b), 67.15(b), and 67.17(b); Final §§ 67.103(c), 67.203(c), and 67.303(c)]

6. The current first-class standard pertaining to pathological conditions of the eye or adnexa that interfere or that may reasonably be expected to interfere with proper function of an eye is substituted in both the second- and third-class standards for the current standards which specify, respectively, "no pathology of the eye" and "no serious pathology of the eye." [Current §§ 67.15(b) and 67.17(b); Final §§ 67.203(e) and 67.303(d)]

7. The "whispered voice test" for hearing is replaced for all classes by a conversational voice test using both ears at 6 feet; an audiometric word (speech) discrimination test to a score of at least 70 percent obtained in one ear or in a sound field environment; or pure tone audiometry according to a table of acceptable thresholds (American National Standards Institute (ANSI), 1969). [Current §§ 67.13(c), 67.15(c), and 67.17(c); Final §§ 67.105(a), 67.205(a), and 67.305(a)]

8. The standards pertaining to the ear, nose, mouth, pharynx, and larynx are revised to more general terms and related to flying and speech communication. Specific references to the mastoid and eardrum are deleted. The current standard, "No disturbance in equilibrium," is changed to, "No ear disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium." The amended standards are the same for all classes. [Current §§ 67.13(c), 67.15(c), and 67.17(c); Final §§ 67.105(b), 67.205(b), and 67.305(b)]

9. "Psychosis," as used in the final rule, refers to a mental disorder in which the individual has delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition, or may reasonably be expected to manifest such symptoms. [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.107(a), 67.207(a), and 67.307(a)]

10. Substance dependence and substance abuse are defined and specified as disqualifying medical conditions. Substance dependence is disqualifying unless there is clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance for not less than the preceding 2 years. Substance abuse is disqualifying if use of a substance was physically hazardous and if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous; or if a person has received a verified positive drug test result under an anti-drug program of the Department of Transportation or one of its administrations within the preceding 2 years. Alcohol dependence and alcohol abuse are included in the terms "substance dependence" and "substance abuse", respectively. [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.107(a) and (b), 67.207(a) and (b), and 67.307(a) and (b)]

11. "Bipolar disorder" is added as a specifically disqualifying condition. This addresses an issue created by a change in nomenclature contained in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III), and continued in the DSM IV. [Current (None); Final §§ 67.107(a), 67.207(a), and 67.307(a)]

12. The general mental standard is amended to add the word "other" before "mental." The final revised standard reads, "No other personality disorder, neurosis, or other mental condition * * *." [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.107(c), 67.207(c), and 67.307(c)]

13. "A transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause," is added as a specifically disqualifying neurologic condition. [Current (None); Final §§ 67.109(a), 67.209(a), and 67.309(a)]

14. The word "seizure," is substituted for "convulsive." [Current §§ 67.13(d), 67.15(d), and 67.17(d); Final §§ 67.109(b), 67.209(b), and 67.309(b)]

15. "Cardiac valve replacement," "permanent cardiac pacemaker implantation," and "heart replacement" are added as specifically disqualifying cardiovascular conditions for all classes of certification. [Current §§ 67.13(e), 67.15(e), and 67.17(e); Final §§ 67.111(a); 67.211 (d), (e), and (f); and 67.311 (d), (e), and (f)]

16. The time period for which an electrocardiogram may be used to satisfy the requirements of the first-class medical certificate is revised to 60 days from the current 90 days. [Current § 67.13(e); Final §§ 67.111(c)]

17. The current table of age-related maximum blood pressure readings for applicants for first-class medical certificates and the reference to "circulatory efficiency" are deleted. Blood pressure will continue to be assessed for all three classes but will be evaluated under the appropriate general medical standards. [Current § 67.13(e); Final §§ 67.113(b), 67.213(b), and 67.313(b)]

18. Current § 67.19, Special issue of medical certificates, is rewritten [Final § 67.401(a)] to provide for, at the discretion of the Federal Air Surgeon, an "Authorization for a Special Issuance of Medical Certificate" (Authorization), valid for a specified period of time. An individual who does not meet the published standards of part 67 may be issued a medical certificate of the appropriate class if he or she possesses a valid Authorization. The duration of any medical certificate issued in accordance with proposed § 67.401 is for the period specified at the time of its issuance or until withdrawal of an Authorization upon which the certificate is based. A new Authorization is required after expiration, and the applicant must again apply for a special issuance of a medical certificate.

19. Final § 67.401(b) provides for a Statement of Demonstrated Ability (SODA) instead of an Authorization. A SODA will be issued with no expiration date to applicants whose disqualifying conditions are static or nonprogressive and who have been found capable of performing airman duties without endangering public safety. A SODA authorizes an aviation medical examiner to issue a medical certificate if the applicant is otherwise eligible.

20. Final § 67.401(e) retains the language of current § 67.19(c) regarding consideration of the freedom of a private pilot to accept reasonable risks to his or her own person or property that are not acceptable in the exercise of commercial or airline transport pilot privileges, and consideration at the same time of the need to protect the safety of persons and property in other aircraft and on the ground.

21. Final § 67.401(f) adds language that explicitly provides that the Federal Air Surgeon may withdraw the Authorization or SODA. An Authorization or SODA may be withdrawn at any time for (1) adverse change in medical condition, (2) failure to comply with its provisions, (3) potential endangerment of public safety, (4) failure to provide medical information, or (5) the making or causing to be made of a statement that is covered by § 67.403.

22. Final § 67.401(i) permits a person to request that the Federal Air Surgeon review a decision to withdraw an Authorization or SODA. The request for a review must be made within 60 days of the service of the letter that withdrew the Authorization or SODA. The review procedures will be on an expedited basis and will provide the affected

holder of an Authorization or SODA a full opportunity to respond to a withdrawal by submitting supporting appropriate evidence.

23. Final § 67.403 differs from current § 67.20 by providing for denial of an airman medical certificate if the application for an airman medical certificate is falsified. Though this consequence is implied, the current regulation specifically provides only for revocation or suspension of certificates. Additionally, § 67.403 provides for denial or withdrawal of any Authorization or SODA if the information provided to obtain it is false, whether the statement was knowingly false or unknowingly incorrect. Finally, § 67.403(c) makes an unknowingly incorrect statement that the FAA relied upon in making its decisions regarding an application for an airman medical certificate or a request for an Authorization or SODA, a basis for denial, revocation, or suspension of an airman medical certificate and the denial or withdrawal of an Authorization or SODA.

24. A new § 67.415 provides that the holder of any medical certificate that is suspended or revoked shall, upon the Administrator's request, return it to the Administrator. The FAA practice always has been to request return of the certificate in such circumstances to avoid any misunderstanding as to the validity of the certificate.

25. Where appropriate, changes are made to eliminate gender-specific pronouns, to replace "applicant" with "person," to use current position titles and addresses, to correct spelling and improve syntax, and to adjust section and paragraph references.

General Discussion of Public Comments

In response to the NPRM, the FAA received over 5,200 written comments from the public. In addition, in January of 1995, the FAA held three public meetings on the proposal, at which approximately 50 individuals and organizations participated. One was held in Washington, D.C., one in Orlando, Florida, and one in Seattle, Washington. Information from both the written comments to the docket and the presentations at these public meetings was considered in the final rule decisions along with the petitions for rulemaking and the comments received to those dockets discussed above.

Commenters include approximately 30 trade associations, over 20 FAA aviation medical examiners (AME's), and over 5,100 members of the general public. Air transport pilots and other commercial pilots, private and recreational pilots, flight schools, and flight instructors were among the public commenters.

A substantial number of commenters oppose the proposed changes on the basis that these changes would be a financial burden, that there is a lack of accident data to support stricter standards, and that the stricter standards would not produce discernible safety benefits. There was little or no opposition, however, to proposed changes that relaxed standards or reduced the regulatory burden.

The FAA carefully considered each comment and all presentations made at the public meetings in determining this final rule. Comments that address specific proposed requirements relevant to the proposed rule are summarized and responded to in the following sections of this preamble. To the extent possible, all comments relevant to the adopted standards and regulatory changes are addressed; issues not relevant to this rulemaking raised in the written comments or at the public meetings are not addressed in this document.

The FAA has determined that several of the proposed stricter standards are not required at this time. The withdrawal of these proposed stricter standards are fully discussed in the relevant sections of this document.

Overall Justification and Authority for This Rulemaking

AOPA, which represents the interests of 330,000 pilots and aircraft owners, states in its comment that there is not sufficient justification to warrant this rulemaking since more than 98 percent of all general aviation accidents do not involve medical factors. AOPA also asserts that the FAA's statutory authority for regulating medical standards does not justify the medical certification program currently in place, especially with respect to persons who exercise only private or recreational flying privileges. AOPA states that it is unable to identify a grant of authority to the Administrator to deny a medical certificate to a pilot based, not on the pilot's present physical ability but on the finding that a condition may reasonably be expected within 2 years after the finding to make the pilot unable to perform the required duties. AOPA believes that the FAA should reconsider whether the proposal goes beyond the intent of the Federal Aviation Act of 1958 and beyond what is necessary to safety in air commerce.

In a related comment, the Independent Pilots Association (IPA) states that "nowhere is the FAA or the Federal Air Surgeon charged with the duty to practice preventive medicine."

FAA Response: The FAA has not gone beyond the intent of its authority in this rulemaking action. As stated previously in this notice, the purpose of this rulemaking is to update the medical standards to reflect current medical knowledge, practice, and terminology. The FAA is authorized under 49 U.S.C. 44703 to find that an applicant for an airman certificate is physically able to perform duties pertaining to the position for which the certificate is sought. The FAA is to issue such a certificate "containing such terms, conditions, and limitations as to duration thereof, periodic or special examinations, tests of physical fitness, and other matters" necessary to assure aviation safety.

It is reasonable that airmen, sharing the same air space and flying over the same populated areas, whether engaged in air transportation or in private operations, must meet certain standards in skills and medical fitness to assure aviation safety. That some distinction in the degree of standards is permissible is reflected in the distinction between types of pilot certificates and classes of medical certificates as required by law. While the FAA is not charged with the duty to practice preventive medicine, determining the medical fitness of airmen requires making an assessment of the risks involved in certain medical conditions and denying medical certification in instances in which the person is, or may be, unable to safely perform aviation activities.

On reconsideration of the proposal and after careful consideration of all the comments and presentations received, the FAA is withdrawing certain proposed requirements. Among the withdrawals are (1) the proposal to shorten the duration of third-class medical certificates for pilots 70 and older, (2) the requirement for a test to determine total blood cholesterol, and (3) electrocardiogram requirements for second-class medical certificates. A more complete discussion of the withdrawal of the requirements occurs in the following sections of the preamble.

One of the FAA's primary concerns is the need to ensure that its regulations maintain the proper balance between cost and benefits. The FAA will only issue a final rule when there is clear evidence that it will enhance safety, and that it will do so at a reasonable cost. This is a longstanding FAA commitment, and a requirement of DOT policies and procedures. In this context, after review of the comments, the FAA is not persuaded that there is yet adequate evidence to show that those costs of the proposals are justified by

the safety benefits that can reasonably be expected.

However, the FAA will continue to monitor accident and health data as part of our responsibility to help ensure that adequate safety is maintained. Consistent with the principles of the Clinton administration's National Performance Review, the FAA will, in the coming months, explore alternative nonregulatory means to reduce medically-related accidents. These alternative administrative actions will not impose the same costs on airmen as the proposals contained in the NPRM, but will assist pilots and aviation medical examiners in identifying and reducing potential medical risks.

National Transportation Safety Board (NTSB) and Judicial Review

Several associations and individuals comment that this rulemaking appears to be an effort by the FAA to change decisions by the NTSB and the courts. Several individuals at the hearings held in conjunction with this rulemaking also expressed this opinion.

FAA Response: The FAA agrees that in some cases these comments are accurate. The FAA promulgates rules and policies when the FAA determines that a substantial public safety interest requires such action. In some circumstances, the NTSB or the courts have determined that the rule language adopted by the FAA does not achieve the FAA's intent. The FAA views the circumstances in which review authorities have disagreed with the FAA's interpretation of its rules as a reflection of regulatory defects and not a reflection of policy defects. This rule corrects the regulatory defects by clarifying or more accurately stating in the regulatory language those policies that the FAA believes are necessary to protect substantial public safety interests.

Discussion of Comments and Amendments to Part 61

Proposed § 61.23 lengthens the current 2-year third-class medical certification period to a 3-tier system: a 3-year period for pilots under age 40, a 2-year period for those age 40 to 69, and annual certification for pilots age 70 and over.

Comments: Most individual commenters expressed support for the increased duration (from 2 years to 3 years) for third-class medical certificates for pilots under age 40. Several AME's comment that it is appropriate to differentiate for age, although opinions of AME's and other commenters vary as to the age at which the frequency of examinations should change. Commenters suggest duration periods for third-class medical certificates ranging from 1 to 5 years.

Several associations, several AME's, and a majority of the individuals who commented on this issue strongly oppose the proposal to increase the frequency of medical examinations for pilots age 70 and over for reasons including the following: the proposal may be illegal under federal age discrimination laws; more frequent examinations will not predict sudden incapacitation; the benefits have not been demonstrated; accident rates are lower for older pilots; and the statistical analysis the FAA used to confirm that incidence of accidents increases with age is supported by an insufficient sample size. The Experimental Aircraft Association (EAA), AOPA, and the Colorado Pilots Association believe all airmen should have a 3-year standard regardless of age because, until medical technology reaches a point where the onset of a heart attack can be accurately predicted, there is no justification for more frequent or different examinations for pilots age 70 or over.

Some commenters say that the requirement will be particularly burdensome to older pilots, many of whom are on a fixed income. One commenter suggests that the FAA pay for annual examinations if they will be required. Several commenters note that such examinations are generally not covered by insurance.

FAA Response: The FAA has decided to lengthen the current 2-year third-class medical certification period to a 2-tier system. For airmen under age 40, medical certificates must be renewed every 3 years. For airmen age 40 and over, the current 2-year duration will remain.

As stated in the NPRM, extending the length of time between examinations for third-class medical certificates of persons under age 40 should result in no significant increase in undetected pathology between required examinations. The FAA, after careful consideration of all comments and testimony received as well as the petitions and comments received to Docket Nos. 24932, 26281, and 27473, has determined that extending the duration between medical examinations can be done with no detriment to safety in the case of younger airmen who are much less likely to suffer medical incapacitation. As with all age groups, those individuals under age 40 manifesting conditions that represent a risk to safety will be denied certification or, if they apply for and receive a special issuance of a medical certificate, will be restricted in their flying activities or examined more thoroughly and frequently, or both.

The final rule will provide for maximum regulatory relief without a decrement to public safety.

The proposal to shorten the duration of third-class medical certificates of airmen over the age of 70 is being withdrawn because on reexamination insufficient data exist to support the revision at this time. Several aviation associations, AME's, and individuals commented that the data used in the proposal did not support the conclusion that decreased accidents would result if the duration of third-class medical certificates for airmen over the age of 70 was shortened. The FAA has determined that the possible reduction of a very few known general aviation accidents that are medically-related cannot be justified when compared with the cost of the proposal. This is in contrast to accidents of airline transport and commercial carriers where a single accident may have significant loss of life and property.

All third-class medical certificates or third-class privileges of a first- or second-class medical certificate issued prior to the effective date of this final rule will remain valid for 2 years from the date of issuance of the certificate unless the validity period has been otherwise limited by the FAA. The period of validity for all third-class airman medical certificates or third-class privileges of a first- or second-class medical certificate issued on or after the effective date of this final rule will be calculated according to the provisions of the final rule unless the validity period is otherwise limited by the FAA.

Section 61.53 provides that: "No person may act as pilot in command, or in any other capacity as a required pilot flight crewmember while he [or she] has a known medical deficiency, or increase of a known medical deficiency, that would make him [or her] unable to meet the requirements for his [or her] current medical certificate." This amendment does not change § 61.53, and the FAA continues to require airmen to comply with that rule. In reducing the frequency of required periodic contacts with knowledgeable health professionals, self-monitoring and personal attention to health become a more important part of the individual airman's responsibility for flight safety.

Consistent with the changes above, the final rule amends § 61.39 to coincide with the duration change in § 61.23. Section 61.39 requires that applicants must possess at least a third-class medical certificate or the third-class privileges of a first- or second-class medical certificate valid under § 61.23

in order to be eligible for a flight test for a certificate, or an aircraft or instrument rating.

Discussion of Comments and Final Rule for Part 67

The following discussion generally addresses comments received and the FAA's response to those comments on the specific standards or requirements in the rule. As noted above, over 5,200 comments were received concerning this rulemaking. The comments addressed by the FAA are broadly representative of these many thousands of comments. Other matters and issues raised by the commenters, such as additional tests and examinations that are performed under the special issuance procedures, are not addressed in this document. The FAA is responding only to comments that are within the scope of this rulemaking.

Lists of Medical Standards

General

"Include, but are not limited to." The proposal uses the word "includes" rather than the word "are" in each section of the medical standards because the proposed medical standards are not, and never have been, meant to be exhaustive in naming all medical conditions that are disqualifying.

Comments: AOPA, EAA, National Air Transportation Association (NATA), and most individual commenters say this provision gives FAA absolute discretion without proper promulgation of regulations; the language is too open-ended and provides no standard at all. AOPA states that because the disqualifying conditions are not enumerated, applicants cannot know if they have a deficiency for which the FAA would disqualify them. One AME says that the proposal gives the FAA too much leeway, and should read "are limited to." A majority of the individual commenters strongly oppose use of the term "include, but are not limited to," saying that it would allow FAA too much unchecked authority over an applicant.

FAA Response: The final rule will not contain the proposed language "include, but are not limited to." Medical conditions identified during an evaluation that are not specifically listed as disqualifying but do not meet the general medical standard regarding safe performance of duties and exercise of privileges, would continue to be disqualifying under general medical standards. The intent of the proposal was to alert individuals of this long-standing FAA practice and not to expand the scope of the regulations.

Vision (Sections 67.103, 67.203, 67.303)

Distant Visual Acuity. The proposal deletes the uncorrected vision standard for first- and second-class medical certificates and requires a distant visual acuity of 20/20 or better, in each eye, with or without correction. For third-class medical certificates, a distant visual acuity of 20/40 or better with or without correction, is required for each eye.

Comments: Comments on the proposal for distant visual acuity were in favor of the changes; one AME notes that the proposal is less stringent than the present standards.

FAA Response: The final rule is the same as proposed in the NPRM. As stated in the NPRM, the FAA practice for many years has been to grant any class medical certificate requested, regardless of uncorrected distant acuity, if the required minimum vision is present or achieved through conventional corrective lenses, there is no evidence of significant eye pathology, and the person is otherwise eligible. Thousands of airmen have demonstrated their ability to safely perform their jobs while using corrective lenses for distant visual acuity that is poorer than 20/100 in each eye. The FAA, after careful consideration of the comments and presentations received as well as the petition and comments received to Docket No. 26156, has determined that the requirements for distant visual acuity may be relaxed. The revision will streamline the process of medical certification by not requiring special issuance for persons who cannot meet an uncorrected distant acuity standard.

Near visual acuity standard. The proposed rule replaces the outdated standards for near visual acuity by requiring for all three classes a near visual acuity of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses.

Comments: United States Pilots Association (USPA) states that the FAA presented no evidence to justify the addition of a near-vision standard. Joint Aviation Authorities (JAA) also notes the lack of accident-supported data, but states that the European opinion is that the pilot should have enough visual capacity to read the aircraft instruments if his or her glasses or lenses are lost in flight. The EAA suggests changing 16 inches to "ability to read an instrument panel," which would preserve the intent of the rule, but would not require any additional equipment or training of AME's.

Three AME's approve and one disapproves of the proposed near visual acuity standards. One AME doubts that a pilot with 20/40 vision can read small print (such as on instrument approach plates) in dim light, but notes that a nearsighted person can compensate by looking around one's spectacle lenses. Farsighted persons with 20/40 vision, however, may not be able to read small print at 16 inches. This commenter suggests (1) supplying AME's with specimen aeronautical charts and plates and requiring that the items be read in normal room light with or without correcting lenses, or (2) raising the near vision standard to at least 20/25.

FAA Response: The FAA agrees with the AMA Report recommendation that all three classes of medical certificates should have the same near visual acuity standards. The final rule is the same as proposed. It eliminates the antiquated terminology in the current standards for first-class medical certification, corrects the inconsistency between standards and practice for second-class medical certification, and establishes a standard for third-class medical certificates. After careful consideration of all comments and presentations received as well as the petition and comments received to Docket No. 26156, the FAA has determined that the near visual acuity standard proposed in the NPRM establishes an objective requirement that is necessary for safety and can be best accomplished by the final rule.

Intermediate visual acuity standard. The NPRM proposed to add a new intermediate visual acuity standard (near vision at 32 inches) for first- and second-class medical certificates for pilots age 50 or older of 20/40, Snellen equivalent, at 32 inches in each eye separately, with or without corrective lenses.

Comments: The AMA states that all pilot applicants older than 50 should have 20/40 visual acuity at 32 inches because they need this degree for proper sight and use of instruments, switches, and other controls.

Regarding intermediate visual acuity, AOPA says that 20/40 at 32 inches over age 50 is unjustified, and that the age criteria is arbitrary. One AME says there are no data or operational experience to suggest that an additional middle vision standard for older pilots is needed. According to one AME, the 32-inch intermediate vision standard is too strict for pilots over 50 and will add to the cost without adding any discernible benefit. According to this commenter, those who need trifocals already have them.

FAA Response: The final rule includes a requirement for intermediate

visual acuity for first- and second-class medical certificates for pilots age 50 or older. This standard is consistent with the International Civil Aviation Organization (ICAO) standards. The AMA Report recommended this intermediate vision standard in light of the eye's diminished ability with age to accommodate intermediate viewing distances. Also, the NTSB has recommended that an intermediate vision standard be established. The FAA, after careful consideration of the comments received as well as the petition and comments received to Docket No. 26156, has determined to adopt the rule proposed in the NPRM; airline transport and commercial pilots need adequate intermediate vision to monitor aircraft instruments and other cockpit equipment. This standard is also necessary to safeguard the public safety.

Color Vision (Sections 67.103(c), 67.203(c), 67.303(c))

The proposed color vision standard for all classes is the "ability to perceive those colors necessary for safe performance of airman duties." Current standards require "normal color vision" for first-class applicants and the ability to distinguish aviation signal colors for second- and third-class applicants.

Comments: The USPA, NATA, and National Agricultural Aviation Association (NAAA) support the proposed simplification of the color vision standard.

One AME states that the current system is adequate to identify the individual with a color vision problem and should be left intact. This commenter states that the proposed NPRM advances no new or improved method of determining color vision abilities.

AOPA and the AMA say that the regulations as proposed leave too much room for inconsistent interpretation; the rule should precisely state what colors are "necessary for the safe performance of airman duties" and what tests should be done. An individual suggests using visual flight rule (VFR) charts and runway and taxi light colors as discriminants for realistic and practical color vision tests. EAA says that the FAA should change the wording "safe performance of airman duties" to "read and understand a sectional aeronautical chart." EAA believes this would ensure the intent of the rule, give the AME a simple inexpensive test, and better define what is necessary for safe performance of duties.

Aerospace Medical Association (ASMA) and Air Transport Association (ATA) oppose the proposed changes. ASMA suggests that the FAA discontinue the color blindness test; the standard should be based on an individual's ability to perform safely.

FAA Response: The final rule for color vision is the same as proposed. As stated in the NPRM, in current practice applicants for certification are tested by use of standard pseudoisochromatic plates or by other approved devices. A passing score defines the applicant as not color deficient. Failure indicates a color deficiency and requires that any medical certificate issued be limited, prohibiting flight at night or by color signal control. The limitation can be removed by successful completion of a practical signal light test or of a medical flight test, as appropriate for the class medical certificate sought and the level of aviation experience of the applicant. This final rule would allow, for all three classes of medical certificates, an individual who fails the test using pseudoisochromatic plates or other approved devices to still obtain a medical certificate without obtaining a waiver as long as the individual can demonstrate an ability to perceive those colors necessary for the safe performance of airman duties. The FAA will provide guidance to AME's to assist in these tests.

The FAA, after careful consideration of the comments and presentations received as well as the petition and comments received to Docket No. 26156, has determined that the color vision standard in the final rule should remain as proposed.

Hearing (Sections 67.105(a), 67.205(a), 67.305(a))

In the proposed rule, the "whispered voice test" for hearing is deleted for all classes and replaced with three alternatives: (1) A conversational voice test using both ears at 6 feet; (2) an audiometric word (speech) discrimination test to a score of at least 70 percent obtained in one ear or in a sound field environment; or (3) pure tone audiometry according to a table of acceptable thresholds (ANSI, 1969).

Comments: Some AME's generally support the proposed hearing standards. ASMA states, however, that the rule language could be interpreted to require audiograms and that the FAA should state in the preamble that it intends for the basic screening test to be the spoken-voice test. ASMA also says that the rule should state that audiometric tests are only used as alternatives for further evaluation of individuals who show reduced hearing acuity.

Many commenters support the "conversational voice" recognition standard as operationally relevant. AOPA and USPA support the proposed standard that allows both ears to be used simultaneously to hear conversational voice spoken at 6 feet.

ATA says a pure tone audiogram followed by a speech discrimination test based upon an audiometric standard guideline would be a far more accurate and objective measurement of hearing than the highly subjective conversational and whispered voice tests.

ATA says that a 70 percent score on an audiometric word discrimination test is too low to support speech comprehension during critical phases of flight; the standard should be 95 percent. Another individual suggests that 85 percent would allow for accurate communication in more cockpit environments. ATA and one AME also believe that the rule is vague, should be more descriptive, and should cite a decibel reading for administering the test.

One AME says that possibly a screening cut-off level for pure-tone audiometry would be appropriate.

AOPA says that the same screening test should apply for those without "normal hearing" and users of hearing aids. According to AOPA, there appears to be no clinical reason for excluding the use of hearing aids within the medical standards.

Several commenters question whether an "and" or an "or" is appropriate between subparagraphs (a)(1) and (a)(2) of §§ 67.105, 67.205, and 67.305. Most think the rule should say "or."

A commenter notes that the standard for 2000 Hz in the chart in § 67.205(c) is 30 for the poorer ear, which is more stringent than the standard of 50 for first-class medical certificate. The commenter believes that this must be a typographical error.

FAA Response: The final rule is the same as proposed, except that the typographical error in the chart in § 67.205(c) is corrected to 50 and the lead-in for paragraph (a) in all three sections reads: "The person shall demonstrate acceptable hearing by at least one of the following tests:" and a period is placed at the end of each subparagraph. These editorial corrections to paragraph (a) are intended to eliminate any confusion or ambiguity. Passing any one of the tests, as required, is acceptable for certification. The FAA anticipates that the conversational voice test will be the most commonly used; however, passing any one of the tests will suffice even if the applicant has failed the other two. While there is some subjectivity to a conversational voice test, it is the simplest and least expensive form of testing. The FAA, after careful consideration of the

comments and presentations received as well as the petition and comments received to Docket No. 26281, has determined that the hearing standards in the final rule should remain as proposed.

The FAA is following the AMA Report recommendations in requiring a 70 percent score in an audiometric word discrimination test. The FAA considers a 95 percent score too restrictive.

As with current policy, if a hearing aid is necessary to meet the standard, an Authorization or SODA is required. In most cases, however, a person using a hearing aid can be issued a medical certificate.

Equilibrium (Sections 67.105(c), 67.205(c), 67.305(c))

The proposal revises the current standard, "No disturbance in equilibrium," to, "No ear disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium." The proposed standards are the same for all classes.

Comments: One commenter states that the ear, nose, throat, and equilibrium revisions are appropriate and realistic for addressing safety.

AOPA and other commenters say that the language relating to vertigo or disturbance of equilibrium is too broad; instead the rule should qualify that an applicant shall have "no disturbance of equilibrium that is severe enough to make piloting an aircraft unsafe." AOPA asserts that vertigo is a common and normal occurrence and disqualification should not be based on a symptom. According to AOPA an episode of in-flight vertigo is not necessarily attributable to an underlying medical condition that is disqualifying. AOPA notes that the FAA intentionally induces vertigo at safety seminars using a "vertigon" chair.

FAA Response: The final rule is the same as proposed. The final rule is more precise than the current rule since it specifies that the vertigo or disturbance of equilibrium be a manifestation of a condition or disease of the ear. It appears commenters are confusing pilot vertigo or spatial disorientation that can occur in flight with vertigo that is a manifestation of a medical condition or disease. In-flight pilot vertigo or spatial disorientation is not related to this medical standard. The FAA has determined, after careful consideration of the comments and presentations received, that the equilibrium standards in the final rule should remain as proposed.

Mental Standards (Sections 67.107, 67.207, 67.307)

Definition of Psychosis. The proposed rule states that "psychosis" refers to "a mental disorder in which the individual has manifested psychotic symptoms or to a mental disorder in which the individual may reasonably be expected to manifest psychotic symptoms." This language change was proposed to be consistent with the diagnostic terminology and classification of mental disorders, published in the DSM III and its successor DSM IV.

Comments: ATA suggests identifying the underlying disorders that FAA considers psychoses, e.g., schizophrenia, paranoid states, or depression. ATA suggests defining psychosis as "an alteration in either thought content or process, or both, to such an extent that the individual suffers from hallucinations, delusions, or other manifestations." One AME states that "psychotic reaction" needs further definition in the rule. IPA suggests that the FAA refrain from referring to a specific edition of the DSM since DSM-IV is the current psychiatric diagnostic standard, not the 15-year old DSM-III referenced in the NPRM. JAA says its Manual of Civil Aviation Medicine gives much more detailed interpretation of its psychiatric and psychological requirements.

FAA Response: On reconsideration and after careful consideration of the comments received, the FAA has changed the final rule language regarding psychosis to be more specific. Paragraph (a)(2) of §§ 67.107, 67.207, and 67.307 reads as follows:

"(2) A psychosis. As used in this section, 'psychosis' refers to a mental disorder in which:

"(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior or other commonly accepted symptoms of this condition; or

"(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition."

At the time of the AMA Report and the FAA review of part 67, the most current DSM was DSM III. Since then, the DSM has been revised and the most current version is DSM IV. The FAA has determined that the revisions between DSM III and DSM IV do not necessitate any substantive changes between the proposed rule and the final rule.

Bipolar disorder. The proposed rule adds bipolar disorder (formerly "manic depressive psychosis") as a specifically disqualifying mental condition because the American Psychiatric Association's nomenclature in DSM III and DSM IV no longer includes bipolar disorder within the category of psychoses.

Comments: One AME and a few individuals support the proposal to make bipolar disorders disqualifying.

AOPA believes bipolar disorder should not be singled out as a disqualifying mental condition, and that applicants should be evaluated on a case-by-case basis. AOPA asserts that bipolar disorders vary in severity and symptoms from one individual to another; some never exhibit the manic symptoms which appear to be the primary concern of the FAA.

FAA Response: The FAA, after careful consideration of the comments and presentations received, has determined that the final rule be the same as proposed. However, since the proposed rule was issued, DSM IV was developed which refers to more than one bipolar disorder and to separate criteria that apply to the different types of bipolar disorders. Although the DSM IV contains a change in classification of this disorder, there is no change in the rule language from the proposed rule language because the disorder, whatever its classification, is considered disqualifying.

The FAA believes these conditions are of concern in the context of airman medical certification and flight safety, and that the agency must amend the mental standards since in accordance with the DSM III and its successor DSM IV, psychoses no longer include bipolar disorders. In consideration of potential risk to flight safety, individuals with this diagnosis are rarely granted certification. Those few individuals who are determined to be eligible for certification through the special issuance provisions must be followed closely for relapse and recurrence of symptoms. By including the new terminology, the standards will clearly reflect the agency's concern about this disorder. Specifically listing bipolar disorders as disqualifying is not a substantive change in FAA policy or practice.

Substance Dependence and Definitions. The proposal updates the standards for alcoholism and drug dependence to make them consistent with DSM III (and subsequently DSM IV) nomenclature which eliminates the term "alcoholism" and substitutes the diagnoses of "substance dependence" and "substance abuse." The proposed revision defines "substance dependence," "substance abuse," and "substance." The proposed revision identifies disqualifying substances or

groups of substances (e.g., alcohol, cocaine, opioids, hallucinogens, cannabis, etc.) and would make dependence on or abuse of them disqualifying. The proposal also makes substance dependence disqualifying unless there is clinical evidence of recovery, including sustained total abstinence for not less than the preceding 2 years in the case of alcohol dependence, and the preceding 5 years in the case of other substance dependence.

Comments: Two AME's generally support the proposed changes regarding substance dependence. AOPA, National Air Traffic Controllers Association (NATCA), EAA, and two other AME's suggest a minimum 2-year abstinence for all substances because they believe the extended period of decertification for substance dependency is without statistical justification. According to these commenters, the AMA data on which the 5-year restriction is based are dated; there are many new treatments and research that indicate a required 5-year abstinence is too strict; and the 5-year rule may reflect some public hysteria concerning drug use. In addition, according to these commenters, there are six times as many alcohol-related accidents as drug-related accidents, bringing into question why the FAA is proposing stricter standards on other substances when alcohol is a greater problem.

Two AME's say the FAA should not broaden the substances and should leave the regulation as is. Another AME says FAA needs to further define "substance" by identifying particular drugs.

EAA says that the FAA should limit the disqualification for muscle relaxants to users of "muscle relaxants with habit-forming potential" because many muscle relaxants have no habit-forming potential.

FAA Response: The FAA, after careful consideration of the comments and presentations received as well as the petitions and comments received to Docket Nos. 26281 and 26330, has decided to make the minimum period of abstinence from alcohol and other substances 2 years because longer term experience with recovery from dependence on drugs or alcohol now suggest that 2 years is adequate for both alcohol and drugs. In many cases, the FAA has granted special issuance to air transport and commercial pilots and has waived the 2-year abstinence period when it was satisfied that certain stringent criteria are met. The criteria can be summarized as follows: (1) A full commitment and partnership of the aviation employer and employee to ensure the employee's continued sobriety through monitoring; (2) full commitment and partnership of the recovering employee with a fellow employee to ensure continued sobriety through monitoring; and (3) frequent evaluations, testing, and attendance at professional aftercare treatment.

Also, the FAA has decided to delete "muscle relaxants" from the list of substances in §§ 67.107(a)(4)(i), 67.207(a)(4)(i), and 67.307(a)(4)(i) in part because the FAA agrees with the EAA comment, but also because muscle relaxants are not included as a substance in DSM III and its successor DSM IV.

To conform with DSM IV terminology, the FAA has changed the reference to "volatile solvents and gases" to "inhalants," a term the FAA considers to be equivalent.

Otherwise the final rule is the same as proposed. The standards are consistent with the AMA Report and address the national concerns about substance dependence.

Substance abuse. As proposed, substance abuse is one of the following:

(1) Use of alcohol within the preceding 2 years in a situation in which that use is physically hazardous, if there has been at any other time an instance of the use of alcohol or another substance also in a situation in which that use was physically hazardous; or

(2) Use of a substance other than alcohol within the preceding 5 years in a situation in which that use is physically hazardous, if there has been at any other time an instance of the use of that substance, alcohol, or another substance also in a situation in which that use was physically hazardous;

(3) Use of a prohibited drug defined in appendix I of part 121 of this chapter within the preceding 5 years; or

(4) Misuse of a substance within the preceding 2 years if alcohol or within the preceding 5 years if another substance, that the Federal Air Surgeon based on case history and appropriate qualified medical judgment, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

Comments: Two AME's and other commenters generally support the proposed changes to the substance abuse standard.

The JAA states that the proposed recommendations are similar to those in the JAA proposals except that a shorter recertification period following alcohol abuse is allowed and the JAA Manual of Civil Aviation Medicine gives much more detailed interpretation of the psychiatric and psychological requirements.

EAA says the broad FAA list of "substances," combined with the definition of "abuse" and the extremely vague issue of "physical hazard" makes it conceivable that abuse could be held as a single misapplication of prescription medication (e.g., amphetamines, tranquilizers, sedatives, and muscle relaxants).

FAA Response: The FAA has decided to make the time periods related to substance abuse of alcohol or other substances 2 years to be consistent with substance dependence abstinence time requirements of this section and for the reasons already given. Otherwise the final rule is the same as proposed, except that §§ 67.107(b)(2), 67.207(b)(2), and 67.307(b)(2) are modified. Instead of prohibiting the "use of a prohibited drug defined in Appendix I of part 121," the final rule language reads "A verified positive drug test result acquired under any anti-drug program or internal program of the U.S. Department of Transportation or any other Administration of the U.S. Department of Transportation." The modified language clarifies the FAA's intention in referencing Appendix I in the proposed rule. The FAA stated in the NPRM preamble that it considers a positive drug test conducted under any rule or internal program of the Department of Transportation to be compelling proof of the use of a prohibited drug for which the drug test was positive.

The changes are intended to provide specific regulatory medical standards and enhance the agency's ability to examine and exclude from aviation a person who, though not substance dependent, manifests recurrent abuse of alcohol or other legal or illegal substances, or has a single violation of DOT drug testing programs within the preceding 2 years. These standards are consistent with the AMA Report and address national concerns about substance abuse.

In referring to use of a substance when "physically hazardous," the standard generally refers to instances such as driving or flying while intoxicated or under the influence of alcohol or drugs, but could also refer to other physically hazardous situations that occurred while a person was under the influence of alcohol or legal or illegal drugs. This term is also used in DSM III and its successor DSM IV. The FAA, after careful consideration of the comments and presentations concerning

substance abuse as well as the petitions and comments received to Dockets Nos. 26281 and 26330, has determined that the rule as modified provides adequate notice to airmen of the required medical standards and is necessary to protect the public safety.

Neurological (Sections 67.109, 67.209, and 67.309)

The FAA proposed three changes to the neurological standards, adding "a single seizure" to the list of disqualifying conditions; using "seizure" rather than "convulsive" to describe potentially disqualifying conditions; and adding a "transient loss of control of nervous system functions" standard.

Comments: ATA, AOPA, and three AME's assert that the proposed requirement that focuses on a single seizure is burdensome and not necessary; a single mild seizure should not be the sole cause for disqualification. ATA notes that a single febrile seizure during childhood, associated with a normal electroencephalogram (EEG), neurological examination, and imaging study, does not increase the risk for further seizure activity over time. EAA suggests rather than disqualifying applicants who have had seizures, AME's be given a checklist and evaluation guide for pilots with a history of a disturbance of consciousness or neurologic function. AOPA cites common causes of single seizure events including low sodium in the blood, heat exhaustion, head injury from which the applicant entirely recovers, and eclampsia during pregnancy.

One AME asserts that the frequency of in-flight incapacitation following seizure episodes is so low as to render this change unnecessary. According to the AME, febrile seizures are common, and the amount of increased paperwork to request special issuance of a medical certificate for individuals who have had these is simply not worth it.

USPA and AOPA say the neurological loss of control definition is too broad and is open to abuse and misinterpretation.

In response to the FAA's statement in the NPRM preamble that neither the AMA-recommended test nor the test by Folstein provides a "useful screening device, alone or in combination, for airman neurological status," the AMA emphasizes the extreme importance of a test of mental fitness in attempting to ensure aviation safety and strongly recommends that the FAA designate or develop a sensitive and more specific test of mental capacity if those proposed by the AMA report are unsatisfactory.

FAA Response: The FAA, after careful consideration of all the comments and presentations received, has decided to withdraw the proposal that specifies that a single seizure is disqualifying. The proposed standard at paragraph (a)(2) will not be added to the first-, second-, or third-class medical certificate requirements. This part of the proposal is being withdrawn because the FAA agrees with commenters that a single febrile seizure in childhood should not in most instances be disqualifying. However, any seizure that has occurred must be reported by the applicant as part of the medical history and could be found to be disqualifying under the general neurological standards of §§ 67.109(b), 67.209(b), and 67.309(b). Also, a single seizure that constitutes a disturbance of consciousness or a transient loss of control of nervous system function(s) without satisfactory medical explanation of the cause would be disqualifying under §§ 67.109(a)(2) or (3), 67.209(a)(2) or (3), and 67.309(a)(2) or 3). Under § 61.53, Operations during medical deficiency, such an occurrence would require an airman to cease exercising the privileges of any airman certificate held until medically evaluated and cleared for airman duties by the FAA.

The proposed change from "convulsive disorder" to "seizure disorder" at paragraph (b) remains in the final rule.

The FAA has determined that the addition of "transient loss of control of nervous system functions" should remain in the final rule. It clarifies the agency's aeromedical concern about such events whether or not they are characterized as disturbances of consciousness and allows for the identification and individual evaluation of persons with this history.

As to mental screening tests, neither the AMA report nor the American Academy of Neurology/American Association of Neurological Surgeons report proposes detailed, objective criteria and tests that could be included in the standards and by which medical certification could be determined. Neither the AMA-recommended test nor the Folstein test provides a useful screening device, alone or in combination, for airman neurological status. Also, neither screening test, alone or in combination, provides predictors of skills relevant to piloting.

Cardiovascular (Sections 67.111, 67.211, and 67.311)

List of Disqualifying Conditions. The proposed rule adds to the list of disqualifying cardiovascular conditions for first-, second-, and third-class airman medical certificates an established medical history of cardiac valve replacement, permanent cardiac pacemaker implantation, and heart replacement.

Comments: None of the commenters specifically object to the disqualification for heart replacement.

Two associations, one AME, and several individuals do not support the proposal to specifically disqualify applicants with cardiac valve replacements or permanent cardiac pacemakers. One association states that the current list of disqualifying conditions is adequate. Many of these commenters say medical technology for valve replacements and pacemakers is excellent and improving, so it would be premature for the FAA to disqualify these heart conditions.

EAA says that for bioprosthetic cardiac valve patients with no signs of heart failure, arrhythmia, or atrial fibrillation, and with a normal functional capacity on stress testing, the FAA should not require the applicant to go through the special issuance process to obtain a medical certificate. According to the commenter, these individuals are at very low risk for sudden incapacitation and can perform normal activities including piloting an aircraft without undue risk. One AME believes that disqualifications for heart valve replacements should be evaluated on an individual basis.

EAA maintains that standby pacemakers or well-functioning permanent pacemakers should be allowed with a satisfactory cardiovascular evaluation and monitoring. Another commenter believes it is appropriate to deny pacemaker users first- and second-class medical certificates, but a pacemaker should not disqualify a person from a third-class medical certificate.

FAA Response: The FAA, after careful consideration of the comments and presentations received as well as the petitions and comments received to Docket Nos. 22054 and 26156, has determined that disqualifying cardiovascular conditions remain in the final rule as proposed. Further, the FAA has determined that these are serious conditions that give rise to safety concerns in the aviation environment specifically with regard to valve failure, pacemaker malfunction, progression of the underlying disease that required

artificial cardiac pacing, organ rejection, or the complications of immunosuppression. As stated in the NPRM preamble, the FAA will continue to consider special issuance of medical certification on a case-by-case basis after specialized medical evaluations to confirm adequate recovery and function and the absence of significant risk in terms of the aviation environment.

These regulations clarify long-standing FAA policy. Previously, the FAA has denied medical certification to airmen with cardiac valve replacement, pacemaker implantation, or heart transplant under the current general medical standards. In the final rule, a medical history of cardiac valve replacement, pacemaker implantation, or heart transplant is disqualifying. A person with such a medical history, however, may apply for and possibly receive, a special issuance of a medical certificate. The FAA will continue to monitor medical technology in this area and will reassess these rules as developments warrant.

Blood Pressure (Proposed §§ 67.111(b), 67.211(b), and 67.311(b)). The proposed rule revises the blood pressure standards established in 1959 applicable to first-class medical certificates. The current table of age-related maximum blood pressure readings for applicants for first-class medical certificates and the reference to "circulatory efficiency" are deleted, and a requirement that average blood pressure while sitting not exceed 150/95 millimeters of mercury is added for applicants of all classes. A medical assessment is specified for all applicants who need or use antihypertensive medication to control blood pressure.

Comments: Four AME's support the proposed blood pressure standard, but one requests that the AME make some notation as to whether this is achieved by approved antihypertensive medication. JAA suggests further assessment of applicants whose blood pressure level is not "consistently 160/95" or lower.

The Boeing Employees Soaring Club, ALPA, USPA, NATA, GAPA, NAAA, three AME's, and many individual commenters do not support the proposed blood pressure standard. They say that it would increase the cost of medical care, would require costly cardiovascular work-ups for people who would not otherwise require therapy, and is not supported by medical data or accident information. Many commenters and one AME do not support the proposal because, according to these commenters, blood pressure naturally increases with age.

ALPA and Boeing Employees Soaring Club say a blood pressure reading could be affected by many factors, including time of day, daily stress, or fear of a visit to their physician, and that the FAA should not have a set blood pressure level in the rule.

AOPA, EAA, and several commenters, including doctors, say that the FAA should not disqualify persons whose blood pressure is stabilized at a lower level with therapy. According to commenters, in the NPRM the FAA implies that treated hypertension is more of a risk than the condition of high blood pressure.

FAA Response: After careful consideration of all the comments and testimony, the FAA has decided to eliminate specific blood pressure requirements in the final rule. For all classes, the final rule makes no specific reference to blood pressure but, rather, requires that the appropriate general medical standard in §§ 67.113(b), 67.213(b), and 67.313(b) be met.

The FAA has determined that a blood pressure standard is unnecessary. Each person's medical condition and treatment regimen, if any, will continue to be evaluated on an individual basis. While the use of an antihypertensive medication is not made specifically disqualifying, a person may be required to undergo further medical assessment.

Electrocardiograms (Proposed §§ 67.111 (c) and (d) and 67.211(d)); Final §§ 67.111 (b) and (c)). The NPRM proposed to add a new requirement for routine resting electrocardiograms (ECG) for second-class medical certification. Applicants would have an ECG after reaching age 35 and every 2 years after reaching age 40. An ECG requirement currently exists for first-class applicants; however, first-class applicants must have an initial ECG after the 35th birthday and annually after reaching age 40. The NPRM did not propose to add an ECG requirement for third-class applicants. The NPRM also proposed to change the validity period for an ECG to meet the requirements of a medical examination. Currently, an ECG made within 90 days before a medical examination can be used to satisfy the first-class application requirement. The proposal was to change to this to 60 days.

Comments: The AMA, ATA, JAA, and two AME's support the proposal.

ASMA, NATA, NAAA, EAA, GAPA, and ALPA do not support the proposal to require ECG's for second-class applicants. National Business Aircraft Association (NBAA), ASMA, AOPA, and EAA cite the lack of cardiac incapacitation as a causal factor in aviation accidents. Many commenters, including doctors, do not support the requirement to administer ECG tests to asymptomatic persons. Six AME's say that the ECG does not predict sudden incapacitation.

A majority of commenters stress the financial burden that ECG testing would create on those who need second-class medical certificates. According to commenters, the FAA's cost estimate for ECG's does not account for the cost to AME's of purchasing the equipment and modems to transmit the readings to the Civil Aeromedical Institute. The ECG test would also increase the amount of time an AME would spend on each pilot. AOPA notes that the FAA anticipates 1,800 applicants will not meet ECG standards, and would have to undergo the cost of additional evaluation to determine eligibility for a medical certificate. AOPA also noted that the FAA's regulatory evaluation estimated that 90 percent of these applicants would ultimately be granted medical certificates. AOPA believes the ECG requirement and follow-up testing is a waste of time and money. The Soaring Society of America suggests that an applicant's regular medical facility could perform this test and certify it to the AME, which would prevent redundant tests and lower the cost and complexity of obtaining the second-class medical certificate.

FAA Response: After careful consideration of the comments and testimony received, the FAA has decided to withdraw the proposal for an ECG requirement for second-class medical certification. There was limited support for the proposal within the medical community; and several aviation associations (including an aeromedical association), AME's, and individuals commented that the cost of implementing this proposal cannot be justified when compared with the current, limited-prognostic capabilities of the routine resting ECG.

The existing ECG requirement for first-class medical certification, an initial ECG after the 35th birthday and annual ECG's after reaching age 40, remains in the final rule. The change from 90 to 60 days for using an ECG to satisfy the first-class medical certification requirement also remains in the final rule. The FAA has determined that the ECG requirement for first-class medical certification, normally held by airline transport pilots, is consistent with the highest level of safety and is cost effective when coupled with the semi-annual examination required for that certificate. An airman holding a first-class medical certificate receives the highest level of medical scrutiny (i.e., semi-annual

examination) because of the nature of his or her employment; the annual ECG is one element of this frequent, multi-factorial, medical surveillance.

Most commercial "commuter" operations (e.g., passenger operations of a turbojet airplane, passenger operations of an airplane having a passenger seating configuration of 10 seats or more, or passenger operations of a multiengine airplane being operated by a commuter air carrier) require pilots to have first-class medical certificates. The remaining population of commercial pilots (e.g., pilots of commuter passenger operations with airplane passenger seating configuration of 9 seats or less; flight instructors; pilots of crop dusting, banner towing, powerline, pipeline inspection operations) is required to hold a second-class medical certificate. As previously stated, the FAA has determined that biennial ECG's for these commercial pilots are not cost effective and that these pilots do not require the same level of medical scrutiny, given their employment, as pilots who are required to have a first-class medical certificate. The FAA, however, will continue to monitor and evaluate the medical/flying histories of those pilots required to have a second-class medical certficate and will, if appropriate, impose an ECG requirement in the future.

Finally, the public should be aware that the FAA uses the ECG to evaluate the medical fitness of second-class medical certificate applicants when sound medical judgment indicates that the test would be reasonable and useful. The FAA routinely requests an ECG when an individual has or may have a medical history or clinical diagnosis of a variety of medical conditions, including cardiovascular disease, hypertension, dysrhythmia, diabetes, peripheral vascular disease, cerebral vascular disease, cardiomyopathy, valvular heart disease, congenital heart disease, or a previously abnormal ECG. The FAA will continue to use the ECG as a diagnostic tool in appropriate situations.

Anticoagulant medications (Proposed §§ 67.111(c), 67.211(c), and 67.311(c)). The proposed rule adds the provision that persons applying for first-, second-, or third-class medical certificates must not use anticoagulant medication.

Comments: EAA, AOPA, two AME's, and several individuals state that the proposed rule is subject to interpretation and could, for example, include aspirin. The two AME's say that the FAA needs to differentiate between anticoagulant and antiplatelet medications regarding which are disqualifying. AOPA says disqualification should be based on the applicant's disease, not on the medicine taken, unless there are specific side effects that directly affect the safety of flight.

EAA supports the prohibition of heparin. AOPA says coumadin use should not be disqualifying, since its track record is well established.

FAA Response: The FAA did not intend for antiplatelet medications (e.g., aspirin) to be included as anticoagulants. After careful consideration of the comments and testimony received, the FAA has decided to withdraw the proposal to add anticoagulant use as a specifically disqualifying medication since the use of these medications could be found disqualifying in this final rule under paragraph (c) of the general medical condition section (see §§ 67.113(c), 67.213(c), and 67.313(c)), of part 67.

Cholesterol Testing (Proposed Section 67.111(f))

The current rule contains no cholesterol standards. The proposed rule adds a new total blood cholesterol testing requirement for first-class applicants after they reach age 50, and annually thereafter. A blood cholesterol level of 300 milligrams per deciliter or more requires applicants to undergo further evaluation. If otherwise eligible, the applicant would be issued a medical certificate pending results of the evaluation.

Comments: The vast majority of individual commenters, as well as NBAA, AOPA, ASMA, and EAA, do not support the proposed requirement for total blood cholesterol determination for first-class medical certification. AOPA, NATA, and ALPA say some individuals believe that the test is invasive and a personal health matter to be discussed with a private physician, not with the FAA. AOPA, EAA, two AME's, and several individuals say factors other than total cholesterol contribute to coronary artery disease. Since the AMA study, Allied Pilots Association (APA), EAA, two AME's and several others note, high density lipoprotein (HDL) and low density lipoprotein (LDL) have been found to better correlate with coronary artery disease (CAD) than total cholesterol.

Nearly half of the AME commenters state that cholesterol testing is not needed because it does not predict an applicant's ability to perform safely. One AME notes that 50 percent of all myocardial infarctions occur in people with cholesterol ranging between 180 and 220, levels well below the FAA's proposed evaluation threshold of 300. NBAA and APA say the link between incidence of high serum cholesterol and aircraft accidents caused by pilot incapacitation is tenuous at best. APA suggests that the FAA consider reviewing cardiovascular risk factors every 3–5 years to develop other, more appropriate measures of cardiovascular risk.

FAA Response: After careful consideration of the comments and testimony received, the FAA has decided to withdraw the proposal to measure the total cholesterol of applicants for first-class medical certification. Several aviation associations, AME's, and individuals commented that there is no scientific evidence that demonstrates the relationship between a specific cholesterol value and the existence of identifiable pathology that represents a threat to aviation safety. Commenters pointed out that a different understanding exists today about total cholesterol level, per se, and pathology compared to when the data that supported the original proposal were compiled. Cholesterol testing, as proposed, is not cost effective. The FAA encourages airmen to have their lipid levels checked as a health measure but is not requiring airmen to do so in the final rule.

Diabetes (Sections 67.113(a), 67.213(a), and 67.313(a))

No change is proposed to the standards concerning airmen with diabetes, currently set forth in paragraph (f)(1) of §§ 67.13, 67.15, and 67.17. In the preamble to the proposed rule, however, FAA states that it has determined that persons who do not meet the medical standard because their diabetes requires oral hypoglycemic drugs would no longer be categorically denied special issuance of airman medical certification. This policy would apply to individuals whose diabetes is without complications and acceptably controlled by diet and oral drugs with appropriate monitoring and other conditions. However, this policy change does not affect the long-standing FAA policy and practice that a diabetic using insulin for control is not eligible for unrestricted or restricted medical certification.

Comments: Two AME's believe that insulin-dependent diabetics should not be allowed any type of pilot's license.

USPA says insulin-dependent diabetics should be acceptable on a case-by-case basis. One commenter believes that diabetic private or recreational pilots should be certificated if their diabetes is under good control.

EAA, two other AME's, and many individuals support permitting

noninsulin-dependent diabetics to obtain special issuance.

A few commenters state that it is unrealistic to exclude all users of hypoglycemic drugs, as proposed in the NPRM. One diabetic noted that 50 percent of men over 65 have "Diabetes II," which does not require insulin or anything other than a mild drug.

FAA Response: After careful consideration of the comments and testimony received as well as the petitions and comments received to docket Nos. 26281 and 26493, the FAA has determined that the current consensus of the medical community supports the FAA position. Many individuals who are not insulin-treated diabetics can, with appropriate monitoring and other conditions, receive a special issuance of their medical certificates to perform the duties authorized by their class of medical certificate without endangering public safety. The final rule is the same as the current rule.

Also, the FAA has determined that, rather than engaging in rulemaking concerning diabetes, it is more appropriate to reexamine its policy on special issuance of medical certificates to persons with insulin-treated diabetes mellitus. On December 29, 1994, subsequent to publication of the NPRM, the Federal Air Surgeon requested comments on a possible policy change with respect to individuals who have a clinical diagnosis of insulin-treated diabetes mellitus (59 FR 67246, December 29, 1994). The docket for this notice closed on March 29, 1995. The FAA will review the comments and testimony received in dockets Nos. 26493 and 27940 concerning diabetes and will publish in a separate notice the agency's determination concerning its policy on special issuance of medical certificates to persons with insulin-treated diabetes mellitus.

Special Issuance (Section 67.401)

Proposed § 67.401(a) limits the duration of any medical certificate issued under the special issuance procedures of this section to the duration of an Authorization for special issuance. When the Authorization expires, or if the FAA withdraws the Authorization, the medical certificate issued pursuant to that Authorization also expires.

Comments: AOPA and IPA say that the extra requirements for special issuance procedures should be withdrawn because they will increase the burden on FAA to write exceptions (especially in a time of government budget cutting and staff reductions), and because applicants will have to pay more and bet their livelihood with each reaffirmation request.

FAA Response: The FAA, after careful consideration of all the comments and testimony received as well as the petitions and comments received to Docket No. 25787, has decided to retain the requirement limiting duration of any class medical certificate to the duration of an Authorization. This will ensure that the medical justification for the special issuance remains valid and the holder of the special issuance undergoes appropriate periodic reevaluation. This change explicitly connects the duration of any special issuance medical certificate to the validity of the document upon which it is based and requires periodic requests for reissuance. The FAA foresees no significant additional administrative burden on the FAA.

The FAA has included specific requirements for an Authorization in the rule language in order to provide procedures for legal documentation and control of validity periods, followup requirements, withdrawals, and functional or operational limitations.

Incorrect Statements by Applicants (Sections 67.401(f)(5) and 67.403(c))

The proposed rule broadens the regulatory basis for action when an applicant or airman provides incorrect information when applying for medical certification. Proposed §§ 67.401(f)(5) and 67.403(c) would allow the FAA the option of denying, suspending, or revoking an airman medical certificate and denying or withdrawing an Authorization or SODA, not only when the holder makes a fraudulent or intentionally false statement, but also when the holder makes an incorrect statement in support of a request for a medical certificate, an Authorization, or SODA or in an entry in any logbook, record, or report that is kept, made, or used to show compliance with the medical certificate, Authorization, or SODA. A suspension, revocation, or withdrawal could occur even if the person did not knowingly make the incorrect statement or entry.

Comments: One AME supports the Authorization and SODA withdrawal proposals.

EAA says the proposed § 67.403(c) statement concerning unknowingly false statements should only call for a review of the medical certificate and possible revocation, if warranted by the corrected information. AOPA notes that the Federal Aviation Act says applicants denied issuance or renewal of a certificate may have an NTSB hearing.

NATCA, IPA, APA, four AME's, and a large number of individual commenters are concerned about what they view as the lack of due process in the decision to withdraw the Authorization. According to these commenters, many innocent errors are made on the applications due to the applicant's unclear memory or misunderstanding of terms on the application. These commenters suggest that the FAA require the AME to contact the pilot and provide a chance to explain and correct the incorrect statements. Commenters say that the wording creates too ambiguous an authority for the FAA and creates the potential for action by the FAA against almost any pilot. Some associations are concerned that individuals whose applications or certificates are denied may actually lose their jobs without benefit of an opportunity to clarify unintentional discrepancies.

FAA Response: The FAA noted in the preamble to the NPRM its concern that medical certification based on incorrect medical data may be inappropriate in the light of the true data. The current regulations do not explicitly provide for withdrawal of an Authorization or SODA or suspension or revocation of a medical certificate when unknowingly incorrect statements are relied upon in the FAA's decision to issue an Authorization, SODA, or medical certificate. The FAA's intent in including language on incorrect statements is to provide a basis for appropriate action when a person provides such unknowingly incorrect information that is relied on by the agency in its decision. The withdrawal, suspension, or revocation in this case is not meant to be punitive, but rather corrects the inappropriate granting of an Authorization, SODA, or medical certificate. The final rule clarifies the FAA's intent by including language in § 67.403(c) that limits the reference to "incorrect statements" to those "upon which the FAA relied."

Return of Medical Certificate Sections 67.401(i)(4) and 67.415

Proposed § 67.401(i)(4) requires surrender to the Administrator of a medical certificate rendered invalid pursuant to a withdrawal in accordance with § 67.401(a). The proposal also adds a requirement in § 67.415 to specify that the holder of a medical certificate that is suspended or revoked must return the medical certificate to the Administrator.

Comments: EAA says that presently airmen are not required to return their medical certificates without a hearing before the NTSB; procedures now exist for emergency suspension or revocation of a certificate based on false information. Therefore, EAA believes

there is no need for this requirement. Three AME's believe that the added requirement for mandatory return of a medical certificate at the request of the Administrator would open the whole process of medical certification to potential abuse by the FAA and should be deleted. Several individuals state that this provision is unnecessary and should be withdrawn; the current rules are sufficient to ensure that pilots fly only with a valid medical certificate.

FAA Response: Current § 67.27(g) provides that the holder of a medical certificate shall surrender it, upon request of the FAA, if its issuance is wholly or partly reversed upon reconsideration. After careful consideration of all the comments and testimony received, the FAA has determined that the language, as proposed, codifies existing practice, parallels the procedures with airman certificates, and clarifies the FAA's intent to require the return of medical certificates that have become invalid. The retention by an airman of an invalid medical certificate is not consistent with proper and efficient enforcement of safety regulations because of the apparent authority of these documents. Inclusion of this requirement, however, does not in any way affect the certificate holder's administrative review or appeal rights.

Regulatory Evaluation Summary

Introduction

Changes to Federal regulations must undergo several economic analyses. First, Executive Order 12866 directs Federal agencies to promulgate new regulations or modify existing regulations only if the potential benefits to society justify its costs. Second, the Regulatory Flexibility Act of 1980 requires agencies to analyze the economic impact of regulatory changes on small entities. Finally, the Office of Management and Budget directs agencies to assess the effects of regulatory changes on international trade. In conducting these assessments, the FAA has determined that this rule: (1) Will generate benefits exceeding its costs and is not "significant" as defined in Executive Order 12866; (2) is not "significant" as defined in DOT's Policies and Procedures; (3) will not have a significant impact on a substantial number of small entities; and (4) will not constitute a barrier to international trade. These analyses, available in the docket, are summarized below.

The majority of the amendments will have insignificant attributable costs and benefits. This evaluation does not address the minor amendments such as changes in syntax, technical corrections, reorganization, updating medical terminology, or adjustments to cross references for conformance purposes.

Furthermore, the evaluation attributes no significant costs or benefits to several other amendments that add a specific disease or medical condition to the list of medical standards. Such additions do not necessarily constitute a change in the standards. Existing regulations include three open-ended (general) medical standards that cover:

> (1) any other personality disorder, neurosis, or mental condition * * *, (2) any other organic, functional, or structural disease, defect, or limitation * * *, and (3) no medication or other treatment * * *.

that the Federal Air Surgeon finds would make, or may reasonably be expected to make, the applicant unable to perform the duties associated with the airman certificate. Thus, the applicable medical standards are not limited to those actually listed in the regulation. As medical knowledge and experience progress, the Federal Air Surgeon may find a previously unlisted disease or condition to be grounds for withholding or restricting a medical certificate, so long as that finding is based on qualified medical judgment.

The addition of specifically disqualifying medical conditions under the amended standards could cause a small number of airmen, who currently hold medical certificates as a result of an order of the National Transportation Safety Board (NTSB) to be disqualified from further medical certification. These airmen were denied medical certification by the FAA under the current general medical standards. For example, the FAA has denied medical certification to airmen who have had cardiac valve replacement and the NTSB has ordered medical certification in some of these cases. Under the amended standards a medical history of cardiac valve replacement is specifically disqualifying and those airmen will no longer be entitled to medical certification. It is expected, however, that medical certification of the affected individuals will continue under the Federal Air Surgeon's special issuance authority once the FAA evaluates the case and is satisfied that the airman's condition has not worsened since the NTSB ordered medical certification. As such, the expected economic impact of the specifically disqualifying medical conditions will be minor.

Discussion of Comments Addressing Economic Evaluation

This section of the summary responds to comments concerning the economic evaluation of the NPRM. The NPRM for this rule included five significant proposals that were withdrawn after careful consideration of the comments received. This section notes, but does not address comments concerning the regulatory evaluation of the withdrawn proposals, since such comments are no longer pertinent.

Comment: The U.S. Small Business Administration (SBA) states in it comment that the FAA's regulatory flexibility analysis for the NPRM does not conform to the Regulatory Flexibility Act (RFA), and that a proper regulatory flexibility analysis must be performed prior to issuing a final rule.

FAA Response: The FAA does not agree. Federal agencies are required to prepare a regulatory flexibility analysis only if the proposed rule would have a significant economic impact on a substantial number of small entities.[1] The NPRM would not have had such impact and this was stated. The SBA also notes that no explanation was provided to support that determination. The FAA agrees and provides the following table of explanation.

[1] *A Guide to Federal Agency Rulemaking*, 2nd edition, Administrative Conference of the United States; 1991; p. 162.

Medical certification category	NPRM 10-year present value	NPRM annualized costs	Active airmen	Average cost per year per active airman
First-class	$5,700,000	$811,551	147,676	$5.50
Second-class	22,700,000	3,231,969	173,435	18.64
Third-class	5,600,000	797,314	325,996	2.45

As shown above, the average annualized cost impact of the proposed rule would have ranged from $2.45 to $18.64 per person subject to medical certification requirements. It would be statistically impossible for the impact of the proposed rule to exceed these averages to such an extent as to have a significant impact (multiple thousands of dollars annually depending on the entity type) on a substantial number (at least one-third) of small entities; even if the rule only affected small entities. Similarly, since the costs of the final rule are approximately 20 percent of the NPRM costs, it follows that the final rule also will not have a significant economic impact on a substantial number of small entities.

Comments: Several associations and numerous individual commenters find it illogical to draw inferences for pilots from the air traffic controllers who were monitored in the Johns Hopkins study. The reasons cited by the commenters include air traffic control (ATC) work is inherently stressful, ATC work is sedentary, controllers are exposed to cathode ray tube monitors and indoor air, controllers have a history of strife between labor and management, and they work on varying shifts.

FAA Response: The FAA disagrees. The Hopkins study was expressly used to quantify the relative differences of primary pathology incidence across age cohorts. The Hopkins results are conclusively supported by other general medical investigation as well as the FAA's own medical certification data for pathology incidence and application denials.

Comments: Four national aviation associations strongly disagree with the NPRM proposal to reduce the duration of third-class medical certificates for persons age 70 and older. The commenters assert that the benefits have not been demonstrated and that the statistical analysis FAA used to confirm that the incidence of pathology related accidents increases with age is supported by an insufficient sample size.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: Numerous individual commenters stated that the proposed higher standards for blood pressure would prove costly to pilots with borderline pressure measurements and that the affected individuals would be required to take extensive additional testing.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: Six major associations disagree with the provision for electrocardiograms, second class and assert that the frequency of medically related aviation accidents, the majority of which are not predictable, does not support the administrative and economic burdens that would be imposed on the affected applicants. Two associations assert that the 40-percent effectiveness level that was assumed in the evaluation is questionable and is a significant error in the cost-benefit analysis. Five associations, two AME's, and numerous individual commenters state that the FAA's cost estimate does not account for the cost for AME's to purchase the necessary medical equipment and modems. They warn that some AME's may withdraw their participation rather than incur the additional costs.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: Several associations assert that requiring a cholesterol test would be a significant administrative and cost burden. One association stated that the regulatory evaluation employed an average laboratory test cost of $10, but that costs range between $15 and $16 in the Washington, D.C. area. One individual commenter asserts that the cost-benefit analysis is flawed because it based cost savings on a cholesterol level lower than 300, and because the analysis assumed that all heart attacks studied represented individuals with critically high cholesterol.

FAA Response: After careful consideration of the testimony and comments received, the FAA has withdrawn this proposed provision.

Comments: One major association states that the addition of the intermediate vision, first and second class is unnecessary and unwarranted, and that it would add costs with no significant safety benefit.

FAA Response: The FAA does not agree. The evaluation estimated that the direct testing costs, including applicant time, would range from $1.30 to $3.86 per year per applicant age 50 and older. Additional costs (for glasses and examinations) would only be incurred by those persons whose intermediate vision was, in fact, deficient, and who could not satisfactorily read their flight instruments. The FAA maintains that these costs are not unreasonable, and that the benefits of commercial pilots being able to read flight instruments are conclusive.

Costs and Benefits That Are Not Quantified

Prior to summarizing the evaluation of the substantive provisions, it is important to note one category of costs and one category of benefits that have not been quantified in this analysis. The evaluation does not explicitly quantify the economic consequences to those individuals who could lose their pilot medical certificate privileges as a result of the additional medical tests or standards. Where such consequences are expected, the evaluation estimates the numbers of persons who may be denied but does not attribute a cost to those actions.

It is recognized that the denial of pilot privileges could mean the loss of a highly valued avocation for some individuals. For others, it could actually result in the loss of primary livelihood. An accurate assessment of the economic valuation of the denials that are projected under the rule is beyond the scope of the evaluation.

At the same time, the evaluation also does not quantify the overwhelming personal health benefits, external to flight safety, that will be afforded to those individuals whose medical conditions will be detected and whose treatment will be enabled by the new tests and standards. On average, third-class medical certificate holders spend only 0.7 percent of their time flying. The evaluation only quantifies the direct benefits of the rule to reduced aviation accidents.

Under existing regulations, the Federal Air Surgeon is charged to deny a medical certificate in those cases where a disease or other physical or mental condition would make, or may be reasonably be expected to make, the applicant unable to perform the duties associated with the medical certificate. Such findings are not capricious, but instead, are based on the case history of the individual and on appropriate, qualified medical judgment. The FAA holds that the severity of a disease or medical condition necessary to warrant a denial is such that the aviation safety and personal health benefits of that action will always exceed the costs associated with the loss of pilot privilege.

Summary of Quantified Costs and Benefits

Vision Amendments, All Classes. The final rule institutes additional vision tests and standards for all three classes. For first- and second-class medical certificate applicants age 50 and older, it adds a new standard (20/40 or better, Snellen equivalent) and a new test for intermediate vision (near vision at 32 inches). Applicants for third-class medical certificates will be subject to a new standard (20/40 or better) and a new test for near vision (16 inches).

The projected 10-year costs of the intermediate vision amendment for first-class medical certificate applicants are: (1) $1.4 million in primary testing costs, (2) $2.1 million in follow-up compliance costs (examinations and glasses) for those persons who would not meet the standard, and (3) $6,147 in direct processing costs for the expected 15 additional persons who could be denied under the provision. In total, it is expected that the intermediate vision amendment for first-class medical certificate applicants would impose an incremental 10-year cost of $3.5 million, with a 1995 present value of $2.5 million.

The projected 10-year costs of the intermediate vision amendment for second-class medical certificate applicants are: (1) $442,224 in primary testing costs, (2) $2.0 million in follow-up compliance costs (examinations and glasses) for those persons who would not meet the standard, and (3) $6,626 in direct processing costs for the expected 17 additional persons who would be denied under the provision. In total, it is expected that the intermediate vision amendment for second-class medical certificate applicants would impose an incremental 10-year cost of $2.4 million, with a 1995 present value of $1.7 million.

The projected 10-year costs of the near vision amendment for third-class medical certificate applicants are: (1) $2.3 million in primary testing costs, (2) $1.1 million in follow-up compliance costs (examinations and glasses) for those persons who would not meet the standard, and (3) $129,690 in direct processing costs for the expected 330 additional persons who would be denied under the provision. In total, it is expected that the near vision amendment for third-class medical certificate applicants would impose an incremental 10-year cost of $3.5 million, with a 1995 present value of $2.5 million. It is emphasized that the denials and costs associated with the near vision requirement are not wholly attributable to the amendment. Although this requirement does not exist in current regulations, the requirement has been in place administratively for some time. Thus, the associated costs are being and would continue to be incurred without this amendment. The economic evaluation of this requirement is provided as information to assess the fact the requirement would explicitly be added to the regulations.

In assessing the benefits of the vision amendments, NTSB accident records were investigated for the periods from 1962 through 1989 for commercial flights and from 1982 through 1989 for general aviation. For these periods, no accident was found where intermediate or near vision deficiency was specifically determined to be the cause. As such, the FAA is not able to quantitatively ascribe the benefits of the three vision amendments based solely on historical accident analysis.

Notwithstanding the absence of documented accidents related to these three provisions, the FAA maintains that such accidents may well have occurred and would continue to occur in the absence of the amendments. The NTSB accident analysis system may not document those cases where a near or intermediate vision problem caused or contributed to accidents. Examples would include deviations from course or altitude, inaccurate monitoring of gauges and other avionics displays, and incorrect setting of aeronautical parameters such as headings or radio frequencies.

While the extent to which intermediate or near vision problems have caused such accidents is unknown, it is the FAA's position that: (1) general aviation pilots require adequate near vision to read charts and checklists, and (2) commercial pilots require adequate intermediate vision to properly monitor aircraft instruments. Although this evaluation is not able to quantify the benefits of the vision amendments, the FAA holds that the benefits will be significant and will exceed the expected costs.

Part 61, Medical Certificate Validity Period, Third-Class. Under the final rule, persons under age 40 will generally only be required to undergo a physical examination every 3 years. Medical certificates for persons age 40 and older will continue to be valid for 2 years.

Other than minor administrative costs to effect the new procedure, there will be no direct expenditures associated with the amendment. In addition, careful consideration of all comments and testimony received, as well as the petitions and comments received to Docket Nos. 24932, 26281, and 27473, leads the FAA to conclude that extending the duration between medical examinations can be done with no detriment to safety in the case of younger airmen, who are much less likely to suffer medical incapacitation.

The FAA has investigated the relative primary pathology incidence rates for persons under and over 40 years of age. As a group, persons under age 40 exhibit 1/27 of the pathology incidence rate of persons 40 and older. Even weighting these rates, by the numbers of pilots by age class, results in an "under age 40" incidence equal to 1/6 that of third-class medical certificate applicants age 40 and older.

The FAA's position on this issue is further supported by a review of the pertinent accident data. National Transportation Safety Board (NTSB) data were reviewed for the period 1982 through 1989. During that period, 259 pathology related, general aviation accidents occurred. Only two of those accidents, however, involved private pilots under age 40 with a potentially detectable primary pathology. One case involved a 37-year-old pilot with a valid medical certificate who suffered a heart attack that had not been predicted. The second accident involved a 25-year-old with a vasovagal syncope who was flying without a medical certificate.

As with all age groups, those individuals under age 40 manifesting conditions that represent a risk to safety will be denied medical certification or, if they apply for and receive a special issuance of a medical certificate, will be restricted in their flying activities and/or examined more thoroughly and frequently.

The primary benefits of this amended provision will derive from the annual reduction in third-class medical certificate applications. FAA compared the projected numbers of applications

under the existing 2 year duration for all ages, against the applications that are expected under the final rule provision extending the duration for persons under age 40 to 3 years. Applications under the final rule were computed by reducing the projected applications for persons under age 40 by a factor of two-thirds. Over the 10-year study period, the part 61 provision is expected to reduce applications by 268,000.

Each avoided examination is valued at $89, consisting of $50 in direct testing costs, and one and one-half hours of the applicant's time valued at $29 per hour. This produces an expected 10-year savings of $23.9 million, with a 1995 present value of $16.7 million, not counting FAA processing costs

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted by Congress to ensure that small entities are not unnecessarily or disproportionately burdened by Government regulations. The RFA requires a Regulatory Flexibility Analysis if a rule would have a significant economic impact, either detrimental or beneficial, on a substantial number of small entities. FAA Order 2100.14A, Regulatory Flexibility Criteria and Guidance, provides threshold cost and small entity size standards for complying with RFA review requirements in FAA rulemaking actions.

The rule is estimated to have a 10 year, 1995 present value cost of $6.6 million, which equates to an annualized cost of $940,000 to the approximately 647,100 active airmen. The average annualized effect per airman is projected to equal $1.45. In light of this information, the FAA finds that the amendment will not have a significant economic impact on a substantial number of small entities.

International Trade Impact Assessment

The final rule will have little or no impact on trade for both U.S. firms doing business in foreign countries and foreign firms doing business in the United States.

Federalism Implications

The regulations herein would not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12866, it is determined that this rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Conclusion

For the reasons discussed in the preamble, and based on the findings in the Regulatory Evaluation and the International Trade Impact Analysis, the FAA has determined that this rule is not major under Executive Order 12866. In addition, the FAA certifies that this rule will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. This rule is considered significant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979). A regulatory evaluation of the rule, including a Regulatory Flexibility Determination and Trade Impact Analysis, has been placed in the docket. A copy may be obtained by contacting the person identified under **FOR FURTHER INFORMATION CONTACT.**

Paperwork Reduction Act

The paperwork burden associated with part 67 is currently approved under OMB number 2120–0034. There is small reduction in paperwork associated with this final rule.

Derivation and Distribution Tables

The Derivation Table below shows the source in current part 67 on which each paragraph of each section of revised part 67 is based. The Distribution Table below shows where each current part 67 section and paragraph can be found in the revised part 67.

Derivation Table

Revised section	Based On
Subpart A	
Section	
67.1	Current §§ 67.1 and 67.21.
67.3	Current § 67.11.
67.5	Current § 67.12.
67.7	Current § 67.3.
Subpart B	
Section	
67.101	Current § 67.13(a) and new language.
67.103(a)	Current § 67.13(b)(1).
67.103(b)	Current § 67.13(b)(2) and new language.
67.103(c)	Current § 67.13(b)(3) and new language.
67.103(d)	Current § 67.13(b)(4).
67.103(e)	Current § 67.13(b)(5).
67.103(f)	Current § 67.13(b)(6) and flush paragraph.
67.105(a)	Current § 67.13(c)(1) and new language.
67.105(b)	Current § 67.13(c)(2), (c)(3), (c)(4), (c)(5), and new language.
67.105(c)	Current § 67.13(c)(6) and new language.
67.107(a)	Current § 67.13(d)(1)(i) and new language.
67.107(b)	New language.
67.107(c)	Current § 67.13(d)(1)(ii) reordered.
67.109(a)	Current § 67.13(d)(2)(i) and new language.
67.109(b)	Current § 67.13(d)(2)(ii).
67.111(a)	Current § 67.13(e)(1) and new language.
67.111(b)	Current § 67.13(e)(2) and (3) and new language.
67.111(c)	Flush paragraph after current § 67.13(e)(5) as modified.
67.113(a)	Current § 67.13(f)(1).
67.113(b)	Current § 67.13(f)(2).
67.113(c)	Current § 67.13(f)(3), added September 9, 1994.
67.115	Current § 67.13(g).
Subpart C	
Section	
67.201	Current § 67.15(a) and new language.
67.203(a)	Current § 67.15(b)(1).
67.203(b)	Current § 67.15(b)(2) and new language.
67.203(c)	Current § 67.15(b)(5) and new language.
67.203(d)	Current § 67.15(b)(3).
67.203(e)	Current § 67.15(b)(4) and new language.
67.203(f)	Current § 67.15(b)(6) and flush paragraph.
67.205(a)	Current § 67.15(c)(1) and new language.
67.205(b)	Current § 67.15(c)(2), (c)(3), (c)(4), (c)(5), and new language.
67.205(c)	Current § 67.15(c)(6) and new language.
67.207(a)	Current § 67.15(d)(1)(i) and new language.
67.207(b)	New language.
67.207(c)	Current § 67.15(d)(1)(ii) reordered.
67.209(a)	Current § 67.15(d)(2)(i) and new language.
67.209(b)	Current § 67.15(d)(2)(ii) and new language.
67.211	Current § 67.15(e)(1) and new language.
67.213(a)	Current § 67.15(f)(1).
67.213(b)	Current § 67.15(f)(2).
67.213(c)	Current § 67.15(f)(3), added September 9, 1994.
67.215	Current § 67.15(g).
Subpart D	
Section	
67.301	Current § 67.17(a) and new language.
67.303(a)	Current § 67.17(b)(1) and new language.
67.303(b)	New language.
67.303(c)	Current § 67.17(b)(3) and new language.
67.303(d)	Current § 67.17(b)(2) and new language.
67.305(a)	Current § 67.17(c)(1) and new language.
67.305(b)	Current § 67.17(c)(2) and (3), and new language.
67.305(c)	Current § 67.17(c)(4) and new language.
67.307(a)	Current § 67.17(d)(1)(i) and new language.
67.307(b)	New language.
67.307(c)	Current § 67.17(d)(1)(ii) reordered.
67.309(a)	Current § 67.17(d)(2)(i) and new language.
67.309(b)	Current § 67.17(d)(2)(ii) and new language.

Derivation Table—Continued

Revised section	Based On
67.311	Current § 67.17(e)(1) and new language.
67.313(a)	Current § 67.17(f)(1).
67.313(b)	Current § 67.17(f)(2).
67.313(c)	Current § 67.17(f)(3), added September 9, 1994.
67.315	Current § 67.17(g).
Subpart E	
Section	
67.401(a)	Current § 67.19(a) and new language.
67.401(b)	New language.
67.401(c)	Current § 67.19(b).
67.401(d)	Current § 67.19(d) and new language.
67.401(e)	Current § 67.19(c).
67.401(f)	New language.
67.401(g)	Current § 67.19(e) and new language.
67.401(h)	Current § 67.19(f) and new language.
67.401(i)	New language.
67.401(j)	New language.
67.403(a)	Current § 67.20(a) and new language.
67.403(b)	Current § 67.20(b) and new language.
67.403(c)	New language.
67.405(a)	Current § 67.23(a).
67.405(b)	Current § 67.23(b).
67.407(a)	Current § 67.25(a) and new language.
67.407(b)	Current § 67.25(a) flush paragraph and new language.
67.407(c)	Current § 67.25(b), as amended September 9, 1994, and new language.
67.407(d)	Current § 67.25(c).
67.409(a)	Current § 67.27(a).
67.409(b)	Current § 67.27(b), as amended September 9, 1994.
67.409(c)	Current § 67.27(c).
67.409(d)	Current § 67.27(d).
67.411(a)	Current § 67.29(a).
67.411(b)	Current § 67.29(b).
67.411(c)	Current § 67.29(c).
67.413(a)	Current § 67.31.
67.413(b)	New language.
67.415	New language.

Distribution Table

Current Section	Revised Section
Subpart A	
Section	
67.1	§ 67.1.
67.3	§ 67.7.
67.11	§ 67.3.
67.12	§ 67.5.
67.13(a)	§ 67.101.
67.13(b)	§ 67.103.
67.13(c)	§ 67.105.
67.13(d)	§ 67.107 and § 67.109.
67.13(e)	§ 67.111 and § 67.113(b).
67.13(f)	§ 67.113.
67.13(g)	§ 67.115.
67.15(a)	§ 67.201.
67.15(b)	§ 67.203.
67.15(c)	§ 67.205.
67.15(d)	§ 67.207 and § 67.209.
67.15(e)	§ 67.211.
67.15(f)	§ 67.213.
67.15(g)	§ 67.215.
67.17(a)	§ 67.301.
67.17(b)	§ 67.303.
67.17(c)	§ 67.305.
67.17(d)	§ 67.307 and § 67.309.
67.17(e)	§ 67.311.

Distribution Table—Continued

Current Section	Revised Section
67.17(f)	§ 67.313.
67.17(g)	§ 67.315.
67.19	§ 67.401.
67.20	§ 67.403.
Subpart B	
Section	
67.21	§ 67.1.
67.23	§ 67.405.
67.25	§ 67.407.
67.27	§ 67.409.
67.29	§ 67.411.
67.31	§ 67.413.

List of Subjects

14 CFR Part 61

Aircraft, Airmen, Alcohol abuse, Drug abuse, Recreation and recreation areas, Reporting and recordkeeping requirements.

14 CFR Part 67

Airmen, Delegations of authority (Government agencies), Health, Medical standards and certification procedures, Reporting and recordkeeping requirements.

The Amendments

In consideration of the foregoing, the Federal Aviation Administration amends parts 61 and 67 of Title 14 Code of Federal Regulations (14 CFR parts 61 and 67) as follows:

PART 61—CERTIFICATION: PILOTS AND FLIGHT INSTRUCTORS

1. The authority citation for part 61 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701–44703, 44707, 44709–44711, 45102–45103, 45301–45302.

2. Section 61.23 is amended by revising paragraphs (a)(3), (b)(2), and (c) to read as follows:

§ 61.23 Duration of medical certificates.

(a)* * *

(3) The period specified in paragraph (c) of this section for operations requiring only a private, recreational, or student pilot certificate.

(b)* * *

(2) The period specified in paragraph (c) of this section for operations requiring only a private, recreational, or student pilot certificate.

(c) A third-class medical certificate for operations requiring a private, recreational, or student pilot certificate issued—

(1) Before September 16, 1996, expires at the end of the 24th month after the month of the date of examination shown on the certificate.

(2) On or after September 16, 1996, expires at the end of the:

(i) 36th month after the month of the date of the examination shown on the certificate if the person has not reached his or her 40th birthday on or before the date of the examination; or

(ii) 24th month after the month of the date of the examination shown on the certificate if the person has reached his or her 40th birthday on or before the date of the examination.

3. Section 61.39 is amended by revising paragraph (a)(3) to read as follows:

§ 61.39 Prerequisites for flight tests.

(a)* * *

(3) Hold a current medical certificate appropriate to the certificate the applicant seeks or, in the case of a rating to be added to the applicant's pilot certificate, at least a current third-class medical certificate issued under part 67 of this chapter;

* * * * *

4. Part 67 is revised to read as follows:

PART 67—MEDICAL STANDARDS AND CERTIFICATION

Subpart A—General

Sec.
67.1 Applicability.
67.3 Issue.
67.5 Certification of foreign airmen.
67.7 Access to the National Driver Register.

Subpart B—First-Class Airman Medical Certificate

67.101 Eligibility.
67.103 Eye.
67.105 Ear, nose, throat, and equilibrium.
67.107 Mental.
67.109 Neurologic.
67.111 Cardiovascular.
67.113 General medical condition.
67.115 Discretionary issuance.

Subpart C—Second-Class Airman Medical Certificate

67.201 Eligibility.
67.203 Eye.
67.205 Ear, nose, throat, and equilibrium.
67.207 Mental.
67.209 Neurologic.
67.211 Cardiovascular.
67.213 General medical condition.
67.215 Discretionary issuance.

Subpart D—Third-Class Airman Medical Certificate

67.301 Eligibility.
67.303 Eye.
67.305 Ear, nose, throat, and equilibrium.
67.307 Mental.
67.309 Neurologic.
67.311 Cardiovascular.
67.313 General medical condition.
67.315 Discretionary issuance.

Subpart E—Certification Procedures

67.401 Special issuance of medical certificates.
67.403 Applications, certificates, logbooks, reports, and records: Falsification, reproduction, or alteration; incorrect statements.
67.405 Medical examinations: Who may give.
67.407 Delegation of authority.
67.409 Denial of medical certificate.
67.411 Medical certificates by flight surgeons of Armed Forces.
67.413 Medical records.
67.415 Return of medical certificate after suspension or revocation.

Authority: 49 U.S.C. 106(g), 40113, 44701–44703, 44707, 44709–44711, 45102–45103, 45301–45303.

Subpart A—General

§ 67.1 Applicability.

This part prescribes the medical standards and certification procedures for issuing medical certificates for airmen and for remaining eligible for a medical certificate.

§ 67.3 Issue.

Except as provided in § 67.5, a person who meets the medical standards prescribed in this part, based on medical examination and evaluation of the person's history and condition, is entitled to an appropriate medical certificate.

§ 67.5 Certification of foreign airmen.

A person who is neither a United States citizen nor a resident alien is issued a certificate under this part, outside the United States, only when the Administrator finds that the certificate is needed for operation of a U.S.-registered aircraft.

§ 67.7 Access to the National Driver Register.

At the time of application for a certificate issued under this part, each person who applies for a medical certificate shall execute an express consent form authorizing the Administrator to request the chief driver licensing official of any state designated by the Administrator to transmit information contained in the National Driver Register about the person to the Administrator. The Administrator shall make information received from the National Driver Register, if any, available on request to the person for review and written comment.

Subpart B — First-Class Airman Medical Certificate

§ 67.101 Eligibility.

To be eligible for a first-class airman medical certificate, and to remain eligible for a first-class airman medical certificate, a person must meet the requirements of this subpart.

§ 67.103 Eye.

Eye standards for a first-class airman medical certificate are:

(a) Distant visual acuity of 20/20 or better in each eye separately, with or without corrective lenses. If corrective lenses (spectacles or contact lenses) are necessary for 20/20 vision, the person may be eligible only on the condition that corrective lenses are worn while exercising the privileges of an airman certificate.

(b) Near vision of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses. If age 50 or older, near vision of 20/40 or better, Snellen equivalent, at both 16 inches and 32 inches in each eye separately, with or without corrective lenses.

(c) Ability to perceive those colors necessary for the safe performance of airman duties.

(d) Normal fields of vision.

(e) No acute or chronic pathological condition of either eye or adnexa that interferes with the proper function of an eye, that may reasonably be expected to progress to that degree, or that may reasonably be expected to be aggravated by flying.

(f) Bifoveal fixation and vergence-phoria relationship sufficient to prevent a break in fusion under conditions that may reasonably be expected to occur in performing airman duties. Tests for the factors named in this paragraph are not required except for persons found to have more than 1 prism diopter of hyperphoria, 6 prism diopters of esophoria, or 6 prism diopters of exophoria. If any of these values are exceeded, the Federal Air Surgeon may require the person to be examined by a qualified eye specialist to determine if there is bifoveal fixation and an adequate vergence-phoria relationship. However, if otherwise eligible, the person is issued a medical certificate pending the results of the examination.

67.105 Ear, nose, throat, and equilibrium.

Ear, nose, throat, and equilibrium standards for a first-class airman medical certificate are:

(a) The person shall demonstrate acceptable hearing by at least one of the following tests:

(1) Demonstrate an ability to hear an average conversational voice in a quiet room, using both ears, at a distance of 6 feet from the examiner, with the back turned to the examiner.

(2) Demonstrate an acceptable understanding of speech as determined by audiometric speech discrimination testing to a score of at least 70 percent obtained in one ear or in a sound field environment.

(3) Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to the following table of worst acceptable thresholds, using the calibration standards of the American National Standards Institute, 1969 (11 West 42d Street, New York, NY 10036):

Frequency (Hz)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Better ear (Db)	35	30	30	40
Poorer ear (Db)	35	50	50	60

(b) No disease or condition of the middle or internal ear, nose, oral cavity, pharynx, or larynx that—

(1) Interferes with, or is aggravated by, flying or may reasonably be expected to do so; or

(2) Interferes with, or may reasonably be expected to interfere with, clear and effective speech communication.

(c) No disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.

§ 67.107 Mental.

Mental standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.

(2) A psychosis. As used in this section, "psychosis" refers to a mental disorder in which:

(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition; or

(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.

(3) A bipolar disorder.

(4) Substance dependence, except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. As used in this section—

(i) "Substance" includes: Alcohol; other sedatives and hypnotics; anxiolytics; opioids; central nervous system stimulants such as cocaine, amphetamines, and similarly acting sympathomimetics; hallucinogens;

phencyclidine or similarly acting arylcyclohexylamines; cannabis; inhalants; and other psychoactive drugs and chemicals; and

(ii) "Substance dependence" means a condition in which a person is dependent on a substance, other than tobacco or ordinary xanthine-containing (e.g., caffeine) beverages, as evidenced by—

(A) Increased tolerance;

(B) Manifestation of withdrawal symptoms;

(C) Impaired control of use; or

(D) Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

(b) No substance abuse within the preceding 2 years defined as:

(1) Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;

(2) A verified positive drug test result acquired under an anti-drug program or internal program of the U.S. Department of Transportation or any other Administration within the U.S. Department of Transportation; or

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No other personality disorder, neurosis, or other mental condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 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;

(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.

(b) No other seizure disorder, disturbance of consciousness, or neurologic condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.111 Cardiovascular.

Cardiovascular standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) Myocardial infarction;

(2) Angina pectoris;

(3) Coronary heart disease that has required treatment or, if untreated, that has been symptomatic or clinically significant;

(4) Cardiac valve replacement;

(5) Permanent cardiac pacemaker implantation; or

(6) Heart replacement;

(b) A person applying for first-class medical certification must demonstrate an absence of myocardial infarction and other clinically significant abnormality on electrocardiographic examination:

(1) At the first application after reaching the 35th birthday; and

(2) On an annual basis after reaching the 40th birthday.

(c) An electrocardiogram will satisfy a requirement of paragraph (b) of this section if it is dated no earlier than 60 days before the date of the application it is to accompany and was performed and transmitted according to acceptable standards and techniques.

§ 67.113 General medical condition.

The general medical standards for a first-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control.

(b) No other organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.115 Discretionary issuance.

A person who does not meet the provisions of §§ 67.103 through 67.113 may apply for the discretionary issuance of a certificate under § 67.401.

Subpart C—Second-Class Airman Medical Certificate

§ 67.201 Eligibility.

To be eligible for a second-class airman medical certificate, and to remain eligible for a second-class airman medical certificate, a person must meet the requirements of this subpart.

§ 67.203 Eye.

Eye standards for a second-class airman medical certificate are:

(a) Distant visual acuity of 20/20 or better in each eye separately, with or without corrective lenses. If corrective lenses (spectacles or contact lenses) are necessary for 20/20 vision, the person may be eligible only on the condition that corrective lenses are worn while exercising the privileges of an airman certificate.

(b) Near vision of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses. If age 50 or older, near vision of 20/40 or better, Snellen equivalent, at both 16 inches and 32 inches in each eye separately, with or without corrective lenses.

(c) Ability to perceive those colors necessary for the safe performance of airman duties.

(d) Normal fields of vision.

(e) No acute or chronic pathological condition of either eye or adnexa that

interferes with the proper function of an eye, that may reasonably be expected to progress to that degree, or that may reasonably be expected to be aggravated by flying.

(f) Bifoveal fixation and vergence-phoria relationship sufficient to prevent a break in fusion under conditions that may reasonably be expected to occur in performing airman duties. Tests for the factors named in this paragraph are not required except for persons found to have more than 1 prism diopter of hyperphoria, 6 prism diopters of esophoria, or 6 prism diopters of exophoria. If any of these values are exceeded, the Federal Air Surgeon may require the person to be examined by a qualified eye specialist to determine if there is bifoveal fixation and an adequate vergence-phoria relationship. However, if otherwise eligible, the person is issued a medical certificate pending the results of the examination.

§ 67.205 Ear, nose, throat, and equilibrium.

Ear, nose, throat, and equilibrium standards for a second-class airman medical certificate are:

(a) The person shall demonstrate acceptable hearing by at least one of the following tests:

(1) Demonstrate an ability to hear an average conversational voice in a quiet room, using both ears, at a distance of 6 feet from the examiner, with the back turned to the examiner.

(2) Demonstrate an acceptable understanding of speech as determined by audiometric speech discrimination testing to a score of at least 70 percent obtained in one ear or in a sound field environment.

(3) Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to the following table of worst acceptable thresholds, using the calibration standards of the American National Standards Institute, 1969:

Frequency (Hz)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Better ear (Db)	35	30	30	40
Poorer ear (Db)	35	50	50	60

(b) No disease or condition of the middle or internal ear, nose, oral cavity, pharynx, or larynx that—

(1) Interferes with, or is aggravated by, flying or may reasonably be expected to do so; or

(2) Interferes with, or may reasonably be expected to interfere with, clear and effective speech communication.

(c) No disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.

§ 67.207 Mental.

Mental standards for a second-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.

(2) A psychosis. As used in this section, "psychosis" refers to a mental disorder in which:

(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition; or

(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.

(3) A bipolar disorder.

(4) Substance dependence, except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. As used in this section—

(i) "Substance" includes: Alcohol; other sedatives and hypnotics; anxiolytics; opioids; central nervous system stimulants such as cocaine, amphetamines, and similarly acting sympathomimetics; hallucinogens; phencyclidine or similarly acting arylcyclohexylamines; cannabis; inhalants; and other psychoactive drugs and chemicals; and

(ii) "Substance dependence" means a condition in which a person is dependent on a substance, other than tobacco or ordinary xanthine-containing (e.g., caffeine) beverages, as evidenced by—

(A) Increased tolerance;

(B) Manifestation of withdrawal symptoms;

(C) Impaired control of use; or

(D) Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

(b) No substance abuse within the preceding 2 years defined as:

(1) Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;

(2) A verified positive drug test result acquired under an anti-drug program or internal program of the U.S. Department of Transportation or any other Administration within the U.S. Department of Transportation; or

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved, finds—

(i) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No other personality disorder, neurosis, or other mental condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

67.209 Neurologic.

Neurologic standards for a second-class 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;

(b) No other seizure disorder, disturbance of consciousness, or neurologic condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

67.211 Cardiovascular.

Cardiovascular standards for a second-class medical certificate are no established medical history or clinical diagnosis of any of the following:

(a) Myocardial infarction;

(b) Angina pectoris;

(c) Coronary heart disease that has required treatment or, if untreated, that

has been symptomatic or clinically significant;

(d) Cardiac valve replacement;

(e) Permanent cardiac pacemaker implantation; or

(f) Heart replacement.

67.213 General medical condition.

The general medical standards for a second-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control.

(b) No other organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.215 Discretionary issuance.

A person who does not meet the provisions of §§ 67.203 through 67.213 may apply for the discretionary issuance of a certificate under § 67.401.

Subpart D—Third-Class Airman Medical Certificate

§ 67.301 Eligibility.

To be eligible for a third-class airman medical certificate, or to remain eligible for a third-class airman medical certificate, a person must meet the requirements of this subpart.

§ 67.303 Eye.

Eye standards for a third-class airman medical certificate are:

(a) Distant visual acuity of 20/40 or better in each eye separately, with or without corrective lenses. If corrective lenses (spectacles or contact lenses) are necessary for 20/40 vision, the person may be eligible only on the condition that corrective lenses are worn while exercising the privileges of an airman certificate.

(b) Near vision of 20/40 or better, Snellen equivalent, at 16 inches in each eye separately, with or without corrective lenses.

(c) Ability to perceive those colors necessary for the safe performance of airman duties.

(d) No acute or chronic pathological condition of either eye or adnexa that interferes with the proper function of an eye, that may reasonably be expected to progress to that degree, or that may reasonably be expected to be aggravated by flying.

§ 67.305 Ear, nose, throat, and equilibrium.

Ear, nose, throat, and equilibrium standards for a third-class airman medical certificate are:

(a) The person shall demonstrate acceptable hearing by at least one of the following tests:

(1) Demonstrate an ability to hear an average conversational voice in a quiet room, using both ears, at a distance of 6 feet from the examiner, with the back turned to the examiner.

(2) Demonstrate an acceptable understanding of speech as determined by audiometric speech discrimination testing to a score of at least 70 percent obtained in one ear or in a sound field environment.

(3) Provide acceptable results of pure tone audiometric testing of unaided hearing acuity according to the following table of worst acceptable thresholds, using the calibration standards of the American National Standards Institute, 1969:

Frequency (Hz)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Better ear (Db)	35	30	30	40
Poorer ear (Db)	35	50	50	60

(b) No disease or condition of the middle or internal ear, nose, oral cavity, pharynx, or larynx that—

(1) Interferes with, or is aggravated by, flying or may reasonably be expected to do so; or

(2) Interferes with clear and effective speech communication.

(c) No disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of equilibrium.

§ 67.307 Mental.

Mental standards for a third-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of any of the following:

(1) A personality disorder that is severe enough to have repeatedly manifested itself by overt acts.

(2) A psychosis. As used in this section, "psychosis" refers to a mental disorder in which—

(i) The individual has manifested delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition; or

(ii) The individual may reasonably be expected to manifest delusions, hallucinations, grossly bizarre or disorganized behavior, or other commonly accepted symptoms of this condition.

(3) A bipolar disorder.

(4) Substance dependence, except where there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. As used in this section—

(i) "Substance" includes: alcohol; other sedatives and hypnotics; anxiolytics; opioids; central nervous system stimulants such as cocaine, amphetamines, and similarly acting sympathomimetics; hallucinogens; phencyclidine or similarly acting arylcyclohexylamines; cannabis; inhalants; and other psychoactive drugs and chemicals; and

(ii) "Substance dependence" means a condition in which a person is dependent on a substance, other than tobacco or ordinary xanthine-containing (e.g., caffeine) beverages, as evidenced by—

(A) Increased tolerance;

(B) Manifestation of withdrawal symptoms;

(C) Impaired control of use; or

(D) Continued use despite damage to physical health or impairment of social, personal, or occupational functioning.

(b) No substance abuse within the preceding 2 years defined as:

(1) Use of a substance in a situation in which that use was physically hazardous, if there has been at any other time an instance of the use of a substance also in a situation in which that use was physically hazardous;

(2) A verified positive drug test result conducted under an anti-drug rule or internal program of the U.S. Department of Transportation or any other Administration within the U.S. Department of Transportation; or

(3) Misuse of a substance that the Federal Air Surgeon, based on case history and appropriate, qualified medical judgment relating to the substance involved, finds—

(i) Makes the person unable to safely perform the duties or exercise the

privileges of the airman certificate applied for or held; or

(ii) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No other personality disorder, neurosis, or other mental condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.309 Neurologic.

Neurologic standards for a third-class 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.

(b) No other seizure disorder, disturbance of consciousness, or neurologic condition that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.311 Cardiovascular.

Cardiovascular standards for a third-class airman medical certificate are no established medical history or clinical diagnosis of any of the following:

(a) Myocardial infarction;

(b) Angina pectoris;

(c) Coronary heart disease that has required treatment or, if untreated, that has been symptomatic or clinically significant;

(d) Cardiac valve replacement;

(e) Permanent cardiac pacemaker implantation; or

(f) Heart replacement.

§ 67.313 General medical condition.

The general medical standards for a third-class airman medical certificate are:

(a) No established medical history or clinical diagnosis of diabetes mellitus that requires insulin or any other hypoglycemic drug for control.

(b) No other organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

(c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—

(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

§ 67.315 Discretionary issuance.

A person who does not meet the provisions of §§ 67.303 through 67.313 may apply for the discretionary issuance of a certificate under § 67.401.

Subpart E—Certification Procedures

§ 67.401 Special issuance of medical certificates.

(a) At the discretion of the Federal Air Surgeon, an Authorization for Special Issuance of a Medical Certificate (Authorization), valid for a specified period, may be granted to a person who does not meet the provisions of subparts B, C, or D of this part if the person shows to the satisfaction of the Federal Air Surgeon that the duties authorized by the class of medical certificate applied for can be performed without endangering public safety during the period in which the Authorization would be in force. The Federal Air Surgeon may authorize a special medical flight test, practical test, or medical evaluation for this purpose. A medical certificate of the appropriate class may be issued to a person who does not meet the provisions of subparts B, C, or D of this part if that person possesses a valid Authorization and is otherwise eligible. An airman medical certificate issued in accordance with this section shall expire no later than the end of the validity period or upon the withdrawal of the Authorization upon which it is based. At the end of its specified validity period, for grant of a new Authorization, the person must again show to the satisfaction of the Federal Air Surgeon that the duties authorized by the class of medical certificate applied for can be performed without endangering public safety during the period in which the Authorization would be in force.

(b) At the discretion of the Federal Air Surgeon, a Statement of Demonstrated Ability (SODA) may be granted, instead of an Authorization, to a person whose disqualifying condition is static or nonprogressive and who has been found capable of performing airman duties without endangering public safety. A SODA does not expire and authorizes a designated aviation medical examiner to issue a medical certificate of a specified class if the examiner finds that the condition described on its face has not adversely changed.

(c) In granting an Authorization or SODA, the Federal Air Surgeon may consider the person's operational experience and any medical facts that may affect the ability of the person to perform airman duties including—

(1) The combined effect on the person of failure to meet more than one requirement of this part; and

(2) The prognosis derived from professional consideration of all available information regarding the person.

(d) In granting an Authorization or SODA under this section, the Federal Air Surgeon specifies the class of medical certificate authorized to be issued and may do any or all of the following:

(1) Limit the duration of an Authorization;

(2) Condition the granting of a new Authorization on the results of subsequent medical tests, examinations, or evaluations;

(3) State on the Authorization or SODA, and any medical certificate based upon it, any operational limitation needed for safety; or

(4) Condition the continued effect of an Authorization or SODA, and any second- or third-class medical certificate based upon it, on compliance with a statement of functional limitations issued to the person in coordination with the Director of Flight Standards or the Director's designee.

(e) In determining whether an Authorization or SODA should be granted to an applicant for a third-class medical certificate, the Federal Air Surgeon considers the freedom of an airman, exercising the privileges of a private pilot certificate, to accept reasonable risks to his or her person and property that are not acceptable in the exercise of commercial or airline transport pilot privileges, and, at the same time, considers the need to protect the safety of persons and property in other aircraft and on the ground.

(f) An Authorization or SODA granted under the provisions of this section to a person who does not meet the applicable provisions of subparts B, C, or D of this part may be withdrawn, at the discretion of the Federal Air Surgeon, at any time if—

(1) There is adverse change in the holder's medical condition;

(2) The holder fails to comply with a statement of functional limitations or operational limitations issued as a condition of certification under this section;

(3) Public safety would be endangered by the holder's exercise of airman privileges;

(4) The holder fails to provide medical information reasonably needed by the Federal Air Surgeon for certification under this section; or

(5) The holder makes or causes to be made a statement or entry that is the basis for withdrawal of an Authorization or SODA under § 67.403.

(g) A person who has been granted an Authorization or SODA under this section based on a special medical flight or practical test need not take the test again during later physical examinations unless the Federal Air Surgeon determines or has reason to believe that the physical deficiency has or may have degraded to a degree to require another special medical flight test or practical test.

(h) The authority of the Federal Air Surgeon under this section is also exercised by the Manager, Aeromedical Certification Division, and each Regional Flight Surgeon.

(i) If an Authorization or SODA is withdrawn under paragraph (f) of this section the following procedures apply:

(1) The holder of the Authorization or SODA will be served a letter of withdrawal, stating the reason for the action;

(2) By not later than 60 days after the service of the letter of withdrawal, the holder of the Authorization or SODA may request, in writing, that the Federal Air Surgeon provide for review of the decision to withdraw. The request for review may be accompanied by supporting medical evidence;

(3) Within 60 days of receipt of a request for review, a written final decision either affirming or reversing the decision to withdraw will be issued; and

(4) A medical certificate rendered invalid pursuant to a withdrawal, in accordance with paragraph (a) of this section, shall be surrendered to the Administrator upon request.

(j) No grant of a special issuance made prior to September 16, 1996, may be used to obtain a medical certificate after the earlier of the following dates:

(1) September 16, 1997; or

(2) The date on which the holder of such special issuance is required to provide additional information to the FAA as a condition for continued medical certification.

§ 67.403 Applications, certificates, logbooks, reports, and records: Falsification, reproduction, or alteration; incorrect statements.

(a) No person may make or cause to be made—

(1) A fraudulent or intentionally false statement on any application for a medical certificate or on a request for any Authorization for Special Issuance of a Medical Certificate (Authorization) or Statement of Demonstrated Ability (SODA) under this part;

(2) A fraudulent or intentionally false entry in any logbook, record, or report that is kept, made, or used, to show compliance with any requirement for any medical certificate or for any Authorization or SODA under this part;

(3) A reproduction, for fraudulent purposes, of any medical certificate under this part; or

(4) An alteration of any medical certificate under this part.

(b) The commission by any person of an act prohibited under paragraph (a) of this section is a basis for—

(1) Suspending or revoking all airman, ground instructor, and medical certificates and ratings held by that person;

(2) Withdrawing all Authorizations or SODA's held by that person; and

(3) Denying all applications for medical certification and requests for Authorizations or SODA's.

(c) The following may serve as a basis for suspending or revoking a medical certificate; withdrawing an Authorization or SODA; or denying an application for a medical certificate or request for an authorization or SODA:

(1) An incorrect statement, upon which the FAA relied, made in support of an application for a medical certificate or request for an Authorization or SODA.

(2) An incorrect entry, upon which the FAA relied, made in any logbook, record, or report that is kept, made, or used to show compliance with any requirement for a medical certificate or an Authorization or SODA.

§ 67.405 Medical examinations: Who may give.

(a) *First-class.* Any aviation medical examiner who is specifically designated for the purpose may give the examination for the first-class medical certificate. Any interested person may obtain a list of these aviation medical examiners, in any area, from the FAA Regional Flight Surgeon of the region in which the area is located.

(b) *Second- and third-class.* Any aviation medical examiner may give the examination for the second- or third-class medical certificate. Any interested person may obtain a list of aviation medical examiners, in any area, from the FAA Regional Flight Surgeon of the region in which the area is located.

§ 67.407 Delegation of authority.

(a) The authority of the Administrator under 49 U.S.C. 44703 to issue or deny medical certificates is delegated to the Federal Air Surgeon to the extent necessary to—

(1) Examine applicants for and holders of medical certificates to determine whether they meet applicable medical standards; and

(2) Issue, renew, and deny medical certificates, and issue, renew, deny, and withdraw Authorizations for Special Issuance of a Medical Certificate and Statements of Demonstrated Ability to a person based upon meeting or failing to meet applicable medical standards.

(b) Subject to limitations in this chapter, the delegated functions of the Federal Air Surgeon to examine applicants for and holders of medical certificates for compliance with applicable medical standards and to issue, renew, and deny medical certificates are also delegated to aviation medical examiners and to authorized representatives of the Federal Air Surgeon within the FAA.

(c) The authority of the Administrator under 49 U.S.C. 44702, to reconsider the action of an aviation medical examiner is delegated to the Federal Air Surgeon; the Manager, Aeromedical Certification Division; and each Regional Flight Surgeon. Where the person does not meet the standards of §§ 67.107(b)(3) and (c), 67.109(b), 67.113(b) and (c), 67.207(b)(3) and (c), 67.209(b), 67.213(b) and (c), 67.307(b)(3) and (c), 67.309(b), or 67.313(b) and (c), any action taken under this paragraph other than by the Federal Air Surgeon is subject to

reconsideration by the Federal Air Surgeon. A certificate issued by an aviation medical examiner is considered to be affirmed as issued unless an FAA official named in this paragraph (authorized official) reverses that issuance within 60 days after the date of issuance. However, if within 60 days after the date of issuance an authorized official requests the certificate holder to submit additional medical information, an authorized official may reverse the issuance within 60 days after receipt of the requested information.

(d) The authority of the Administrator under 49 U.S.C. 44709 to re-examine any civil airman to the extent necessary to determine an airman's qualification to continue to hold an airman medical certificate, is delegated to the Federal Air Surgeon and his or her authorized representatives within the FAA.

§ 67.409 Denial of medical certificate.

(a) Any person who is denied a medical certificate by an aviation medical examiner may, within 30 days after the date of the denial, apply in writing and in duplicate to the Federal Air Surgeon, Attention: Manager, Aeromedical Certification Division, AAM–300, Federal Aviation Administration, P.O. Box 26080, Oklahoma City, Oklahoma 73126, for reconsideration of that denial. If the person does not ask for reconsideration during the 30-day period after the date of the denial, he or she is considered to have withdrawn the application for a medical certificate.

(b) The denial of a medical certificate—

(1) By an aviation medical examiner is not a denial by the Administrator under 49 U.S.C. 44703.

(2) By the Federal Air Surgeon is considered to be a denial by the Administrator under 49 U.S.C. 44703.

(3) By the Manager, Aeromedical Certification Division, or a Regional Flight Surgeon is considered to be a denial by the Administrator under 49 U.S.C. 44703 except where the person does not meet the standards of §§ 67.107(b)(3) and (c), 67.109(b), or 67.113(b) and (c); 67.207(b)(3) and (c), 67.209(b), or 67.213(b) and (c); or 67.307(b)(3) and (c), 67.309(b), or 67.313(b) and (c).

(c) Any action taken under § 67.407(c) that wholly or partly reverses the issue of a medical certificate by an aviation medical examiner is the denial of a medical certificate under paragraph (b) of this section.

(d) If the issue of a medical certificate is wholly or partly reversed by the Federal Air Surgeon; the Manager, Aeromedical Certification Division; or a Regional Flight Surgeon, the person holding that certificate shall surrender it, upon request of the FAA.

§ 67.411 Medical certificates by flight surgeons of Armed Forces.

(a) The FAA has designated flight surgeons of the Armed Forces on specified military posts, stations, and facilities, as aviation medical examiners.

(b) An aviation medical examiner described in paragraph (a) of this section may give physical examinations for the FAA medical certificates to persons who are on active duty or who are, under Department of Defense medical programs, eligible for FAA medical certification as civil airmen. In addition, such an examiner may issue or deny an appropriate FAA medical certificate in accordance with the regulations of this chapter and the policies of the FAA.

(c) Any interested person may obtain a list of the military posts, stations, and facilities at which a flight surgeon has been designated as an aviation medical examiner from the Surgeon General of the Armed Force concerned or from the Manager, Aeromedical Education Division, AAM–400, Federal Aviation Administration, P.O. Box 26082, Oklahoma City, Oklahoma 73125.

§ 67.413 Medical records.

(a) Whenever the Administrator finds that additional medical information or history is necessary to determine whether an applicant for or the holder of a medical certificate meets the medical standards for it, the Administrator requests that person to furnish that information or to authorize any clinic, hospital, physician, or other person to release to the Administrator all available information or records concerning that history. If the applicant or holder fails to provide the requested medical information or history or to authorize the release so requested, the Administrator may suspend, modify, or revoke all medical certificates the airman holds or may, in the case of an applicant, deny the application for an airman medical certificate.

(b) If an airman medical certificate is suspended or modified under paragraph (a) of this section, that suspension or modification remains in effect until the requested information, history, or authorization is provided to the FAA and until the Federal Air Surgeon determines whether the person meets the medical standards under this part.

§ 67.415 Return of medical certificate after suspension or revocation.

The holder of any medical certificate issued under this part that is suspended or revoked shall, upon the Administrator's request, return it to the Administrator.

Issued in Washington, D.C. on March 12, 1996.

David R. Hinson,

Administrator.

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