Society of U. S. Naval Flight Surgeons

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VOL. XVI, NO. 3 **NEWSLETTER** **JULY 1992**

PRESIDENT'S COLUMN

In my new capacity as your President, one of the things that struck home during the recent Aerospace Medical Association meeting was Dr. Mike Berry's final speech as the AsMA President. He made the comment that he had a whole bunch of plans as he came into office but now realizes that he had to play the hand he was dealt and make the best of it. That's certainly true in my case as well. In my case, the difference is that I knew it at the beginning of the year as opposed to coming to that realization at the end of my tenure as President of SUSNFS.

That having been said, the "hand" that Dick Weaver has handed over to me is in great shape and getting better. An incoming president couldn't realistically ask for more. My overall goal for the year is to have SUSNFS in at least as good condition as it is now if not somewhat better. At the same time, I fully appreciate that I am not the one who will decide how good the society is but rather my fellow officers and most importantly, the membership itself. If the society membership provides strong support, SUSNFS can become one of the more powerful voices in AsMA.

At this point you're probably asking yourself (I hope) "How can I support SUSNFS?" Easy. Pay your dues promptly, contribute to our outstanding Newsletter which is the envy of other societies and military services, pay your dues promptly and provide feedback and suggestions on how you would like to see your organization improved. The fact that I mentioned dues twice is self-explanatory.

Before discussing some of the more detailed issues, I want to reiterate a point that I tried to make at the Monday Navy Luncheon at AsMA. It's worth repeating. If my overall goal this year is to make SUSNFS an even healthier organization and stronger voice in AsMA, while continuing to serve the interests of the SUSNFS membership, my specific goal is to foster an era of absolute cooperation among the Naval aeromedical communities. From my perspective in Washington, I get to witness the elver shrinking of the force structure. All too often, our friends in the Line take the meat ax to medical billets first. One can't help but get the nagging feeling that in some corners of the Navy and Marine Corps we may not be appreciated as much as we would like or think we alre.

The only way to turn this very real perception around is to demonstrate yet one more time that the entire aeromedical team is a valued asset not to be disposed of quickly. And, the only way we can accomplish that is by truly poolilng all efforts and working as a team in every sense of the word. Parochialism by anyone community is a totally unaffordable luxury. The price of extinction from the biillet file is too high and not worth it.

Time and again I have had the chance to review instances in which flight surgeons, aerospace physiologists, and aerospace experimental psychologists have worked together on a common problem. Not only did the problem glet solved quicker, the sum of the effort was synergistic. Have lunch with someone from another corps and talk it over, please!

During the AsMA meeting the SUSNFS Board of Governors held a meeting. We're happy to report that the sale of SUSNFS dodads and sundries was a big success and helped to increase our financial position. The exact details will be provided later.

In the area of the Newsletter, we will be including more information about the inner workings of AsMA as well as the Society report that is presented to the Executive Council of AsMA. Steve Hart will be providing some quick blurtls on the key issues that AsMA is dealing with. (The better informed the members of SUSNFS are, the stronger we will be.) Additionally we are looking for more input from the Fleet and FMF as well as items of interest to and/or written by our enlisted shipmates.

(Continued on Page 3)

Society of U. S. Naval Flight Surgeons

1 April 1992

From: President, Society of U.S. Naval Flight Surgeons
To: Executive Council, Aerospace Medical Association

Subj: ANNUAL STATUS REPORT OF THE SOCIETY OF U.S. NAVAL FLIGHT SURGEONS, A CONSTITUENT ORGANIZATION OF THE AEROSPACE MEDICAL ASSOCIATION

1. To date, since the beginning of our fiscal year in April, the Society has maintained a steady membership roll with the normal exclusions from dues in arrears and the normal addition of eager new members. Current membership stands at 450, and our rolls also contain 163 non member subscriptions of the Society Newsletter. The financial position of the Society is stable. Our membership fees increased this year (for the first time in 15 years!) from $10 to $15 for membership and subscription, and from $200 to $300 for Lifetime Membership.

2. Our eight-page quarterly Newsletter continues to draw many accolades from within and outside the Society. The informational and educational value of material contributed to the Newsletter is always appreciated in the Fleet.

3. The Society, as always, is proud to sponsor the annual Richard E. Luehrs Memorial Award, given to the Outstanding Naval Flight Surgeon. Inputs form the Fleet, and Fleet Reserve are expected in by April 22, at which time our Awards Committee will select the deserving winner.

4. We have two new annual awards which are now sponsored by the Society. The first is the Ashton-Greybiel Publishing Award presented to the member who displays excellence in research and article publishing. The second is the AVT of the Year Award (Aviation Technician) presented to the enlisted individual who displays excellence in his/her work and support of the Naval Aviation Community. We were proud to present these two awards for the first time, at the Aerospace Medical Association Meeting, May 1991, and the Naval Aeromedical Problems Course, October 91, respectively.

5. We continue to sponsor the Annual Navy Aeromedical Problems Course, which has been a great success story since its debut in 1986. The October 1991 course was a resounding success, with high marks given to all presenters who participated in the theme of "The Aeromedical Planning, Operations, and Consequences of Desert Shield/Storm". The course was also noted for record attendance with 220 Flight Surgeons and 120 Aviation Technicians.

6. The Navy Flight Surgeon's Handbook, created at the Naval Aerospace Medical Institute and which was on sale at AsMA last year, has been a hot item this fiscal year with almost 200 sold. It will again be available at the Annual AsMA Convention in May.

R. A. WEAVER
CAPT, MC, USN (Ret)

President's Column...

(Make them part of the team, too.) Under the heading of new business, it has become clear that the secretary/ treasurer needs computer support that belongs to the Society and not "borrowed." Toward this end, the Board of Governors has authorized the purchase of a MODEST lap top computer. This should really pay for itself in terms of tracking dues payments.

There was one final piece of business at our little meeting dealing with awards and expanding the number the Society gives out. We are now in a financial position to do this as long as we don't go hog wild and give past presidents of SUSNFS a couple of grand for being nice folks. The one award that is near and dear to me and is in keeping with the direction I hope we will all move in will be for that individual in the aeromedical community who best exemplifies the principles and spirit of cooperation in aerospace medicine (or words to that effect.) The award will be open to any of the three communities and will probably consist of a plaque and stipend.

This is probably enough for a first effort. I look forward to seeing you at the Problems Course and hearing from you any time. Please remember, we all know how good we are and what we as a team can provide to the Navy and Marine Corps. We just need to stay around a bit longer to help in the effort to make Naval Aviation the best and safest it has ever been.

Semper Fi.

CAPT R. E. HAIN
MC USN

SECRETARY-TREASURER NOTES

"Throw the bums out!" has been heard across the country during this election year marked by the banking scandal, a mega-rich independent candidate, and not one, but two presidential candidates who were Naval Officers (and one who wasn't!). Never one to stay above the fray, SUSNFS has also been caught up in the election fever. As a result, new officers are now steadfastly manning our society's helm, charting a safe course through the turbulent tides of these tumultuous times (don't you love that nautical talk?). The long and short of it is -"Hey Howdy" is gone; long live, "Hey. ..". Well, I'm not sure "Hey what," yet. While I ponder that weighty decision let me bring you up to date on our recent elections.

CAPT Bob Hain has fleeted up to President and CAPT Ed Antosek is the Vice President (President-elect). CAPT E.J. Sacks is the Emeritus member, CDR John Nickle and LCDR Dean Bailey are the Senior and Junior Members at Large, respectively. For the next two years I'll have the opportunity to write this quarterly column as the new Secretary-Treasurer.

Before detaching, "Hey Howdy" swore me into the secret fraternity of SUSNFS Secretary-Treasurers. According to Dave, our only tradition is to continually harangue everyone to pay their dues. As this is my first column, I'll skip it this **one** time (provided no one tells him). I am at liberty to say that anyone who is more than a year in arrears by the end of this year's Problems Course will be removed from the rolls. In keeping with Dave's aggressive marketing of Flight Surgeon items, we are looking to expand our product line. In addition to the 14K Mess Dress and Sweetheart Wings, SUSNFS binders with or without newsletter reprints, and Flight Surgeon f-iandbooks, we are exploring adding shirts with embroidered Flight Surgeon wings. Ideas include a "polo" style shirt for the men, and a turtleneck for the ladies. If anyone has other/better ideas drop me a line or give me a call. My home phone is (904) 432-6948.

The Sec-Tres fraternity's only other tradition is to remind (harangue) everyone to send us a change of address when moving. My first official act is to inform you that **OUR ADDRESS** has changed. Bruce Bohnker, Forrestal SMO, pointed out that using NAMI as a return address could give the appearance of a conflict of interest, i.e., using government facilities for non-governmental activities. While we all know that just isn't true, SUSNFS will no longer use NAMI for our mailing address. The new one is:

Society of U.S. Naval Flight Surgeons
P.O. Box 33008
NAS, Pensacola, FL 32508-3008

So send us your ideas, address changes, and dues. While untrue of the other officers, my election proves that SUSNFS members, like the American people, are prone to vote first, and think about it later. Still, I am honored by your decision to elect me secretary-treasurer and look forward to working with each of you. With your supp,ort, the next *two* years are sure to be both productive and fun. Make your plans now to attend the Problems Course in November. See you there!

LCDR GLENN MERCANT
MC USN

AWARDS COMMITTEE

Congratulations to the 1992 Flight Surgeons of the Year! They are as follows:

NAVAIRLANT - LT Gregory R. Polston, MC, USNR
FMFLANT - LT Perry S. Bechtle, MC, USNR
NAVAIRPAC - LT Bradley W. Nordyke, MC, USNR
3rd MAW - LT Cynthia M. Peterson, MC, USN
1st MEB - LT James D. Kelly, MC, USNR

CNATRA - LT Rudolph Triana, MC, USNR

These six winners were judged by a panel of experienced Flight Surgeons for the Richard E. Luehrs Memorial Award and the recipient was LT Gregory R. Polston, MC, USNR. Bravo Zulu!

The winner of the second annual Dr. Ashton Graybiel Memorial Award for "Outstanding Publication" by an operational flight surgeon as CDR Dave Hiland, MC, USN. Congratulations Dave! This award is open to all operational Flight Surgeons and publications to be submitted for consideration for '93 should be sent to:

SUSNFS Awards Committee
c/o CAPT E.J. Sacks
P.O. Box 33008
NAS Pensacola, FL 32508-3008

CAPT E.J. SACKS
MC, USN
CODE 22, NAMI

CODE 42 SPEAKS

It was certainly good to see a number of you at the recent AsMA Scientific Meeting. Several of you discussed specific cases or general problems with me at that meeting and I would encourage continued dialogue regarding issues of concern to you. These efforts are in the best interest of our aviators.

Several issues have been reviewed by the Aeromedical Advisory Council since the last article. Those that have received BUM ED approval are enumerated below. Please share this information with your fellow Flight Surgeons and the AVT's, our partners in the aeromedical business.

Slit lamp examination (SLE) for Class II candidates. All aviation candidates should receive a SLE during their entrance physical. These examinations can be conducted by the local physician, flight surgeon or any eye professional (optometrist or ophthalmologist). It is not necessary to dilate these patients prior to the examination, but dilation can be performed at the discretion of the examining clinician. A normal SLE shall be noted on the SF-88. Any normal variants, such as a prominent Schwalbe's line, cortical dot opacities, persistent pupillary membranes, pigment stars, etc., shall also be noted on the SF-88 at the time of examination. All abnormalities shall be appropriately noted and, when possible, diagrammed, accompanied with measurements (if applicable) on the SF-88.

Annual refraction and new Rx for Class I personnel. All Class I aviation personnel shall be required to: (1) Receive a manifest refraction to best visual acuity (BVA) at the time of their annual flight physical; (2) If current spectacles do not correct to 20/20 or better in both eyes, the aviator is grounded until he/she receives a current prescription; (3) If new spectacles are required, two pair of clear and one pair of tinted flight glasses, with the BVA correction, should be ordered from NOSTRA; and (4) In the event the aviator's prescription is unchanged, inspection of current spectacles for scratches and other imperfections is necessary. If any surface damage is noted, replacement pairs of clear and tinted flight glasses should be ordered. A change to OPNAVINST 3710.7N (NATOPS) is being submitted to reflect this requirement.

Decomplression sickness (DCS). All cases should be reviewed by NAMI Hyperbaric Medicine Committee. Any DCS, Type I or II, with residual deficits or persistent symptoms is NPQ, no waiver. Bubble contrast ECHO is still required on all altitude DCS cases. **Type I DCS:** Designated personnel - one or two episodes of Type I DCS, PQ. More than two episodes, NPQ, waiver recommended after review by NAM I Code 42 / Hyperbaric Medicine. Non-designated personnel -single episode, PQ. Prior Type I DCS (EPTE) with subsequent Type I Altitude DCS, NPQ waiver recommended after review by NAMI Codje 42 / Hyperbaric Medicine. **Type II DCS:** Designated personnel - single episode, NPQ, waiver recommended (one time submission only). More than one episode, NPQ, waiver considered by NAMI 42 / Hyperbarilc Medicine. Non-designated personnel (already in training) - NPQ, waiver considered by NAMI Code 42 and Hyperbaric Medicine on a case-by-case basis.

Cholelithiasis. Either candidates or designated personnel with a single large asymptomatic gallstone as an incidental finding shall be found NPQ, with a waiver recommerlded as long as they remain asymptomatic.

Pneumothorax. Waiver recommendations for spontaneous pneumothorax will vary dependent upon whether the individual is a candidate, or already designated.

Candidates - May be considered for a waiver if:
(1) Three years have passed without recurrence, if the patient was treated with a chest tube re-inflation only, anld CXR and PFT's are normal.
(2) Six months following chemical pleurodesis via tube thoracostomy only, and CXR and PFT's are normal.
(3) Six months following a formal thoracotomy with pleural abrasions, and CXR and PFT's are normal.
(4) Recurrent spontaneous pneumothoraces are permanently disqualifying.
(5) A chamber run is not required of candidates during 1their evaluation.

Designated -May be considered for a waiver if:
(1) One year has passed without recurrence, if the patient was treated with chest tube re-inflation only, and CXR, PFT's and altitude chamber run are normal, or;

(2) Three months following chest tube pleurodesis, and CXR, PFT's, and altitude chamber run are normal, or;

(3) Three months following pleural abrasion which involved a formal thoracotomy with normal CXR, PFT's, and altitude chamber run,

(4) Recurrent pneumothorax requires a definitive procedure.

Breast implants. Candidates and designated female personnel who have undergone augmentation mammoplasty are physically qualified for all duty involving flying, provided a minimum of six weeks has elapsed postoperatively without complication, and the patient presents written clearance from her surgeon to resume unlimited physic,al activity.

Social worker/Psych. Any Mental Health examination of aviation personnel must be performed by a qualified Psychiatrist or Psychologist. This is to include: placement on Medical Boards, Return to Duty, or Consult requests from Flight Surgeons.

CDR C.J. NICKLE
MC, USN
CODE 42, NAMI

MIRACLES DO HAPPEN -- BUT NOT IN UNCORRECTED DVA!

Weekly Scenario: Phone call from CDR Nickle (Code 42): Mr. Fritz "Inspector Javert" Koppy has ferreted out yet another miracle: another aircrewman who has gone from 20/50 to 20/20. What should we do? Deep sigh from me, "Send the fiches over. I'll check into it." Sometimes the answer is obvious; usually it isn't. What has happened? Anyone of a half dozen scenarios. Herewith they are presented.

1. Sloppy paperwork. Corrected DVA went into the first space in Block 59 on SF88 (which is meant for **uncorrected** DVA) instead of the "Corr to 20/" space. **Corrective action:** EMI (or threat of same) for your corpsman.

2. Subject squinted and squeaked out 20/20 line (pinhole effect). **Corrective action:** Better examining techniques. You, or your corpsman, watch the **patient,** not the AFVT or the eye chart. Many myopes squint instinctively to see better - they're not trying to cheat, they just can't help it. If you can't talk patient into stopping the squinting, then just have him move to larger and larger letters until he stops squinting and record **that** figure as the uncorrected DVA (you can write in "without squinting" if you or the patient are the defensive types).

3. Memorization. Don't laugh. It's more common than you would imagine, especially on Snellen Eye Chart. **Corrective Action:** Different eye charts or Good Lites in which there are **100** 20/20 letters -nobody memorizes all these. These are easy ones. Let's go on to tougher problems.

4. Subject wearing contact lenses (either purposely concealin~J the fact or thinking it doesn't matter). **Corrective Action:** Look and identify with slit lamp, have subject rernove them and recheck.

5. Subjeict has undergone radial keratotomy and either denies it or "didn't think it was important." **Corrective Action:** Slit lamp exam shows tell-tale radial corneal scars, usually 4 to 8 in number. Any NAM I trained FS can spot this. It's NPQ.

6. Myope has used pilocarpine to create pinhole pupil (it's happe!ned). **Corrective Action:** Pen Lite exam reveals tiny, fixed pupils. NPQ.

Now let's go to the toughies.

7. Patient undergoing Orthokeratology. This is a procedure in which a rigid contact lens is purposely fitted too flat, in order to flatten the cornea and (temporarily) correct myopia (NPQ). **Correction Action:** Sorry - can't help you much. Experienced eye specialists can sometimesi detect punctate corneal stippling, distorted keratometric mires, or even get a topographic map of the cornea, a videokeratograph (VKG), to aid in detection, but it's not foolproof. Flight Surgeon needs to refer to eye specialist and **alert** the specialist to the marked improvement in uncorrected DVA. Don't accuse, just inquire - why?

8. Excimer Laser Photofractive Keratectomy (PRK). Revolutionary new technique to sculpt the cornea to correct myopia and astigmatism. Even eye specialists are going to have a tough time detecting this, utilizing sophisticated techniques such as contrast sensitivity testing, pachymetry (measuring corneal thickness) and videokeratography. Again, refer this to your friendly eye specialist. '(ou might suspect an ac;ute infection of paranoia in NAMI Code 23 (Ophthalmology), but believe me, we've seen **every single one** of these methods except PRK, and I hope a few of these haven't already slipped past us. Not that any except RK are necessarily permanently NPQ; we just need to **identify** them.

9. Why, you may well ask, would a 20/40 designated naval aviator squint, do orthokeratology, RK, or PRK, when he's PQ SGI with glasses on? Machismo? Inconvenience of spectacles? Look better at the O'Club bar? Lots of reasons, and they **do** these things. The real spooky one is the guy who ortho K's to 20/20 to pass his eye test, but then stops the procedure until his next eye exam, and so flies around for the intervening 11 months with 20/40 VA (hopefully without **you** in the backseat).

PRK is almost certain to be approved by the FDA for general pulblic usage in little over a year and I predict it's going to be wildly popular. Whereas it hasn't yet been decided what the military is going to do about it, we do

want to **know** about it, so be alert. Oh yes, obviously, pay equal attention to the guy who went from 20/30 to 20/70. Find out **why**. You may be doing the patient a **real** favor.

Bottom line: Use plain common sense. There are no miracles in uncorrected visual acuity, and there's **always** an explanation. Try and find it.

CAPT A.S. MARKOVITS, MC, USN
CODE 23, NAMI

FROM THE FLEET

MYOSITIS OSSIFICANS

Myositis ossificans is characterized by heterotopic bone formation as the result of injury, single or multiple, that results initially in a hematoma. This gradually calcifies and then ossifies, with predilection for the deltoid, brachialis, quadriceps, and hamstrings. As the initial swelling and tenderness subside, a firm mass becomes palpable and may cause restriction of motion, paresthesia, or neuropathy. Initial x-rays are poorly defined, but gradually a clearly defined dense mass is seen.

Early aspiration of large, well localized hematomas may prevent maturation, and ice and elevation are recommended initially. Heat and exercise are then used, though vigorous physical therapy may increase disability. If painful or disabling, delayed surgery is recommended after maturation is complete. Premature surgery results in exuberant recurrence.

This lesion is commonly seen as the result of "tacking on the crow" of a Petty Officer Third Class, or the "blood stripe" of a Marine Corporal. Hematomas of the thigh often accompany the latter, from knee jabs to the thigh in the PO3, the lesion is almost always found in the brachial groove, between the deltoid and the brachialis of the left arm. It may be bilateral in Marines, as their rank is worn on both sleeves.

X-ray findings may vary considerably. Rather acute angled, mountain-appearing elevations, exuberant calculus appearing growths, or gently rounded hillocks may be seen. One lesion from nearly twenty years earlier was largely resorbed, but still recognizeable by a thickening of the bone over several inches in the characteristic brachial groove.

This time honored tradition needs to be evaluated in the light of the injury and disability that may result, and should be strongly discouraged. This undoubtedly is an unusual occupational injury, that should be documented on routine physical examinations, especially at separation.

CDR DENNIS DEAKINS, MC, USN
SENIOR MEDICAL OFFICER
U.S.S. INDEPENDENCE (CV-62)

RAMs CORNER

SUNBURN AND GLOC

A mishap always brings about a flurry of activity dedicated to piecing together the preceding sequence of events. Special importance is being placed on the 72 hour history of mishap crew activities. Nutritional status, rest state, personal stressors and medical illness are always given special attention. Any recreational activities that have occurred, particularly those involving outdoor activities such as diving, swimming or water skiing are considered positive signs of health and overall fitness. But are they positive signs of fitness to fly?

Sunburn is the frequent result of outdoor fun, even during this era of raised awareness of the dangers of solar radiation. Aircrew are as susceptible to sunburn as anyone, perhaps more so during early summer, or while on mid-winter southern deployments. More than one aviator has sat in the cockpit following a playful outdoor weekend, wincing as he fastens the restraint harness against sunburned skin, and then lit up the engines and launched.

So, is there a problem? A cursory review of reference texts and recent literature would indicate that it has not been consiidered important enough to merit much attention. Intuitively, a severe sunburn that makes flying impractical would make a 'down chit' mandatory. But, what about the majority of aircrew who appear moderately or even mildly sunburned. Should they be flying?

Many years ago a senior Pensacola Flight Surgeon was confronted with the case of a 21-year-old dive bomber pilot who complained of blackout while flying. He had preiviously been healthy and had experienced no prior difficulties with G tolerance. The referring Flight Surgeon suspected a psychological disturbance. Of note, the pilot had suffered a sunburn the day before the onset of his problem.

The consulting Pensacola Flight Surgeon had been engaged ir1 research involving tilt-table experiments and the effects of low level G manipulation on heart rate and blood pressure. He had demonstrated reduced blackout thresholds, in two other cases involving sunburn, and concluded that the dive bomber pilot suffered from sunburn reduced blackout threshold. On resolution of the sunburn, G tolerance was restored. Based on this and other cases, the Flight Surgeon warned that the failure to associate decreased blackout with sunburn could lead to mismanagement of cases. He recommended that Flight Surgeons be made aware of the phenomenon.

There are two conclusions:

1. In the absence of conflicting data, Flight Surgeons can assume that G-LOC tolerance will be reduced in a sunburned aviator, and should judge fitness to fly accordingly.

2. The old fellows can still teach us a lot.

Reference:

1. Grabiel A, Patterson JL, Packard JM. Sunburn as a cause of temporary lowering of blackout threshold in flyers. J. Aviation Med.:270-5, Aug 1948.

MAJOR BOB BANKS
CANADIAN FORCES, RAM

1992 NAVY AEROMEDICAL PROBLEMS COURSE

The 1992 Aeromedical Problems Course will be held 17 through 20 November at the Naval Aerospace Medical Institute. The course is aimed at operational Flight Surgeons, Aviation Medical Examiners, Aviation Medical Safety Officers, Aerospace Physiologists, Aerospace Experimental Psychologists, Aerospace Medical Technicians, Aerospace Physiology Technicians, and medical researchers. During the course, the attendees will receive an update on aerospace operational requirements and standards as well as knowledge of recent studies which affect the operational flight environment. The heavy demands in the rapidly changing milieu of aerospace medicine require continual updating of the operational specialists' information base and knowledge of current aeromedical problems and standards; attendance is a must if you want to stay current.

You may register for the course using the enclosed registration form. There will be a $5 registration fee. For all officers who are pre-registered, the detailers will bring their Officer Data Cards and allot time for career counseling.

BOQ/BEQ reservations are limited and will be made on a first come/first served basis. If you have any questions, call either ENS Chargois, LCDR Morin, or CAPT Arthur at DSN 922-2457/8 or commercial (904) 452-2457/8.

PLEASE PASS THIS INFORMATION TO YOUR AVTs AND APTs..

NAMI TRAINING NEWS

Student Flight Surgeon Class 92002 graduates and heads to thle Fleet on 25 June 1992. Congratulationss to LT Eric Hansen as the Fox flag recipient and to LCDR Thomas Merry as the Surgeon General's Awardee.

On the Resident in Aerospace Medicine (RAM) front, the following are completing the Masters in Public Health year:

CAPT Gary Reams	UAB
CDR Bill Yauneridge	Univ. of Pittsburgh
CDR Jiml DeVoll	Columbia
LCDR Glenn Merchant	Tulane
LCDR Terry Puckett	Tulane

Fair winds and following seas to the newest Aerospace Medicine Specialists:

CDR Dan Callan	USS Vinson (CVN-70)
CDR Gene Dowell	USS Nimitz (CVN-68)
CDR J.R. Heil	USS Saratoga (CV-60)
LCDR Dave Shiveley	USS America (CV-66)

The Graduate Medical Education Selection Board meets 26-30 October 1992. Those of you interested in an exciting career in Aerospace Medicine need to apply ASAP. Givle me a call for more info and an interview.

CAPT C.I. DALTON
MC, USN
CODE 32, NAMI

ADDRESS CHANGE

NAME _____ RANK _____

STREET _____

CITY _____ STATE _____ ZIP _____

-- EDITORIAL POLICY--

The views expressed are those of the individual authors and not necessarily those of the Society of U.S. Naval Flight Surgeons.

This Newsletter is published quarterly by the Society on the first of January, April, July and October. Material for publication is solicited from the membership and should be typed **double spaced,** reaching the Editor at least one month prior to the scheduled date of publication. Unsigned material will not be considered.

Correspondence should be addressed to:

CAPT CONRAD DALTON, MC, USN
Editor, SUSNFS Newsletter
P.O. Box 33008
NAS Pensacola, FL 32508-3008

1992 AEROMEDICAL PROBLEMS COURSE
REGISTRATION FORM

Name: _____ Rank/Rate: _____
NAME AS YOU WOULD LIKE IT TO APPEAR ON THE CERTIFICATE

Duty station: _____ Telephone: _____

Address: _____

_____

Make checks payable to:
Aeromedical Problems Course

Do you need a BOQ/BEQ reservation? ☐ Yes ☐ No

Course registration fee (mandatory)			$5.00
Coffee & donuts/fruit for the week - Officers	$15	☐	_____
Coffee & donuts/fruit for the week - AVT/APTs	$8	☐	_____
Tuesday evening Officers' social	$8	☐	_____
Tuesday evening AVT/APT dinner	$10	☐	_____
Thursday evening officers' banquet	$25	☐	_____

Total enclosed: _____

Mail to: Problems Course (Code 32), Naval Aerospace Medical Institute, NAS Pensacola, FL 32508