[ORAL ARGUMENT NOT YET SCHEDULED]

No. 17-5267

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

JANE DOE et al.,

Plaintiffs-Appellees,

v.

DONALD J. TRUMP et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia, No. 17-cv-1597
Before the Honorable Judge Colleen Kollar-Kotelly

PLAINTIFFS-APPELLEES' OPPOSITION TO DEFENDANTS-APPELLANTS' EMERGENCY MOTION FOR ADMINISTRATIVE STAY AND PARTIAL STAY PENDING APPEAL

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INTRODUCTION

The government failed before the district court to carry its heavy burden of justifying a stay of the court's preliminary injunction against the bar on accession of transgender people into military service. The government's motion before this Court reprises the same unpersuasive arguments, and should likewise be rejected.

The Secretary of Defense determined in June 2016 that the military would no longer categorically ban accession by transgender people, effective July 1, 2017. The Secretary ordered the Department of Defense ("DOD") and the military departments to prepare for the accession of transgender people as of that date. DOD immediately began taking the necessary steps—including training relevant personnel—to prepare to implement the new policy by July 1, 2017, substantially completing its preparations well before that date. In addition, because Secretary Mattis extended the deadline to January 1, 2018, the government has had nearly six additional months to prepare.

As the district court correctly found, the government cannot credibly claim that it will be irreparably harmed by implementing a policy that it was on track to implement six months ago. Yet a stay of the injunction would inflict serious irreparable harms on Plaintiffs. Allowing the military to exclude transgender people from accession while this case proceeds would subject all Plaintiffs, including those who are currently serving, to irreparable constitutional and other

harms by "brand[ing] and stigmatiz[ing] Plaintiffs as less capable of serving in the military [and by] reduc[ing] their stature among their peers and officers." Add.84. It would affect Plaintiff Regan Kibby even more directly, preventing him from completing his final two years at the Naval Academy. Similarly, Plaintiff Dylan Kohere would remain unable to enroll in ROTC.

Nor has the government shown it is likely to succeed on the merits of its appeal. The facially discriminatory ban on accession and service by transgender people serves no governmental interest sufficient to satisfy the Fifth Amendment, and the district court's injunction barring its enforcement is both the ordinary remedy for unconstitutional government action and the only order that would grant Plaintiffs full relief. The public interest likewise lies in denying a stay and keeping the injunction in place. The military itself has concluded that barring transgender people from service harms the Armed Forces. And the public interest would be disserved by allowing an unconstitutionally discriminatory ban to take effect.

Finally, the government's delay in seeking a stay undermines its arguments. The district court issued the preliminary injunction on October 30, 2017. If the government was concerned that complying with that order would be unduly burdensome, it could and should have moved for a stay immediately. Its delay in doing so strongly suggests that the government's claims of harm should not be credited. The government's motion should be denied.

BACKGROUND

1. Following the 2010 repeal of a federal statute that barred military service by openly gay individuals, military leaders recognized that the Armed Forces also had valuable members who were transgender, many of whom had specialized skills and training. SA42-43; SA70.[1] As former Army Secretary Eric Fanning explained, "[p]articularly among commanders in the field, there was an increasing awareness that there were already capable, experienced transgender service members in every branch, including on active deployment on missions around the world." SA43.

In July 2015, Secretary of Defense Ashton Carter ordered that a Working Group be convened to review and study military service by transgender individuals and to formulate recommendations for future policy. SA22. The Working Group had approximately 25 members, including a senior uniformed officer and a senior civilian official from each service branch; representatives of the Surgeons General for each branch of service also participated. *Id*. The Working Group reported to senior DOD personnel at meetings attended by the Joint Chiefs of Staff, the Chairman, the Vice Chairman, the Service Secretaries, the Secretary of Defense, and the Assistant Secretary of Defense. SA111.

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[1] Citations prefixed with SA refer to Plaintiffs-Appellees' Supplemental Addendum.

The Working Group "consider[ed] all available … evidence, … to thoroughly investigate any possible issue or concerns about how permitting open service might affect any aspect of military efficiency or readiness." SA71. "The goal was to ensure that the input of the Services would be fully considered before any changes in policy were made and that the Services were on board with those changes." SA109. The Group consulted with medical, personnel, and readiness experts; senior military personnel who supervised transgender servicemembers; and transgender servicemembers on active duty. SA23; SA71-72. The Group also commissioned the RAND Corporation's National Defense Research Institute to study the impact of permitting transgender servicemembers to serve and enlist openly. SA23-25; Add.19.

Based on its investigation, the Working Group concluded that barring transgender people from military service undermined military effectiveness and readiness. Exclusion required "the discharge of highly trained and experienced servicemembers, leaving unexpected vacancies in operational units and requiring the expensive and time-consuming recruitment and training of replacement personnel." SA26-27. The Working Group found that the short periods of non-deployability that some transgender servicemembers might experience as a result of gender transition-related treatments would be negligible, especially when compared to the non-deployability associated with medical conditions the military

does not consider disqualifying, like pregnancy and appendicitis, SA25-26; SA128-129. The Group also found that related medical costs would comprise an "exceedingly small" share of DOD health expenditures. Add.19; SA117 (military leaders considered financial impact to be "budget dust").

With respect to accession, the Working Group concluded that "barring service by transgender people reduces the pool of potential qualified recruits … based on a characteristic that has no relevance to their ability to serve." SA74. The accession policy recommended by the Working Group evaluates transgender applicants based on "the same standards applied to persons with other medical conditions, which seek to ensure that those entering service are free of medical conditions or physical defects that may require excessive lost time from duty." SA47. By contrast, the military's previous policy treated transgender people anomalously and irrationally by excluding them from service based on a treatable condition that only some transgender people experience, even while non-transgender people with other treatable conditions were not categorically barred from service. SA8-9. As a result, unlike people with other treatable conditions, transgender individuals were excluded from service even if they were mentally and physically healthy and capable of serving. SA7-8.

Based on the Working Group's research and conclusions, on June 30, 2016, Secretary Carter issued Directive-Type Memorandum 16-005 ("DTM 16-005"),

which set forth the policy "that service in the United States military should be open to all who can meet the rigorous standards for military service and readiness," and that, "[c]onsistent with the policies and procedures set forth in this memorandum, transgender individuals shall be allowed to serve in the military." Add.98. With respect to accession, DTM 16-005 required that, no later than July 1, 2017, medical standards be updated to prevent disqualification from enlistment based solely on an individual's transgender status. Add.100. The standards require a licensed medical provider to certify that the applicant has completed gender transition and has been stable in the newly assigned gender for 18 months. *See* Add.100-101; SA9; SA17-18.

Those criteria are comparable to accession criteria for other treatable medical conditions on which Military Entrance Processing Stations ("MEPS") personnel are regularly trained. SA17-18; SA66; SA89; Add.119. The criteria for assessing transgender applicants are "straightforward and do not require extensive or detailed knowledge." SA18. Relevant military personnel routinely review diagnoses, confirm time periods of stability, and assess functionality for people with a wide range of medical conditions. SA8-9.[2] The accession policy for

[2] DOD guidance sets forth an extensive list of medical conditions and associated criteria that must be met for enlistment. *See generally* SA143-183. For example, individuals with polycystic ovarian syndrome may enlist if they do not experience metabolic complications, but may not if they do. SA158. People with a history of asthma meet enlistment criteria if they have been stable for a 3-year

transgender candidates "does not involve any unique complexities or burdens and is well within the capacity of military personnel involved in the enlistment review process." SA18.

Military leaders who oversaw the first six months of training throughout the service branches confirmed that the military was on track for accession of transgender personnel to begin by July 1, 2017, the initial target date. SA65-67; SA88-90; Add.119-120. Indeed, nearly a quarter of the 1,045 MEPS personnel cited by Defendants as in need of "in-depth knowledge of the [accession] standards" (Add.106) were trained in the accession policy on a single day in May 2017. SA17. The military received an additional six months to prepare for the new accession policy on June 30, 2017, when Secretary Mattis deferred its effective date to January 1, 2018. Add.96.

On July 26, 2017, President Trump announced via Twitter that the government "will not accept or allow transgender individuals to serve in any capacity in the U.S. military." Add.25. On August 25, 2017, the President directed the Secretaries of Defense and Homeland Security to prohibit accession of transgender people into the military past January 1, 2018. Add.91. That directive

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period—with no need of medication or acute medical care—and meet threshold tests for lung function. SA150. Individuals with cleft palate defects may enlist as long as surgical repair results in the ability to drink through a straw. SA148.

also reinstated, effective March 23, 2017, the pre-June 2016 rules barring transgender people from serving in the Armed Forces, thereby rendering current transgender servicemembers subject to discharge as of that date. Add.90-91.

2. On October 30, 2017, the district court enjoined the President's ban with respect to both the accession and retention of transgender people. Plaintiffs, five active-duty transgender servicemembers and two transgender students pursuing military careers, brought this action challenging the accession and retention bans on equal protection grounds, among others. Particularly relevant here, Plaintiff Regan Kibby is a midshipman at the United States Naval Academy. SA91. He may not remain enrolled at the Academy unless he is eligible for accession. SA98. Under the accession ban, he is not, *id.*, and the government has provided no assurances that he will be permitted to continue his education if the ban goes into effect. Plaintiff Dylan Kohere wishes to participate in ROTC but cannot enroll as a cadet in light of the accession ban. Add.115.

Having concluded that the accession and retention bans are likely unconstitutional and will irreparably harm Plaintiffs without a preliminary injunction, the district court enjoined their enforcement and required Defendants to "revert to the status quo" that existed before the President's directive, under which, as relevant here, the military would start to allow accession by transgender individuals on January 1, 2018. Add.11; Add.89. The government did not file a

notice of appeal until November 21, sought "clarification" from the district court about the injunction on November 22, and after that "clarification" was provided on November 27, waited further until December 6 to request a stay from the district court. Having waited five weeks before even seeking a stay from the district court, which was denied, the government has now filed an "emergency" motion with this Court.

3. On December 11—the same day the district court denied the government's stay motion—DOD issued a press release stating that "it *will begin* processing transgender applicants for military service on January 1, 2018," and that "[t]his policy *will be implemented* while the Department of Justice appeals" the relevant court orders. SA133 (emphasis added).

ARGUMENT

A stay pending appeal is available "only under extraordinary circumstances," and the "district court's conclusion that a stay is unwarranted is entitled to considerable deference." *Ruckelshaus v. Monsanto Co.*, 463 U.S. 1315, 1316 (1983) (Blackmun, J., in chambers). The government has not carried its "'heavy burden'" to justify such relief here, *id.*, as (1) it has not "made a strong showing that [it] is likely to succeed" in challenging the injunction on appeal; (2) it will not "be irreparably injured absent a stay"; (3) a stay would injure all Plaintiffs

and, in particular, Plaintiffs Kibby and Kohere; and (4) a stay is not in the public interest. *See Nken* v. *Holder*, 556 U.S. 418, 434 (2009).

I. THE GOVERNMENT IS UNLIKELY TO SUCCEED IN CHALLENGING THE PRELIMINARY INJUNCTION

The government argues that it is likely to succeed in reversing or narrowing the injunction on appeal because the district court purportedly disregarded Secretary Mattis's "independent discretion" to defer the January 1 deadline, entered a nationwide injunction rather than limiting relief to the Plaintiffs, and misapplied the relevant law. The district court carefully considered and rejected each of those arguments. Nothing in the government's application justifies revisiting or reversing those conclusions.

A. Secretary Mattis Has No Independent Authority To Defer Accession Of Transgender People Beyond January 1

Secretary Mattis is bound by the district court's injunction. As the district court explained, "[t]he President controls the United States military," and "[t]he directives of the Presidential Memorandum, to the extent they are definitive, are the operative policy toward military service by transgender service members." Add.45. The Presidential Memorandum mandates that the Secretary "*shall* … maintain the currently effective policy [banning] accession of transgender individuals into military service beyond January 1, 2018." Add.90 (emphasis added). Having concluded that the ban was likely unconstitutional, the district

court properly enjoined *all* Defendants—including the Secretary—from taking steps to effectuate it, regardless of the authority under which they purport to operate.

In addition, the government's explanation for *why* Secretary Mattis seeks to delay the accession policy—to "study the issue further" (Mot. 8)—makes clear that any delay is not, in fact, being sought as an independent exercise of the Secretary's judgement. The study to which the government's argument refers is precisely the same study that Defendants unsuccessfully argued justified the indefinite delay of the accession policy in the first instance. Add.44-49; *see* Add.5-6. Defendants should not be allowed to circumvent the district court's order in this manner. In any event, the government offers no explanation why the Secretary's discretion to indefinitely extend the bar on accession would be any less offensive to the Constitution than the accession ban itself.

B. The Injunction Is Not Overbroad

Nor is the injunction barring enforcement of the accession ban overbroad. In "most civil-rights cases," plaintiffs seek "injunctive or declaratory relief that will halt a discriminatory … practice" or "strike down … a rule … on the ground that it is constitutionally offensive"—relief that "benefit[s] all other persons subject to the practice or the rule." 7A Wright & Miller, *Federal Practice & Procedure* § 1771 (3d ed. 2017). Thus, the "ordinary result" when a policy is held facially invalid is

to enjoin it in its entirety, not merely its application to the plaintiff. *National Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998); *see also, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2307 (2016) (affirming injunction against state law based on claims by abortion providers); *Citizens United v. FEC*, 558 U.S. 310, 331 (2010) (explaining that distinction between facial and as-applied challenges "goes to the breadth of the remedy" that is "necessary to resolve a claim"); *Kolender v. Lawson*, 461 U.S. 352, 353-354 (1983) (affirming injunction against state loitering statute in challenge brought by single individual); *Wrenn v. District of Columbia*, 864 F.3d 650, 667 (D.C. Cir. 2017) (injunction against D.C. gun law based on claims by individual plaintiffs denied gun licenses); *Lederman v. United States*, 291 F.3d 36, 48 (D.C. Cir. 2002) (remanding for entry of injunction barring enforcement of demonstration ban based on claim by individual).

All of the Plaintiffs in this case challenge both the accession and retention bans, which function together to exclude transgender individuals from military service based solely on their transgender status. And all Plaintiffs, including those currently serving, are injured by the continuation of a ban on accession that singles out transgender individuals as a class and derogates the service of *all* transgender people. The scope of the injunction is necessary to redress the "nature and extent" of that constitutional violation. *Hills v. Gautreaux*, 425 U.S. 284, 294 (1976).

C. The Government's Other Arguments Are Unavailing

1. Plaintiffs Have Standing To Challenge The Accession Ban

The government's contention that the harms to Plaintiffs Kibby and Kohere are too remote to establish an injury-in-fact is meritless. *First*, although Kibby will not be eligible to commission into service until he graduates from the Naval Academy in May 2020, and Kohere (who wishes to participate in ROTC) will not graduate from college until Spring 2021, both face *immediate* harms from the accession ban. To remain enrolled at the Naval Academy, Kibby must be eligible for accession, and the government has provided no assurances that he will be permitted to continue his education there if the ban is extended beyond January 1, 2018. SA98. Likewise, as Defendants admit, the ban prevents Kohere from enrolling *now* as a cadet in ROTC. Add.115; SA104.

Second, there is nothing "attenuated" (Mot. 12) about the future harm a ban on accession inflicts on these Plaintiffs. As the district court correctly found based on an extensive record, Kibby "is substantially likely to attempt to accede, and to encounter a competitive barrier at the time of his accession due to his status as a transgender individual." Add.58. The same applies to Kohere, who seeks to enroll in ROTC in order to pursue a military career. SA101.[3] Both thus have standing to

[3] Because the presence of one party with standing is sufficient to satisfy the requirements of Article III, the district court did not separately analyze Kohere's standing to challenge the accession ban. Add.57 n.6.

challenge the accession ban given the substantial risk it creates that they will be denied entrance into the military. *See Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 718-719 (2007) (parents "whose elementary and middle school children may be denied admission to the high schools of their choice when they apply for those schools in the future" had standing to challenge race-based admission policies, notwithstanding the possibility that the "children … will not be denied admission to a school based on their race").

Finally, the ban on accession "brands and stigmatizes [all] Plaintiffs as less capable of serving in the military." Add.84. Those constitutional and stigmatic harms are not "abstract" (Mot. 16) but direct and personal injuries to Plaintiffs currently serving as well as those seeking to serve. *See infra* pp.21-22; SA32-38; SA62-63; SA85-86.

2. The Ban Cannot Withstand Heightened Scrutiny

The district court was "convinced" (Add.69) that Plaintiffs are likely to succeed on their claim the accession ban violates the Fifth Amendment's guarantee of equal protection based on "a number of factors—including the sheer breadth of the exclusion ordered by the [ban], the unusual circumstances surrounding the President's announcement of [it], the fact that the reasons given for [it] do not appear to be supported by any facts, and the recent rejection of those reasons by

the military itself." Add.14; *see* Add.7. The government fails to show that the district court erred in any of these conclusions, much less all of them.

The government does not seriously dispute that heightened scrutiny applies to discrimination against transgender individuals. Nor could it: Transgender people satisfy all the criteria of a suspect or quasi-suspect class, Add.70-72, and such discrimination is "inextricably intertwined with gender classifications" and "inherently discriminates" based on a person's "failure to conform to gender stereotypes," *id*. at 73-74. The district court's conclusion in this regard is amply supported by a wall of recent authority.[4]

Rather, the government urges deference to the President's ban simply because this case involves the military. But as this Court held thirty years ago, "[t]he military has not been exempted from constitutional provisions that protect the rights of individuals." *Emory v. Secretary of Navy*, 819 F.2d 291, 294 (D.C.

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[4] *See Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1320-1321 (11th Cir. 2011); *Smith v. City of Salem*, 378 F.3d 566, 572-575 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215-216 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d 1187, 1200-1203 (9th Cir. 2000); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 140 (S.D.N.Y. 2015); *Board of Educ. of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 872-874 (S.D. Ohio 2016). The government cites (at 19) one decade-old, out-of-circuit decision, but that case undertook no serious analysis of equal protection and assumed without deciding that a sex-stereotyping theory *could* apply under Title VII.

Cir. 1987). Moreover, as the district court explained, the cases the government relies on are inapplicable here because, among other things, the "study and evaluation of evidence that … warranted judicial deference is completely absent from the current record." Add.81. To the contrary, before adopting the policy that President Trump abruptly reversed, the military carefully studied the issue of service by transgender people and determined that military readiness and effectiveness strongly favored *allowing* accession and continued service by qualified transgender individuals. Add.18-19, 78.[5] In the face of that meticulous examination and long-term planning, the President's unjustified turnabout can be explained only by "negative attitudes," "fear," and an "instinctive … guard[ing] against people who appear to be different … from ourselves"—which cannot survive *any* level of review. *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 448 (1985); *Board of Trustees of Univ. of Alabama v. Garrett*, 531 U.S. 356, 374 (2001) (Kennedy, J., concurring).[6]

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[5] The government attempts to marshal a justification for the ban from the RAND Report (Mot. 18-19)—a proffer it never made below, and with good reason. As the district court recounted in detail, the Report "largely debunk[ed] any potential concerns about unit cohesion, military readiness, deployability or health care costs related to transgender military service," and the military concluded from the study that a continued ban "would *undermine*" rather than advance "military effectiveness and readiness." Add.78 (emphasis added).

[6] The government tries to recast Plaintiffs' equal protection claim as a "disagree[ment] with where the military 'has drawn the line.'" Mot. 19. But there is a stark difference—not mere line-drawing—between barring transgender

II. DEFENDANTS WILL NOT BE IRREPARABLY HARMED BY COMPLYING WITH THE JANUARY 1 DATE FOR NONDISCRIMINATORY ACCESSION

Defendants claim they are unprepared to implement a nondiscriminatory accession policy adopted in June 2016 and thus will be irreparably harmed by being required to do so by January 1, 2018. But, as the district court found, that claim is not credible and cannot carry the government's heavy burden here.

First, the government's professed need for more time to prepare for accession is contradicted by the record. Defendants have had nearly 18 months to prepare for transgender people to join the military. *See supra* pp.5-7. The testimony of the former service secretaries, as well as a psychiatrist personally involved in training military personnel, is that the military was actively working to meet its July 1, 2017 deadline and had substantially prepared to do so by the end of 2016. SA17; SA67; SA89; Add.120. The government offers no reason why the military would not have been prepared to implement the new accession policy by that date—much less by January 1, 2018, six months later.

Recent public statements by DOD also contradict Defendants' assertion that the military is not ready to implement the accession policy on January 1. As recently as December 11—the same day the district court denied the government's

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individuals from *ever* serving in the military and permitting qualified transgender individuals to access. Moreover, contrary to the government's suggestion, there is no evidence of waivers having ever been granted for accession by transgender individuals. Add.16-17.

stay motion—DOD issued a press release stating that "it will begin processing transgender applicants for military service on January 1, 2018," and that "[t]his policy will be implemented while the Department of Justice appeals" the relevant court orders. SA133.

Second, Defendants' complaint that additional time is needed because accession screening for transgender individuals involves "'a complex medical condition'" (Mot. 14-15) is equally unpersuasive. Gender dysphoria is no more complex than many other medical conditions for which the military already screens applicants to determine whether they can serve, based on criteria related to the treatment, stability, or severity of the condition. *See supra* p.6 n.2; SA8-9; SA18; SA131.

DTM 16-005 requires that transgender individuals obtain "certifi[cation] by a licensed medical provider" that their transition is complete and that they have been stable for 18 months in their "preferred gender," with no "clinically significant distress or impairment in social, occupational, or other important areas of functioning," and since any surgery. Add.100; SA9. Contrary to the statements of the government's declarant, *see* Add.107 (arguing that accession standards are "complex" and require "multifaceted review of applicant's medical history"), these criteria are "straightforward," "do not require extensive or detailed knowledge," and are "well within the capacity of military personnel involved in the enlistment

review process" to apply, SA18; *see also* SA66 (screening required for transgender applicants relies on "preexisting, well-understood procedures, rather than carving out any new process specifically designed for accessions of [transgender] individuals").

Third, Defendants' claim that a stay is warranted because otherwise some transgender individuals may not be "'physically or psychologically equipped'" to serve (Mot. 15) is unfounded. As the district court explained, such concerns "could be raised about *any* service members" and do not explain the need to "deny accession to *all* transgender people who meet the relevant physical, mental and medical standards for service." Add.77. The accession policy ensures that applicants with a history of gender dysphoria meet the same medical standards applied to all others. Add.100; SA18. In light of that policy, Defendants' professed concern that "'some' transgender individuals 'could' suffer from medical conditions that impede their duties" "appear … to be based on unsupported, 'overbroad generalizations about the different talents, capacities, or preferences' of transgender people." Add.76-77.

Fourth, Defendants argue that allowing accession of transgender individuals starting on January 1, 2018 would result in "'duplicative' implementation costs" because the military might "execute a new policy" or "return to the old one" depending on the outcome of its study and this appeal. Mot. 15. Defendants do

not suggest, however, that any new accession policy would differ materially from the ban the President already directed and the district court enjoined. In any event, "speculative assertions" that Defendants' review *might* result in a new policy that *might* pass constitutional muster cannot be used to substantiate a claim of irreparable harm. *See Toxco Inc. v. Chu*, 724 F. Supp. 2d 16, 30 (D.D.C. 2010) (rejecting speculation as basis for establishing irreparable harm).

Finally, as the district court found, "Defendants' portrayal of their situation as an emergency is belied by their litigation tactics." Add.9. Had they truly been concerned that complying with a preliminary injunction issued on October 30, 2017 would be impossible on January 1, 2018, Defendants could and should have appealed and sought a stay immediately. The fact that they did neither strongly suggests that their assertions about burden and lack of preparedness should not be credited. *Ruckelshaus*, 463 U.S. at 1317-1318. Having waited to seek a stay of the injunction, Defendants can hardly claim now that they face an impossible task in meeting a deadline they have known about all that time and had been working to meet for over a year before the President's announcement.

III. PLAINTIFFS WILL BE HARMED BY A STAY OF THE INJUNCTION

The equities strongly favor Plaintiffs. The government, in trying to tip the balance, focuses exclusively on the accession plans of Kibby and Kohere, and disregards both the immediate harms to those Plaintiffs' education and the

irreparable constitutional and stigmatic harms that all Plaintiffs, including those currently serving, will suffer from a stay of the district court's injunction. As already explained, Kibby and Kohere—who are personally subject to the accession ban—will face the irreparable loss of educational opportunities available through the Naval Academy and ROTC. *See supra* pp.8, 13-14; Add.84. The government does not dispute Kibby's ineligibility to return to the Naval Academy while the accession ban is in place. SA98; Add.120. And Defendants *admit* that the ban prevents Kohere from enrolling as a cadet in his university's ROTC program. Add.115. Those serious and irreparable harms weigh heavily against granting a stay.

Moreover, as the district court held, "[t]he impending ban" on both the accession and retention of transgender individuals "brands and stigmatizes Plaintiffs as less capable of serving in the military, reduces their stature among their peers and officers, stunts the growth of their careers, and threatens to derail their chosen calling or access to unique educational opportunities." Add.84. Those harms flow just as much from the ban on accession as retention: An accession ban sends a clear message that transgender servicemembers are inferior and that their presence in the military will soon end.

These are not "abstract" injuries that ought to be ignored for purposes of this stay motion. Mot. 16. Rather, the record before the district court was replete with

evidence from Plaintiffs themselves, as well as the former service secretaries and military experts, explaining the concrete, negative effects the ban has on Plaintiffs and other transgender servicemembers. *E.g.*, SA32-38; SA62-63; SA85-86. These "serious ongoing harms," including "irreparable" injuries from the likely "violations of Plaintiffs' rights to equal protection," outweigh the government's "bare invocation of 'national defense,'" with "absolutely no support" in the record. Add.83-84; *see Faulkner v. Jones*, 10 F.3d 226, 229-230 (4th Cir. 1993) (affirming district court's weighing of constitutional injuries to female applicant from denial of access to all-male cadet corps against at most minimal injury to military college).

IV. A STAY IS NOT IN THE PUBLIC INTEREST

Lastly, Defendants argue that implementing the nondiscriminatory accession policy on January 1 is against the public interest because it will harm the public fisc and national defense. As already discussed, these claims of harm are unsupported. *See supra* pp.17-20. And the government notably does *not* contend that any harm would result from enlisting qualified transgender people. Indeed, as the military previously concluded, any harm to the public is more likely to come from delaying the accession of capable and committed transgender people who are ready to serve—just as those before them have served for years. Add.86 ("[T]here is absolutely no support for the claim that the ongoing service of transgender

people would have *any* negative effect on the military at all. In fact, there is considerable evidence that it is the *discharge* and *banning* of such individuals that would have such effects."). A stay, moreover, would prolong the accession ban's violation of constitutional rights—which "is always contrary to the public interest." *Gordon v. Holder*, 721 F.3d 638, 653 (D.C. Cir. 2013) ("'[T]he Constitution is the ultimate expression of the public interest.'"). The public interest thus unequivocally lies in keeping the injunction in place.

CONCLUSION

The motion for a partial stay should be denied.

Respectfully submitted.

/s/ Paul R.Q. Wolfson

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December 15, 2017

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g)(1), the undersigned hereby certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(f), the brief contains 5,185 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word 2016 in 14-point Times New Roman font. As permitted by Fed. R. App. P. 32(g)(1), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

/s/ Paul R.Q. Wolfson
PAUL R.Q. WOLFSON

December 15, 2017

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiffs-Appellees are Dylan Kohere, Regan V. Kibby, and six pseudonym plaintiffs (Jane Doe 1, Jane Doe 2, Jane Doe 3, Jane Doe 4, Jane Doe 5, and John Doe 1).

Defendants-Appellants are the Defense Health Agency; the United States Coast Guard; the United States Department of the Air Force; the United States Department of the Army; the United States Department of the Navy; the United States of America; Donald J. Trump, in his official capacity as President of the United States; Kirstjen Nielsen, in her official capacity as Secretary of Homeland Security; Heather A. Wilson, in her official capacity as Secretary of the Air Force; James N. Mattis, in his official capacity as Secretary of Defense; Joseph F. Dunford, Jr., in his official capacity as Chairman of the Joint Chiefs of Staff; Raquel C. Bono, in her official capacity as Director of the Defense Health Agency; Richard V. Spencer, in his official capacity as Secretary of the Navy; and Mark T. Esper, in his official capacity as Secretary of the Army.

The following states, as well as the District of Columbia, participated in the district court as amici curiae in support of Plaintiffs: Massachusetts, California,

Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, and Vermont.

The following organizations participated as amici curiae in the district court in support of Plaintiffs: American Academy of Family Physicians, American Academy of Nursing, American College of Physicians, American Medical Women's Association, American Nurses Association, Association of Medical School Pediatric Department Chairs, Endocrine Society, GLMA: Health Professionals Advancing LGBT Equality, National Association of Social Workers, Pediatric Endocrine Society, World Professional Association for Transgender Health, Trevor Project, National Center for Transgender Equality, Tennessee Transgender Political Coalition, TGI Network of Rhode Island, Transgender Allies Group, Transgender Legal Defense & Education Fund, TransOhio, Transgender Resource Center of New Mexico, and Southern Arizona Gender Alliance.[*]

B. Rulings Under Review

Defendants-Appellants' motion for a stay of the preliminary injunction pending appeal does not directly seek review of a decision of the District Court. The motion contemplates, however, an appeal of the October 30, 2017 decision of Judge Colleen Kollar-Kotelly regarding Plaintiffs' application for a preliminary

[*] The district court granted leave to amici curiae to participate when it issued the preliminary injunction on October 30, 2017. *See* Add.71 n.8.

injunction and Defendants' motion to dismiss. ECF Nos. 60, 61 (reproduced in Appellants' addendum at pp. 10-89). The motion also raises issues substantially similar to those addressed in a December 11, 2017 order issued by Judge Kollar-Kotelly denying a stay. ECF No. 75 (reproduced in Appellants' addendum at pp. 1-9).

C. Related Cases

The instant motion is the first time this case has come before this Court. A preliminary injunction barring enforcement of the same government policy has been issued against substantially similar defendants in *Stone v. Trump*, No. 17-2459 (D. Md. Nov. 21, 2017), ECF No. 85, and a notice of appeal has been filed with the Fourth Circuit, No. 17-2398 (4th Cir.). A similar preliminary injunction has also been entered in *Karnoski v. Trump*, No. 17-1297, (W.D. Wash. Dec. 11, 2017), ECF No. 103, and a notice of appeal has been filed with the Ninth Circuit, which has not yet assigned a case number for the appeal.

/s/ Paul R.Q. Wolfson
PAUL R.Q. WOLFSON

December 15, 2017

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**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, George R. Brown, declare as follows:

1. I make this declaration based on my own personal knowledge.

PROFESSIONAL BACKGROUND

2. I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman, contributing to administrative, teaching, and research missions of the Department of Psychiatry, consulting on clinical cases at the University and at Mountain Home Veterans Health Administration ("VHA") Medical Center, where I also hold an appointment, and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves research, teaching, and consulting about transgender health in military and civilian populations.

3. I also hold a teaching appointment related to my expertise with transgender healthcare and research at the University of North Texas Health Services Center ("UNTHSC"). My

responsibilities include teaching and consultation with UNTHSC and the Federal Bureau of Prisons staff regarding transgender health issues.

4. I graduated from the University of Rochester in Rochester, New York in 1979 Summa Cum Laude with a double major in biology and geology. I earned my Doctor of Medicine degree with Honors from the University of Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at the United States Air Force Medical Center at Wright-Patterson Air Force Base in Ohio. From 1984-1987, I worked in and completed the United States Air Force Integrated Residency Program in Psychiatry at Wright State University and Wright-Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

5. I began seeing patients in 1983, and I have been a practicing psychiatrist since 1987 when I completed my residency. Over the last 33 years, I have evaluated, treated, and/or conducted research with between 600 and 1000 individuals with gender disorders in person, and over 5100 patients with Gender Dysphoria during the course of research-related chart reviews. The vast majority of those patients have been active duty military personnel or veterans.

6. For three decades, my research and clinical practice has included extensive study of transgender health and care of transgender individuals, including three of the largest studies focused on the health-care needs of transgender service members and veterans. Throughout that time, I have done research with, taught on, and published peer-reviewed professional publications specifically addressing the needs of transgender military service members. *See* Brown Ex. A (CV).

7. I have authored or coauthored 38 papers in peer-reviewed journals and 19 book chapters on topics related to Gender Dysphoria and transgender healthcare, including the chapter

on Gender Dysphoria in Treatments of Psychiatric Disorders (3d ed. 2001), a definitive medical text published by the American Psychiatric Association.

8. In 2014, I coauthored a study along with former Surgeon General Joycelyn Elders and other military health experts, including a retired General and a retired Admiral, entitled "Medical Aspects of Transgender Military Service." Elders J, Brown GR, Coleman E, Kolditz TA, *Medical Aspects of Transgender Military Service*. Armed Forces and Society, 41(2): 199-220, 2015; published online ahead of print, DOI: 10.1177/0095327X14545625 (Aug. 2014) ("2014 Report"). The study was published in the military peer-reviewed journal, Armed Forces and Society. A true and correct copy of that report is attached hereto as Exhibit B.

9. I have served for more than fifteen years on the Board of Directors of the World Professional Association for Transgender Health ("WPATH"), the leading international organization focused on transgender health care. WPATH has over 2,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of Gender Dysphoria.

10. I was a member of the WPATH committee that authored Version 7 of the Standards of Care, published in 2011, which is the current version, and I am on the committee to revise the Standards of Care (Version 8).

11. I have been an active member of WPATH since 1987 without interruption and I have presented original research work on topics relating to Gender Dysphoria and the clinical treatment of transgender people nationally and internationally frequently over the past 3 decades. I have testified or otherwise served as an expert on transgender health issues in cases heard by numerous federal district courts and a federal tax court. I have provided and continue to provide

trainings on transgender health issues for the VHA as well as throughout the Department of Defense.

12. After the Department of Defense announced the change in policy towards transgender servicemembers in 2016, I conducted the first two large military trainings on the provision of health care to transgender service members. The first was for the Marine Corp in the spring of 2016. The second was for a tri-service meeting of several hundred active duty military clinicians and commanders in the fall of 2016. Since the issuance of Department of Defense Instruction 1300.28 in October 2016, which, among other things, implemented the policies and procedures in Directive-type Memorandum 16-005 and established a construct by which transgender service members may transition gender while serving, I have also conducted trainings for a national group of military examiners (MEPSCOM) and for Army clinicians at Fort Knox, Kentucky. I have been centrally involved in the development, writing, and review of all national directives in the VHA relating to the provision of transgender health care for veterans. Finally, I coauthored the national formulary that lists the medications provided by the VHA for the treatment of Gender Dysphoria in veterans.

GENDER DYSPHORIA

13. The term "transgender" is a term used to describe someone who experiences any significant degree of misalignment between their gender identity and their assigned sex at birth.

14. Gender identity describes a person's internalized, felt sense of who they are as male or female. For most people, their gender identity is consistent with their assigned birth sex. Most individuals assigned female at birth, grow up, develop, and manifest a gender identity typically associated with girls and women. Most individuals assigned male at birth, grow up, develop, and manifest a gender identity typically associated with boys and men. For transgender

people, that is not the case. Transgender women are individuals assigned male at birth who have a persistent gender identification associated with female identity. Transgender men are individuals assigned female at birth who have a persistent gender identification associated with male identity.

15. Experts agree that gender identity has a major biological component. Experts also agree that gender identity is set early in life, is deep-seated, and impervious to external influences. Gender identity is often referred to as a person's brain sex. This is, in part, because studies focused on determining the origins of a person's gender identity have shown that the human brain is significantly influenced by exposure to hormone levels before birth. Brain studies that correlate brain patterns of transgender individuals with non-transgender individuals who have the same gender identity further contribute to a body of research that supports a biological basis for gender identity and transgender identities.

16. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association ("DSM-5") (2013) is the current, generally recognized authoritative handbook on the diagnosis of mental disorders relied upon by mental health professionals in the United States, Canada, and other countries. The content of the DSM-5 reflects a science-based, peer-reviewed process by experts in the field.

17. According to the DSM-5, transgender identity is not a mental disorder. Gender dysphoria is a diagnostic term that refers to clinically significant distress associated with an incongruence or mismatch between a person's gender identity and assigned sex.

18. Gender Dysphoria is mental distress or discomfort based on the experience of discordance between the sex assigned at birth and a person's gender identity or brain sex. Because of the inflexibility of the brain sex, the experience of being transgender is sometimes

described as having, or being born in, the wrong body. The emotional distress experienced as a result of being in the wrong body is the hallmark symptom associated with Gender Dysphoria.

19. Only the subset of transgender people who have clinically significant distress or impairment qualify for a diagnosis of Gender Dysphoria.

20. Gender dysphoric persons may live for a significant period of their lives in denial of those symptoms. Some transgender people may not initially understand the emotions associated with gender dysphoria and not have the language or resources to find support for the distress as experienced as a result of them until well into adulthood. Younger people in increasing numbers have access to medical and mental health resources that help them understand their experience and allow them to obtain medical support at an earlier age.

TREATMENT FOR GENDER DYSPHORIA

21. Gender Dysphoria is understood as a condition that is amenable to treatment. Commission Report at 9; WPATH Standards of Care, Version 7; William Byne, et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder* (2012).[1] With appropriate treatment, individuals with a Gender Dysphoria diagnosis can be fully cured of all symptoms.

22. Treatment of Gender Dysphoria is well-established and highly effective. The protocol is set forth in the WPATH Standards of Care and in the Endocrine Society Guidelines.[2] The WPATH Standards of Care were first developed in 1979. Currently in their seventh version, the Standards of Care set forth the authoritative protocol for the evaluation and treatment of

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[1] *Available at* https://www.researchgate.net/publication/228071071_Report_of_the_American_Psychiatric_Association_Task_Force_on_Treatment_of_Gender_Identity_Disorder.

[2] *Available at* https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines.

Gender Dysphoria. This is the approach followed by clinicians caring for transgender veterans with Gender Dysphoria nationally in the VHA. As stated above, I was a member of the WPATH committee that authored Version 7 of the Standards of Care, published in 2011. That document is attached hereto as Exhibit C.

23. Depending on the individual, a treatment plan for persons diagnosed with Gender Dysphoria may involve psychotherapeutic, pharmacological, and surgical components. The goal in all cases for which there is a treatment plan is to enable the individual to live all aspects of one's life consistent with his or her gender identity or brain sex.

24. Pharmacological care, when needed, typically includes hormonal reassignment. Surgical care, often referred to as either sex reassignment or gender confirmation surgery, includes a range of procedures that conform the person's body to be consistent with persons of the same gender identity. There is a wide range in the treatment sought by those suffering from Gender Dysphoria. Some need both hormone therapy and surgery, while others need both or neither.

25. The care and treatment necessary for transgender individuals in the military is already provided to non-transgender individuals, whether therapy, hormonal treatments, or surgeries. Accordingly "[t]ransgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals are unfit for duty." 2014 Report at 14.

PRE-2016 MILITARY POLICY

26. Prior to 2016, military policy treated Gender Dysphoria inconsistently with other curable conditions. Department of Defense instructions contain an extensive list of physical and mental conditions that disqualify a person from enlisting in the military and which can be used as

the basis to separate someone from service. For instance, persons with autism, schizophrenia and delusional disorders (or a history of treatment for these conditions) are excluded from enlistment. Prior to 2016, that list also contained conditions relating to Gender Dysphoria, such as change of sex and transsexualism.

27. The purpose of disqualifying applicants based on certain physical and mental conditions is to ensure that service members are free of contagious diseases that endanger others, free of conditions or defects that would result in excessive duty-time lost and would probably result in separation, able to perform without aggravating existing conditions, and capable of completing training and adapting to military life.

28. Because Gender Dysphoria is a treatable and curable condition, unlike other excluded conditions, its inclusion on the list of disqualifying conditions was inappropriate. Despite having a treatable condition, persons who had a change of sex were disqualified from joining the military.

29. This was inconsistent with how persons with other curable medical conditions were treated. The result of this inconsistency was that transgender personnel were excluded or singled out for disqualification even when they were mentally and physically healthy.

30. For example, persons with certain illnesses, such as Attention Deficit Hyperactivity Disorder and simple phobias, could be admitted when their conditions could be managed without imposing undue burdens on others. Individuals with Attention Deficit Hyperactivity Disorder are prohibited from enlisting unless they meet five criteria including documenting that they maintained a 2.0 grade point average after the age of 14. Similarly, individuals with simple phobias are banned from enlisting unless they meet three criteria including documenting that they have not required medication for the past 24 continuous months. Likewise, members with

mood and anxiety disorders treated by medication were not categorically barred from deployment despite the well-known high rates of recurrence of these psychiatric disorders.

31. In short, even though the Defense Department allowed those with manageable conditions to serve, the former regulation barred transgender service without regard to its treatability and the person's ability to serve.

JUNE 2016 POLICY CHANGE

32. The military lifted the ban on open service by transgender military personnel following a June 30, 2016 announcement made by then Secretary of Defense Ashton B. Carter.

33. Under new accessions procedures – which were adopted but never put into effect – transgender individuals whose condition was stable for 18 months at the time of enlistment would be eligible to enlist. As the procedures describe, a "history of gender dysphoria" as well as a "history of medical treatment associated with gender transition" are disqualifying *unless*, as to the former, a licensed medical provider certifies that the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months, and as to the latter, that "the applicant has completed all medical treatment associated with the applicant's gender transition; and the applicant has been stable in the preferred gender for 18 months." DTM-16-005 Memorandum and Attachment (June 30, 2016). Finally, for applicants presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months. *Id.*

34. In other words, the procedures require those seeking to enlist who had any therapy or surgeries to have medical confirmation that they have been stable for the last 18 months. Similarly, those applicants taking cross-sex hormones as follow-up to their transition would also need certification that they had been stable on such hormones for 18 months.

MEDICAL JUSTIFICATIONS FOR THE TRANSGENDER BAN ARE UNFOUNDED

35. Based on my extensive research and experience treating transgender people, most of whom have served this country in uniform, my experience reviewing the medical implications of a ban on transgender service members, and my involvement in implementing the 2016 policies allowing transgender individuals to serve openly, it is my opinion that the medical objections to open service by transgender service members are wholly unsubstantiated.

36. Similarly, in a unanimous resolution published on April 29, 2015, the American Medical Association announced its support for lifting the ban on transgender service in the military.[3]

MENTAL HEALTH

37. Arguments based on mental health of transgender persons are completely inadequate to justify prohibiting transgender individuals from serving in the military. Being transgender is not a mental defect or disorder. Scientists have long abandoned psychopathological understandings of transgender identity, and do not classify the incongruity between a person's brain sex and one's assigned sex as a mental illness. To the extent a person's incongruity between their brain sex and their birth sex creates clinically significant distress (Gender Dysphoria), that distress is curable through appropriate medical care. The availability of a cure distinguishes Gender Dysphoria from other mental health conditions such as autism, bipolar disorder, or schizophrenia for which there are no cures. There is no reason to single out transgender personnel for separation or even limitation of service based only on the diagnosis or

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[3] *Available at* http://archive.palmcenter.org/files/A-15%20Resoultion%20011.pdf.

treatment of Gender Dysphoria. Rather, determinations should be made on a case-by-case basis depending on the individual's fitness to serve, as is done with other treatable conditions.

38. Moreover, the military already provides mental health evaluation services and counseling, which is the first component of treatment for Gender Dysphoria. RAND Corporation, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report") at 79, attached as Exhibit D.

39. Sixty years of clinical experience have demonstrated the efficacy of treatment of the distress resulting from Gender Dysphoria. *See* 2014 Report at 6 ("a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress"). Moreover, "empirical data suggest that many non-transgender service members continue to serve despite psychological conditions that may not be as amenable to treatment as gender dysphoria." *Id.* at 7.

40. Concerns about suicide and substance abuse rates among transgender individuals are also irrelevant. At accession, all prospective military servicemembers undergo a rigorous examination to identify any pre-existing mental health diagnoses that would preclude accessions. Once someone is serving in the military, they must undergo an annual mental and physical health screen, which includes a drug screen. If one of these screenings indicates that a person suffers from a mental illness or substance abuse, then that would be the potential impediment to joining or remaining in the military. The mere fact that a person is transgender, however, does not mean that person has a mental health issue, substance abuse problem, or is suicidal.

HORMONE TREATMENT

41. The argument that cross-sex hormone treatment is too risky and complicated for military medical personnel to administer and monitor is unsubstantiated and illogical. The risks

associated with cross-sex hormone treatment are low and not any higher than for the hormones that many non-transgender personnel currently take.

42. The military has vast experience with accessing, retaining and treating non-transgender individuals who need hormone therapies or replacement. These include gynecological conditions such as dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy or oophorectomy and genitourinary conditions like renal or voiding functions, any of which are referred for a fitness evaluation only when they affect duty performance.

43. In addition, when service members develop hormonal conditions during service whose remedies are biologically similar to cross-sex hormone treatment, those members are not discharged and may not even be referred for a medical evaluation board. Examples include male hypogonadism, menstrual disorders and current, or history of, pituitary dysfunction.

44. Military policy also allows service members to take a range of medications, including hormones, while deployed in combat settings. 2014 Report at 9. Whether anabolic steroids or antipsychotic drugs, Department of Defense policy provides "few medications are inherently disqualifying for deployment." *Id.* (quoting Dept. of Defense, Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications, 2006 at para. 4.2.3). Access is predictable, as "[t]he Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide." *Id.* As to cross-sex hormones at least, clinical monitoring for risks and effects is not complicated, and with training and/or access to consultations, can be performed by a variety of medical personnel in the Department of Defense, just as is the case in the VHA.

45. A study done by the RAND Corporation, an independent, nonpartisan, military think tank confirms the conclusions I draw from my experience with the military and in the 2014 Report. *See* RAND Report. Specifically, the RAND Report noted that Military Health Services maintains and supports all of the medications used for treatment of Gender Dysphoria and has done so for treatment of non-transgender service members. In other words, all of the medications used by transgender service members for treatment of Gender Dysphoria are used by other service members for conditions unrelated to Gender Dysphoria. *See* RAND Report at 8 ("Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients."). Part of my role with the Department of Defense over the past 18 months has been to provide this continuing education.

SURGERY

46. Nor is there any basis for the argument that a transgender servicemember's potential need for transition surgery presents unreasonable risks or burden. The risks associated with gender-confirming surgery are low.

47. Critics have also cited non-deployability, medical readiness, and constraints on fitness for duty as reasons to exclude transgender individuals from service. Such arguments are also unsubstantiated and illogical. As a general matter, transgender servicemembers are just as medically fit for service and deployable as non-transgender servicemembers.

48. Even prior to the 2016 transgender policy change, military surgeons were called upon to perform surgeries, such as those for blast victims, whose core procedures are the same as or similar to surgeries needed for transgender health. RAND Report at 8 ("Surgical procedures

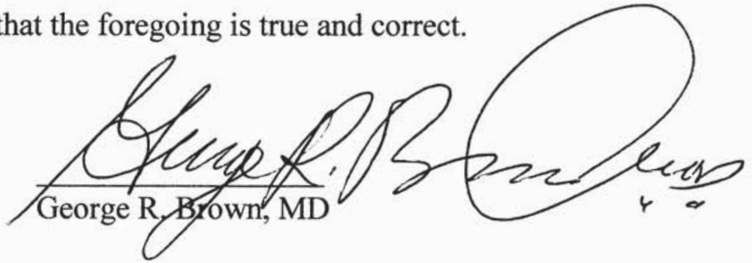
quite similar to those used for gender transition are already performed within the MHS for other clinical indications."). The RAND Report noted the benefit of military coverage of transgender surgeries because of the contribution it can make to surgical readiness and training. *Id.* ("performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained.").

CONCLUSION

49. There is no evidence that being transgender alone affects military performance or readiness and there is no medical justification for the categorical exclusion of transgender individuals from the Armed Forces.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: August 30, 2017



George R. Brown, MD

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA
IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL

I, George R. Brown, declare as follows:

1. I make this declaration based on my own personal knowledge.

2. As set forth in my previous declaration dated August 30, 2017, submitted by me in this case in support of Plaintiffs' motion for preliminary injunctive relief, I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman, contributing to administrative, teaching, and research missions of the Department of Psychiatry, consulting on clinical cases at the University and at Mountain Home Veterans Health Administration ("VHA") Medical Center, where I also hold an appointment, and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves research, teaching, and consulting about transgender health in military and civilian populations. My CV is attached to my earlier declaration.

3. I reviewed the declaration submitted in the case by Lernes Hebert and am responding to the statements set forth therein.

4. On June 30, 2016, the military changed its policy from one that categorically excluded transgender people from enlistment to one that authorizes the enlistment of qualified transgender individuals. The policy the military adopted and set forth in DTM 16-005 authorizes enlistment for individuals who have a diagnosis of gender dysphoria upon a demonstration that they have completed gender transition and have been stable in the newly assigned gender for 18 months. The target effective date for that policy was originally 1 year from the date of its announcement, or July 1, 2017. The day before July 1, 2017, that date was moved to January 1, 2017.

5. Following the adoption of DTM 16-005, the military began training throughout the branches to meet the initial target date of July 1, 2017 for implementation. I was part of that process and trained approximately 250 medical personnel working in Military Entrance Processing Stations (MEPS) throughout the military, including medical division personnel, chief and assistant chief medical officers and fee-based medical providers on the accessions policy. That training took place in San Antonio, Texas on May 2, 2017.

6. I have in-depth familiarity both with the transgender enlistment policy and military enlistment policies as they relate to medical clearances and reviews for enlistees.

7. I do not agree that implementing the accessions policy in DTM 16-005 by January 1, 2018, will impose extraordinary burdens on the military. The implementation of accessions criteria for transgender enlistees is no more complex than other accessions criteria on which MEPS personnel are knowledgeable and regularly trained.

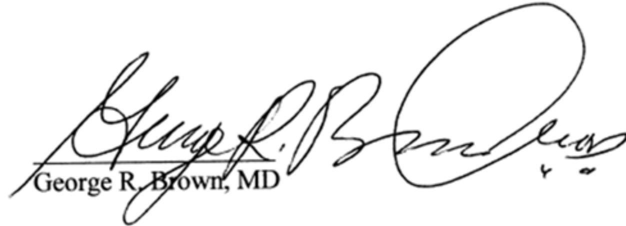
8. The accessions criteria for transgender people are straightforward and do not require extensive or detailed knowledge. To the contrary, it simply requires MEP personnel to identify applicants who have a diagnosis of gender dysphoria, a diagnosis with which medical professionals should already be familiar. It also involves review of the individual's substantiating and supporting medical documentation to confirm that the period of stability (18 months) has been met. This process does not involve any unique complexities or burdens and is well within the capacity of military personnel involved in the enlistment review process.

9. Acting Deputy Assistant Secretary Hebert's statement that "personnel involved in that accession enterprise have rotated in the past several months" is not a legitimate reason to delay implementing the accessions policy for transgender people. Military personnel rotations are ordinary shifts that are expected and anticipated throughout the military. The training and redundancies within the military system anticipate routine staff turnover. Nothing about routine staff turnover should justify a delay of enlistment policy implementation.

10. Any minimal burden imposed on MEPS as a result of implementing the accessions policy for transgender people will be further reduced by the small number of transgender people who are likely to seek enlistment. Based on decades of medical experience and research, only a small percentage of the overall population are transgender. There is no reason to expect MEPS to receive a large number of enlistment applications from transgender enlistees on or after January 1. I personnaly have trained Hundreds of MEPS personnel. The system includes multiple redundancies to ensure backup availability to review enlistment materials should any even be needed.

11. Based on my knowledge and experience, I do not agree that the military will be unprepared on January 1, 2018 to implement the transgender enlistment policy set forth in DTM 16-005.

DATED: December 8, 2017



George R. Brown, MD

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF BRAD R. CARSON

I, Brad Rogers Carson, declare as follows:

1. I served as the Acting Under Secretary of Defense for Personnel and Readiness ("USD P&R") from April 2, 2015 to April 8, 2016. In that capacity, and at the direction of the Secretary of Defense, I led a group of senior personnel drawn from all of the armed services to develop, over many months of information collection and analysis, a Department-wide policy regarding service by transgender people, all as more fully described below.

PROFESSIONAL BACKGROUND

2. I attended Baylor University and obtained an undergraduate degree in history in 1989. After college, I attended Trinity College in Oxford, England on a Rhodes Scholarship and earned a Master's degree in Politics, Philosophy, and Economics. When I returned to the United States, I attended the University of Oklahoma College of Law, graduating with a law degree in 1994.

3. After I graduated law school, I practiced as an attorney at the law firm Crowe & Dunlevy. From 1997 to 1998 I served as a White House Fellow, where I worked as a Special

Assistant to the Secretary of Defense. From 2001 to 2005, I served in Congress as the Representative for the State of Oklahoma's 2nd District.

4. In addition to my civilian career, I am also a commissioned officer in the United States Navy Reserve. I currently serve in the Individual Ready Reserve. I deployed to Iraq in 2008 as Officer-in-Charge of intelligence teams embedded with the U.S. Army's 84th Explosive Ordnance Disposal Battalion. In Iraq, our teams were responsible for investigation of activities relating to improvised explosive devices and the smuggling of weapons and explosives. For my service in Iraq, I was awarded the Bronze Star Medal and other awards.

5. I have held several leadership positions within the Department of Defense ("DoD"). In 2011, I was nominated by the President to serve as General Counsel to the United States Army and unanimously confirmed by the U.S. Senate. As General Counsel, my duties included providing legal advice to the Secretary, Under Secretary, and Assistant Secretaries of the Army regarding the regulation and operation of the U.S. Army. I also assisted in the supervision of the Office of the Judge Advocate General. I served as General Counsel to the United States Army until March 2014.

6. In late 2013, while serving in that position, I was nominated by the President to serve as Under Secretary of the Army. I was unanimously confirmed by the U.S. Senate in February 2014 and sworn in on March 27, 2014. As Under Secretary of the Army, I was the second ranking civilian official in the Department of the Army. My responsibilities included the welfare of roughly 1.4 million active and reserve soldiers and other Army personnel, as well as a variety of matters relating to Army readiness, including oversight of installation management and weapons and equipment procurement. With the assistance of two Deputy Under Secretaries, I directly supervised the Assistant Secretaries of the Army for Manpower and Reserve Affairs;

Acquisition, Logistics and Technology; Financial Management and Comptroller; Installations, Energy and Environment; and Civil Works. My responsibilities involved the management and allocation of an annual budget amounting to almost $150 billion.

7. I was appointed by the President to serve as acting USD P&R in April 2015. In that capacity, I functioned as the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense for Total Force Management with respect to readiness; National Guard and Reserve component affairs; health affairs; training; and personnel requirements and management, including equal opportunity, morale, welfare, recreation, and quality of life matters. My responsibilities over these matters extended to more than 2.5 million military personnel.

DEVELOPMENT OF POLICY REGARDING TRANSGENDER SERVICE MEMBERS

8. On July 28, 2015, then-Secretary of Defense Ashton B. Carter ordered me, in my capacity as USD P&R, to convene a working group to formulate policy options for DoD regarding transgender service members (the "Working Group"). Secretary Carter ordered the Working Group to present its recommendations within 180 days. In the interim, transgender service members were not to be discharged or denied reenlistment or continuation of service on the basis of gender identity without my personal approval. A true and accurate copy of the July 28, 2015 order is attached hereto as Exhibit A.

9. The Working Group included roughly twenty-five members. Each branch of military service was represented by a senior uniformed officer (generally a three-star admiral or general), a senior civilian official, and various staff members. The Surgeons General and senior representatives of the Chaplains for each branch of service also attended the Working Group meetings.

10. The Working Group formulated its recommendations by collecting and considering evidence from a variety of sources, including a careful review of all available scholarly evidence and consultations with medical experts, personnel experts, readiness experts, health insurance companies, civilian employers, and commanders whose units included transgender service members.

THE FINDINGS OF THE RAND REPORT

11. On behalf of the Working Group, I requested that RAND, a nonprofit research institution that provides research and analysis to the Armed Services, complete a comprehensive study of the health care needs of transgender people, including potential health care utilization and costs, and to assess whether allowing transgender service members to serve openly would affect readiness.

12. In 2016, RAND presented the results of its exhaustive study in a report entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report"), a true and accurate copy of which is attached as Exhibit B.

13. The RAND Report explained that according to the American Psychiatric Association, the term transgender refers to "the broad spectrum of individuals who identify with a gender different from their natal sex." The RAND Report also explained that "transgender status alone does not constitute a medical condition," and that "only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD)." For those individuals, the recognized standard of care includes some combination of psychosocial, pharmacological, and/or surgical care. "Not all patients seek all forms of care." "While one or more of these types of treatments may be medically necessary for

some transgender individuals with GD, the course of treatment varies and must be determined on an individual basis by patients and clinicians."

14. The RAND Report evaluated the capacity of the military health system (MHS) to provide necessary care for transgender service members. The RAND Report determined that necessary psychotherapeutic and pharmacological care are available and regularly provided through the MHS, and that surgical procedures "quite similar to those used for gender transition are already performed within the MHS for other clinical indications." In particular, the MHS already performs reconstructive surgeries on patients who have been injured or wounded in combat. "The skills and competencies required to perform these procedures on transgender patients are often identical or overlapping." In addition, the RAND Report noted that "performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries."

15. The RAND Report also examined all available actuarial data to determine how many transgender service members are likely to seek gender transition-related medical treatment. The RAND Report concluded that "we expect annual gender transition-related health care to be an extremely small part of overall health care provided to the AC [Active Component] population."

16. The RAND Report similarly concluded that the cost of extending health care coverage for gender transition-related treatments is expected to be "an exceedingly small proportion of DoD's overall health care expenditure."

17. The RAND Report found no evidence that allowing transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness.

18. The RAND Report found that the estimated loss of days available for deployment due to transition-related treatments "is negligible." Based on estimates assuming the highest utilization rates, it concluded that the number of nondeployable man-years due to gender transition-related treatments would constitute 0.0015 percent of all available deployable labor-years across both the Active Component and Select Reserves.

19. The RAND Report also found no evidence that permitting openly transgender people to serve in the military would disrupt unit cohesion. The RAND Report noted that while similar concerns were raised preceding policy changes permitting open service by gay and lesbian personnel and allowing women to serve in ground combat positions, those concerns proved to be unfounded. The RAND Report found no evidence to expect a different outcome for open service by transgender persons.

20. The RAND Report examined the experience of eighteen other countries that permit open service by transgender personnel—including Israel, Australia, the United Kingdom, and Canada. The Report found that all of the available research revealed no negative effect on cohesion, operational effectiveness, or readiness. Some commanders reported that "increases in diversity led to increases in readiness and performance."

21. The Rand Report also identified significant costs associated with separation and a ban on open service, including "the discharge of personnel with valuable skills who are otherwise qualified."

ISSUES CONSIDERED BY THE WORKING GROUP

22. The Working Group sought to identify and address all relevant issues relating to service by openly transgender persons, including deployability. In addition to taking into consideration the conclusions of the RAND Report, the Working Group discussed that while

some transgender service members might not be deployable for short periods of time due to their treatment, this is not unusual, as it is common for service members to be non-deployable for periods of time due to medical conditions such as pregnancy, orthopedic injuries, obstructive sleep apnea, appendicitis, gall bladder disease, infectious disease, and myriad other conditions. For example, the RAND Report estimated that at the time of the report, 14 percent of the active Army personnel—or 50,000 active duty soldiers—were ineligible to deploy for legal, medical, or administrative reasons.

23. The Working Group also addressed the psychological health and stability of transgender people. In addition to taking into account the conclusions of the RAND Report, the Working Group concluded, based on discussions with medical experts and others, that being transgender is not a psychological disorder. While some transgender people experience gender dysphoria, that condition is resolved with appropriate medical care. In addition, the Working Group noted the positive track record of transgender people in civilian employment, as well as the positive experiences of commanders with transgender service members in their units.

24. The Working Group also concluded that transgender service members would have ready access to any relevant necessary medication while deployed in combat settings. It determined that military policy and practice allows service members to use a range of medications, including hormones, while in such settings. The MHS has an effective system for distributing prescribed medications to deployed service members across the globe, including those in combat settings.

25. The Working Group also concluded that banning service by openly transgender persons would require the discharge of highly trained and experienced service members, leaving

unexpected vacancies in operational units and requiring the expensive and time-consuming recruitment and training of replacement personnel.

26. The Working Group also concluded that banning service by openly transgender persons would harm the military by excluding qualified individuals based on a characteristic with no relevance to a person's fitness to serve.

27. I concluded my service as USD P&R on April 8, 2016. By that time, the Working Group was unanimously resolved that transgender personnel should be permitted to serve openly in the military.

RECENT REVERSAL OF POLICY

28. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."

29. President Trump's stated rationale for a ban on military service by openly transgender service members is unfounded and refuted by the comprehensive investigation and review performed by the Working Group.

30. In addition to contravening the Working Group's conclusions and the exhaustive supporting evidence that was collected, I believe that prohibiting transgender individuals from serving openly in the military is harmful to the public interest for several reasons. My belief is based on my experience as USD P&R and in other leadership positions within DoD, and upon my active duty experience in Iraq.

31. First, a prohibition on service by openly transgender individuals would degrade military readiness and capabilities. Many military units include transgender service members who are highly trained and skilled and who perform outstanding work. Separating these service members will deprive our military and our country of their skills and talents.

32. Second, banning military service by openly transgender persons would impose significant costs that far outweigh the minimal cost of permitting them to serve. A study authored in August 2017 by the Palm Center and professors associated with the Naval Postgraduate School estimated that separating transgender service members currently serving in the military would cost $960 million, based on the costs of recruiting and training replacements. A true and correct copy of the August 2017 Palm Center study is attached hereto at Exhibit C.

33. Third, the sudden and arbitrary reversal of the DoD policy allowing openly transgender personnel to serve will cause significant disruption and thereby undermine military readiness and lethality. This policy bait-and-switch, after many service members disclosed their transgender status in reliance on statements from the highest levels of the chain of command,

conveys to service members that the military cannot be relied upon to follow its own rules or maintain consistent standards.

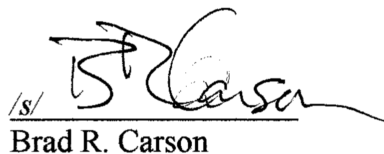
34. Fourth, in addition to the breach of transgender service members' trust resulting in the deprivation of their careers and livelihood, the President's policy reversal will cause other historically disadvantaged groups in the military, including women and gay and lesbian service members, to question whether their careers and ability to serve as equal members of the military may also be sacrificed.

35. Fifth, those serving in our Armed Forces are expected to perform difficult and dangerous work. The President's reversal of policy puts tremendous additional and unnecessary stress on transgender service members, their command leaders, and those with whom they serve.

36. In short, the President's reversal of the policy permitting military service by openly transgender individuals has had, and will continue to have, a deleterious effect on readiness, force morale, and trust in the chain of command in the Armed Services.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: August 28, 2017



/s/
Brad R. Carson

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF MARK J. EITELBERG
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Mark J. Eitelberg, declare as follows:

1. I am a Professor Emeritus at the Naval Postgraduate School in Monterey, California. I have personal knowledge of the matters stated in this declaration and can competently testify to these facts.

2. I received a Master of Public Administration degree from New York University in 1973 and a Ph.D. in Public Administration in 1979, also from New York University. I joined the faculty of the Naval Postgraduate School as an Adjunct Research Associate Professor in 1982. I was tenured as an Associate Professor in 1995 and promoted to Professor of Public Policy in 1999. I retired from federal service in April 2017. Upon retirement, in recognition of my distinguished service, I was designated Emeritus Professor of the Naval Postgraduate School. I served with the New Jersey Army National Guard and the U.S. Army Reserve from 1970 to 1976, the last two years as Staff Sergeant.

3. My teaching and research at the Naval Postgraduate School focused on military manpower and personnel policy analysis and military sociology/psychology. Among my research interests are the following: population participation ("representation") in the military; the All-Volunteer Force; military force management and manpower policy; military manpower selection, classification, and utilization; and equal opportunity and diversity management. My honors include the Robert M. Yerkes Award (for outstanding contributions to military psychology by a non-psychologist) from the Society for Military Psychology, a division of the American Psychological Association, and the Department of the Navy Superior Civilian Service Award. I have served on the Board of Editors of the journals *Armed Forces & Society* and *Military Psychology*. I was Editor-in-Chief of *Armed Forces & Society* from 1998 through 2001. A true and correct copy of my curriculum vitae and a list of my publications are attached to this declaration as Exhibit A.

4. I am aware that, on June 30, 2016, the Department of Defense announced it would begin allowing transgender persons to serve openly in the military. As stated in the official announcement and news release (NR-246-16): "Effective immediately, service members may no longer be involuntarily separated, discharged or denied reenlistment solely on the basis of gender identity. Service members currently on duty will be able to serve openly." This change in policy followed a careful review by a comprehensive working group that included high-ranking uniformed and civilian personnel as well as medical experts and other highly knowledgeable persons. The new policy assured current service members that they could reveal their gender identity if they chose to do so. The policy also established procedures for transgender service members to receive appropriate medical care for gender transition. Subsequently, many

transgender service members informed their chain of command and their peers that they are transgender.

5. I am also aware that, in a series of informal comments on July 26, 2017, and later in a formal memorandum on August 25, 2017, President Donald Trump directed that the policy allowing transgender individuals to serve openly in the military "return to the longstanding policy and practice" that prohibited transgender persons from serving in any capacity. Up to this point, for over one year previously, transgender service members were told that the Department of Defense had "ended" its ban on transgender Americans serving in the U.S. military. Under this policy and a forthcoming implementation plan, transgender service members will once again be subject to discharge by the Department of Defense on March 23, 2018.

6. Based on my knowledge, experience, and research in the fields of military manpower and personnel policy, military sociology, and military psychology, the newly announced policy is significantly harming service members who have disclosed they are transgender. This is not merely a potential problem or future hardship due to the scheduled March 23, 2018 date on which they will become subject to being separated. The new policy prevents transgender service members from serving equally with their peers; it imposes substantial limitations on their opportunities within the military; and it negatively impacts their day-to-day relationships with co-workers and other service members.

7. Military service opportunities are generally structured through career tracking by occupational area within each separate service, with scheduled training and skill-level assessments, operational assignments (or tours) and deployments, windows for advancement, and increased responsibilities based on experience, time-in-service, conduct, and performance. At the same time, as with any occupation, discretionary judgments or decisions within a service

member's chain of command can have a strong impact on one's job opportunities or daily life. Naturally, these decisions are influenced by expectations regarding a service member's future in the military. From an operational perspective, commanders understandably are reluctant to invest significant resources in the training or development of individuals who might leave military service in the near future, or to entrust them with important assignments. This dynamic is similar to what occurs in other large organizations when an employee is known to be departing several months in advance. Transgender service members who informed others of their gender identity based on the government's pledge that they could serve openly as of June 30, 2016, believing that "ending the ban" would not be temporary, have no secure future in the military beyond March 23, 2018.

8. Transgender service members leaving military service would likely be held in their present duty location, pending a confirmed date of their involuntary separation. Lost opportunities and personal problems would ensue, particularly if the service member has a family, children in school, or other dependents. Previously scheduled training, deployment, change of duty station, or other planned career events would be canceled by the military to save related costs, minimize organizational disruption, and simplify discharge. Some of these service members would continue to work in their present positions until separation; others would be temporarily "stashed" in another work unit; and some might be placed in a "make-work" situation or "holding pattern" while awaiting separation. If the person has a particularly important skill, knowledge, or expertise, she or he may be asked to train a replacement. In other cases, an individual scheduled for discharge may be gradually relieved of duties or assignments as their responsibilities are delegated to others. Depending on the supervisor's views and management style, this might mean the person slated for discharge will be required to perform

tasks no one else wants or be assigned less challenging, repetitive tasks that do not enhance their skill development.

9. Such reductions in responsibility have an impact even on service members whose departure from the military is voluntary and who have begun to make plans for their post-military life. The impact is much more severe for those who had been planning to remain in the military but are unexpectedly facing the prospect of involuntary separation, because their accumulated efforts to excel or advance and their career aspirations essentially disappear upon discharge. The potential harm to these women and men economically is undeniable; added to this is the psychological distress of being told that their performance in service to the nation is meaningless when measured against their gender identity. They had volunteered to serve their country, to accept the associated risks, and to perform well and honorably. The military considered them qualified to serve when they joined. Surely, many would want to understand why their gender identity now makes them unqualified to serve their country, and to such a degree that they should be removed from the military.

10. The President's memorandum also harms transgender service members in another way. According to the memorandum, "the previous Administration failed to identify a sufficient basis to conclude" that terminating the ban on transgender persons "would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." Consequently, "meaningful concerns" remain regarding the "negative effects" of removing a ban on transgender persons. In essence, the President's directive reestablishes the *reasons* for prohibiting military service by transgender persons prior to the policy change of June 30, 2016, negating the conclusions of the comprehensive working group that supported removing the ban as well as any

training, guidance, regulations and forms, protocols, and supporting networks developed by the military to facilitate transition.

11. In reversing the previous policy, the President's directive instructs commanders and other service members that transgender individuals are detrimental to the military. No further explanation is provided, merely a statement that the present basis for concluding otherwise is insufficient. Although commanders would attempt to ensure that transgender personnel continue to be treated with dignity and respect, as emphasized in training, the President's directive to discharge transgender personnel erodes the value that members serving with them place on their contributions or performance. Reestablishing reasons for discharging transgender personnel legitimizes any bias or prejudice that may have existed among non-transgender members prior to training. As a result, transgender service members are being currently harmed and restricted artificially from being able to serve as equals with their peers.

12. In previous cases of involuntary discharge, service members slated for separation are viewed commonly as a nuisance and may be harassed by co-workers or treated differently by commanders prior to the member's departure. Additionally, as a service member approaches involuntary discharge, documented cases indicate that superiors may be less than complimentary in evaluating the member's performance, perhaps motivated to confirm the basis for separation. For transgender personnel facing involuntary discharge under the new policy, this could mean an unfairly low or negative performance rating rather than one based solely on merit. Consequently, the announced ban has the current effect of inducing conscious and unconscious bias among peers and commanders that ultimately harms transgender personnel by limiting their service opportunities and chances for advancement and promotion.

13. The President's memorandum identifies the potential disruption of unit cohesion as a key factor in reversing the policy of June 2016 and discharging transgender service members. Clearly, unit cohesion is a critical element in the military. Historically, this purported concern has been used to justify U.S. military policies of racial and gender segregation. More recently, unit cohesion served as a reason for the policy known as "Don't Ask, Don't Tell" (DADT). DADT itself stimulated considerable research by scholars to better understand unit cohesion and how it can be improved in the military. Previous studies have identified "task cohesion" (compared with "social cohesion") as most important in accomplishing a military mission. Strong bonds among service members are important in undertaking a mission and are particularly apparent in smaller military units, among persons on deployments, and among those who serve under dangerous conditions.

14. As noted, the President's directive places transgender personnel in a "holding pattern," subject to involuntary discharge on March 23, 2018. Knowing this, military commanders and co-workers are obviously less likely to bond with transgender service members and more inclined to keep them at a distance. Transgender personnel are thus more prone to be viewed as unimportant to a unit's cohesiveness and treated as such when working with their peers. Mutual trust and respect erode as co-workers see transgender personnel as "them," on the way out. Clearly, working relationships, as well social relationships, will suffer. Transgender personnel may feel isolated and alone. Added to this is the understanding among co-workers and commanders alike that transgender personnel are identified by the new policy as a potential detriment to military effectiveness and unit cohesion. Based upon current understanding of unit cohesion, the President's directive will damage the bond between transgender personnel and

their co-workers and thus disrupt the very unit cohesion that it seeks to protect. It also puts transgender troops in harm's way while serving, especially when deployed in active combat.

15. Being branded as disruptive or unworthy of service also carries consequences that are unique to the military context and differ from the dignitary harms suffered by those who face discrimination in civilian life. Military service is widely understood as an integral element of citizenship, and many regard it as a civic duty. Historically, the military has served as a path for members of minority groups, immigrants, and social outcasts to gain recognition as true and loyal citizens. When the military adopts a policy that degrades or demeans a group of service members, the message goes out to the larger society that such treatment is acceptable. This is especially observable during times when the military is held in high esteem by the general public. Indeed, according to annual Gallup polling, the U.S. military is "the most trusted institution" in the country. This has been true from 1989 to 1996 and from 1998 to 2017, with 72 percent of adult Americans presently expressing "a great deal" or "quite a lot" of confidence in the military. Barring individuals who are physically, medically, intellectually, educationally, emotionally, and morally qualified to serve based on a personal characteristic that is irrelevant to their ability sends a powerful message that the government distrusts or disapproves of the excluded group or sees them as unfit. African-Americans, Japanese-Americans, women, and gay and lesbian people once faced such official disapproval. Barring demographic groups from equal service gives them the overt stigma of civic inferiority.

16. Being labeled unworthy to serve also impairs service members' ability to carry out their duties safely and effectively. Since people serving in the military depend upon each other so much, particularly under life-threatening circumstances, being isolated or mistrusted can have enormous consequences. If others see someone in the unit as not being as of equal value,

they may not work as effectively with them or protect them as well as they would other unit members. And, unlike in civilian life, it is often difficult to escape the military workplace, which may be on a ship at sea, deployed overseas, or living on a base in close quarters with one's peers.

17. One final harm should be mentioned. The President's memorandum brands transgender personnel in a way that will follow them well into the future. Stained by the claim they are disruptive or damaging to a working unit's effectiveness—followed by their consequent separation from the military—transgender personnel may be irreparably harmed in finding post-service employment. Military recruiting advertisements often say that "it's a great place to start" and that military training and experience are invaluable to those seeking employment in the civilian job market. A natural result of the ban for transgender personnel is to diminish their opportunities for civilian employment following military service.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: October 15, 2017

Mark J. Eitelberg

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF ERIC K. FANNING
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Eric K. Fanning, declare as follows:

Background and Experience

1. I served as Secretary of the Army from May 18, 2016 to January 20, 2017.

2. I received a Bachelor's Degree in History from Dartmouth College in 1990. From 1991 until 1996, I worked in various government positions in Washington, D.C., as a research assistant with the House Armed Services Committee, a special assistant in the Office of the Secretary of Defense, and Associate Director of Political Affairs at the White House. From 1997 to 1998, I worked on the national and foreign assignment desks at CBS News in New York. Subsequently, I worked at Robinson, Lerer & Montgomery, a strategic communications firm. From 2001 to 2006, I was Senior Vice President for Strategic Development at Business Executives for National Security, a Washington, D.C.-based think tank, where I was in charge of

international programs and all regional office operations in six cities across the country. I next served as managing director at CMG, another strategic communications firm. From 2008 to 2009, I was Deputy Director of the Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism, which issued its report in December of 2008.

3. From 2009 to 2013, I served as the Deputy Under Secretary of the Navy and Deputy Chief Management Officer. In this role, I led the department's business transformation and governance processes and coordinated efforts to identify enterprise-wide efficiencies. From April 18, 2013 to February 17, 2015, I served as Under Secretary of the Air Force after being nominated by the President to that position and confirmed by the Senate. From June 21, 2013 through December 20, 2013, I served as Acting Secretary of the Air Force.

4. In March 2015, I was assigned as the Special Assistant to the Secretary and Deputy Secretary of Defense (Chief of Staff). In this role, I helped manage Secretary of Defense Ashton Carter's transition into office, built his leadership team, and oversaw the day-to-day staff activities of the Office of the Secretary of Defense.

5. On June 30, 2015, President Barack Obama directed me to serve as Acting Under Secretary of the Army and Chief Management Officer. In that position, I served as the Secretary of the Army's senior civilian assistant and principal adviser on matters related to the management and operation of the Army, including development and integration of the Army Program and Budget. From November 3, 2015 to January 11, 2016, I served as Acting Secretary of the Army. On November 3, 2015, President Obama nominated me to serve as Secretary of the Army, and the Senate confirmed my nomination on May 17, 2016.

6. As Secretary of the Army, I was head of the Department of the Army and had statutory responsibility for all matters relating to the United States Army: manpower, personnel, reserve affairs, installations, environmental issues, weapons systems and equipment acquisition, communications, and financial management. Subject to the authority, direction, and control of the Secretary of Defense, the Secretary of the Army is responsible for all affairs of the Department of the Army, including the morale and welfare of personnel. My personnel-related oversight responsibilities included the development and implementation of recruitment, training, retention, and medical policies for active duty and reserve Army personnel. For duties other than those as a member of the Joint Chiefs of Staff, the Chief of Staff of the Army, the most senior uniformed Army officer, operated under my authority, direction, and control.

The Army

7. The Army is the largest of the service branches of the United States Armed Forces and performs land-based military operations. The Department of the Army is one of the three military departments of the Department of Defense ("DoD"). The Army has an annual budget of more than $140 billion, inclusive of funding for Overseas Contingency Operations. For fiscal year 2017, the projected end strength for the Active Army is 460,000 soldiers, with an additional 335,000 soldiers in the Army National Guard, and 195,000 in the United States Army Reserve, for a total of 990,000. As of 2016, the Army had approximately 190,000 soldiers deployed to 140 countries in support of U.S. geographic Combatant Command missions. The Army's command structure includes three Army Commands, ten Army Service Component Commands,

and thirteen Direct Reporting Units, operating in the field and from bases and facilities located across the United States and around the world.

8. The Army's core mission is to fight and win our Nation's wars by providing prompt, sustained land dominance across the full range of military operations and spectrum of conflict in support of combatant commanders. It does this by executing statutory directives, including organizing, equipping, and training forces for the conduct of prompt and sustained combat operations on land, and by accomplishing missions assigned by the President, Secretary of Defense and combatant commanders.

9. The Army is the most formidable ground combat force on earth and one of the largest employers in the United States. The Army's continued excellence in executing its many missions is largely due to deliberate investments in soldier training, equipping, and leader development. Soldiers receive training at the highest level, not only in the classroom, but also through rigorous instruction under intense pressure and realistic battlefield conditions. Many Army personnel are employed in highly technical roles that require lengthy and expensive specialized training. Particularly in light of these investments in personnel, recruitment and retention of capable and qualified soldiers is crucial to Army readiness.

Development of DoD Policy

10. In 2010, Congress voted to repeal the so-called Don't Ask, Don't Tell statute that previously had prevented gay, lesbian, and bisexual persons from serving openly in the military. The repeal statute required the President, the Secretary of Defense, and the Chairman of the Joint Chiefs of Staff to certify that allowing individuals to serve openly regardless of their sexual

orientation would be consistent with the standards of military readiness, military effectiveness, unit cohesion, and recruiting and retention of the Armed Forces. That certification was provided to Congress on July 22, 2011, following a process of review, both before and after passage of the repeal statute, of the impact of the change and of the training and other policy changes that would be necessary to implement it.

11. The repeal of Don't Ask, Don't Tell raised questions about the Armed Forces' policy on service by transgender individuals. Particularly among commanders in the field, there was an increasing awareness that there were already capable, experienced transgender service members in every branch, including on active deployment on missions around the world.

12. In August 2014, the Department of Defense issued a new regulation, DODI 1332.18, *Disability Evaluation System (DES).* The regulation eliminated a DoD-wide list of conditions that would disqualify persons from retention in military service, including the categorical ban on open service by transgender persons. This new regulation instructed each branch of the Armed Forces to reassess whether disqualification based on these conditions, including the ban on service by transgender persons, was justified. As of August 2014, there was no longer a DoD-wide position on whether transgender persons should be disqualified for retention.

13. In February 2015, just a few days after Secretary of Defense Ashton Carter took office, I accompanied him on a trip to Kandahar, Afghanistan, in my capacity as his chief of staff. At an open town hall-style meeting with service members, Secretary Carter was asked about his views on service by transgender service members in an austere environment like

Afghanistan. The Secretary's response was that he had not given the issue much study, but his "fundamental starting point" was "that we want to make our conditions and experience of service as attractive as possible to our best people in our country." He stated that the "important criteria" was, "Are they going to be excellent service members?"

14. The Kandahar town hall received significant media coverage. As a result, senior officials, including the offices of the Joint Chiefs of Staff, began to inquire about the Secretary's plans concerning the policy on transgender service members.

15. On July 28, 2015, after consultations with the secretaries of the military departments, Secretary Carter directed Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group ("the "Working Group") to study the policy and readiness implications allowing transgender persons to serve openly in the Armed Forces. The Working Group was asked to start with the presumption that transgender persons could serve openly unless objective, practical impediments were identified, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness. A true and accurate copy of this directive is attached hereto as Exhibit A.

16. By the time Secretary Carter directed the formation of the Working Group, I had moved out of my position in his office to become Acting Under Secretary of the Army. Subsequently, from November 3, 2015 to January 11, 2016, I served as Acting Secretary of the Army, and then as Secretary of the Army beginning May 18, 2016. During my time as Acting Secretary and Secretary, I oversaw the Department of the Army's participation in the Working Group. The Working Group met as a whole and also assigned various sub-groups to research

and analyze discrete issues and report their findings. I met regularly with members of the Working Group to discuss their progress and the Army's input on the issues discussed.

17. The Working Group considered information from a variety of sources, including medical and other experts, drawn from both within and outside of the Department of Defense; senior military personnel who supervised transgender service members; and transgender people on active duty. The input of commanders reflected their high regard for the transgender staff serving under their command.

18. Members of the Working Group discussed the evidence relating to the costs of permitting transgender persons to serve openly in the military, and the evidence relating to the impact of service by transgender people on operational effectiveness and readiness. Members of the Working Group noted that while transgender service members might have short periods when they were not deployable due to their medical treatment, such periods are not unusual for service members generally, who may take time off due to medical conditions or other reasons.

19. The Working Group also considered that providing medical care for transgender individuals is becoming increasingly prevalent in both public and private sectors alike. Over a third of Fortune 500 companies currently offer employee health insurance plans with transgender-inclusive coverage. Similarly, nondiscrimination policies at two-thirds of Fortune 500 companies now cover gender identity.

20. With respect to the public sector, the Working Group learned that all civilian federal employees have access today to a health insurance plan that provides comprehensive coverage for transgender-related care and medical treatment.

21. Members of the Working Group also discussed the disruptive effect of banning service by transgender people, since such a ban necessitates the discharge of highly trained and experienced service members, leaving unexpected vacancies in operational units and requiring the expensive and time-consuming recruitment and training of replacement personnel.

22. Members of the Working Group also discussed the negative impact of continuing to ban service by transgender people on overall military readiness because it reduces the pool of potential, qualified recruits for military service.

23. The Working Group also considered the 2016 report of a study that the DoD had commissioned from the RAND Corporation, a federally funded research center sponsored by the Defense Secretary's Office, the Joint Staff, the Unified Combatant Command, and the defense Intelligence Community, about the healthcare needs of transgender service members, the associated costs of extending healthcare coverage for transition-related treatments, and the potential readiness implications of allowing transgender service members to serve openly. A true and accurate copy of the report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report"), is attached as Exhibit B.

24. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would amount to "an exceedingly small proportion of … overall DoD health care expenditures." (xi-xii.) The RAND Report further noted that there was no evidence that allowing transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness. Among other things, the RAND Report found that eighteen other countries that permit open service by transgender personnel—including Israel,

Australia, the United Kingdom, and Canada—had not identified any negative impacts on operational effectiveness or readiness. Based on its analysis of allied militaries and the expected rate at which American transgender service members would require medical treatment that would affect their fitness for duty or deployability, RAND's analysis concluded that there would be "minimal impact on readiness from allowing transgender personnel to serve openly." (47.)

25. At the conclusion of its discussion and analysis, the members of the Working Group did not identify any basis for a blanket prohibition on open military service of transgender people. Likewise, no one suggested to me that a bar on military service by transgender persons was necessary for any reason, including readiness or unit cohesion.

26. The Working Group communicated its conclusions to the Secretary of Defense, including that permitting transgender people to serve openly in the United States military would not pose any significant costs or risks to readiness, unit cohesion, morale, or good order and discipline.

27. The Working Group also agreed that the accession policy should be changed to allow transgender people to enlist. The Working Group agreed that the medical standards for accession into the Military Services by transgender persons should be based upon the same standards applied to persons with other medical conditions, which seek to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Based upon that standard, the Working Group agreed that an applicant with a history of gender dysphoria or of treatment for gender dysphoria should be able to accede when

the applicant has completed all medical treatment associated with the applicant's medical condition and has been stable in the preferred gender for a specified period of time.

28. The Working Group also provided comprehensive input regarding all aspects of implementing any change to related military policy. That included addressing practical concerns, like housing and uniform standards for transgender personnel, including when a transitioning service member should be authorized to conform to the standard of the gender to which they were transitioning.

29. The guiding principle behind the Working Group deliberations was that all who are qualified to serve should have the opportunity to do so. The ban on transgender service members was the last categorical ban on otherwise qualified potential service members. No qualified American who can meet the enlistment and retention standards should be excluded from the opportunity to serve.

30. On June 30, 2016, Secretary of Defense Ashton Carter issued Directive-type Memorandum (DTM) 16-005, entitled "Military Service of Transgender Service Members" ("DTM 16-005"), a true and accurate copy of which is attached as Exhibit C.

31. The purpose of DTM 16-005 was to "[e]stablish[ ] policy, assign[ ] responsibilities, and prescribe [ ] procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services." DTM 16-005 was applicable to all Military Departments, including the Army, as well as all organizational entities within the DoD, including the Joint Chiefs of Staff.

32. In DTM 16-005, the Secretary of Defense noted that the "defense of the Nation requires a well-trained, all-volunteer force comprised of Active and Reserve Component Service members ready to deploy worldwide on combat and operational missions." Consistent with and in service to that requirement, DTM 16-005 set forth the policy of the DoD:

> The policy of the Department of Defense is that service in the United States military should be open to all who can meet the rigorous standards for military service and readiness. Consistent with the policies and procedures set forth in this memorandum, transgender individuals shall be allowed to serve in the military.

33. In DTM 16-005, the Secretary of Defense set forth DoD's "position, consistent with the U.S. Attorney General's opinion, that discrimination based on gender identity is a form of sex discrimination."

34. Through DTM 16-005, the Secretary of Defense ordered the Secretaries of the Military Departments, including the Army to identify all DoD, Military Department, and Service issuances in need of revision in light of the DoD change in policy, and to submit proposed revisions to the Undersecretary of Defense for Personnel and Readiness ("USD P&R"). USD P&R was tasked with drafting revisions to all necessary issuances consistent with DTM 16-005.

35. DTM 16-005 also detailed procedures with respect to military service of transgender individuals concerning (i) separation and retention, (ii) accessions, (iii) in-service transition, (iv) medical policy, (v) equal opportunity, (vi) education and training, and (vii) implementation and timeline.

36. With respect to separation and retention, DTM 16-005 provided that, "[e]ffective immediately, no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity." In

addition, transgender service members would "be subject to the same standards as any other Service member of the same gender[.]"

37. Concerning accessions, DTM 16-005 required that no later than July 1, 2017, USD P&R update DoD Instruction 6130.03, which establishes medical standards, which, if not met, are grounds for rejection for military service. Specifically, DTM 16-005 instructed USD P&R to revise DoD Instruction 6130.03 to reflect that:

> (1) individuals with a history of gender dysphoria would not be disqualified from serving on that basis if a licensed medical provider certifies "the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months";
>
> (2) individuals with a history of medical treatment associated with gender transition would not be disqualified from serving on that basis if a licensed medical provider certifies "the applicant has completed all medical treatment associated with the applicant's gender transition[,] … has been stable in the preferred gender for 18 months," and … has been stable on any "cross-sex hormone therapy post-gender transition … for 18 months"; and
>
> (3) individuals with a history of sex reassignment or genital reconstruction surgery would not be disqualified from serving on that basis if a licensed medical service provider certifies that 18 months have elapsed since the surgery, and "no functional limitations or complications persist, nor is any additional surgery required."

38. DTM 16-005 further ordered that effective October 1, 2016, "DoD will implement a construct by which transgender Service members may transition gender while serving in accordance with DoDI 1300.28 [In-Service Transition for Transgender Service Members]." DoDI 1300.28 established a construct by which transgender service members may transition gender while serving, proscribed procedures for changing a service member's gender

marker in the Defense Enrollment Eligibility Reporting System (DEERS), and specified medical treatment provisions for transgender service members.

39. Through DTM 16-005, the Secretary of Defense also ordered USD P&R to "develop and promulgate education and training materials to provide relevant, useful information for transgender Service members, commander, the force, and medical professionals regarding DoD policies and procedures on transgender service" no later than October 1, 2016. Each Military Department, including the Department of the Army, was also ordered to issue implementing guidance and a written force training and education plan no later than November 1, 2016, detailing the Department's plan and program for training and educating its assigned force, including medical professionals.

40. When Secretary Carter publicly announced the issuance of DTM 16-005 on July 1, 2016, he quoted at length the Army's senior general and Chief of Staff, Mark Milley, to convey the principle that Americans who want to serve and can meet our standards should be afforded the opportunity to compete to do so: "The United States Army is open to all Americans who meet the standard, regardless of who they are. Embedded within our Constitution is that very principle, that all Americans are free and equal. And we as an Army are sworn to protect and defend that very principle. And we are sworn to even die for that principle. So if we in uniform are willing to die for that principle, then we in uniform should be willing to live by that principle."

Change, Development, and Implementation of Army Policy

41. To begin implementing DTM 16-005 as applied to the Army, on July 1, 2016, I issued Army Directive 2016-30, titled "Army Policy on Military Service of Transgender Soldiers." A true and accurate copy of Army Directive 2016-30 is attached hereto as Exhibit D.

42. Army Directive 2016-30 was effective immediately and applies to all personnel in the Active Army, U.S. Army Reserve, Army National Guard, and Army National Guard of the United States. It states that "it is Army policy to allow open Service by transgender Soldiers. The Army is open to all who can meet the standards for military service and remains committed to treating all Soldiers with dignity and respect while ensuring good order and discipline. Transgender Soldiers will be subject to the same standards as any other Soldier of the same gender. An otherwise qualified Soldier will not be involuntarily separated, discharged, or denied reenlistment or continuation of service solely on the basis of gender identity." The Directive required the Assistant Secretary of the Army for Manpower and Reserve Affairs (the "ASA (M&RA)") to establish, no later than July 5, 2016, a Transgender Service Implementation Group to develop policies and procedures for transgender service, as well as a Service Central Coordination Cell (SCCC), comprised of medical, legal, and military personnel experts, to serve as a resource for commanders' inquiries and requests. By October 1, 2016, the ASA (M&RA) was directed to recommend a policy addressing service of transgender soldiers, including "a process by which transgender soldiers may transition gender while serving consistent with mission, training, operational, and readiness needs and a procedure where by a Soldier's gender marker will be changed in [the Defense Enrollment Eligibility Reporting System (DEERS)]." In

the meantime, the Directive established a process whereby gender marker changes would be handled via Exceptions to Policy (ETPs) processed by the SCCC and ASA (MR&A), with weekly reports summarizing the ETPs to be provided to me and the Army Chief of Staff.

43. Army Directive 2016-30 also instructed the ASA (M&RA) to create a force-wide training and implementation plan no later than November 1, 2016, to be completed across the Army by July 1, 2017. By the end of 2016, the Army had completed the necessary training and education to ensure that all members of the force understood and could implement the core provisions of the Army's policy on the military service for transgender soldiers.

44. Army Directive 2016-30 also instructed that the Army would continue to provide medically necessary care to all soldiers, and that the Army would issue further guidance to its medical providers no later than 45 days following the publication of guidance from the DoD on medical care for transgender service members.

45. On October 7, 2016, I issued a further directive, Army Directive 2016-35, which "establishes policies and procedures for gender transition in the Army." A true and accurate copy of Army Directive 2016-35 is attached hereto as Exhibit E.

46. Army Directive 2016-35 provides that "a Soldier eligible for military medical care with a diagnosis from a military medical provider indicating that gender transition is medically necessary will be provided medical care and treatment for the diagnosed medical condition." The Directive provides that gender transition in the Army begins with a diagnosis that gender transition is medically necessary and ends when the Soldier's gender marker in DEERS is changed to show the Soldier's preferred gender. The Directive further states that for

policies and standards that differ according to gender, the Army will recognize a Soldier's gender based on the gender marker that appears in DEERS. It states that "the Army applies, and Soldiers are expected to meet, all standards for uniforms and grooming, body composition assessment, physical readiness testing, participation in the Military Personnel Drug Abuse Testing Program, and other military standards" according the gender marker in DEERS.

47. Army Directive 2016-35 includes detailed procedures to be followed by soldiers with a medical diagnosis indicating that gender transition is medically necessary. These procedures require consultation with the soldier's chain of command and differ depending on the soldier's duty status and eligibility for military medical care. When a soldier has completed gender transition and is stable in his or her preferred gender as confirmed by a military medical provider, the soldier may request approval of a change to their gender marker in DEERS, which must be supported by "legal documentation supporting a gender change, consisting of a certified copy of a State birth certificate, a certified copy of a court order, or a U.S. passport showing the Soldier's preferred gender."

48. Army Directive 2016-35 also provides guidance for commanders, directing that they "should approach a Soldier undergoing a gender transition in the same way they would approach a Soldier undergoing any medically necessary treatment. . . . Commanders will balance the needs of the individual transitioning Soldier and the needs of the command in a manner that is comparable to the actions available to the commander in addressing comparable medical circumstances unrelated to gender transition." The Directive instructs commanders to consider actions, such as adjusting the dates of gender transition or discussing extended leave options, in

the same manner as such actions would be considered for other medical circumstances unrelated to gender transition.

49. Army Directive 2016-35 also requires soldiers to use the billeting, bathroom, and shower facilities associated with their gender marker in DEERS. However, commanders are given discretion to employ reasonable accommodations to respect the modesty and privacy interests of soldiers, provided that no soldier is required on the basis of gender identity to use a facility not required of other soldiers with the same gender marker.

50. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook ("DoD Handbook"). A true and accurate copy of the DoD Handbook is attached hereto at Exhibit F. The DoD Handbook is intended as a practical day-to-day guide to assist all service members in understanding the Department of Defense's policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

> The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job.

Harms of Recent Announcements

51. In reliance on the policy changes described above, many military personnel have disclosed their transgender status to their chain of command since 2016. During my time as Secretary of the Army, I did not receive any reports that such disclosures, or the presence of transgender soldiers generally, harmed the readiness, operational effectiveness, or morale of any

Army units. To the contrary, I am aware of commanders who believed that transgender service members under their command were capable and well-qualified to serve.

52. On July 7, 2016, less than a week after Secretary Carter issued DTM 16-005, I visited Fort Jackson, South Carolina, where the Army's newest recruits received Basic Combat Training (BCT)—the introduction soldiers receive as they enter the Army. BCT takes 10 weeks to complete, and recruits undergo intensive training for 12-14 hours a day, Monday through Saturday. Fort Jackson is U.S. Army's main production center for Basic Combat Training, and it trains 50 percent of the Army's Basic Combat Training load and 60 percent of the women entering the Army each year. It also is home to the Army's Drill Sergeant School, which trains all active and Reserve component drill instructors.

53. During my visit, the Commanding General asked me if I'd like to meet a transgender drill instructor, Sergeant Ken Ochoa. Sergeant Ochoa and I met privately for nearly 30 minutes, and I inquired about his experience in the Army generally, and at Fort Jackson in particular. He told me that his experience at Fort Jackson was impressive, and although he was relieved at Secretary Carter's announcement that transgender soldiers could now serve openly, his command had already taken steps to ensure he was able to bring all of his abilities to his job and present himself authentically. His principal concern, however, was that his next post would not be as accommodating, and without formal policies to change his gender marker in DEERS, he might be forced to wear a uniform inconsistent with his gender identity.

54. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25,

2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."

55. I am not aware of any evidence to support President Trump's stated rationale for a total ban on transgender individuals serving in the military. Despite months of research, the members of the Working Group did not find that permitting transgender soldiers to serve would hinder any of these interests. Nor did any senior Army leaders raise these concerns with me. Because I was responsible for all Army training and readiness, such concerns would have been of great interest to me, if they existed. But they did not.

56. Based on my experience as Secretary of the Army and in other senior leadership positions within the DoD and the military departments, I believe a reversal of current DoD policy permitting open service by transgender service members would be profoundly harmful to the public interest and to our military.

57. **Loss of Qualified Personnel.** Discharging current transgender service members or prohibiting their reenlistment or continuation in service would result in the loss of highly qualified and trained personnel. Many transgender service members have specialized training or

hold leadership positions. Their training and professional development has required a significant investment of taxpayer dollars, an investment whose return depends on their continued service. In addition to losing the benefit of that investment in training and leadership development, taxpayers would bear the cost of recruiting and training replacement personnel. With an all-volunteer military, recruiting is a particular challenge, especially with a strong economy in which the military is competing for talent with the private sector.

58. **Effects of Uncertainty on Military Readiness**. The policy announced by the President unnecessarily creates uncertainty and instability for current transgender service members and their commanders. After serving openly and without incident for many months if not much longer, commanders must now deal with the prospect that key personnel may not be able to continue their service, thus impeding military readiness. This uncertainty also impacts decisions about education, training, and promotion, as commanders will be required to consider the possibility that a service member will be discharged based on a factor such as gender identity which is irrelevant to competence or fitness to serve. At the level of military policymaking, the President's action disrupts years of careful research, planning, and implementation work, reopening an issue that senior officials had already addressed comprehensively, and creating a new distraction for senior leadership at a time when our country faces unprecedented military challenges around the world.

59. **Loss of Morale and Unit Cohesion.** The President's reversal of policy is deeply harmful to morale because it impairs service members' trust in their command structure and their ability to rely on established policy.

60. Commanders have told the enlisted soldiers they command that they must treat transgender service members the same as all others. Now they are being directed by the Commander in Chief that those same soldiers are unfit to serve. The new policy reinstitutes discrimination with no factual basis to do so. Imposing new discriminatory standards without any justification is enormously disruptive to unit cohesion and undermines the principle of mutual respect which is essential to the military's effectiveness.

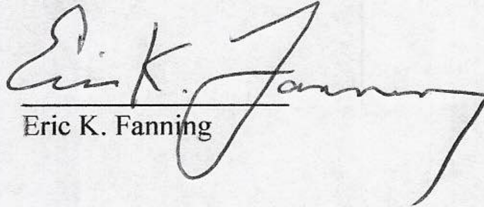
61. In addition, forcing transgender soldiers to lie and hide their transgender status to avoid separation undermines unit cohesion by eroding the bonds of trust among soldiers. It puts non-transgender soldiers in the position of having to choose between reporting fellow soldiers or violating policy. When urging Congress to repeal the ban against service by openly lesbian, gay, and bisexual service members, Admiral Mullen, the former Chairman of the Joint Chiefs, said: "No matter how I look at this issue, I cannot escape being troubled by the fact that we have in place a policy which forces young men and women to lie about who they are in order to defend their fellow citizens. For me personally, it comes down to integrity—theirs as individuals and ours as an institution." The same is true of a policy that forces service members to lie about being transgender.

62. In the Army Directives described above, and in many other documents, the Armed Forces have told transgender service members that they may disclose their transgender status and serve openly, without fear of discharge based on their transgender status. Dramatically reversing course and now using that information as a basis for separating these

soldiers from their service is an unprecedented betrayal of the trust that is so essential to achieving the mission of all of the armed forces.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: August 28, 2017



Eric K. Fanning

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al.,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
DONALD TRUMP, et al.,	)	
Defendants.	)	

**SUPPLEMENTAL DECLARATION OF ERIC K. FANNING
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Eric K. Fanning, declare as follows:

1. As set forth in my earlier declaration signed and dated August 28, 2017, I oversaw the Department of the Army's participation in the Working Group that comprehensively reviewed military policy with regard to transgender persons serving openly in each of the service branches and which attempted to identify any practical, objective impediments to such service. It was based upon that review and the recommendations of that group that the Department of Defense announced on June 30, 2016, that transgender service members could openly serve in the U.S. military.

2. My earlier declaration also sets forth my awareness of the announcements of a new policy on transgender service, both through Twitter in late July 2017, and then in a Presidential Memorandum ("the Memorandum") issued by the White House on August 25, 2017. Although providing the Secretaries of Defense and Homeland Security the opportunity to review the current policies, the Memorandum sets March 23, 2018 as the date by which the June 2016

policy "shall" be reversed (section 3) and transgender individuals will be subject to discharge as a result of disclosure of their transgender status.

3. Based on my knowledge and experience in military personnel and readiness challenges, as a result of service as a senior executive in each of the three military departments as well as Chief of Staff to the Secretary of Defense, the recently announced policy change is causing significant harm to current servicemembers who have already disclosed their status as an individual who is also transgender to their commanders.

4. The Memorandum asserts that the "previous Administration" had an "[in]sufficient basis" for allowing open service, and therefore, this Administration is directing the reversal of policy changes that had enabled open service based on its "meaningful concerns" about the impact of open service on "under military effectiveness and lethality, disrupt unit cohesion, or tax military resources."

5. In my experience, this communicates that the Commander in Chief of the U.S. military believes that transgender service members are unfit for military duty solely because of their transgender status. It degrades the value of transgender individuals not only to those service members themselves, but gives license to their leaders and fellow service members to do the same, in an environment where the ability to unqualifiedly and mutually rely on each other is an indispensable element of service. The Memorandum on its face marks these service members as deserving of impending involuntary discharge.

6. The Memorandum alone, and certainly when animated by the President's tweets, causes harm by preventing transgender service members from serving on equal terms with other service members based on their merit; serves to substantially limiting their advancement and promotion opportunities in the military; and undermines their standing with superiors and peers,

as described above. Opportunity to succeed and advance in the military should not depend on gender identity, nor any other factor other than ability to meet the required standards.

7. The harm extends beyond the individuals involved to the whole ethos of the military as a meritocracy where all Americans who want to serve and can meet its standards should be afforded the opportunity to do so. Unjustified, categorical bans on Americans qualified and ready to serve diminishes that organizing principle.

8. Furthermore, the Presidential Memorandum and Secretary of Defense Jim Mattis' August 29, 2017 announcement that he will "carry out the president's policy direction" by "develop[ing] a study and implementation plan" sends the clear message to American society that the U.S. Army is not, as General Mark Milley, the Army's Chief of Staff and highest ranked officer, declared in 2016 "open to all Americans who meet the standard, regardless of who they are."

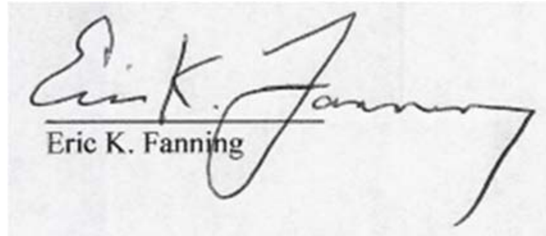
9. That declaration is essential to ensuring the military has access to the best and brightest America has to offer and that those who seek to serve know that they will be judged by their performance alone, rather than the artificial prejudices that once hampered the advancement and acceptance of African Americans, women, religious minorities, and gays and lesbians in our nation's armed forces.

10. In addition, when the military fails to keep pace with the demographic change of our nation and departs from the core principle of opportunity for all that can meet its high standards, it results in an erosion of understanding between those who serve and those who freedom those service members defend. The President's tweets and directive undoubtedly exacerbate this divide, both by creating a single class of Americans he deems unfit to serve and dividing the nation by telling them that only these individuals are unfit.

11. Finally, during my tenure as Secretary of the Army, I am unaware of any instance prior to or after June 2016 when a transgender person seeking to enlist or accept a commission in the Army was granted a waiver from the Army's medical accession standards.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: October 15, 2017



No. 17-5267

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JANE DOE 1 et al.,
Plaintiffs-Appellees,

v.

DONALD J. TRUMP, President of the United States, et al.
Defendants-Appellants

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DECLARATION OF ERIC K. FANNING IN SUPPORT OF APPELLEES' OPPOSITION TO APPELLANTS' EMERGENCY MOTION FOR ADMINISTRATIVE STAY AND PARTIAL STAY PENDING APPEAL

I, Eric K. Fanning, declare as follows:

1. As noted in my previous declarations in this case signed and dated August 28, 2017 and October 15, 2017, I served as Secretary of Army from May 18, 2016 to January 20, 2017. As Secretary, I oversaw the Department of the Army's participation in the Working Group that comprehensively reviewed

military policy with regard to transgender persons serving openly in each of the service branches and which attempted to identify any practical, objective impediments to such service. It was based upon that review and the recommendations of that group that the Department of Defense announced on June 30, 2016, that transgender service members could openly serve in the U.S. military.

2. The Working Group's recommendations also resulted in change of military standards for accessions, also announced on June 30, 2016, to authorize transgender individuals to enlist and commission into the Armed Forces.

3. Based on my experience in military personnel and operations, implementing that change required training throughout the Services—training that required preparation, development, and effective implementation. However, much of the new process for transgender accessions mirrored an existing process. These changes to policy for transgender accession, set forth in DTM 16-005, were consistent with standards already in place authorizing individuals with a range of medical conditions to accede to military service. As a result, the training program was designed to focus on helping military professionals understand the terminology and range of possible documentation unique to transgender individuals to assist them in applying to preexisting, well-understood procedures, rather than carving out any new process specifically designed for accessions of these individuals.

4. At the time I left office, less than a year ago, the Department of Defense was on track to fully implement the change in accession policy effective July 1, 2017. Based on the training and implementation efforts that took place during my time of service, and my understanding that any such efforts were not halted before June 30, 2017, I cannot identify any reason why the military would not be prepared to permit accessions of transgender people by January 1, 2018, six months beyond the initial target date that had been set for the accessions policy change.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: December 14, 2017

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF DEBORAH LEE JAMES
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Deborah Lee James, declare as follows:

Background and Experience

1. I served as the Secretary of the United States Air Force ("USAF") from December 20, 2013 to January 20, 2017.

2. I hold a Bachelor's Degree in Comparative Area Studies from Duke University (1979), and a Master's Degree in International Affairs from Columbia University (1981). From 1983 until 1993, I worked as a professional staff member for the Armed Services Committee of the United States House of Representatives, including as a senior advisor to the Subcommittee for Military Personnel and Compensation. From 1993 to 1998, I served as Assistant Secretary of Defense for Reserve Affairs, responsible for advising the Secretary of Defense on all matters pertaining to roughly 1.8 million National Guard and Reserve personnel. I then held a variety of senior positions at Science Applications International Corporation (SAIC), including as President of the Technical and Engineering Sector overseeing more than 8,000 employees.

3. As Secretary of the USAF, I functioned as the chief executive of the Department of the Air Force, with the authority to conduct all of its affairs, subject to the authority, direction, and control of the Secretary of Defense. As Secretary, I had comprehensive oversight responsibility for (i) the Department of the Air Force's annual budget, (ii) overseeing the organization, training, supplying, equipping and mobilization of USAF personnel, and (iii) overseeing the construction and maintenance of military equipment, buildings, and structures. In connection with my personnel-related oversight responsibilities, I administered the development and implementation of recruitment, retention, and medical policies for active duty and reserve USAF personnel. Among the people who directly reported to me was the Chief of Staff of the USAF, the most senior uniformed USAF officer.

The Air Force

4. The USAF is the aerial warfare service branch of the United States Armed Forces. It is one of the three military departments of the Department of Defense ("DoD"). The USAF, with an annual budget of more than $139 billion, operates thousands of military and surveillance aircraft and controls hundreds of intercontinental ballistic missiles and military satellites. It employs over 600,000 Airmen and civilian employees. The USAF, including the Air Force Reserve and Air National Guard, operates over 300 flying squadrons, consisting of 8 to 24 aircraft each, worldwide. Air Force bases are located across the United States and span the globe.

5. The USAF has several core missions. First, it ensures American superiority in air and space across the globe. This superiority protects all of our other armed services from air attack during their operations. Second, the USAF is responsible for intelligence, surveillance, and reconnaissance, a function that is also essential to the integrated operation of the Armed

Forces. Third, it is also a core mission to enable rapid global mobility. The USAF projects American power rapidly across the face of the earth and enables swift deployment as well as the ability to sustain operations by delivering essential equipment, supplies, and personnel. Fourth, the USAF has its global strike capabilities as an essential mission. The ability to strike globally underlies our deterrence; the USAF's combat capabilities allow it to threaten, disable, or destroy any target around the globe. Lastly, the USAF is also charged with command and control. It provides access to reliable communications and information networks so that the military services as a whole can operate jointly in a coordinated fashion globally and at a high level of intensity.

6. The USAF is one of the most technologically sophisticated organizations on the planet, dwarfing the technological capabilities of individual companies in the private sector. Our aircraft, spacecraft, weapons, and surveillance equipment contain the most advanced new technologies devised by human ingenuity. Many USAF personnel train for years to function effectively in the USAF. Recruitment and retention of capable and qualified Airmen is of critical importance to the readiness of the USAF.

Change and Development of DoD Policy

7. By 2014, it had become clear that the United States Armed Service, including the USAF, had valued members who were transgender with specialized skills. Starting in 2014, the DoD took steps to consider military policy concerning the open service of transgender service members against the backdrop of the military's critical need for qualified personnel.

8. In August 2014, the Department of Defense issued a new regulation, DODI 1332.18, *Disability Evaluation System (DES).* The regulation eliminated a department-wide list of conditions that would disqualify persons from retention in military service, including the

categorical ban on open service by transgender persons. This new regulation instructed each branch of the Armed Forces to reassess whether disqualification based on these conditions, including the ban on service by transgender persons, was justified. As of August 2014, there was no longer a department-wide position on whether transgender persons should be disqualified for retention.

9. On July 28, 2015, Secretary of Defense Ashton Carter ordered Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group").

10. As Secretary of the Air Force, I was responsible for supervising the Department of the Air Force's participation in the Working Group. The Working Group met both as a whole and in smaller groups tasked with investigating and analyzing specific issues. I met regularly with members of the Working Group to discuss their progress and the Air Force's positions on the issues discussed.

11. The Working Group engaged in a comprehensive examination of the issues presented by permitting transgender people to serve openly. The goal was to be as comprehensive as possible, considering all available scholarly literature and evidence, and to thoroughly investigate any possible issues or concerns about how permitting open service might affect any aspect of military efficiency or readiness.

12. The Working Group included military and civilian personnel, readiness and medical experts from each of the services along with medical experts from the Defense Health Agency. It solicited information from both senior military personnel who supervised transgender

service members and transgender people on active duty. It also examined the experiences of civilian employers and of foreign militaries who permit transgender people to serve openly.

13. The Working Group also considered a report from the RAND Corporation, a federally funded research center that regularly provides research and analysis to the Armed Forces. The RAND Corporation was asked by the Under Secretary of Defense for Personnel and Readiness to conduct a study "to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness implications of allowing transgender members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly." A true and accurate copy of the report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report"), is attached as Exhibit A.

14. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would amount to "an exceedingly small proportion of … overall DoD health care expenditures." It found that the Military Health Service (MHS) has the capacity to provide this care, and that doing so would improve the capacity of the MHS by helping MHS surgeons "maintain a vitally important skill required of military surgeons to effectively treat combat injuries." (8.) Considering a variety of utilization data, including data from the Veterans Health Administration, the RAND Report concluded that only a very small number of service members will access some type of gender transition-related treatment annually. (30.) The RAND Report found that the costs of providing health care for transgender service members would likewise be very small, amounting to an insignificant percentage of the overall DoD healthcare budget: "[E]ven in the most extreme scenario we were able to identify using the

private health insurance data, we expect only a 0.13-percent ($8.4 million out of $6.2 billion) increase in AC health care spending." (36.)

15. The RAND Report concluded that permitting transgender people to serve openly would have no significant impact on military readiness or efficiency. The RAND Report examined the deployability of transgender persons before transition, during transition, and post-transition. It concluded that even assuming the highest estimates of utilization rates, the impact of permitting transgender solders to serve openly and to obtain appropriate health care would be minimal, amounting to "0.0015 percent of available deployable labor-years across the AC and SR." (42.)

16. The RAND Report also found no evidence that permitting transgender soldiers to serve openly would have any significant negative impact on unit cohesion. Rather, the available evidence, including the experience of permitting service by openly gay personnel, suggests the opposite. In particular, the available evidence indicates that "direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance." (44.)

17. The RAND Report found that available research on foreign militaries showed no evidence that "allowing transgender people to serve openly has had any negative effects on operational effectiveness, cohesion, or readiness." (45.) The Working Group also met directly with representatives from some of these foreign militaries, who confirmed that permitting open service had no significant deleterious effects.

18. The Working Group compared the potential loss of deployability associated with transition-related health care with the loss of deployability associated with other, much more common medical conditions. The Working Group considered impacts to readiness and advice from experts indicating that the circumstance should not be treated differently.

19. The Working Group also considered that both private and public employers increasingly are providing coverage for transition-related health care, including the health insurance coverage available to civilian federal employees.

20. The Working Group also considered that banning transgender service members results in the loss of otherwise qualified personnel, which may leave critical positions unexpectedly vacant, as well as the financial loss involved in having to replace trained and, in some instances, highly skilled personnel.

21. The Working Group also considered that barring service by transgender people reduces the pool of potential qualified recruits and irrationally excludes individuals based on a characteristic that has no relevance to their ability to serve.

22. Based on its comprehensive and careful review, the Working Group agreed that transgender people should be permitted both to enlist and to serve openly in the United States military.

23. With regard to accession, the Working Group agreed that transgender persons should be subject to the same medical standards applied to persons with other medical conditions. Those standards are designed to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. The Working Group therefore agreed that applicants with a history of gender dysphoria or of treatment for gender dysphoria be permitted to enlist only if they have completed all medical treatment associated with gender transition and been stable in the preferred gender for a specified period of time.

24. The Working Group agreed upon a variety of other changes to related military policy, based on the same principle of securing equal treatment of transgender persons under existing standards.

25. On June 30, 2016, Secretary of Defense Ashton Carter issued Directive-type Memorandum (DTM) 16-005, entitled "Military Service of Transgender Service Members" ("DTM 16-005"), a true and accurate copy of which is attached as Exhibit B.

26. The purpose of DTM 16-005 was to "[e]stablish[ ] policy, assign[ ] responsibilities, and prescribe [ ] procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services." DTM 16-005 was applicable to all Military Departments, including the USAF, as well as all organizational entities within the DoD, including the Joint Chiefs of Staff.

Change, Development, and Implementation of USAF Policy

27. To implement DTM 16-005 as applied to the Air Force, on October 6, 2016, I issued an Air Force Policy Memorandum entitled "*Air Force Policy Memorandum for In-Service Transition for Airmen Identifying as Transgender*" (the "AFPM") jointly with the U.S. Air Force Chief of Staff, General David Goldfein. General Goldfein is a fighter pilot who has served in the Air Force for over 30 years (including multiple combat deployments). A true and accurate copy of the AFPM is attached hereto as Exhibit C.

28. The policy and guidance in the AFPM, which was effective immediately for all USAF personnel, "provides unit personnel, supervisors, commanders, transgender Airmen and the medical community a construct by which transgender Airmen may transition gender while serving," and "outlines policies for accessing, separating, and retaining transgender Airmen." Further, the policies and procedures reflected in the AFPM "are premised on the conclusion that

open service by transgender Airmen who are subject to the same standards and procedures as other members of the same gender with regard to their medical fitness for duty, physical fitness, dress and appearance standards, deployability, and retention, is consistent with military service and readiness." The AFPM thus provides that "no otherwise qualified Airman may be involuntarily separated, discharged or denied reenlistment or continuation of service solely on the basis of their gender identity."

29. With respect to individuals presently serving in the USAF, the AFPM states that transgender Airmen will be responsible to meet all standards for uniforms and grooming, physical fitness, and use of facilities according to the Airmen's gender marker in the Military Personnel Data System ("MilPDS"), subject to the approval of an Exception to Policy ("ETP") request.

30. The AFPM further provides that when a transgender Airman's medical provider formally advises the Airman's commander that the Airman's transition is complete, the Airman can "provid[e] … either a certified copy of a state birth certificate reflecting the member's preferred gender, a certified copy of a court order reflecting the member's preferred gender, or a United States passport reflecting the member's preferred gender." And, per the AFPM, the Airman's commander may then authorize an update to the Airman's gender marker in MilPDS, which then "will be transmitted to and updated in DEERS." The Airman will thereafter be responsible for meeting all gender-related standards in accordance with the updated gender marker.

31. To allow USAF commanders to address medical needs in a manner consistent with military mission and readiness, the AFPM sets forth detailed procedures concerning medical treatment for transgender Airmen with a diagnosis from a medical military provider

indicating that gender transition is medically necessary. Airmen with such a diagnosis must notify their commander and "identify all medically necessary care and treatment that is part of the Airman's medical treatment plan and a projected schedule for such treatment, including an estimated date for a change in the member's gender marker in MilPDS." A military medical provider's diagnosis must be confirmed by the Medical Multidisciplinary Team, taking into account "the severity of the transgender Airman's medical condition and the urgency of any proposed medical treatment." All gender transition plans must include timing, as approved by the Airman's unit commander in consultation with the Airman and military medical personnel.

32. The AFPM also provides that "[t]ransgender Airmen selected for deployment will not be prevented from deploying if they are medically qualified." "Any determination that a transgender Airman is non-deployable at any time will be consistent with established Air Force standards, as applied to other Airmen whose deployability is similarly affected in comparable circumstances unrelated to gender transition."

33. In addition, the AFPM identified the following Air Force Instructions ("AFI") to be revised to conform with the updated DoD policy concerning service of transgender individuals, consistent with the policy announced in the AFPM: (i) AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers; (ii) AFI 36-2905, Fitness Program; (iii) AFI 36-2903, Dress and Personal Appearance of Air Force Personnel; (iv) AFI 36-3208, Administrative Separation of Airmen; (v) AFI 36-3209, Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members; (vi) AFI 48-123, Medical Examinations and Standards; and (vii) AFI 32-6005, Unaccompanied Housing Management.

34. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook ("DoD Handbook"). A true and accurate copy of

the DoD Handbook is attached hereto at Exhibit D. The DoD Handbook is intended as a practical day-to-day guide to assist all service members in understanding the Department of Defense's policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

> The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job.

The Harms Caused by the Recent Reversal of Policy

35. Relying on the DTM 16-005 and the Air Force Policy Memorandum, many service members disclosed their transgender status to their commanding officers and took other steps in reliance on the policy permitting service by openly transgender personnel. I am unaware of any evidence that this caused any harm to Air Force operations.

36. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve "in any capacity" in the Armed Forces.

37. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."

38. I am not aware of any evidence to support President Trump's stated rationales for reversing the policy permitting open service. The Working Group spent months carefully collecting and considering the available evidence related to this issue, including examining how permitting open service by transgender persons would affect the very factors referenced in the August 25 memorandum. The Working Group did not find that permitting transgender soldiers to serve would impose any significant costs or have a negative impact on military effectiveness or readiness. The Working Group also found that barring transgender people from military service causes significant harms to the military, including arbitrarily excluding potential qualified recruits based on a characteristic with no relevance to their ability to serve.

39. In addition to being contrary to the careful study performed and conclusions drawn by the Working Group and the Secretary of Defense, it is my assessment, based on my experience as Secretary of the Air Force and in other leadership positions within the DoD and other defense-related institutions, that banning transgender people from enlisting or openly serving in the military would harm both the military and the broader public interest, for several reasons.

40. **Loss of Qualified Personnel.** First, banning current transgender service members from enlisting or serving in the military will result in the loss of qualified recruits and trained personnel, reducing readiness and operational effectiveness. Some transgender service members are senior and hold important leadership positions. The military has invested significant resources in the education and training of these personnel. Those resources are squandered when they are separated for reasons unrelated to their ability or performance.

41. The loss of qualified personnel as a result of separating transgender service members could be particularly acute at USAF. The USAF is currently facing a reduced pool of

qualified potential recruits. Unlike many private-sector companies, which can fill vacancies by simply tapping an experienced and flexible labor pool, the USAF has to grow its own set of skilled specialists, and that can take years. If the USAF were to lose any pilots because of the ban on transgender service members, that would be especially expensive given the crisis level of pilots who cost millions of dollars to train.

42. Deployability. Allowing transgender service members to openly serve does not create any unique issues relating to deployability. Any time that a given service member cannot deploy, we rely on force management models, the reserve component, and in some cases, civilian support to meet mission requirements. Military processes exist to manage any exigencies as they arise. Responding to any deployability issues to the extent that they may arise for some individual transgender service members creates no greater challenges than those recently addressed by, for example, a change in maternity leave policies for pregnant service members.

43. **Erosion of Trust in Command.** Second, the President's abrupt reversal of policy is harmful to military readiness because it erodes service members' trust in their command structure and its professionalism. The military's effectiveness depends on a relationship of mutual trust between leaders and followers. That trust, and the prompt following of commands, is essential to the unit cohesion and rapid response required to address unexpected crises or challenges. Following the adoption of the policy permitting open service by transgender persons in 2016, military leaders instructed service members that they should not discriminate against their transgender colleagues. For that policy to be abruptly reversed will inevitably erode trust in the reliability and integrity of military decision making.

44. This sudden reversal is harmful both to transgender service members and to other formerly disfavored groups that have been recently integrated into the military and into combat

roles. In 2011, the Don't Ask, Don't Tell policy prohibiting gay, lesbian and bisexual people from openly serving in the military was repealed. More recently, DoD also removed remaining barriers for women serving in certain combat positions. The sudden reversal of the DoD's recently adopted policy of inclusion sends a dangerous message that policies promoting the inclusion and equal treatment of other groups may similarly be arbitrarily reversed.

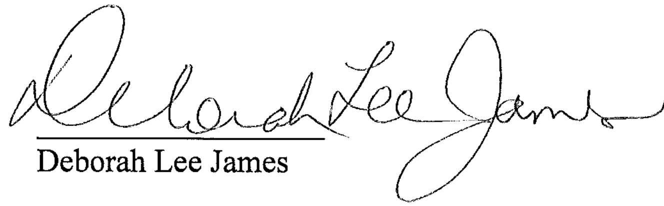
45. **Readiness and Morale.** Third, the sudden reversal of a policy adopted after substantial deliberation will also have a deleterious effect on morale, as it undermines the confidence of service members that important military policy decisions will be based on a rational, careful, and thoughtful process. Airmen and other service members must believe that the orders and policies they are required to follow are based on reasonable decisions, not impulse or whim. This trust in the rationality and professionalism of our military leadership is also a key factor in recruiting and retaining talented personnel. The sudden reversal of the June 2016 policy undermines that trust.

46. Banning openly transgender service members will also have a negative impact on recruitment and retention, which are critical concerns in our all-volunteer services. Such a ban will arbitrarily eliminate otherwise highly qualified and valuable individuals who wish to serve, including those who are already enrolled in Reserve Officer Training Corp programs and military academies, based on a characteristic that has no bearing on fitness for military service. Preventing the accession of transgender individuals who have met the rigorous requirements for enrollment in a military academy is particularly senseless and damaging and will result in the loss of extremely talented and well-qualified future leaders. The negative impact of such irrational and prejudicial policies on the public perception of the Armed Services—including the perception of potential recruits—should not be underestimated.

47. The impact to morale engendered by the abrupt reversal of the policy permitting open service by transgender people will not only have an effect on the morale of our current service members. Any suggestion that those serving to protect and defend our country will not have the fullest support of their entire chain of command will also have a negative impact on the USAF's ability to recruit highly qualified candidates who can perform at the highest levels necessary to complete the USAF's core missions.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: August 29TH, 2017



Deborah Lee James

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

**SUPPLEMENTAL DECLARATION OF DEBORAH LEE JAMES
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Deborah Lee James, declare as follows:

1. As noted in my prior declaration, I served as the Secretary of the United States Air Force ("USAF") from December 20, 2013 to January 20, 2017. As Secretary, I was responsible for supervising the Department of the Air Force's participation in a working group convened by the Department of Defense in 2015 to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group").

2. Based on the Working Group's analysis and recommendations, the Department of Defense announced in June 2016 that it would begin to allow transgender people to serve openly in the Armed Forces.

3. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25,

2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. The President's memorandum stated that the military would return to the pre-June 2016 policy on March 23, 2018.

4. Based on my experience regarding military personnel, and in particular personnel and operations of the USAF, the President's announced decision to ban openly transgender people from serving in the military effective March 23, 2018 is presently harming transgender people currently serving in the military in several significant respects.

5. Airmen are typically deployed for periods of time that exceed several months, and planning for a deployment begins several months in advance of the deployment. Commanders in charge of overseeing deployments must take into account the certainty with which Airmen will be available for the entire length of a deployment when making assignment decisions.

6. Given the President's announcement that transgender service members will be subject to separation from the military beginning March 23, 2018, commanders cannot rely on transgender Airmen being able to complete deployments that continue beyond that date. Transgender Airmen with deployment terms that extend beyond March 2018 will thus lose opportunities for assignments because command will not be able to determine with certainty that transgender Airmen will be present for the entire duration of the deployment. In addition to negatively impacting individual Airmen, this uncertainty harms USAF readiness and capabilities where commanders are not able to make assignments based solely on the capabilities and experiences of those under their command.

7. Even outside the deployment context, transgender Airmen will lose out on assignments, opportunities, and experiences they would otherwise receive but for the President's

announcement that they will be subject to separation in March 2018. Commanders will be reluctant to invest time and money on training transgender Airmen for important or significant assignments or tasks where commanders believe the Airmen will be expected to leave the USAF in the near future.

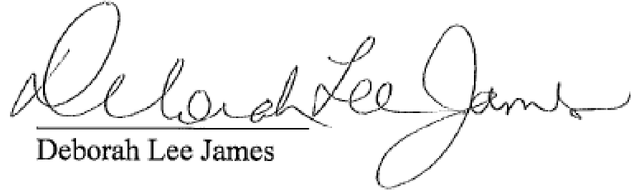
8. In addition, the President's announced ban on transgender people serving in the military creates a sub-class of service members, placing transgender people on unequal footing as compared to their non-transgender peers for reasons having nothing to do with their capabilities or past performance, and suggesting that transgender Airmen are unworthy of their comrades' trust and support. A lack of trust among service members is deeply concerning, as trust and respect throughout the chain of command is essential to promote military effectiveness. Thus, in addition to causing present harm to transgender Airmen, the President's ban will have a deleterious effect on the USAF's effectiveness and capabilities as well.

9. The President's announced ban is also anathema to the ethos of the military in general, and in particular the USAF. In the USAF, individual Airmen are given assignments and receive commendations and promotions on the basis of their individual merit and skill set. The USAF, and the military in general, are weakened when this fundamental building block of their identities is fractured through suggesting that service members should be judged based on characteristics having nothing to do with their ability to perform their job.

10. Finally, I am not aware of any instance – before or after June 2016 – where a transgender person seeking to join the military was granted a waiver to the ban on service of openly transgender individuals. Even if a transgender person were to seek a waiver at this time, doing so would be futile in light of the President's order making transgender service members subject to separation beginning in March 2018.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: October 12, 2017



Deborah Lee James

No. 17-5267

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JANE DOE 1 et al.,
Plaintiffs-Appellees,

v.

DONALD J. TRUMP, President of the United States, et al.
Defendants-Appellants

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DECLARATION OF DEBORAH LEE JAMES IN SUPPORT OF APPELLEES' RESPONSE TO APPELLANTS' EMERGENCY MOTION FOR ADMINISTRATIVE STAY AND PARTIAL STAY PENDING APPEAL

I, Deborah Lee James, declare as follows:

1. As noted in my previous declarations in this case signed and dated August 29, 2017 and October 12, 2017, I served as the Secretary of the United States Air Force ("USAF") from December 20, 2013 to January 20, 2017. As Secretary, I was responsible for supervising the Department of the Air Force's

participation in a working group convened by the Department of Defense in 2015 to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group"). On June 30, 2016, then Secretary of Defense Ashton Carter announced that the military would allow transgender people to openly serve. Included within that announcement and change of policy was a direction that the military would adopt changes to the accessions policy to begin allowing accession by transgender people starting on July 1, 2017.

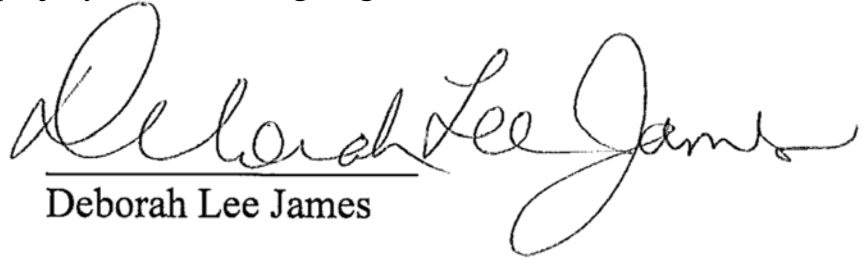
2. Based on my personal knowledge, the USAF had nearly completed the necessary preparations for implementing the change in accessions policy when I left office in January 2017.

3. The change in accessions to authorize transgender people to serve was consistent with the approach generally for authorizing people to serve with curable or treatable medical conditions. It included notifying and training medical personnel across the services regarding information relating to the underlying medical condition associated with some transgender individuals and the period of stability after treatment necessary for enlistment.

4. The preparations for implementing the change in policy could readily have been completed by the initial target date of July 1, 2017, well within the current, target date of January 1, 2018.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: December 14, 2017



Deborah Lee James

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al.,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
DONALD TRUMP, et al.,	)	
Defendants.	)	

**DECLARATION OF REGAN V. KIBBY
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Regan Kibby, declare as follows:

1. I am a nineteen year old midshipman at the United States Naval Academy in Annapolis, Maryland. I have completed the first two years of my Naval Academy education, double majoring in English and History. I am transgender.

Early Education and Entrance to the Naval Academy

2. I was born in San Diego and lived there until the fifth grade, when I moved to North Carolina. Spending my formative years in a big military town like San Diego made the thought of serving present for me from an early age.

3. My father had served in the Navy, which ingrained in me a deep recognition of the pride and honor associated with military service. I always felt that if I could serve my country in the Armed Forces, I should. It felt like a duty.

4. In high school I enrolled in the Junior Reserve Officers' Training Corps. My instructors recognized that I had potential and encouraged me to begin planning for my future,

including looking into the service academies. I did research, and by my junior year I was set on attending an academy.

5. I applied to the summer seminars at the United States Military Academy, the United States Air Force Academy, and the United States Naval Academy and got accepted to all of them. I attended each in consecutive weeks during the summer after my junior year of high school. At the beginning of senior year I did a candidate visit to the Coast Guard Academy.

6. I was very driven to do what it took to get into an academy. I focused hard on sports, extracurricular activities, and JROTC. I excelled at academics, took advanced classes, and never received less than A. I had strong test scores.

7. I found I was drawn to maritime service and decided to apply to the Naval and Coast Guard academies. I also applied to Norwich University and the Virginia Military Institute and was accepted to both with a full Navy Reserve Officers' Training Corps scholarship.

8. When I was accepted to the Naval Academy, I immediately decided to enroll there. My Induction Day occurred on July 1, 2015, and I joined the class of 2019. I was extremely proud to become a midshipman and knew I was where I wanted to be.

9. My first two years at the Naval Academy have been a rigorous and rewarding experience. After I graduate, I hope to perform my service as a Surface Warfare Officer aboard a Navy ship.

Transgender Identity and Coming Out at the Naval Academy

10. I always felt out of place in the social roles that were expected of me as a result of the sex assigned to me at birth. For a while I did not have the words to describe how I felt. In middle school I learned the term "transgender" and tried to learn more about it. At the time I did

not quite know why I felt so drawn to the subject, but I knew that learning about the identity and seeing the stories of transgender people made me feel inexplicably happy and right.

11. Around the same time, I was getting more serious about a future in the military. During my freshman year of high school Don't Ask Don't Tell was repealed, but transgender people were still prohibited from military service. Some part of me internalized the reality that being transgender and being in the military were not coinciding identities, and as a result I tried not to think about my gender. I stopped doing research and did not discuss it with anyone, and before long I had succeeded in burying that short span of partial realization. Unfortunately, I also buried the feelings of happiness and rightness I had briefly experienced.

12. Due to my masculine appearance and behavior, many people in school automatically perceived me as gay. Instead of openly identifying myself as transgender, even to myself, I accepted that label. Even though being labelled gay in rural North Carolina is not easy, I think I subconsciously knew that it was easier than being transgender.

13. On July 28, 2015, after I started at the Naval Academy, Secretary of Defense Ashton Carter issued an order announcing that transgender people could not be separated from the military on the basis of their gender identity.

14. Following this announcement, I started to allow myself to think more about my identity. I started being more open and honest with myself and began remembering things I had tried to ignore. After a period of self-realization, a few months into freshman year, I started to come out as transgender.

15. The first people I came out to were in Navy Spectrum, an organization for LGBT midshipmen and their allies. I also talked to my sister, with whom I am really close. I then came out to my three roommates, all of whom were very accepting. After that, I came out to the rest

of my family, and during my second semester in early 2016, I came out to my chain of command including my Company Officer.

Developing a Transition Plan to Serve Openly

16. My Company Officer was very accepting and supportive and made sure everyone treated me with respect. Because my chain of command was awaiting the conclusions of the Working Group on transgender service members that had been formed following Secretary Carter's order, no policy was yet available for them to follow.

17. In June of 2016, Secretary of Defense Ashton Carter announced that transgender people would be able to serve openly in the U.S. armed forces and that, starting on July 1, 2017, transgender people would be eligible to enlist in the military on equal terms with others.

18. I was completing summer school and summer training at the time and immediately emailed my Company Officer and asked if he had heard about the new policy or how it would be implemented at the Naval Academy. He did not have any information, but he said he would try to learn more and we scheduled a meeting for the start of the school year.

19. At that meeting, my Company Officer put me in touch with the Brigade Medical Officer (BMO) to begin the process of getting a diagnosis and a medical treatment plan.

20. In the fall of 2016, I met with the BMO. No guidelines for implementation of the new policy had been issued yet, but we knew the first step would be receiving an official diagnosis and an annotation in my medical record that transition was medically necessary. I scheduled an appointment with a psychiatrist and received both of those things.

21. Later that fall, the Navy issued a directive outlining the protocol for gender transition for service members, including midshipmen, as well as guidelines for the requirements that a transgender person would have to meet in order to be eligible to enlist. I met again with

the BMO and began discussing the rest of the process for my treatment plan. This involved many consultations with different medical professionals. I met multiple times with mental health care providers, an endocrinologist, and a plastic surgeon to develop my treatment plan.

22. The military's policy on accessions requires transgender individuals to have had eighteen months of stability in their gender identity prior to accession, meaning that everything in the treatment plan must be completed and a physician must certify that my transition is complete eighteen months before I can be commissioned. While all midshipmen are members of the military, we are still considered part of an accessions program since we do not receive our commission until graduation.

23. My treatment plan involves hormone therapy, top surgery, and real life experience. Once my doctor signs off that my treatment plan is complete, I can change the gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), thus beginning the eighteen-month period of stability required for accessions.

24. Early on in the development of my treatment plan, during the winter of 2016-2017, the BMO and I started looking into how transitioning would impact my commissioning. We knew that approval and implementation of my plan would take many more months and that accessions happen immediately following graduation. Counting backward, we calculated that in order to have fully transitioned eighteen months prior to graduation (halfway through my junior year), I would need to take a year off from the academy.

25. I went through the standard medical and legal processes to request an official medical leave of absence from the Naval Academy. Working with the Transgender Care Team at Portsmouth's Naval Medical Center, we finalized the treatment plan.

26. At the end of this past school year, in May of 2017, the Commandant and Superintendent officially approved the medical transition plan and the request for a year-long medical leave of absence. I was the first midshipman to receive clearance to transition while enrolled at the Academy. Upon approval of this plan, I felt a huge sense of relief that I would not have to make a choice between two fundamental parts of my identity: being transgender and serving my country. I looked forward to graduating from the Academy and beginning my military service without having to hide who I am. Knowing that I could serve openly gave me confidence and hope for the future, and pride in our country and our Armed Forces.

27. During the month of June, I went on a regularly scheduled four-week summer training for midshipmen. Upon returning to the Naval Academy, I completed my leave paperwork. Two weeks after that I returned to North Carolina to begin my medical leave.

28. During my year of medical leave, in addition to receiving hormone therapy under the supervision of an endocrinologist, I intend to do everything I can to ensure that my return to the Naval Academy is successful and that I will be a valuable service member. I will keep in touch regularly with the Academy. I am interning at a law firm to gain professional experience. I am taking an EMT class in order to learn valuable skills, including how to save lives. I am completing a rigorous exercise and training regimen so that I will be able to meet the male fitness standards upon my return. I can already meet the male standards for push-ups and sit-ups and will be working hard on my run time. I am looking forward to returning to the Academy in the fall of 2018 and completing my education.

The July 2017 Tweet and the August 25, 2017 Memorandum

29. On July 26, 2017, the President tweeted that transgender service members would no longer be allowed to serve in the military "in any capacity."

30. I first found out about the President's tweets through an email I received from one of my professors, offering comfort and support. Without asking what the email referred to, I Googled "transgender military." Then I saw the tweet.

31. I was devastated. The entire future I had planned for myself was crumbling around me, and I did not know what to do. To be told that you are less than, that you are not worthy, is a terrible feeling. Throughout the next few days I oscillated between anger at the unfairness of my situation and intense sadness at everything I was losing. I had a hard time focusing throughout the day. More than once I woke up crying.

32. Then, on August 25, 2017, I learned that President Trump issued a memorandum to the Secretary of Defense, directing him to reverse the policy permitting open service of transgender people.

33. When I came out as transgender I was relying on formal policies by the Navy and the Secretary of Defense that service members could no longer be separated or dismissed for being transgender, and that transgender persons would be eligible to enlist in the service provided they could demonstrate eighteen months of stability in their gender identity prior to accession. If the President's new ban means that these policies are not true, and if the new ban is permitted to stand, I will never be able to serve as a member of the Armed Forces. This causes me great distress, as the implications for my future are dire.

34. I am living in a state of uncertainty because I have not been able to obtain any assurances from my chain of command about my return to the Academy or my future military service. They have been silent because they have not known how the previously announced policies will change.

35. Now that the President has officially reversed the policy permitting open service, I am extremely concerned that I will not be permitted to remain at the Naval Academy.

36. Under the policy announced in the President's August 25, 2017 memorandum, I am ineligible to be commissioned as an officer in the Navy. If a midshipman becomes ineligible to be commissioned for any reason, they are no longer eligible to attend the Naval Academy. If that happens to me, I will suffer many different losses:

37. **Loss of Opportunity**. The Naval Academy provides incredible educational and professional development opportunities unparalleled at other institutions. We have access to travel experiences, study abroad programs, and unique internships, and of course we have the unique opportunity of beginning our professional careers by serving in the military after graduation. If I am removed from the Naval Academy, I will no longer have access to these opportunities, which cannot be replicated or even remotely approached by any civilian school.

38. **Loss of Connection to Military Network.** When one graduates with the prestigious degree that the Naval Academy provides, a connection is immediately forged to a unique network of academy alumni. From talking with fellow classmates and alumni, I understand this network is extremely valuable through the rest of your life, connecting you to others through this shared unique, intense, and rigorous experience. If I am removed from the Naval Academy, I will be deprived of access to this network of individuals of whom I long to be a part.

39. **Loss of Unique Academic and Leadership Opportunities.** The service academies are extremely selective and take less than 10% of applicants. Achieving admission is an impressive feat in and of itself. After enrollment, the courses are academically rigorous and demanding. The Naval Academy has some of the best programs in the nation in science,

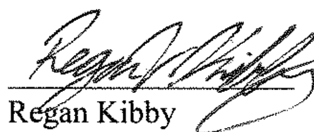
technology, engineering, mathematics, and liberal arts. The Academies also have extremely high physical fitness standards, higher even than the rest of the military. This is a point of pride for Naval Academy attendees. Graduation from the academy carries with it a recognition of unique intellectual and physical prowess, as well as a commitment to military service. I am extremely proud of my enrollment and academic success at the Naval Academy. If I am removed from the Academy, I will lose not only the benefit of my hard work and dedication, but the unique academic and leadership opportunities that no civilian university can provide.

40. **Loss of Reputation and Prestige**. The prestige associated with the service academies is widely recognized throughout the military and civilian society. The feeling of immense pride I have when I wear the midshipman uniform in public is something I deeply treasure. The idea that I may be prohibited from returning to the Naval Academy and prohibited from wearing that uniform again leaves me deeply saddened. If I am not permitted to return to the Naval Academy, as the President's new policy states, I will be forever deprived of the irreplaceable regard and esteem that benefit graduates of the Naval Academy throughout their lives.

41. **Damage to Self-Perception**. The President's statements and reversal of the policy permitting open service have changed the way I view myself. To be told that I can't serve my country even though I am willing and extremely qualified is incredibly frustrating and demoralizing, especially when there are so many others who could choose to serve but don't. When the most powerful man in the world publicly announces that I am not worthy to serve based on a factor that has nothing to do with my ability, dedication, or performance, it is deeply painful, and it is a pain I will have to bear all my life if I am not allowed to return to the Naval Academy.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: August 28, 2017



Regan Kibby

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF DYLAN KOHERE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Dylan Kohere, declare as follows:

1. I am eighteen years old and a first-year student the University of New Haven in West Haven, Connecticut. I am a member of the Army Reserve Officers' Training Corps (ROTC) program at the University. I am transgender.

Early Life and Entry into Army ROTC

2. I grew up in New Jersey, where my parents still live. I have been interested in military service since I was quite young. Both of my grandfathers served in the military, and I had always been attracted to the idea of serving my country in the armed forces. My goal today is to spend my entire career in the military.

3. I considered enlisting directly after high school but eventually decided that going to college and enrolling in ROTC would be a better option for me. With ROTC, I can get a college education before I start my service and will have the career opportunities that come with being commissioned as an officer.

4. I have just started my first year of college and am living in ROTC housing. At this point in my program, we do not wear uniforms, but we have physical training three times per week and classroom instruction one day per week.

Transgender Identity and Coming Out

5. From a very young age, I was always interested in the things boys were interested in. I spent most of my time with the boys and did "guy stuff." At that point, I did not know what being transgender meant, and I did not openly identify as a boy. I was just myself.

6. Everyone around me accepted my gender nonconformity until sometime during middle school. At that point, some people started to make fun of me for being too masculine. That was when I started to understand that there are stereotypes and expectations that people have about gender and how boys and girls are supposed to act. I started trying to conform to those stereotypes by making my appearance more feminine like the girls around me. I was depressed and really unhappy when I looked at the person in the mirror, because I knew that was not who I was.

7. When I entered high school, I became a member of the school's Gay-Straight Alliance ("GSA"). In the GSA, our first meeting was about transgender issues, and I began to learn more about what gender identity is. During my freshman year, I began to come out as transgender, first to close friends and then to my family and others.

8. I had a good support system at my high school. My friends were very supportive, and there were also some very supportive teachers. By my senior year, I was president of the school GSA.

9. So far, everyone in the ROTC program has been very accepting of my transgender identity. My Sergeant knows I am transgender and has been supportive. I asked her whether

there are any regulations that might affect my participation in ROTC and she said she didn't know.

10. I have started working with medical professionals to begin a treatment plan for my transition. At this point, my health care is paid for by my parents' health insurance. I expect that my transition will be complete long before I graduate from college.

Effect of Changing Military Policy on Service by Transgender People

11. A big part of the reason I was comfortable coming out as transgender in the ROTC was the announcement in the summer of 2016 that transgender people would be able to serve openly in the military. I was so excited that I would be able to achieve my goal of serving while remaining true to who I am.

12. On July 26, 2017, as I was getting ready to go to college and enter ROTC, the President tweeted that transgender service members would no longer be allowed to serve in the military "in any capacity."

13. I was shocked and angry. I felt that the plans I had made for the rest of my life were being thrown out the window. I felt like I was no longer in control of my life, as if my life plans and goals were in someone else's hands.

14. On August 25, 2017, I learned that President Trump sent a memorandum to the Secretary of Defense and ordered him to reverse the policy allowing transgender people to serve openly in the military.

15. When I came out as transgender in my ROTC program, I was relying on the official policy announced in 2016 that transgender people would be able to serve openly. If the President's new ban means that the policy allowing open service is not true, and if the new ban is permitted to stand, I will never be able to serve as a member of the Armed Forces. It is

disheartening to learn that I could be denied an opportunity to serve based on something that has nothing to do with my ability or performance.

16. I am living with a great deal of uncertainty because I have not been able to obtain any information about my future military service or how it will affect my participation in ROTC. I am very concerned that I will not be allowed to complete my ROTC program or enter the military.

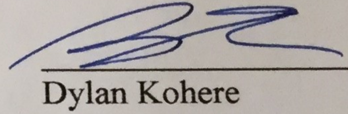
17. I will lose many things if the President's ban prevents me from serving or completing ROTC. First of all, I will lose educational and career opportunities. ROTC provides unique educational benefits and training, including extensive leadership training not available to other college students. This training is valuable in itself, but especially so because ROTC leads to a unique and very important career opportunity by allowing graduates to enter service as a military officer. If I am not allowed to enter military service or remain in ROTC, I will no longer have access to these opportunities, which is especially difficult for me since I had planned to make my entire career in military service.

18. If I am not allowed to continue in ROTC or sign a commitment to military service, I will also lose the opportunity to apply for a ROTC scholarship. I will have to pay for my own education, losing tens of thousands of dollars in tuition and living expenses that I could have earned with a scholarship.

19. The President's statements and reversal of the policy permitting open service have also affected the way I view my future prospects and life goals. To be told that I cannot serve for reasons that have nothing to do with my ability is hard to deal with, and I am frustrated by the unfairness of my situation. I want to serve in the military because I want to serve my country. To be denied that opportunity is extremely painful.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: August 28, 2017



Dylan Kohere

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	)	Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF RAYMOND EDWIN MABUS, JR.
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Raymond Edwin Mabus, Jr., declare as follows:

Background and Experience

1. I served as the United States Secretary of the Navy from May 19, 2009 to January 20, 2017.

2. Prior to serving as Secretary of the Navy, I earned a Bachelor's degree in English and Political Science from the University of Mississippi in 1969, a Master's Degree in political science from Johns Hopkins University in 1970, and a J.D. from Harvard Law School in 1976. Prior to attending law school, I served from 1970 until 1972 in the Navy aboard the cruiser USS Little Rock, achieving the rank of Lieutenant, junior grade. Following law school, I worked as a law clerk in the United States Court of Appeals for the Fifth Circuit. From 1977 until 1978, I worked as legal counsel for the Cotton Subcommittee of the Agriculture Committee of the United States House of Representatives. From 1979 to 1980, I was an associate at the law firm of Fried, Frank, Harris, Shriver and Kampleman in Washington, D.C. and from 1980 to 1983, I

was Legal Counsel and Legislative Assistant to the Governor of Mississippi. From 1984 to 1988, I served as Mississippi State Auditor (an elected position), and from 1988 to 1992 as Governor of Mississippi. From 1994 to 1996 I served as the United States Ambassador to Saudi Arabia. From 1998 to 2000 I served as President of Frontline Global Services, a consulting company. From 2003-2007 I served as Chairman of Foamex, Incorporated, a public manufacturing company, and from 2006 to 2007 as Foamex's Chief Executive Officer as well.

3. As Secretary of the Navy, I functioned as the chief executive of the Department of the Navy, with the authority to conduct all of its affairs. As Secretary, I had comprehensive oversight responsibility for (i) the Department of the Navy's annual budget, (ii) overseeing the recruitment, organization, training, supplying, equipping, mobilizing, and demobilizing of Navy personnel, and (iii) overseeing the construction, outfitting, and repair of naval equipment, ships, and facilities. I was also responsible for the formulation and implementation of policies and programs that are consistent with the national security policies and objectives established by the President and the Secretary of Defense.

4. In connection with my personnel-related oversight responsibilities, I oversaw the administration of recruitment, retention, and medical policies for active duty and reserve Navy personnel. As Secretary, I performed these duties before, during, and after the end of the "Don't Ask, Don't Tell" ban on gay service members serving openly in the military in 2011.

5. Also during this period, I oversaw the Navy and the Marine Corps through the end of United States military operations in Iraq and the surge of tens of thousands of United States troops in Afghanistan. I am keenly aware that the recruitment and retention of capable and qualified service members is of critical importance to the readiness of the Navy and the Marines.

The Navy

6. The Department of the Navy comprises two uniformed Services of the United States Armed Forces: the United States Navy and the United States Marine Corps. It is one of the three military departments of the Department of Defense ("DoD"). The Navy, with an annual budget of more than $160 billion, maintains more than 270 deployable battle force ships, operates more than 3,700 military aircraft, and employs nearly 900,000 active duty, reserve, and civilian employees.

7. The mission of the Navy is to maintain, train and equip combat-ready Naval forces capable of winning wars, deterring aggression and maintaining freedom of the seas.

Development of DoD Policy Relating to Service by Openly Transgender Persons

8. On July 28, 2015, Secretary of Defense Ashton Carter ordered Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group to identify and address the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group"). A true and accurate copy of this order is attached hereto as Exhibit A. The Working Group was ordered to present its findings and recommendations to the Secretary of Defense within 180 days. In the interim, pursuant to the July 28, 2015 order, no service member could "be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness."

9. As Secretary of the Navy, I was responsible for supervising the Department of the Navy's participation in the Working Group. The Working Group met as a whole and also assigned various sub-groups to research and analyze discrete issues and report their findings. I

met multiple times per week with my deputy to the Working Group, the Navy General Counsel, who would update me on the progress of the Working Group and the Navy's positions on the issues discussed.

10. The Working Group was tasked with evaluating the hurdles, impediments, and concerns potentially raised by open service of transgender service members. They sought to identify all potential impacts on the Services and develop recommendations to address them.

11. The Working Group met and engaged in a detailed, deliberative, carefully run process. The goal was to ensure that the input of the Services would be fully considered before any changes in policy were made and that the Services were on board with those changes.

12. The Working Group conducted a comprehensive review of relevant evidence, including: research and data; information obtained from medical, personnel, and readiness experts; and information obtained from discussions with transgender service members and commanders who supervised transgender service members. The Working Group also considered the experiences of civilian employers and insurance companies.

13. The Working Group also considered a study that the DoD commissioned from the RAND Corporation. That study examined all of the available research about the healthcare needs of transgender service members, the anticipated costs of providing healthcare coverage for transition-related treatments, and the potential readiness implications of allowing transgender service members to serve openly. A true and accurate copy of the report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report"), is attached as Exhibit B.

14. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would be extremely small and that there was no evidence that allowing

transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness. The RAND Report also concluded that the Military Health Service could provide appropriate transition-related healthcare to transgender persons. The RAND Report also identified various DoD policies that would need to be changed to permit transgender service members to serve openly, including "transgender-specific DoD instructions that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes."

15. Members of the Working Group discussed the full range of considerations relevant to assessing the potential impacts of permitting transgender service members to serve openly, including evidence relating to the costs of providing appropriate healthcare and evidence relating to the impact of service by transgender people on operational effectiveness and readiness. For example, the Working Group considered that while some transgender service members might be undeployable for short periods due to medical treatments, the overall loss of deployable time would not be significant and was consistent with the standard applied to other service members, who may take time off due to comparable medical treatments.

16. The Working Group also noted that many private and public health insurance plans now cover transition-related care and that all civilian federal employees have access to a health insurance plan that provides comprehensive coverage for such care. This was helpful to ascertain both the costs of providing such care and utilization rates, as well as to demonstrate the need for the military to keep pace with contemporary medical science and practice in the provision of healthcare to our service members.

17. The Working Group also consulted with representatives from the Armed Forces of other nations that permit openly transgender persons to serve. Those consultations confirmed

that permitting such service is not disruptive to military readiness and has not led to significantly increased costs or posed any other significant problems. The RAND Report considered the experiences of other countries as well and found no evidence of any adverse impacts. Noting the most extensive research on how a policy of open service affects readiness and unit cohesion has been conducted in Canada, the RAND Report noted that "the researchers heard from commanders that the increased diversity improved readiness."

18. The Working Group considered that banning service by openly transgender people has numerous negative impacts, including requiring the discharge of highly trained and experienced service members, causing unexpected vacancies in operational units, and requiring the expensive and time-consuming recruitment and training of replacement personnel.

19. The Working Group also recognized that despite a ban on transgender service members, transgender persons continued to serve in the military, but were forced to lie about and hide their identities, to the detriment both of those service members and of the military as a whole. As a result, the Working Group recognized that the primary impact of the policy was to cause harms similar to those caused by "Don't Ask, Don't Tell."

20. During the period in which the Working Group was in operation, the proceedings of the Working Group were reported to and reviewed by upper level Department of Defense personnel at meetings attended by the Joint Chiefs of Staff, the Chairman, the Vice Chairman, the Service Secretaries, the Secretary of Defense, and the Assistant Secretary of Defense. At these meetings, the activities of the Working Group would be shared along with their preliminary views. The meeting attendees would then discuss any comments they may have had on those views.

21. By the conclusion of its discussions and analysis, all members of the Working Group (including the senior uniformed military personnel) expressed their agreement that transgender people should be permitted to serve openly in the United States Armed Forces.

22. In or around April 2016, the Working Group communicated its view to the Secretary of Defense along with detailed recommendations regarding the full range of relevant policies and practical concerns, such as guidelines involving access to healthcare, housing and uniform standards, and when a transitioning service member should be authorized to conform to the standard of the gender to which they were transitioning.

23. On June 30, 2016, Secretary of Defense Ashton Carter accepted the recommendations of the Working Group, and issued Directive-type Memorandum (DTM) 16-005, entitled "Military Service of Transgender Service Members" ("DTM 16-005"), a true and accurate copy of which is attached as Exhibit C.

Change, Development, and Implementation of Navy Policy

24. Following the Secretary of Defense's announcement, the Navy's implementation of the new policy was straightforward. We focused on the administrative tasks of promulgating and implementing the appropriate processes. Having presided over the Navy during the rollout of prior policy changes such as the repeal of "Don't Ask, Don't Tell" and the complete integration of women into ground combat, I can confirm that the implementation of open service for transgender service members was relatively low-key, triggered fewer emotional responses, and was viewed as "no big deal."

25. To implement DTM 16-005 as applied to the Navy, on November 4, 2016, I issued SECNAV Instruction 1000.11 concerning Service of Transgender Sailors and Marines (the "Instruction"). A true and accurate copy of the Instruction is attached hereto as Ex. D.

26. The policy and guidance in the Instruction, which was effective immediately for all Department of Navy ("DON") personnel, established "policy for the accession and service of transgender Sailors and Marines, to include the process for transgender Service Members to transition to transgender in-service." The policies and procedures in the Instruction "are based on the premise that open service by transgender persons who are subject to the same medical, fitness for duty, physical fitness, uniform and grooming, deployability, and retention standards and procedures is consistent with military service and readiness." The Instruction provides that "transgender individuals shall be allowed to serve openly in the DON," and that any "discrimination based on gender identity is a form of sex discrimination."

27. Pursuant to the Instruction, on November 7, 2016, Chief of Naval Personnel, Vice Admiral R. P. Burke, issued interim guidance in NAVADMIN 248/16 (the "Policy") regarding "policy, regulations and procedures related to the service of transgender Navy personnel." The Policy, which "applies to all Navy military personnel," remains in effect "until superseded or cancelled." A true and accurate copy of the Policy is attached hereto as Ex. E.

28. As with the Instruction, the Policy provides that "transgender individuals shall be allowed to serve openly in the Navy. The Policy was "premised on the conclusion that transgender persons are fully qualified and are subject to the same standards and procedures as other Service Members with regard to their medical fitness for duty, physical fitness, uniform and grooming standards, deployability, and retention." The Policy thus declares that "[n]o otherwise qualified Service Member may be involuntarily separated, discharged, or denied reenlistment or continuation of service solely on the basis of gender identity or an expressed intent to transition gender."

29. With respect to individuals serving in the Navy or Marine Corps, the Instruction and Policy state that transgender Sailors and Marines will be responsible to meet all standards for uniforms and grooming, body composition assessment, physical readiness testing, Military Personnel Drug Abuse Testing Program participation and other military standards according to their gender marker in DEERS, subject to the approval of an Exception to Policy ("ETP") request.

30. To allow DON commanders to address medical needs in a manner consistent with military mission and readiness, the Policy sets forth detailed procedures concerning medical treatment for transgender service members with a diagnosis from a medical military provider indicating that gender transition is medically necessary. Service members with such a diagnosis must notify their commanding officer and request commanding officer approval for the timing of medical treatment associated with gender transition. The commanding officer is the final approval authority for a transition plan. Commanding officers must respond to a gender transition request "within a framework that ensures readiness by minimizing impacts to the mission (including deployment, operational, training, exercise schedules, and critical skills availability), as well as the morale, welfare, and good order and discipline of the command." Furthermore, the Policy provides that timing of a medical treatment plan "should consider the individual's planned rotation date (PRD), deployment or other operational schedules, and potential impact on major career milestones, whenever possible."

31. The Policy further provides detailed instructions regarding an in-service transition. The transition plan is considered complete once (1) a military medical provider documents that the service member has completed the care outlined in a medical treatment plan; (2) the service member obtains an appropriate document showing legal proof of gender change;

(3) the service member's commanding officer provides written permission to change the gender marker in the Navy Personnel Administrative Systems/DEERS; (4) the service member submits for the gender marker change; and (5) the gender marker is changed in the Navy Personnel Administrative Systems/DEERS.

32. As set forth in the Policy, in order to have a gender marker changed in the Navy Personnel Administrative Systems/DEERS, the service member must submit the required documentation showing legal proof of gender change and the commanding officer's written approval to Navy Personnel Command.

33. The Policy also provides that "[a]ll Service Members are world-wide assignable as their medical fitness for duty permits." "Any determination that a transgender Sailor or Marine is non-deployable at any time will be consistent with established DON standards, as applied to other Sailors and Marines whose deployability is similarly affected in comparable circumstances unrelated to gender transition."

34. Both the Instruction and Policy provide that effective July 1, 2017, the Navy and Marine Corps will begin accessing transgender applicants who meet all standards.

35. In addition, the Policy included policy changes related to: (1) privacy in berthing and showering facilities as set forth in OPNAVINST 3120,32D, Standard Organization Regulations of the U.S. Navy; (2) drug testing and urinalysis as set forth in OPNAVINST 5350.4D, Navy Alcohol and Drug Abuse Prevention and Control Program; and (3) physical fitness assessment standards as set forth in OPNAVINST 6110.1J, Physical Readiness Program.

36. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook ("DoD Handbook"). A true and accurate copy of the DoD Handbook is attached hereto at Exhibit F. The DoD Handbook is intended as a

practical day-to-day guide to assist all service members in understanding the Department of Defense's policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

> The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job.

The Impact of Reversing the Policy Permitting Service by Openly Transgender People

37. Numerous military personnel disclosed their transgender status to the military in 2016 and 2017 in reliance upon the Department of Defense's statements that it would not discharge them on that basis, as articulated in DTM 16-005 and other documents. I did not receive any reports that such disclosures harmed the operational effectiveness of any Navy units.

38. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces due to "the tremendous medical costs and disruption that transgender in the military would entail."

39. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."

40. President Trump's stated rationales for reversing the policy and banning military service by transgender people make no sense. They have no basis in fact and are refuted by the comprehensive analysis of relevant data and information that was carefully, thoroughly, and deliberately conducted by the Working Group.

41. As discussed above, the RAND Report concluded that any costs associated with providing appropriate healthcare to transgender service members would be "exceedingly small." In fact, the maximum financial impact estimated by the RAND Report is an amount so small it was considered to be "budget dust," hardly even a rounding error, by military leadership.

42. The claim that permitting transgender people to serve openly would be "disruptive" has no foundation. The same claim was used to oppose racial integration of the military in the 1940s, the increased recruiting of women in the 1970s, and the repeal of "Don't Ask Don't Tell." In each case, the prediction that disruption would ensue has not been borne out. Studies have shown that diversity actually improves unit cohesion. Units become closer when individual service members are respected for who they are.

43. Any evidence that permitting such service would be disruptive is entirely lacking. Since the policy permitting open service went into effect, transgender service members have been able to serve openly and have caused no disruption.

44. In addition to being contrary to the overwhelming weight of the evidence considered by the Working Group and the Secretary of Defense, a reversal of the DoD policy permitting open service and the banning of accessions by transgender people, in my assessment, based on my experience as Secretary of the Navy, disserves the public interest, for several reasons.

45. **Loss of Qualified Personnel**. First, banning transgender service members will produce vacancies in the Services, creating an immediate negative impact on readiness. The United States Armed Forces rely on an all-volunteer force, some portion of which are transgender service members. The impact of the loss of those individuals, who serve at all levels of service, is significant. Banning transgender service members will cause the loss of competent and experienced individuals, who will be difficult to replace. The Navy has invested in their education, and training. In addition to losing any return on that investment, taxpayers will bear the cost of identifying, recruiting, and training replacement personnel. Our ability to replace those individuals will also be hampered by the parallel reduction in the size of our potential recruiting pool. Artificial exclusionary barriers like this weaken the military.

46. **Unit Cohesion**. Second, banning transgender service members negatively impacts unit cohesion, a fundamental component of readiness. The only relevant qualification for the job of serving in the Armed Forces is whether an individual is capable of performing the job. Diversity in the form of nationality, religion, race, who one loves, gender, or gender identity only strengthens the force. Conversely, when the military asks people to lie about who they are in order to enlist or remain in the military, it weakens the military and has a negative impact on unit cohesion. Members of units know each other well and develop strong bonds. Unit members can tell when other unit members are lying. A policy that forces unit members to be dishonest with one another, including a ban on service by openly transgender people, weakens these bonds.

47. **Erosion of Trust in Command.** Third, arbitrary decisionmaking erodes trust in military leadership. I was dismayed by the abrupt reversal, because so much careful thought had gone into development of the policy, with consensus at the highest levels of military leadership. Furthermore, the initial directive to reverse policy through the Twitter medium was delivered

entirely outside the normal pathway of legitimate orders issued through the chain of command, and the most recent memorandum of August 25, 2017 was also issued in a highly unusual manner. It is also unprecedented to reverse policy in such an abrupt manner. I cannot recall another instance in United States military history of such a stark and unfounded reversal of policy, or of any example in our nation's history in which a minority group once permitted to serve has been excluded from the military after its members had been allowed to serve openly and honestly.

48. Even individuals who had reservations at the time the Working Group was announced trusted in the process and believed it was a fair and deliberative process that met the high standards of the military. This abrupt reversal leaves the impression among service members that military decision making is instead arbitrary and subject to political whims.

49. For transgender service members themselves, the reversal represents the ultimate mistreatment and breach of trust. In DTM-005 and in other documents issued by the Department of Defense, the military informed transgender service members that they could come forward to disclose their transgender status and serve openly, rather than facing discharge. Many transgender service members came forward based on those statements. They risked their jobs, housing, and progress towards retirement benefits in reliance on our word that we would treat their disclosures fairly and in good faith. Using that information now as a basis for separating these soldiers from their service is an unprecedented betrayal of the trust that is so essential to achieving the mission of all of the armed forces. The reversal penalizes transgender service members for doing what DoD encouraged them to do. Transgender service members, their chain of command, and their colleagues who may lose people on whom they rely, must now deal with this enormous distraction, thus detracting from military readiness.

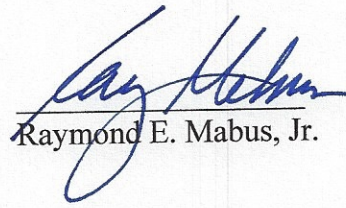
50. This sudden reversal also undermines the morale and readiness of other groups who must now deal with the stress and uncertainty created by this dangerous precedent, which represents a stark departure from the foundational principle that military policy will be based on military, not political, considerations. In 2011, the "Don't Ask, Don't Tell" policy prohibiting gay, lesbian, and bisexual people from openly serving in the military (Department of Defense Directive 1304.26) was repealed. More recently, DoD also removed remaining barriers for women serving in certain ground combat positions. The sudden reversal of the DoD's policy with respect to transgender service members sets a precedent suggesting that these policies may be abruptly reversed for baseless reasons as well.

51. This sudden reversal may also have a chilling effect on the confidence of other service members that they will continue to be able to serve. Religious and ethnic minorities who have seen an increase in discrimination under the current administration may fear that the military may seek to ban them next, creating a culture of fear that is anathema to the stability and certainty that makes for an effective military.

52. This sudden reversal undermines the confidence of all service members that important military policy decisions will be made under careful review and consistent with established process. Rational decisionmaking in the adoption of and change to policy impacts the military's ability to recruit and retain competent, high-performing people. The sudden reversal of policy makes recruitment and retention more difficult, as does the damage done to the military's image and reputation as promoting fairness and equality and of being open to all qualified Americans. That image and reputation are critical to the military's ability to attract talented and idealistic young people. Actions that tarnish that reputation cause real harm.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: August 29, 2017



Raymond E. Mabus, Jr.

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al., *Plaintiffs*, v. DONALD TRUMP, et al., *Defendants*.	Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF MARGARET C. WILMOTH
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Margaret Chamberlain Wilmoth, declare as follows:

Background and Experience

1. I served as Deputy Surgeon General for Mobilization, Readiness and Army Reserve Affairs in the Office of the Surgeon General of the United States Army from July 2014 to May 1, 2017.

2. I received a Bachelor's degree in Nursing from the University of Maryland in 1975, followed by a Master's Degree in Nursing from the University of Maryland in 1979. I received a Ph.D. in Nursing from the University of Pennsylvania in 1993. I received a Master's Degree in Strategic Studies from the United States Army War College in 2001. I am a Registered Nurse.

3. My family's history of military service dates back to the Revolutionary War. As a small child, I grew up hearing the stories of an aunt who was a nurse and a neighbor who had

served as an Army nurse during World War II. From the time I was 6 or 7 years old, I knew I wanted to be an Army nurse. When I graduated with my nursing degrees at the end of the Vietnam War, the Army was drawing down, so I went into civilian practice. I spent the first seven years of my nursing career as a teacher and researcher.

4. While I was teaching at the University of Delaware, my father, who had joined the Air Force Reserve after serving as a pilot, encouraged me to pursue my dream of serving as an Army nurse by joining the United States Army Reserve (U.S.A.R.). I joined the U.S.A.R. in 1981 and served in various capacities during over thirty-five years in service, achieving the ranks of Captain, Major, Lieutenant Colonel, Colonel, Brigadier General, and Major General, before my retirement from the military on May 1, 2017. When I was promoted to Brigadier General in 2005, I became the first nurse and first woman to command a medical brigade as a general officer. When I was promoted to Major General, I became only the third nurse from the Army Reserve ever to achieve that rank.

5. From July of 2008 through October 2011, I served as Assistant for Mobilization and Reserve Affairs in the Office of the Secretary of Defense for Health Affairs. From October 2011 through July of 2014, I served in the Control Group. In July of 2014, I was appointed Deputy Surgeon General for Mobilization and Reserve Affairs. When I received this appointment, I became the first nurse in the more than 106-year history of the Army Reserve and the first woman to serve in this position. I held this position until my retirement from the military on May 1, 2017.

6. In August of 2014, I was also appointed by the Secretary of the Army to the Army Reserve Forces Policy Committee, where I most recently served as Deputy Chair. This

congressionally-mandated committee's role includes advising the Secretary of the Army on major policy matters directly affecting the reserve components and the mobilization preparedness of the Army. I held this position until my retirement from the military on May 1, 2017.

7. In my more than three-and-a-half decades of service, I received many decorations, including the Distinguished Service Medal, Defense Superior Service Medal, the Legion of Merit Medal, the Meritorious Service Medal, the Army Commendation Medal, and the Army Achievement Medal. I also hold the Expert Field Medical Badge and was awarded the 9A proficiency designation in medical surgical nursing by the Surgeon General, U.S. Army. I am a member of the Order of Military Medical Merit.

8. My civilian professional experience includes academic appointments at Central Missouri State University, University of Kansas, University of North Carolina at Charlotte, and Georgia State University. At Georgia State, I served as Dean of and Professor at the Byrdine F. Lewis School of Nursing and Health Professions at Georgia State University. I also served as a Health Policy Fellow at the Robert Wood Johnson Foundation. I am also a Fellow of the American Academy of Nursing, where I have served as Co-Chair of the Military/Veterans Expert Panel. In August of 2017, I joined the University of North Carolina School of Nursing as the Executive Dean and Associate Dean for Academic Affairs.

9. Throughout my academic and research careers, my practice and research focus has been in psychosocial oncology. My research led to the development of a subspecialty in psychosexual oncology, which focuses on how surgery, chemotherapy, radiation, and immunotherapy impact body image, sexuality, and fertility. I have had more than sixty

psychosexual oncology academic papers published on topics such as comparing the effects of lumpectomy vs. mastectomy on sexual behaviors; and strategies to help nurses become comfortable with psychosexual assessments of patients.

Formation of Working Group

10. On July 28, 2015, Secretary of Defense Ashton Carter directed Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group (the "Working Group") to study the policy and readiness implications allowing transgender persons to serve openly in the Armed Forces. The Working Group was asked to determine whether there were any objective, evidence-based impediments to permitting transgender people to serve openly and, if not, to develop an implementation plan for changing the policy to permit open service with the goal of maximizing military readiness. A true and accurate copy of this directive is attached hereto as Exhibit A.

11. When Secretary Carter directed the formation of the Working Group, I was serving as Deputy Surgeon General for Mobilization, Readiness, and Army Reserve Affairs. I was asked by Surgeon General, United States Army to serve as that office's representative to the Working Group. At the Working Group, I was able to provide the benefit of my medical expertise, my academic research, and my knowledge of the workings of the Military Health System and the Defense Health Agency. I participated in the meetings of the Working Group from its initial meeting in the summer of 2015 though the final meeting in late spring of 2016.

Working Group Process

12. The Working Group addressed many topics, one of which was determining how the medical needs of transgender service members could be met by the military. With respect to that topic, our process involved three steps: (1) Understanding the medical needs of transgender service members; (2) identifying how those needs could be met within the Military Health System; and (3) developing policies and protocols to ensure transgender service members could serve openly and have their medical needs met. The Working Group focused on ensuring that transgender service members' medical needs would be treated in the same manner and under the same framework as the medical needs of other service members, unless that proved unworkable.

13. **Step 1: Understanding Medical Needs.** The first step for the members of the Working Group was to establish a baseline level of knowledge among all Working Group members about the medical needs of transgender service members. We educated ourselves by meeting with experts from the civilian sector so we could begin to understand what being transgender means. We wanted to learn about the full range of medical treatment that might be required for a transgender service member. We sought to understand how an individual might go through a transition process and what the medical components of that process might be. We spoke to internal medicine experts, psychologists, endocrinologists, and surgeons who educated the Working Group regarding all aspects of transgender care including mental health treatment, pharmaceutical treatment, and surgical treatment.

14. **Step 2: Identifying How Medical Needs Could Be Met Within the Military Health System**. After we understood the universe of potential medical needs of transgender

service members, we focused on how the Military Health System (MHS) could meet those needs. For the large majority of medical care needs, we found that MHS was already providing the same or substantially similar services to other service members, and that there would be little, if any, additional burden on MHS from the provision of the required medical services to transgender service members.

15. With respect to hormonal therapy, we learned that MHS already provides this service to service members. Women frequently receive hormonal therapy, as do other service members who have adrenal or pituitary deficiencies that require hormone replacement therapy. The Working Group concluded that providing similar care for transgender individuals from a pharmaceutical perspective would not be a complicating issue or an additional burden.

16. The Working Group also examined whether there were any deployment-related obstacles to providing pharmaceutical care that requires routine doses of medication. We learned that service members with chronic conditions requiring routine medications regularly take with them enough medication to last for at least the first ninety (90) days of their deployment. Examples of such medications would include birth control, hormone replacement therapy, and medications to address low testosterone, hypertension, and osteoporosis, among other conditions. Each Combatant Command sets rules in the form of Personnel Policy Guidance that specifies any special restrictions on deployability of members to that Command, including medical restrictions. For example, a theatre that has only intermittent access to a medical supply train might require service members to bring extra medical supplies or restrict certain service members from serving in particular locations. Such issues are readily addressed in the field through the Personnel Policy

Guidance, and no unique or different issues would be raised by the pharmaceutical needs of transgender service members. The Working Group concluded that no additional burden on deployability would be created by transgender service members who required routine medication.

17. With respect to gynecological care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have hindered transgender service members from seeking gynecological care through MHS would no longer be an issue. Transgender service members would now be able to receive all routine medical care including gynecological services through MHS, allowing for more complete and coordinated care for the service members. The Working Group concluded that no additional burden on MHS would be created by the provision of gynecological care to transgender service members.

18. With respect to mental health care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have inhibited transgender service members from seeking mental health care through MHS would no longer be an issue. Because transgender service members would now be able to seek such care, if needed, openly through MHS, the Working Group expected that the service members would benefit from more complete and coordinated care. The Working Group concluded that no additional burden on MHS would be created by the provision of mental health care to transgender service members.

19. The Working Group also examined whether there were any deployment or readiness related obstacles associated with addressing the mental health needs of transgender

service members. The Working Group educated itself in part by consulting with our counterparts in Israel, the United Kingdom, and Australia, where open service by transgender individuals is permitted. We learned that those services have seen no reduced ability to serve from transgender service members due to mental health or other gender identity related issues. The Working Group also examined our own military's existing policies and learned that there is a rigorous screening process for all individuals applying to join the military that includes examination of mental health. The Military Entrance Processing Stations (MEPS) (enlistment processing offices) evaluate psychological stability as a component of fitness to serve. Additionally, once individuals are in active or reserve service, mental health is evaluated on an annual basis as part of the Periodic Health Assessment (PHA). The Working Group found that there was no reason to think that these pre-existing military policies, when applied to transgender service members serving openly, would not adequately protect the services from any mental health issues interfering with deployment.

20. With respect to surgical therapy, the Working Group consulted with surgical experts to determine whether there were any aspects of surgical therapy for transgender service members in which MHS did not already have the requisite expertise. We learned that MHS employs general surgeons, urologists who perform urological surgeries, and obstetrician/gynecologists who perform gynecological surgeries. Those skill sets are present in a substantial capacity within MHS, and MHS is able to address most routine surgical needs at or near the location of its service members. We learned, for instance, that surgeries for transgender service members would be relatively rare and that many of those surgeries are already routinely provided to non-transgender service members, such as hysterectomies or chest surgeries. For

surgeries requiring particular expertise, MHS maintains major medical centers that are equipped to provide a broader array of services. For surgeries requiring expertise outside of MHS's capacity, service members are typically referred out to civilian providers. The non-routine surgical needs of a transgender service member could be addressed either though training or contracting with surgeons with the appropriate expertise to MHS, or through the normal process for referring out of MHS to civilian providers. The Working Group concluded that the surgical needs of transgender service members could be addressed through either of these methods without creating additional burden on MHS.

21. The Working Group also learned that the development of gynecology/genitourinary (GYN/GU) surgical expertise within MHS could have an added benefit for MHS beyond the provision of surgical care to transgender service members. MHS struggles with ensuring that their medical providers acquire and retain the skills they need to serve in a wartime scenario. Having surgeons engage in training in the surgical techniques needed to perform sex-reassignment surgery would provide analogous surgical skills required to address, for instance, blast injuries in wartime scenarios. Having the expertise to address genital mutilation from a blast would be a benefit for MHS and all service members.

22. **Step 3: Policy Development**. Throughout this educational process, the Working Group members developed a deep understanding of the medical needs of transgender service members. Next, we turned our focus to developing a policy that would address the psychological and physical needs of transgender individuals and treat those individuals fairly while keeping

readiness and deployability at the forefront. Developing the protocol was an iterative process involving multiple rounds of drafting, gathering input from the services, and redrafting.

23. The Working Group concluded that there were no barriers that should prevent transgender service members from serving openly in the military. Open service by transgender service members would not impose any significant burdens on readiness, deployability, or unit cohesion. For those seeking to join the military, the Working Group recommended that the medical standards for accession into the Military Services by transgender persons be based upon the same standards applied to persons with other medical conditions, which seek to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Based upon that standard, the Working Group recommended that the new accessions policy permit enlistment so long as an applicant with a history of gender dysphoria or of treatment for gender dysphoria has completed all medical treatment associated with the applicant's medical condition and has been stable in the preferred gender for a sufficient period of time.

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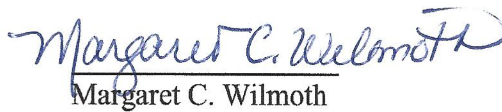
24. The Working Group's process for developing the protocol and recommendations was deliberative and thoughtful, involved significant amounts of research and education, and in the end resulted in a policy that all services supported. We were very proud to have developed a policy that treats transgender service members as the equal of their fellow service members, and as soldiers, sailors, marines, cuttermen, and airmen first.

I declare under the penalty of perjury that the foregoing is true and correct.

Dated: August 30, 2017



Margaret C. Wilmoth

IMMEDIATE RELEASE

DoD Complying with Court Orders to Access Transgender Persons into the Military

Press Operations

Release No: NR-417-17
Dec. 11, 2017

As required by recent federal district court orders, the Department of Defense recently announced it will begin processing transgender applicants for military service on January 1, 2018. This policy will be implemented while the Department of Justice appeals those court orders.

The United States District Court for the District of Columbia ordered DoD to implement, effective January 1, 2018, the accession policy issued by former Secretary Carter in 2016. DoD and the Department of Justice are actively pursuing relief from those court orders in order to allow an ongoing policy review scheduled to be completed before the end of March.

Under the 2016 Carter policy, a history of gender dysphoria is disqualifying unless, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months. Additionally, a history of medical treatment associated with gender transition is disqualifying unless, as certified by a licensed medical provider, the applicant has completed all medical treatment associated with the applicant's gender transition, the applicant has been stable in the preferred gender for 18 months, and if presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months.

Guidance also includes specific details for recruits with a history of sex reassignment or genital reconstruction surgery. Under the updated standards, these procedures would be disqualifying unless, as certified by a licensed medical provider, a period of 18 months has elapsed since the date of the most recent surgery, no functional limitations or complications persist, and no additional surgeries are required.

Department of Defense
INSTRUCTION

NUMBER 6130.03
April 28, 2010
Incorporating Change 1, September 13, 2011

USD(P&R)

SUBJECT: Medical Standards for Appointment, Enlistment, or Induction in the Military Services

References: See Enclosure 1

1. PURPOSE. This Instruction:

a. Reissues DoD Directive (DoDD) 6130.3 (Reference (a)) as a DoD Instruction (DoDI) in accordance with the authority in DoDD 5124.02 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for physical and medical standards for appointment, enlistment, or induction in the Military Services.

b. Establishes medical standards, which, if not met, are grounds for rejection for military service. Other standards may be prescribed for a mobilization for a national emergency.

c. Incorporates and cancels DoDI 6130.4 (Reference (c)).

2. APPLICABILITY. This Instruction applies to:

a. OSD, the Military Departments (including the Coast Guard at all times, including when it is a service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as the "DoD Components").

b. The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with title 10, United States Code (Reference (d)).

c. The United States Merchant Marine Academy in accordance with section 310.56 of title 46, Code of Federal Regulations (Reference (e)).

USCA Case #17-5267 Document #1709120 Filed: 12/15/2017 Page 171 of 222

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy to:

a. Utilize common physical standards for the appointment, enlistment, or induction of Service personnel and eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

b. Precisely define any medical condition that causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing the International Classification of Diseases (ICD) (Reference (f)), Current Procedural Terminology (CPT) (Reference (g)), and the Healthcare Common Procedure Coding System (HCPCS) (Reference (h)), and annotate qualification decisions by standard medical terminology, rather than codes. The standards in this Instruction shall be for the acquisition of personnel in the Military Services.

c. Ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that probably will endanger the health of other personnel.

(2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.

(3) Medically capable of satisfactorily completing required training.

(4) Medically adaptable to the military environment without the necessity of geographical area limitations.

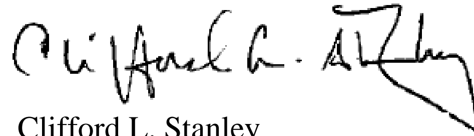
(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3 for Medical and Personnel Executive Steering Committee (MEDPERS) information. Procedures and standards for implementation are in Enclosure 4.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. This Instruction is effective immediately.



Clifford L. Stanley
Under Secretary of Defense for
Personnel and Readiness

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, or Induction," December 15, 2000 (hereby cancelled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005 (hereby cancelled)
(d) Title 10, United States Code
(e) Section 310.56 of title 46, Code of Federal Regulations
(f) International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)[1]
(g) American Medical Association, Current Procedural Terminology (CPT®), Fourth Edition, 2010 Revision, Chicago, IL, 2010[2]
(h) 2010 Healthcare Common Procedure Coding System (HCPCS) Level II Codes from Centers for Medicare and Medicaid Services (CMS)[2]
(i) American National Standards Institute ANSI S3.6-2004, "Specification for Audiometers"[3]
(j) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition

[1] Available at http://www.cdc.gov/NCHS/icd/icd9cm.htm.
[2] Available at https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp
[3] Available from the American National Standards Institute, 1819 L Street, N.W., Washington, D.C. 20036 or on the Internet at http://www.ansi.org/

ENCLOSURE 2

RESPONSIBILITIES

1. PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (PDUSD(P&R)). The PDUSD(P&R), under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall:

a. Ensure that the standards in Enclosure 4 are implemented throughout the U.S. Military Entrance Processing Command.

b. Eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

c. Convene the MEDPERS under the joint guidance of the Deputy Under Secretary of Defense for Military Personnel Policy (DUSD(MPP)) and Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD(HA)). MEDPERS responsibilities are in Enclosure 3.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall:

a. Review, approve, and issue to the Secretaries of the Military Departments technical modifications to the standards in Enclosure 4.

b. Provide guidance to the DoD Medical Examination Review Board to implement the standards in Enclosure 4.

c. Eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT OF THE COAST GUARD. The Secretaries of the Military Departments and Commandant of the Coast Guard shall:

a. Direct their respective Services to apply and uniformly implement the standards contained in this Instruction.

b. Authorize the waiver of the standards in individual cases for applicable reasons and ensure uniform waiver determinations.

c. Authorize the changes in Service-specific visual standards (particularly for officer accession programs) and establish other standards for special programs. Notification of any

proposed changes in standards shall be provided to the ASD(HA) at least 60 days before implementation.

d. Ensure that accurate ICD codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.

e. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the Military Services.

ENCLOSURE 3

MEDPERS

1. MEDPERS convenes quarterly under the joint guidance of the DUSD(MPP) and PDASD(HA).

2. MEDPERS shall:

a. Provide policy oversight and guidance to the accession medical and physical standards setting process through the Accession Medical Standards Working Group.

b. Direct research and studies as necessary to produce evidence-based accession standards utilizing the Accession Medical Standards Analysis and Research Activity.

c. Ensure medical and personnel community coordination when formulating policy changes that affect each community and other relevant DoD *and* Department of Homeland Security~~, and Department of Transportation~~ organizations.

ENCLOSURE 4

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

1. APPLICABILITY. The medical standards in this enclosure apply to:

a. Applicants for appointment as commissioned or warrant officers in the Active and Reserve Components.

b. Applicants for enlistment in the Military Services. For medical conditions or defects predating original enlistment, these standards apply to enlistees' first 6 months of active duty.

c. Applicants for enlistment in the Reserve Components and federally recognized units or organizations of the National Guard. For medical conditions or defects predating original enlistment, these standards apply during the enlistees' initial period of active duty for training until their return to Reserve or National Guard units.

d. Applicants for reenlistment in Regular and Reserve Components and in federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since discharge.

e. Applicants for the Scholarship or Advanced Course Reserve Officer Training Corps (ROTC), and all other Military Services' special officer personnel procurement programs.

f. Cadets and midshipmen at the U.S. Service academies and students enrolled in ROTC scholarship programs applying for retention in their respective programs.

g. Individuals on the Temporary Disability Retired List (TDRL) who have been found fit on reevaluation by the Physical Disability Evaluation System (PDES) and who elect to return to active duty or to active status in the Reserve Components within the time standards prescribed by Service Regulations. These individuals are exempt from this Instruction for the conditions for which they were found fit on reevaluation by the PDES.

h. All individuals being inducted into the Military Services.

2. MEDICAL STANDARDS. Throughout this enclosure, ICD, CPT and HCPCS codes are included with most medical conditions and procedures, usually parenthetically, to aid cross-referencing. Unless otherwise stipulated, the conditions listed in this enclosure are those that do NOT meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified by the general systems described in *sections* 3-~~30~~*31* of this enclosure.

3. HEAD

a. Deformities of the skull, face, or mandible (738.19, 744.9, 754.0) of a degree that shall prevent the individual from the proper wearing of a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull (756.0 or 738.19) not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a 25-cent piece.

4. EYES

a. Lids

(1) Current symptomatic blepharitis (373.0x).

(2) Current blepharospasm (333.81).

(3) Current dacryocystitis, acute (375.32), or chronic (375.42).

(4) Defect or deformity of the lids or other disorders affecting eyelid function (374.4x, 374.50, 374.85, 374.89, 743.62), complete, or significant ptosis (374.3x, 743.61), sufficient to interfere with vision or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid (173.1, 198.2, 216.1, 232.1, 238.8, 239.89), other than small, non-progressive, asymptomatic, benign lesions.

b. Conjunctiva

(1) Current acute or chronic conjunctivitis (372.1x, 077.0). Seasonal allergic conjunctivitis (372.14) DOES meet the standard.

(2) Current pterygium (372.4x) if condition encroaches on the cornea in excess of 3 millimeters, interferes with vision, is progressive, or a history of recurrence after any prior surgical removal (372.45).

c. Cornea

(1) Corneal dystrophy or degeneration of any type (371.x), including but not limited to keratoconus (371.6x) of any degree.

(2) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy (RK), astigmatic keratotomy (AK), or corneal implants (Intacs®)

(3) Corneal refractive surgery performed with an excimer laser, including but not limited to photorefractive keratectomy (PRK) (HCPCS S0810), laser epithelial keratomileusis (LASEK), and laser-assisted in situ keratomileusis (LASIK) (HCPCS S0900) (ICD-9 code for each is P11.7) if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) For corneal refractive surgery, at least 180 days recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.

(d) There have been complications and/or medications or ophthalmic solutions, or any other therapeutic interventions such as sunglasses, are required.

(e) Post-surgical refraction in each eye is not stable as demonstrated by at least two separate refractions at least 1 month apart, with initial refraction at least 90 days post-procedure, and the most recent of which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.50 diopters for cylinder vision.

(4) Current or recurrent keratitis (370.xx)

(5) Documented herpes simplex virus keratitis (054.42, 054.43).

(6) Current corneal neovascularization, unspecified (370.60), or corneal opacification (371.00, 371.03) from any cause that is progressive or reduces vision below the standards prescribed in this Instruction.

(7) Current or history of uveitis or iridocyclitis (364.00-364.3).

d. Retina

(1) Current or history of any abnormality of the retina (361.00-362.89, 363.14-363.22), choroid (363.00-363.9) or vitreous (379.2x).

e. Optic Nerve

(1) Any current or history of optic nerve disease (377.3), including but not limited to optic nerve inflammation (363.05), optic nerve swelling, or optic nerve atrophy (377.12, 377.14).

(2) Any optic nerve anomaly.

f. Lens

(1) Current aphakia (379.31, 743.35), history of lens implant (V45.61, V43.1) (CPT 66982-66986), or current or history of dislocation of a lens (379.32-379.34, 743.37).

(2) Current or history of opacities of the lens (366.xx), including cataract (366.9).

g. Ocular Mobility and Motility

(1) Current or recurrent diplopia (368.2).

(2) Current nystagmus (379.5x) other than physiologic "end-point nystagmus."

(3) Esotropia (378.0x), exotropia (378.1x), and hypertropia (378.31): For entrance into Service academies and officer programs, the individual Military Services may set additional requirements. The Military Services shall determine special administrative criteria for assignment to certain specialties.

h. Miscellaneous Defects and Diseases

(1) Current or history of abnormal visual fields (368.9) due to diseases of the eye or central nervous system (368.4x), or trauma.

(2) Absence of an eye (V43.0, V45.78), clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.xx).

(3) Current unilateral or bilateral exophthalmoses (376.21-376.36).

(4) Current or history of glaucoma (365.xx), ocular hypertension, pre-glaucoma (365.0-365.04), or glaucoma suspect.

(5) Any abnormal pupillary reaction to light (379.4x) or accommodation (367.5x).

(6) Asymmetry of pupil size greater than 2mm.

(7) Current night blindness (264.5, 368.6x).

(8) Current or history of intraocular foreign body (360.50-360.69, 871.x).

(9) Current or history of ocular tumors (190.0, 190.8-190.9, 198.4, 224.0, 224.8-224.9, 234.0, 238.8, 239.89, V10.84).

(10) Current or history of any abnormality of the eye (360) or adnexa (376, 379.9), not specified in subparagraphs 4.h.(1)-(9) of this enclosure, which threatens vision or visual function V41.0-V41.1, V52.2, V59.5).

5. VISION

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):

(1) 20/40 in one eye and 20/70 in the other eye (369.75).

(2) 20/30 in one eye and 20/100 in the other eye (369.75).

(3) 20/20 in one eye and 20/400 in the other eye (369.73).

b. Current near visual acuity of any degree that does not correct to 20/40 in the better eye (367.1-367.32).

c. Current refractive error (hyperopia (367.0), myopia (367.1), astigmatism (367.2x)), in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.

d. Any condition requiring contact lenses for adequate correction of vision, such as corneal scars and opacities (370.0x) and irregular astigmatism (367.22).

e. Color vision (368.5x) requirements shall be set by the individual Services.

6. EARS

a. Current atresia of the external ear (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5x), chronic otitis externa (380.15-380.16, 380.23), or severe external ear deformity (380.32, 738.7, 744.01, 744.3) that prevents or interferes with the proper wearing of hearing protection.

b. Current or history of Ménière's Syndrome or other chronic diseases of the vestibular system (386.xx).

c. History of cochlear implant.

d. Current or history of cholesteatoma (385.3x)

e. History of any inner (P20) (CPT 69801-69930) or middle (P19) (CPT 69631-69636, 69676) ear surgery excluding successful tympanoplasty (CPT 69635) performed during the preceding 180 days.

f. Current perforation of the tympanic membrane (384.2x) or history of surgery to correct perforation during the preceding 180 days (P19) (CPT 69433, 69436, 69610, 69631-69646).

g. Chronic Eustachian tube dysfunction as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization (PE) tube within the last 3 years.

7. HEARING All hearing defects are coded with ICD-9 code 389.xx.

a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute (ANSI S3.6-2004) (Reference (i)) and shall be used to test the hearing of all applicants.

b. Current hearing threshold level in either ear greater than that described in subparagraphs 7.b.(1)-(3) of this enclosure does not meet the standard:

(1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of not more than 30 decibels (dB) on the average with no individual level greater than 35 dB at those frequencies.

(2) Pure tone level not more than 45 dB at 3000 cycles per second or 55 dB at 4000 cycles per second for each ear.

(3) There is no standard for 6000 cycles per second.

c. Current or history of hearing aid use (V53.2).

8 NOSE, SINUSES, MOUTH, AND LARYNX

a. Current cleft lip or palate defects (749.xx) not satisfactorily repaired by surgery or that interfere with use or wear of military equipment, or that prevent drinking from a straw.

b. Current ulceration of oral mucosa, including tongue (528.6), excluding apthous ulcers.

c. Current chronic conditions of larynx including vocal cord paralysis (478.3x) or history of laryngeal papillomatosis.

d. History of non-benign polyps, (478.4) chronic hoarseness (78.49), chronic laryngitis (476.0) or spasmodic dysphonia.

e. Current anosmia or parosmia (781.1).

f. History of recurrent epistaxis with more than one episode per week of bright red blood from the nose occurring over a 3-month period (784.7) within the last 3 years.

g. Current nasal polyp or history of nasal polyps (471.x), unless more than 12 months have elapsed since nasal polypectomy (CPT 30110, 30115, 31237-31240) and/or sinus surgery, and asymptomatic.

h. Current perforation of nasal septum (478.1, 478.19, 748.1).

i. Current chronic sinusitis (473) as evidenced by chronic purulent discharge, symptoms requiring frequent medical attention, or computed tomography (CT) scan.

j. Current or history of deformities, or conditions or anomalies of the upper alimentary tract (750.9), mouth (750.26), tongue (750.1x), palate, throat, pharynx, larynx (748.3), and nose (748.1), that interfere with chewing (V41.6), swallowing, speech, or breathing.

9 DENTAL

a. Current diseases or pathology of the jaws or associated tissues that prevent normal functioning. Those diseases or conditions include but are not limited to temporomandibular disorders (524.6x) and/or myofascial pain (784.0). A minimum of 6 months healing time must elapse for any individuals completing surgical treatment of any maxillofacial pathology lesions.

b. Current severe malocclusion (524.00-524.29, 524.4), which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

c. Eight or more grossly (visually) cavitated and/or carious teeth (521.0x). Applicants who are edentulous must have functioning dentures. Lack of a serviceable prosthesis that prevents adequate biting and chewing of a normal diet. Individuals undergoing endodontic care are acceptable for entry into the Delayed Entry Program (DEP) only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment shall be completed prior to being sworn to active duty.

d. Current orthodontic appliances (mounted or removable, i.e., Invisalign®) for continued active treatment (V53.4). Permanent or removable retainers are permissible. Individuals undergoing active orthodontic care are acceptable for accession (including DEP) only if a civilian or military orthodontist provides documentation that active orthodontic treatment shall be completed prior to being sworn into active duty. Entrance to active duty will not occur until all orthodontic treatment is documented to be completed.

10 NECK

a. Current symptomatic cervical ribs (756.2).

b. Current congenital cyst(s) (744.4x) of branchial cleft origin or those developing from the remnants of the thyroglossal duct (759.2).

c. Current contraction (723.5, 754.1)) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent it interferes with the proper wearing of a uniform or military equipment, or is so disfiguring as to interfere with or prevent satisfactory performance of military duty.

11. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM

a. Current abnormal elevation of the diaphragm (either side) (756.6). Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1) or other thoracic or abdominal organ (793.2).

b. Current abscess of the lung (513.0) or mediastinum (513.1).

c. Current or history of recurrent acute infectious processes of the lung, including but not limited to viral pneumonia (480.x), pneumococcal pneumonia (481), bacterial pneumonia (482.xx), pneumonia due to other specified organism (483.x), pneumonia infectious disease classified elsewhere (484.x), bronchopneumonia (organism unspecified) (485), and pneumonia (organism unspecified) (486).

d. Airway hyper responsiveness including asthma (493.xx), reactive airway disease, exercise-induced bronchospasm (519.11) or asthmatic bronchitis (493.90), reliably diagnosed and symptomatic after the 13th birthday.

(1) Reliable diagnostic criteria may include any of the following elements: substantiated history of cough, wheeze, chest tightness, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 12 months.

(2) Individuals *DO* MEET the standard if within the past 3 years they meet ALL of the criteria in subparagraphs 11.d.(2)(a)-(d).

(a) No use of controller or rescue medications (including, but not limited to inhaled corticosteroids, leukotriene receptor antagonists, or short-acting beta agonists).

(b) No exacerbations requiring acute medical treatment.

(c) No use of oral steroids.

(d) A current normal spirometry (within the past 90 days), performed in accordance with American Thoracic Society (ATS) guidelines and as defined by current National Heart, Lung, and Blood Institute (NHLBI) standards.

e. Chronic obstructive pulmonary disease (491).

(1) Current or history of bullous or generalized pulmonary emphysema (492).

(2) Current bronchitis (490), acute or chronic symptoms over 3 months occurring at least twice a year (491).

f. Current or history of bronchiectasis (494). Bronchiectasis during the first year of life is not disqualifying if there are no residual or sequelae.

g. Current or history of bronchopleural fistula (510.0), unless resolved with no sequelae.

h. Current chest wall malformation (754.89), including but not limited to pectus excavatum (754.81) or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion.

i. History of empyema (510.9).

j. Pulmonary fibrosis (515).

k. Current foreign body in lung (934.8, 934.9), trachea (934.0), or bronchus (934.1).

l. History of thoracic surgery (32-33), (CPT 32035-32999, 33010-33999, 43020-43499) including open and endoscopic procedures.

m. Current or history of pleurisy with effusion (511.9) within the previous 2 years.

n. Current or history of pneumothorax (512) occurring during the year preceding examination if due to trauma (860) or surgery, or occurring during the 2 years preceding examination from spontaneous (512.8) origin.

o. Recurrent spontaneous pneumothorax (512.8).

p. History of chest wall surgery (34-34.9), including breast (85-85.9), during the preceding 6 months, or with persistent functional limitations.

12. HEART

a. History of valvular repair or replacement (CPT 33400-33478).

(1) Current or history of the following valvular conditions as defined by the current American College of Cardiology and American Heart Association guidelines:

(a) Severe pulmonic regurgitation.

(b) Severe tricuspid regurgitation.

(c) Moderate pulmonic regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.

(d) Moderate tricuspid regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.

(e) Moderate or severe mitral regurgitation.

(f) Mild, moderate, or severe aortic regurgitation.

(2) The following are considered normal variants that meet accession standards:

(a) Trace or mild pulmonic regurgitation.

(b) Trace or mild tricuspid regurgitation.

(c) Trace or mild mitral regurgitation in the absence of mitral valve prolapse.

(d) Trace aortic insufficiency.

b. Mitral valve prolapsed (396.3) with normal exercise tolerance not requiring medical therapy DOES meet the standard.

c. Bicuspid aortic valve (746.4), in the absence of stenosis or regurgitation as in *sub*paragraph*s* 12.a.*(1)(a)-(f)*, DOES meet the standard.

d. All valvular stenosis (396).

e. Current or history of atherosclerotic coronary artery disease (410).

f. Current or history of pacemaker or defibrillator implantation (CPT 3320-33249).

g. History of supraventricular tachycardia (427.0).

(1) History of recurrent atrial fibrillation (427.31) or flutter (427.32).

(2) Supraventricular tachycardia (427.0) associated with an identifiable reversible cause and no recurrence during the preceding 2 years while off all medications DOES meet the standard.

(3) Those with identified atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (such as Wolff-Parkinson-White (WPW) syndrome) (426.7) who have undergone successful ablative therapy with no recurrence of symptoms after 3 months and with documentation of normal electrocardiograph (ECG) meet the standard.

h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment.

i. Abnormal ECG patterns (794.31):

(1) Long QT (426.82).

(2) Brugada pattern.

(3) WPW syndrome (426.7) pattern unless associated with low risk accessory pathway by appropriate diagnostic testing.

j. Current or history of ventricular arrhythmias (427.1) including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions. Occasional asymptomatic unifocal premature ventricular contractions meet the standard.

k. Current or history of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block (426.12), and third-degree AV block (426.0).

l. In the absence of cardiovascular symptoms, the following meet the standard:

(1) Sinus arrhythmia.

(2) First degree AV block (426.11).

(3) Left axis deviation of less than -45 degrees.

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker (427.89) or ectopic atrial rhythm (427.89).

(7) Sinus bradycardia (427.81).

(8) Mobitz type I second-degree AV block (426.13).

m. Current or history of conduction disturbances such as left anterior hemiblock (426.2), right or left bundle branch block (426.4) do not meet the standard unless asymptomatic with a normal echocardiogram.

n. Current or history of cardiomyopathy (425), cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), dilation (429.3), or congestive heart failure (428).

o. History of myocarditis (422) or pericarditis (420) unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year.

p. Current persistent tachycardia (785.0) (as evidenced by average heart rate of 100 beats per minute or greater over a 24-hour period of continuous monitoring).

q. Current or history of congenital anomalies of heart and great vessels (746). The following conditions meet the standard with an otherwise normal current (within 6 months) echocardiogram.

(1) Dextrocardia (746.87) with situs inversus (759.3) without any other anomalies.

(2) Ligated or occluded patent ductus arteriosus (747.0).

(3) Corrected atrial septal defect (745.9) or patent foramen ovale (745.5) without residua.

(4) Corrected ventricular septal defect (745.4) without residua.

r. History of recurrent syncope and or presyncope (780.2), including black out, fainting, loss or alteration of level of consciousness (excludes vasovagal reactions with identified trigger such as venipuncture) unless there has been no recurrence during the preceding 2 years while off all medication.

s. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion) that impairs a physically active lifestyle.

t. History of rheumatic fever (390).

13. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM

a. Esophageal Disease

(1) Current or history of esophageal disease (530.0-530-9), including but not limited to ulceration, varices, fistula, or achalasia.

(2) Gastro-Esophageal Reflux Disease (GERD) (530.81), with complications~~, including stricture, or maintenance on acid suppression medication, other dysmotility disorders; or chronic or recurrent esophagitis (530.1)~~.

(a) Stricture or B-ring.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagitis.

(e) Extraesophageal complications; reactive airway disease; recurrent sinusitis or dental complications.

~~(3) Current or history of reactive airway disease associated with GERD (530.81).~~

(~~4~~*3*) History of surgical correction *(fundoplication or dilation)* for GERD within 6 months ~~(P42-esophageal correction, P43-stomach correction, and P45-intestinal correction) (CPT 43257)~~*(45.89)*.

(~~5~~*4*) Current or history of dysmotility disorders~~ and chronic or recurrent esophagitis (530).~~*, to include diffuse esophageal spasm, nutcracker esophagus, non-specific motility disorder, and achalasia.*

(5) Eosinophilic esophagitis.

(6) Other esophageal strictures, for example lye or other caustic ingestion.

b. Stomach and Duodenum

(1) Current ~~gastritis, chronic or severe (535), or non-ulcerative dyspepsia that requires maintenance medication~~ *dyspepsia requiring medication; or history of dyspepsia lasting 3 or more consecutive months and requiring medication within the preceding 12 months.*

(2) ~~Current or history of ulcer of the stomach or duodenum confirmed by X-ray or endoscopy (533).~~ *Gastric or duodenal ulcers:*

(a) Current ulcer or history of treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within preceding 5 years confirmed by endoscopy.

(3) History of surgery for peptic ulceration or perforation (533.0-599.9).

(4) History of gastroparesis.

(5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).

(6) History of gastric varices.

c. Small and Large Intestine

(1) Current or history of inflammatory bowel disease, including but not limited to ~~unspecified~~ *indeterminate* (558.9), ~~regional enteritis or~~ Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556.2).

(2) Current infectious colitis not otherwise specified (009.1).

(~~2~~*3*) Current or history of intestinal malabsorption syndromes (579.9), including but not limited to *celiac sprue, pancreatic insufficiency,* post-surgical and idiopathic (579). Lactase

deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.

(~~3~~*4*) Current or history of gastrointestinal functional and motility disorders within the past 2 years, including but not limited to pseudo-obstruction, megacolon, history of volvulus, or chronic constipation (564.0) and or diarrhea (787.91), regardless of cause, persisting or symptomatic in the past 2 years.

(~~4~~*5*) History of gastrointestinal bleeding (578), including positive occult blood (792.1), if the cause has not been corrected. Meckel's diverticulum (751.0), if surgically corrected more than 6 months prior DOES meet the standard.

(~~5~~*6*) Current or history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention *or prescription medication* or to interfere with normal function.

(~~6~~*7*) History of bowel resection (CPT 44202-44203).

(~~7~~*8*) Current or history of symptomatic diverticular disease of the intestine (562).

(9) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer syndrome.

d. Hepatic-Biliary Tract

(1) Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function.

(2) Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3).

(3) Current or history of symptomatic cholecystitis (575.10), unless successfully surgically corrected~~, acute or chronic, with or without cholelithiasis (574)~~; postcholecystectomy syndrome; or other disorders of the gallbladder and biliary system (576). Cholecystectomy DOES meet the standard if performed more than 6 months prior to examination and patient remains asymptomatic. ~~Fiberoptic~~ *Endoscopic* procedure to correct ~~sphincter dysfunction or cholelithiasis~~ *choledocholithiasis*, if performed more than 6 months prior to examination and patient remains asymptomatic, MAY meet the standard.

(4) History of sphincter of Oddi dysfunction.

(5) Choledochocyst.

(6) Primary biliary cirrhosis or primary sclerosing cholangitis.

(~~4~~*7*) Current or history of pancreatitis, acute (577.0) or chronic (577.1).

(8) Pancreatic cyst.

(9) History of pancreatic surgery.

(~~5~~*10*) Current or history of metabolic liver disease, including but not limited to hemochromatosis (275.0), Wilson's disease (275.1), or alpha-1 anti-trypsin deficiency (273.4). *Gilbert's syndrome DOES meet the standard.*

(~~6~~*11*) Current enlargement of the liver from any cause (789.1).

e. Anorectal

(1) Current anal fissure or anal fistula (565).

(2) Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6), within the last 2 years. *History of removal of juvenile or inflammatory polyp DOES meet the standard.*

(3) Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last 60 days.

~~f. Spleen~~

~~(1) Current splenomegaly (789.2).~~

~~(2) History of splenectomy (P41.5) (CPT 38100-38129), except when resulting from trauma.~~

~~g~~*f*. Abdominal Wall

(1) Current hernia (except for small or asymptomatic umbilical hernias), including but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553).

(2) History of open or laparoscopic abdominal surgery (CPT 22900-22999, 43500-49999) during the preceding 6 months (P54). Uncomplicated laparoscopic appendectomies (CPT 44970) meet the standard after 3 months.

~~h~~*g*. Obesity. History of any gastrointestinal procedure for the control of obesity (CPT 43644-43645, 43770-43775, 43842-43848, 43886-43888) or artificial openings, including but not limited to ostomy (V44).

14. FEMALE GENITALIA

a. Current or history of abnormal ~~uterine bleeding (626.2)~~ *menstruation unresponsive to medical management within the last 12 months*, including but not limited to menorrhagia, metrorrhagia, or polymenorrhea.

b. ~~Current unexplained~~ *Primary* amenorrhea (626.0).

c. Current unexplained secondary amenorrhea (626.0).

~~c~~*d*. Current ~~or history of~~ dysmenorrhea (625.3) that is *unresponsive to medical therapy and is* incapacitating to a degree recurrently ~~necessitating~~ *requiring* absences of more than a few hours from routine activities.

~~d~~*e*. ~~Current or history of e~~*E*ndometriosis (617) *that is unresponsive to medical therapy*.

~~e~~*f*. History of major abnormalities or defects of the genitalia ~~such as~~ *including but not limited to* change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

~~f~~*g*. ~~Current or history of~~ *Persistent or clinically significant* ovarian cyst(s) (620.2) ~~when persistent or symptomatic~~.

h. Polycystic ovarian syndrome (256.4) with metabolic complications.

~~g~~*i*. ~~Current p~~*P*elvic inflammatory disease (614) ~~or history of recurrent pelvic inflammatory disease. Current or history of chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9)~~ *within the preceding 30 days*.

j. Chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9).

~~h~~*k*. ~~Current p~~*P*regnancy (V22), ~~until~~ *through* 6 months after the ~~end~~ *completion* of the pregnancy (CPT 59150, 59151, 59400, 59409, 59510, 59514, 59610, 59612, 59812-59857).

~~i. History of congenital absence of the uterus (752.3).~~

~~j~~*l*. ~~Current~~ *Symptomatic* uterine enlargement due to any cause (621.2).

~~k~~*m*. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity ~~requiring~~ *to require* frequent intervention or to interfere with normal function. *Herpes does not meet the standard if:*

(1) Current lesions are present.

(2) Chronic suppressive therapy is needed.

(3) There are three or more outbreaks per year.

(4) Any outbreak in the past 12 months interfered with normal function.

(5) Treatment included hospitalization or intravenous therapy.

~~l~~*n*. ~~Current or history of~~ ~~*a*~~*A*bnormal gynecologic cytology *within the preceding 2 years*, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding atypical squamous cells of undetermined significance without human papillomavirus (079.4) and confirmed low-grade squamous intraepithelial lesion (622.9). For the purposes of this Instruction, confirmation is by colposcopy or repeat cytology.

15. MALE GENITALIA

a. Absence of one or both testicles, congenital (752.89) or undescended (752.51). ~~Unilateral loss of a testis, unrelated to cancer, DOES meet the standard.~~

b. Current *or history of* epispadias (752.62) ~~or hypospadias (752.61), when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction~~.

c. Current or history of surgery for proximal hypospadias (752.61).

d. Distal (coronal) hypospadias without history of surgery DOES meet the standard.

e. Distal (coronal) hypospadias treated with surgery when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction.

~~c~~*f*. Current enlargement or mass of testicle ~~or,~~ epididymis (608.9), *or spermatic cord*.

~~d~~*g*. Current *or history of recurrent* orchitis or epididymitis (604.90).

~~e~~*h*. History of penis amputation (878.0) (CPT 54125, 54130-54135).

i. Current penile curvature if associated with pain.

~~f~~*j*. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. *Herpes does not meet the standard if:*

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There are three or more outbreaks per year.

(4) Any outbreak in the past 12 months interfered with normal function.

(5) Treatment included hospitalization or intravenous therapy.

k. Current or history of urethral condyloma acuminatum.

~~g~~*l*. Current acute prostatitis (601.0) ~~or~~*,* chronic prostatitis (601.1), *or chronic pelvic pain syndrome*.

~~h~~*m*. Current hydrocele (603) ~~with greatest dimension of 4 centimeters or greater or symptomatic~~ *or spermatacele associated with pain or which precludes a complete exam of the scrotal contents*.

~~i~~*n*. Left varicocele (456.4), if *painful or* symptomatic, or associated with testicular atrophy, or varicocele larger than the testis.

o. Left varicocele (456.4) that does not reduce or decompress completely when supine.

~~j~~*p*. ~~Any~~ *Bilateral or* right varicocele (456.4).

~~k~~*q*. Current or history of chronic *or recurrent* scrotal pain or unspecified symptoms associated with male genital organs (608.9).

~~l~~*r*. History of major abnormalities or defects of the genitalia such as change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

16. URINARY SYSTEM

a. Current ~~cystitis,~~ or history of chronic ~~or~~*/* recurrent cystitis (595)*, interstitial cystitis, or painful bladder syndrome*.

b. Current urethritis, or history of chronic or recurrent urethritis (597.80).

c. History ~~of enuresis (788.30) or incontinence of urine (788.30), or the control of it with medication or other treatment past the 15th birthday.~~ *or treatment of the following voiding symptoms within the previous 12 months:*

(1) Urinary frequency or urgency more than every 2 hours on a daily basis.

(2) Nocturia more than two episodes during sleep period.

(3) Enuresis (788.30).

(4) Incontinence of urine, such as urge or stress.

(5) Urinary retention.

(6) Dysuria.

d. History of need for urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

e. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

~~d~~*f*. Current ~~hematuria (599.7), pyuria, or other findings indicative of urinary tract disease (599).~~ *or history of abnormal urinary findings:*

(1) Gross hematuria (599.7).

(2) Microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collected urinalyses).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalyses).

~~e~~*g*. Current or recurrent urethral *or ureteral* stricture (598) or fistula (599.1) *involving the urinary tract*.

~~f~~*h*. Conditions associated with the kidneys, including:

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) (CPT 50220-50236).

(2) Asymmetry in size or function of kidneys.

(3) History of renal transplant.

(~~2~~*4*) Current *chronic or recurrent* pyelonephritis (590.0) ~~(chronic or recurrent),~~ or any other unspecified infections of the kidney (590.9).

(~~3~~*5*) Current or history of polycystic kidney (753.1).

(~~4~~*6*) Current or history of horseshoe kidney (753.3).

(~~5~~*7*) Current or history of hydronephrosis (591).

(~~6~~*8*) Current or history of acute (580) *nephritis* or chronic (582) ~~nephritis~~ *kidney disease* of any type.

(9) History of acute kidney injury requiring dialysis.

(~~7~~*10*) Current or history of proteinuria (791.0) ~~greater than 200 milligrams in 24 hours or~~ *with* a protein-to-creatinine ratio greater than 0.2 in a random urine sample~~, if greater~~ *more* than 48 hours after strenuous activity~~, unless consultation determines the condition to be benign orthostatic proteinuria~~. *Benign orthostatic proteinuria MEETS the standard.*

(~~8~~*11*) Current or history of *symptomatic* urolithiasis (592) within the preceding 12 months. ~~Recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.~~

(12) History of stone(s) greater than 4mm in size, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

(13) History of urolithiasis requiring surgical treatment or intervention requiring hospitalization.

17. SPINE AND SACROILIAC JOINTS

a. Ankylosing spondylitis or other inflammatory spondylopathies (720).

b. Current or history of any condition, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active vocation in civilian life (724), or is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion.

(2) It requires external support.

(3) It requires limitation of physical activity or frequent treatment.

c. Current deviation or curvature of spine (737) from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active vocation in civilian life.

(2) It interferes with the proper wearing of a uniform or military equipment.

(3) It is symptomatic.

(4) There is lumbar or thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 50 degrees when measured by the Cobb Method.

d. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0) (CPT 22532-22812).

e. Current or history of fracture or dislocation of the vertebra (805).

(1) Vertebral fractures that do NOT meet the standard:

(a) Compression fractures involving more than or equal to 25 percent of a single vertebra.

(b) Compression fractures involving less than 25 percent of a single vertebra occurring within the past 12 months or it is symptomatic.

(c) Any compression fracture that is symptomatic.

(2) Vertebral fractures that DO MEET the standard:

(a) Compression fractures involving less than 25 percent of a single vertebra if it occurred more than 1 year before the accession examination and the applicant is asymptomatic.

(b) A history of fractures of the transverse or spinous process IF the applicant is asymptomatic.

f. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by X-ray or kyphosis.

g. Current herniated nucleus pulposus (722) or history of surgery to correct (CPT 63001-63200). A surgically corrected asymptomatic single-level lumbar or thoracic diskectomy with full resumption of unrestricted activity DOES meet the standard.

h. Current or history of spina bifida (741) when symptomatic, when there is more than one vertebral level involved, or with dimpling of the overlying skin. History of surgical repair of spina bifida.

i. Current or history of spondylolysis congenital (756.10-756.12) or acquired (738.4).

j. Current or history of spondylolisthesis congenital (756.12) or acquired (738.4).

18. UPPER EXTREMITIES

a. Limitation of Motion. Current active joint ranges of motion less than:

(1) Shoulder (726.1)

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3)

(a) Flexion to 130 degrees.

(b) Extension to 15 degrees.

(3) Wrist (726.4). A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.

(4) Hand (726.4)

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb (726.4). Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers

(1) Absence of the distal phalanx of either thumb (885).

(2) Absence of any portion of the index finger.

(3) Absence of distal and middle phalanx of the middle or ring finger of either hand irrespective of the absence of the little finger (886).

(4) Absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand (886).

(5) Absence of hand or any portion thereof (887), except for specific absence of fingers as noted in subparagraphs 18.b.(1)-(4).

(6) Current polydactyly (755.0).

(7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar, median, or radial nerve (354), sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

c. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness or symptoms that prevents satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder (719.41), the upper arm (719.42), the forearm (719.43), and the hand (719.44); or chronic joint pain as a late effect of fracture of the

upper extremities (905.2), as a late effect of sprains without mention of injury (905.7), and as late effects of tendon injury (905.8).

19. LOWER EXTREMITIES

a. General

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), knee (717.9), ankle and or foot (719.47) that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.

(2) Current leg-length discrepancy resulting in a limp (736.81).

b. Limitation of Motion. Current active joint ranges of motion less than:

(1) Hip (due to disease (726.5) or injury (905.2))

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees.

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee (due to disease (726.6) or injury (905.4))

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle (due to disease (726.7) or injury (905.4) or congenital)

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle

(1) Current absence of a foot or any portion thereof (896).

(2) Absence of a single lesser toe or any portion thereof that is asymptomatic and does not impair function DOES meet the standard.

(3) Deformity of the toes (735.9) that prevents the proper wearing of military footwear or impairs walking, marching, running, maintaining balance, or jumping.

(4) Symptomatic deformity of the toes (acquired (735) or congenital (755.66)), including but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), or overriding toe(s) (735.8).

(5) Clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or causes symptoms when walking, marching, running, or jumping.

(6) Rigid or symptomatic pes planus (acquired (734) or congenital (754.61)).

(7) Current ingrown toenails (703.0), if infected or symptomatic.

(8) Current or history of recurrent plantar fasciitis (728.71).

(9) Symptomatic neuroma (355.6).

d. Leg, Knee, Thigh, and Hip

(1) Current loose or foreign body in the knee joint (717.6).

(2) History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.

(3) History of surgical reconstruction of knee ligaments (P81.4) (CPT 27427-27429) DOES meet the standard if 12 months has elapsed since reconstruction, and the knee is asymptomatic and stable.

(4) Recurrent ACL reconstruction (CPT 27427, 27407).

(5) Symptomatic medial (717.82) or lateral (717.42) meniscal injury. The following DOES meet the standard if asymptomatic and released to full and unrestricted activity:

(a) Meniscal repair (CPT 27403), more than 6 months after surgery.

(b) Partial meniscectomy (CPT 27332-27333) more than 3 months after surgery.

(6) Meniscal transplant (CPT 29868).

(7) Symptomatic medial (844.1) and lateral (844.0) collateral ligament instability.

(8) Current or history of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Calve-Perthes Disease) (732.1), or slipped capital femoral epiphysis of the hip (732.2).

(9) Hip dislocation (835) within 2 years preceding examination. Hip dislocation after 2 years DOES meet the standard if asymptomatic and released to full unrestricted activity.

(10) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4) within the past year.

(11) Stress fractures (733.95, V13.52), recurrent or single episode during the past year.

20. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES

a. Current or history of chondromalacia (717.7), including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome (719.46), osteoarthritis (715.3), or traumatic arthritis (716.1).

b. Current joint dislocation if unreduced, or history of recurrent dislocation, subluxation or instability of the hip (835), elbow (832), ankle (837), or foot.

c. History of any dislocation, subluxation or instability of the knee (718.86) or shoulder.

d. Current or history of osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints that has interfered with a physically active lifestyle, or that prevents the satisfactory performance of military duty.

e. Fractures

(1) Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or interferes with proper wearing of equipment or military uniform. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

f. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities (V43).

g. Current or history of contusion of bone or joint (923, 924), ; an injury of more than a minor nature that shall interfere or prevent performance of military duty, or shall require frequent or prolonged treatment, without fracture, nerve injury, open wound, crush, or dislocation, that occurred in the preceding 6 months and recovery has not been sufficiently completed or rehabilitation resolved.

h. History of joint replacement or resurfacing of any site (V43.6) (CPT 24363, 27130-27132, 27447).

i. Current or history of neuromuscular paralysis, weakness, contracture, or atrophy (728) of sufficient degree to interfere with or prevent satisfactory performance of military duty, or requires frequent or prolonged treatment.

j. Current symptomatic osteochondroma or history of multiple osteocartilaginous exostoses (727.82).

k. Current osteoporosis (733.0) as demonstrated by a reliable test such as a dual energy x-ray absorptiometry scan (DEXA).

l. Current osteopenia (733.9) until resolved.

m. Current osteomyelitis (730.0) or history of recurrent osteomyelitis.

n. Current or history of *osteochondral defect, formerly known as* osteochondritis dissecans (732.7).

o. History of cartilage surgery, including but not limited to cartilage debridement, chondroplasty, microfracture, or cartilage transplant procedure (CPT 20910, 20912, 21230, 21235, 27412, 27415, 29866-29867).

p. Current or history of any post-traumatic (958.9) or exercise-induced (729.7-79) compartment syndrome.

q. Current or history of avascular necrosis of any bone.

r. Current or history of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

21. VASCULAR SYSTEM

a. Current or history of abnormalities of the arteries (447), including but not limited to aneurysms (442), arteriovenous malformations, atherosclerosis (440), or arteritis (such as Kawasaki's disease) (446).

b. Current or medically managed hypertension (401). Hypertension is defined as systolic pressure greater than 140 mmHg and or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on each of 2 or more consecutive days (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 or more consecutive days).

c. Current or history of peripheral vascular disease (443.9), including but not limited to diseases such as Raynaud's Disease (443.0) and vasculidities.

d. Current or history of venous diseases, including but not limited to recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).

e. Current or history of deep venous thrombosis (453.40).

f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement (CPT 34001-37799).

g. History of Marfan's Syndrome (759.82).

22. <u>SKIN AND CELLULAR TISSUES</u>

a. Current diseases of sebaceous glands including severe and or cystic acne (706), or hidradenitis suppurativa (704-705), if extensive involvement of the neck, scalp, axilla, groin, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of military equipment. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (Accutane®), do not meet the standard until 8 weeks after completion of therapy.

b. Current or history of atopic dermatitis (691) or eczema (692.9) after the 12th birthday.

(1) <u>Atopic Dermatitis</u>. Active or history of residual or recurrent lesions in characteristic areas (face, neck, antecubital and or popliteal fossae, occasionally wrists and hands).

(2) <u>Non-Specific Dermatitis</u>. Current or history of recurrent or chronic non-specific dermatitis to include contact (692) (irritant or allergic), or dyshidrotic dermatitis (705.81) requiring more than treatment with over the counter medications.

c. Cysts if:

(1) The current cyst (706.2) (other than pilonidal cyst) is of such a size or location as to interfere with the proper wearing of military equipment.

(2) The current pilonidal cyst (685) is evidenced by the presence of a tumor mass or a discharging sinus, or is a surgically resected pilonidal cyst (CPT 11770-11772) that is symptomatic, unhealed, or less than 6 months post-operative.

d. Current or history of bullous dermatoses (694), including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa, (757.39). Resolved bullous impetigo DOES meet the standard.

e. Current or chronic lymphedema (457.1).

f. Current or history of furunculosis or carbuncle (680) if extensive, recurrent, or chronic.

g. Current or history of severe hyperhidrosis of hands or feet (705.2, 780.8) unless controlled by topical medications.

h. Current or history of congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation. History of Dysplastic Nevus Syndrome (232).

i. Current or history of keloid formation (701.4), including but not limited to pseudofolliculitis and keloidalis nuchae (706.1), if that tendency is marked or interferes with the proper wearing of military equipment.

j. Current lichen planus (cutaneous and/or oral) (697.0).

k. Current or history of neurofibromatosis (Von Recklinghausen's Disease) (237.7).

l. History of photosensitivity (692.72), including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus.

m. Current or history of psoriasis (696.1).

n. Current or history of radiodermatitis (692.82).

o. Current or history of scleroderma (710.1).

p. Current or history of chronic urticaria lasting longer than 6 weeks or recurrent episodes of urticaria (708.8) within the past 24 months not associated with angioedema, hereditary angioedema (277.6), or maintenance therapy for chronic urticaria, even if not symptomatic.

q. Current symptomatic plantar wart(s) (078.19).

r. Current scars (709.2), or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of military clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty.

s. Prior burn (949) injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with the satisfactory performance of military duty due to decreased range of motion, strength, or agility.

t. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties. For systemic fungal infections, refer to paragraph 24.~~w~~*q*. of this enclosure.

23. BLOOD AND BLOOD-FORMING TISSUES

a. Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction. ICD-9 codes for diagnosed anemia include hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).

b. Current or history of coagulation defects (286), including but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), or Henoch-Schönlein Purpura (287.0).

c. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0).

d. Spleen

(1) Current splenomegaly (789.2).

(2) History of splenectomy (P41.5) (CPT 38100-38129), except when accomplished for trauma or conditions unrelated to the spleen or for hereditary spherocytosis (282.0).

24. SYSTEMIC

a. Current or history of disorders involving the immune mechanism, including immunodeficiencies (279).

b. Presence of human immunodeficiency virus or serologic evidence of infection (042, V08) or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing.

~~c. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9).~~

~~d. Current or history of progressive systemic sclerosis (710.1), including Calcinosis, Raynaud's phenomenon, Esophogeal dysmotility, sclerodactyly, telangiectasia (CREST) Variant.~~

~~e. Current or history of Reiter's disease (099.3).~~

~~f. Current or history of rheumatoid arthritis (714.0).~~

~~g. Current or history of Sjögren's syndrome (710.2).~~

~~h. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegener's granulomatosis (446.4).~~

~~i~~*c*. Tuberculosis (010)

(1) Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years.

(2) Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty.

(3) Individuals with a past history of active tuberculosis more than 2 years before appointment, enlistment, or induction meet the standard if they have received a complete course of standard chemotherapy for tuberculosis.

(4) Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest X-ray) (795.5). Individuals with a tuberculin reaction in accordance with ATS and United States Public Health Service (USPHS) guidelines are eligible for enlistment, induction, and appointment, provided they have received chemoprophylaxis in accordance with ATS and USPHS guidelines. A negative QuantiFERON®-TB Gold (QFT®-G) with a positive tuberculin skin test DOES meet the standard.

~~j~~*d*. Current untreated syphilis (097).

~~k~~*e*. History of anaphylaxis (995.0).

(1) History of anaphylaxis to stinging insects (989.5). A cutaneous only reaction to a stinging insect under the age of 16 DOES meet the standard. Applicants who have been treated for 3-5 years with maintenance venom immunotherapy DO meet the standard.

(2) History of systemic allergic reaction to food or food additives (995.60-995.69). Systemic allergic reaction may be defined as a temporally related, systemic, often multi-system, reaction to a specific food. The presence of a food-specific immunoglobulin E antibody without a correlated clinical history DOES meet the standard.

(3) Oral allergy syndrome.

(4) Hypersensitivity to latex (V15.07).

(5) Exercise-induced anaphylaxis (with or without food).

(6) Idiopathic anaphylaxis (995.0).

(7) Acute, early, or immediate anaphylactic onset.

(8) History of systemic allergic reaction or angioedema.

~~l~~*f*. Current residual of tropical fevers, including but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty.

~~m~~*g*. History of malignant hyperthermia (995.86).

~~n~~*h*. History of industrial solvent or other chemical intoxication (982) with sequelae.

~~o~~*i*. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years.

~~p~~*j*. History of rheumatic fever (390).

~~q~~*k*. Current or history of muscular dystrophies (359) or myopathies.

~~r~~*l*. Current or history of amyloidosis (277.3).

~~s~~*m*. Current or history of eosinophilic granuloma (277.8) and all other forms of histiocytosis (202.3). Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, DOES meet the standard.

~~t~~*n*. Current or history of polymyositis (710.4) or dermatomyositis complex (710.3) with skin involvement.

~~u~~*o*. History of rhabdomyolysis (728.88).

~~v~~*p*. Current or history of sarcoidosis (135).

~~w~~*q*. Current systemic fungus infections (117). For localized fungal infections, refer to paragraph 22.t. of this enclosure.

25. ENDOCRINE AND METABOLIC

a. Current ~~or history of~~ adrenal dysfunction (255).

b. ~~Current or history of diabetes mellitus (249.xx, 250.xx).~~ *Diabetes mellitus (250) disorders, including:*

(1) Current or history of diabetes mellitus (250).

(2) Current or history of pre-diabetes mellitus defined as fasting plasma glucose 110-125 milligrams per deciliter (mg/dL) and glycosylated hemoglobin greater than 5.7 percent.

(3) History of gestational diabetes mellitus.

(4) Current persistent glycosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).

c. Current or history of pituitary dysfunction (253)*, to include history of growth hormone use. Non-functional microadenoma (less than 1cm) DOES meet the standard.*

d. Current or history of ~~gout (274).~~ *diabetes insipidus.*

e. Current or history of hyperparathyroidism (252.0) or hypoparathyroidism (252.1).

f. The following thyroid disorders:

(1) Current goiter (240). *Symmetrical simple goiter less than two times normal size with no nodules by ultrasound and normal thyroid function tests DOES meet the standard.*

(2) Thyroid nodule (241.0). A solitary thyroid nodule less than 5mm or less than 3cm with benign histology or cytology DOES meet the standard.

(~~2~~*3*) Current hypothyroidism (244) ~~uncontrolled by medication~~. *Individuals with two normal thyroid stimulating hormone tests within the preceding 6 months DOES meet the standard.*

(~~3~~*4*) Current or history of hyperthyroidism (242.9). *In remission off of anti-thyroidal medication with normal thyroid function tests for a minimum of 12 months and without evidence of thyroid associated ophthalmopathy DOES meet the standard.*

~~(4) Current thyroiditis (245).~~

g. Current nutritional deficiency diseases, including but not limited to beriberi (265.0), pellagra (265.2), and scurvy (267).

~~h. Current persistent glucosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).~~

~~i.~~*h.* Current or history of acromegaly, including but not limited to gigantism (253.0), or other disorders of pituitary function (253).

~~j.~~*i.* Dyslipidemia ~~on medical management requiring more than one medication.~~ *with low-density lipoprotein (LDL) greater than 200mg/dL or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or LDL greater than 190 mg/dL on therapy.* All those on medical management must have demonstrated no medication side effects (such as myositis, myalgias, or transaminitis) for a period of 6 months.

~~k.~~ *j.* Metabolic syndrome beyond the 35th birthday. Metabolic syndrome is defined in accordance with NHLBI and American Heart Association (2005) as any three of the following:

(1) Medically controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.

(2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.

(3) Medically controlled dyslipidemia or triglycerides greater than 150 mg/dl.

(4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dl in men or less than 50 mg/dl in women.

(5) Fasting glucose greater than 100 mg/dl.

k. Metabolic bone disease.

(1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

l. Male hypogonadism.

m. Current or history of islet-cell tumors, nesideoblastosis, or hypoglycemia.

26. RHEUMATOLOGIC

a. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9).

b. Current or history of progressive systemic sclerosis (710.1), including calcinosis, Raynaud's disease or phenomenon, esophageal dysmotility, sclerodactyly, telangiectasia (CREST) variant.

c. Current or history of Reiter's disease (099.3).

d. Current or history of rheumatoid arthritis (714.0).

e. Current or history of Sjögren's syndrome (710.2).

f. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegener's granulomatosis (446.4). Henoch-Schonlein Purpura occurring before the age of 19 with 2 years remission and no sequelae DOES meet the standard.

g. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0).

h. Current or history of gout (274).

i. Current or history of inflammatory myopathy including polymyositis or dermatomyositis.

j. Current or history of non-inflammatory myopathy to include but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.

k. Current or history of fibromyalgia, myofascial pain, or chronic wide-spread pain.

l. Current or history of chronic fatigue syndrome.

m. Current or history of spondyloarthritis including ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.

n. Current or history of joint hypermobility syndrome.

o. Current or history of hereditary connective tissue disorders including but not limited to Marfan's syndrome, Ehlers-Danlos syndrome, and osteogenesis imperfecta.

2~~6~~*7*. NEUROLOGIC

a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation (437).

b. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9).

c. Current or history of disorders of meninges, including but not limited to cysts (349.2). Asymptomatic incidental arachnoid cyst demonstrated to be stable by neurological imaging over a 6-month or greater time period DO meet the standard.

d. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), peripheral nerves (337), or muscles (728).

e. History of headaches (784.0), including but not limited to migraines (346) and tension headaches (307.81) that:

(1) Are severe enough to disrupt normal activities (such as loss of time from school or work) ~~of~~ more than twice per year in the past 2 years.

(2) Require prescription medications more than twice per year within the last 2 years.

f. Migraine (346) or migraine variant (346.2) associated with neurological deficits other than scotoma.

g. Cluster headaches (339.0).

h. History of head injury (854.0) if associated with:

(1) Post-traumatic seizure(s) occurring more than 30 minutes after injury.

(2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.

(3) Persistent impairment of cognitive function.

(4) Persistent alteration of personality or behavior.

(5) Unconsciousness of 24 hours or more post-injury

(6) Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.

(7) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging until resolved and 12 months has elapsed since injury.

(8) Associated abscess (326) or meningitis (958.8).

(9) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.

(10) Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

i. History of moderate head injury (854.03).

(1) Moderate head injuries are defined as:

(a) Unconsciousness of more than 30 minutes but less than 24 hours, or

(b) Amnesia, or disorientation of person, place, or time, alone or in combination, more than 24 hours but less than 7 days duration post-injury, or

(c) Linear skull fracture.

(2) After 12 months post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

j. History of mild head injury (854.02).

(1) Mild head injury is defined as:

(a) Unconsciousness of less than 30 minutes post-injury.

(b) Amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.

(2) After 1 month post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

k. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

l. Current or history of infectious processes of the central nervous system, including but not limited to meningitis (322), encephalitis (323), neurosyphilis (094), or brain abscess (324), if occurring within 1 year before examination, required surgical treatment, or if there are residual neurological defects.

m. Current or history of paralysis, weakness, lack of coordination, chronic pain (including but not limited to chronic regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).

n. Any seizure occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorders (307.20) (e.g., Tourette's (307.23)).

p. Current or history of central nervous system shunts of all kinds (V45.2).

q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

2~~7~~*8*. SLEEP DISORDERS

a. Chronic insomnia (780.5). Within the past year, had difficulty sleeping, or used medications to promote sleep for more than 3 nights per week, over a period of 3 months.

b. Sleep-related breathing disorders (327). Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea (327.2).

c. Current or history of narcolepsy, cataplexy (347-347.11), or other hypersomnia disorders (327.13-19).

d. Circadian rhythm disorders requiring treatment (307.45).

e. Current or history of parasomnia (327.44, 327.49), including but not limited to sleepwalking, enuresis, or night terrors (307.46), after the age of 15.

f. Current diagnosis or treatment of sleep-related movement disorders to include restless leg syndrome (327.5).

2~~8~~*9*. LEARNING, PSYCHIATRIC, AND BEHAVIORAL

a. Attention Deficit Hyperactivity Disorder (ADHD) (314) UNLESS the following criteria are met:

(1) The applicant has not required an Individualized Education Program or work accommodations since the age of 14.

(2) There is no history of comorbid mental disorders.

(3) The applicant has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.

(4) During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations.

(5) Documentation from the applicant's prescribing provider that continued medication is not required for acceptable occupational or work performance.

(6) Applicant is required to enter service and pass Service-specific training periods with no prescribed medication for ADHD.

b. History of learning disorders (315), including but not limited to dyslexia (315.02), UNLESS applicants demonstrated passing academic and employment performance without utilization of academic and or work accommodations at any time since age 14.

c. Pervasive developmental disorders (299 series) including Asperger Syndrome, autistic spectrum disorders, and pervasive developmental disorder-not otherwise specified (299.9).

d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298).

e. History of bipolar disorders (296.4-7) and affective psychoses (296.8).

f. History of depressive disorders, including but not limited to major depression (296), dysthymic disorder (300.4), and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional (to include V65.40), or any inpatient treatment in a hospital or residential facility.

g. Depressive disorder not otherwise specified (311), or unspecified mood disorder (296.90), UNLESS:

(1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional (to include V65.40).

(2) The applicant has been stable without treatment for the past 36 continuous months.

(3) The applicant did not require any inpatient treatment in a hospital or residential facility.

h. History of a single adjustment disorder (309) within the previous 3 months, or recurrent episodes of adjustment disorders.

i. Current or history of disturbance of conduct (312), impulse control (312.3), oppositional defiant (313.81), other behavior disorders (313), or personality disorder (301).

(1) History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military Services.

(2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service.

j. Encopresis (307.7) after 13th birthday.

k. History of anorexia nervosa (307.1) or bulimia (307.51).

l. Other eating disorders (307.50; 52-54) including unspecified disorders of eating (307.59) occurring after the 13th birthday.

m. Any current receptive or expressive language disorder, including but not limited to any speech impediment or stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or *the ability* to repeat commands.

n. History of suicidal behavior, including gesture(s) or attempt(s) (300.9) or history of self-mutilation or injury used as a way of dealing with life and emotions.

o. History of obsessive-compulsive disorder (300.3) or post-traumatic stress disorder (309.81).

p. History of anxiety disorders (300.01), anxiety disorder not otherwise specified (300.00), panic disorder (300.2), agoraphobia (300.21, 300.22), social phobia (300.23), simple phobias (300.29), other acute reactions to stress (308) UNLESS:

(1) The applicant did not require any treatment in an inpatient or residential facility.

(2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional (to include V65.40).

(3) The applicant has not required treatment (including medication) for the past 24 continuous months.

(4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.

q. Current or history of dissociative, conversion, or factitious disorders (300.1), depersonalization (300.6), hypochondriasis (300.7), somatoform disorders (300.8), or pain disorder related to psychological factors (307.80 and .89).

r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.

s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).

t. Current or history of other mental disorders (all 290-319 not listed) that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.

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u. Prior psychiatric hospitalization for any cause.

~~29~~*30*. TUMORS AND MALIGNANCIES

a. Current benign tumors ~~(M8000)~~ or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome.

b. Current or history of malignant tumors (V10).

c. Skin cancer (other than malignant melanoma) that is removed with no residual DOES meet the standard.

3~~0~~*1*. MISCELLANEOUS

a. Current or history of parasitic diseases, if symptomatic or carrier state, including but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), or unspecified infectious and parasitic disease (136.9).

b. Current or history of other disorders, including but not limited to cystic fibrosis (277.0) or porphyria (277.1), that prevent satisfactory performance of duty, or require frequent or prolonged treatment.

c. Current or history of cold-related disorders, including but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2).

d. Current residual effects of cold-related disorders (991.9), including but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache.

e. History of angioedema, including hereditary angioedema (277.6).

f. History of receiving organ or tissue transplantation (V42).

g. History of pulmonary (415) or systemic embolization (444).

h. History of untreated acute or chronic metallic poisoning, including but not limited to lead, arsenic, silver (985), beryllium (985.3), or manganese (985.2), or current complications or residual symptoms of such poisoning.

i. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0).

j. History of three or more episodes of heat exhaustion (992.3).

k. Current or history of a predisposition to heat injuries (992.0-992.8), including disorders of sweat mechanism (705.0-705.9), combined with a previous serious episode.

l. Current or history of any unresolved sequelae of heat injury (992.0-992.8), including but not limited to nervous, cardiac, hepatic, or renal systems.

m. Current or history of any condition that, in the opinion of the medical officer, shall significantly interfere with the successful performance of military duty or training (should use specific ICD code whenever possible, or 796.9).

n. Any current acute pathological condition, including but not limited to acute communicable diseases, until recovery has occurred without sequelae.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
ANSI	American National Standards Institute
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ATS	American Thoracic Society
AV	atrioventricular
CPT	Current Procedural Terminology
CREST	Calcinosis, Raynaud's phenomenon, Esophogeal dysmotility, sclerodactyly, telangiectasia
dB	decibel
DEP	Delayed Entry Program
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DUSD(MPP)	Deputy Under Secretary of Defense for Military Personnel Policy
ECG	electrocardiograph
GERD	Gastro-Esophageal Reflux Disease
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
ICD	International Classification of Diseases
LASEK	laser epithelial keratomileusis
LASIK	laser-assisted in situ keratomileusis
LDL	*low-density lipoprotein*
LTBI	latent tuberculosis infection
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dl	milligrams per deciliter
mmHg	millimeters of mercury
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
PRK	photorefractive keratectomy
PDASD(HA)	Principal Deputy Assistant Secretary of Defense for Health Affairs
PDES	Physical Disability and Evaluation System
PDUSD(P&R)	Principal Deputy Under Secretary of Defense for Personnel and Readiness

QFT®-G	QuantiFERON®-TB Gold
ROTC	Reserve Officer Training Corps
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USPHS	United States Public Health Service
WPW	Wolff-Parkinson-White

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this Instruction.

anemia. A hemoglobin level of less than 13.5 for males and less than 12 for females.

Department of Health and Human Services (HHS). The U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Military Department. Defined in Joint Publication 1-02 (Reference (j)).

Military Service(s). Defined in Reference (j).

NHLBI. An agency within the National Institutes of Health (NIH) that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.

NIH. An agency within the HHS that serves as the steward of medical and behavioral research for the Nation. Its mission is science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.

QFT®-G. An in vitro laboratory diagnostic test using a whole blood specimen. It is an indirect test for Mycobacterium tuberculosis-complex (i.e., M. tuberculosis, M. bovis, M. africanum, M. microti, M. canetti) infection, whether tuberculosis disease or latent tuberculosis infection (LTBI). It cannot distinguish between tuberculosis disease and LTBI, and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations.

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of December, 2017, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

/s/ Paul R.Q. Wolfson
PAUL R.Q. WOLFSON