HAS 105F AIR FORCE ADMISSIONS AND DISPOSITIONS PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. Which item is included in Comprehensive Information?

A. Diagnosis

B. Name

C. Rank

D. Date of Admission

2. How can admission/disposition records support continuity of care?

A. By ensuring timely transfer of information to receiving teams, enabling appropriate follow-up and avoidance of gaps in care

B. By increasing paperwork

C. By restricting information sharing

D. By delaying information transfer until after discharge

3. Which determination covers a condition existed prior to service and not aggravated by service?

A. Not In Line of Duty Due to Own Misconduct

B. In Line of Duty

C. Existed Prior to Service, LOD not applicable

D. Not In Line of Duty, Not Due to Own Misconduct

4. The Command Interest Report provides what?

A. A list of all current patients in alphabetic order

B. List of all deaths in the MTF for the specified timeframe

C. VIP Death Report

D. A list of special interest patients

5. Which activity best reflects ongoing quality improvement in admissions and dispositions?

A. Monitoring patient satisfaction alone.

B. Tracking readmission rates without acting on data.

C. Documenting errors without changes.

D. Implementing changes based on measured outcomes.

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6. Which transfer moves a patient from one ward to another within the same hospital?

A. Inter-Ward Transfer

B. Inter-Service Transfer

C. Intra-Ward Transfer

D. Ward Absence

7. Which statement best describes informal LOD processing?

A. Requires a formal investigation

B. Ends with a report to the member

C. Medical Officers Review

D. No Misconduct or Negligence is indicated

8. Which status describes a short ward absence where the patient must report back before 2400 the same day?

A. Ward Absence

B. Subsisting Out

C. Convalescent Leave

D. AWOL

9. What forms of documentation are critical for accurate admissions records?

A. Intake forms, consent forms, vital signs, allergies, medications, procedures, and the physician's orders and discharge instructions.

B. Only the physician's orders.

C. Billing statements and insurance forms.

D. Laboratory reports from the last year.

10. Moving a patient from one service to another within the same ward is called what?

A. Inter-Service Transfer

B. Inter-Ward Transfer

C. In-Patient Transfer

D. Ward Absence

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Answers

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1. A
2. A
3. C
4. D
5. D
6. A
7. D
8. A
9. A
10. A

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Explanations

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1. Which item is included in Comprehensive Information?

A. Diagnosis

B. Name

C. Rank

D. Date of Admission

In medical records, Comprehensive Information centers on the patient's actual health issue and the care it requires. The diagnosis is the key clinical fact because it names the condition driving the treatment, guides the treatment plan, and informs disposition decisions such as level of care, needed specialists, and expected outcomes. Administrative details like the patient's name, rank, or the date of admission identify who the patient is and when they entered care, but they do not convey the medical problem or care needs. So the diagnosis is included in Comprehensive Information because it directly communicates the medical condition that shapes all subsequent decisions.

2. How can admission/disposition records support continuity of care?

A. By ensuring timely transfer of information to receiving teams, enabling appropriate follow-up and avoidance of gaps in care

B. By increasing paperwork

C. By restricting information sharing

D. By delaying information transfer until after discharge

Continuity of care depends on getting the right patient information to the next care team quickly. Admission and disposition records capture essential details at transitions—why the patient came in, current diagnoses, medications, allergies, treatment plans, and discharge or transfer instructions. Providing this data promptly to the receiving team allows them to plan appropriate follow-up, coordinate post-discharge care, perform medication reconciliation, and monitor for issues, which helps prevent gaps in care. Adding more paperwork, restricting information sharing, or delaying information transfer undermines this goal by slowing handoffs or leaving the next team without critical context.

3. Which determination covers a condition existed prior to service and not aggravated by service?

A. Not In Line of Duty Due to Own Misconduct

B. In Line of Duty

C. Existed Prior to Service, LOD not applicable

D. Not In Line of Duty, Not Due to Own Misconduct

The question checks how a condition present before enlistment is classified when it was not aggravated by service. When a medical issue exists prior to joining and service did not worsen it, the appropriate designation is Existed Prior to Service. This label signals that the condition predated the individual's military service and has no service-related aggravation, so a Line of Duty (LOD) determination isn't applicable. If the condition had been worsened by service, it would fall under In Line of Duty; if it were tied to misconduct, other LOD distinctions would apply. But for a pre-existing condition with no aggravation, Existed Prior to Service, LOD not applicable is the correct fit.

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4. The Command Interest Report provides what?

A. A list of all current patients in alphabetic order

B. List of all deaths in the MTF for the specified timeframe

C. VIP Death Report

D. A list of special interest patients

The Command Interest Report is a tool for giving leadership visibility into patients who require command-level awareness and oversight due to special factors—such as sensitive conditions, high visibility, or potential impact on mission or policy. Because of that focus, it provides a targeted list of special interest patients, not a full patient roster or a mortality-specific list. So it's not a complete alphabetical list of current patients, nor a compilation of all deaths in a given timeframe, nor a report limited to VIP deaths. It's specifically designed to flag and track those individuals the command needs to monitor closely.

5. Which activity best reflects ongoing quality improvement in admissions and dispositions?

A. Monitoring patient satisfaction alone.

B. Tracking readmission rates without acting on data.

C. Documenting errors without changes.

D. Implementing changes based on measured outcomes.

Ongoing quality improvement relies on turning measured outcomes into actions that change how admissions and dispositions are handled. The best approach is to implement changes based on what the data show, then re-measure to see if those changes actually improve the process. This creates a continuous feedback loop: collect data, decide on interventions, apply them, and observe the results. Monitoring patient satisfaction alone provides useful feedback but doesn't drive improvement because there's no follow-through to change practices. Tracking readmission rates without acting on the data shows measurement without improvement. Documenting errors without any changes highlights issues but doesn't fix them. Implementing changes based on measured outcomes directly ties data to action, moving the process toward real, ongoing improvement.

6. Which transfer moves a patient from one ward to another within the same hospital?

A. Inter-Ward Transfer

B. Inter-Service Transfer

C. Intra-Ward Transfer

D. Ward Absence

This item tests how hospital movements are named based on where the patient goes. When a patient moves from one ward to a different ward but stays inside the same hospital, the correct term is an inter-ward transfer. It specifies changing location across wards while remaining within the facility. Moving within the same ward would be an intra-ward transfer, which doesn't describe changing wards. Transferring between services or specialties would be inter-service, which isn't about moving to another ward. Leaving the ward entirely would be a ward absence, not a ward-to-ward move. So the inter-ward transfer is the right phrasing for this scenario.

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7. Which statement best describes informal LOD processing?

A. Requires a formal investigation

B. Ends with a report to the member

C. Medical Officers Review

D. No Misconduct or Negligence is indicated

Informal LOD processing is used when there's no indication of fault in the incident—that is, no misconduct or negligence is involved. This path allows a quick determination that the injury or event occurred in the line of duty without any fault on the member's part, so a formal investigation isn't needed. Saying that no misconduct or negligence is indicated captures that outcome and is why this option is the best choice. A formal investigation would be unnecessary in these situations, and the other items describe steps or reviews that aren't inherent to informal processing.

8. Which status describes a short ward absence where the patient must report back before 2400 the same day?

A. Ward Absence

B. Subsisting Out

C. Convalescent Leave

D. AWOL

Managing patient movements on the ward relies on specific statuses to balance care, safety, and bed availability. A short ward absence where the patient must report back before midnight the same day is ward absence. It communicates that the patient is temporarily away from the ward under supervision and is required to return by 2400 to continue care and keep the bed and staff aligned with the schedule. The other options describe different circumstances: leaving without permission is not authorized and would be AWOL; a convalescent leave implies a longer period away for recovery; subsisting out covers a different, longer or non-ward-related arrangement. So this brief, same-day, return-by-2400 scenario fits ward absence best.

9. What forms of documentation are critical for accurate admissions records?

A. Intake forms, consent forms, vital signs, allergies, medications, procedures, and the physician's orders and discharge instructions.

B. Only the physician's orders.

C. Billing statements and insurance forms.

D. Laboratory reports from the last year.

The key idea is that accurate admissions records require a complete set of documents that capture who the patient is, what they need, and how care should proceed. Intake forms establish the patient's identity, reason for admission, medical history, and baseline information. Consent forms document the patient's authorization for treatment and protect both patient and facility legally. Vital signs provide a starting point for assessing current status and monitoring changes. Allergies and medications are essential for safety and proper treatment planning, preventing adverse reactions and ensuring correct drug reconciliation. Procedures and the physician's orders show what has been done and what should happen next, guiding the care team. Discharge instructions outline post-admission plans, follow-up care, and safety steps, which are crucial for a smooth transition and reducing readmission risk. Other options miss important pieces: focusing only on the physician's orders leaves out baseline data and safety checks; billing and insurance forms are administrative, not clinical records; and last year's lab reports may be outdated and don't reflect the current admission needs.

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10. Moving a patient from one service to another within the same ward is called what?

A. Inter-Service Transfer

B. Inter-Ward Transfer

C. In-Patient Transfer

D. Ward Absence

Moving a patient from one service to another within the same ward is an inter-service transfer. Here, the care team switches to a different clinical department or specialty (for example, from medicine to surgery) while the patient stays in the same physical area. The key idea is a change in the service responsible for care, not a change in location. This differs from moving to a different ward (inter-ward transfer) where the patient physically relocates to another ward. It's also broader than an in-patient transfer, which doesn't specify whether the change is in service or location. Ward absence refers to a patient being away from the ward temporarily, not a change in the service providing care.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://has105f.examzify.com

We wish you the very best on your exam journey. You've got this!

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